APPLICATION FOR CHANGING OF BENEFIT

Name of Policyholder: _____

Policy No.: _____

Name of Insured Person: _____

Current Plan: _____

Request to change benefit as below:

	Upgrade	Downgrade	Terminate	Add
Inpatient benefit	☐ _____	☐ _____		
Outpatient benefit	☐ _____	☐ _____	☐ _____	☐ _____
Optional benefit (*)	☐ _____	☐ _____	☐ _____	☐ _____
Treatment Area Limited option (TAL)			☐ _____	☐ _____

(*) If adding Personal accident benefit, please submit the Personal accident insurance application

IMPORTANT NOTE:

FOR THE UPGRADE OF INPATIENT BENEFIT

1. Inpatient benefit(s) of any condition existing before the effective date of upgrading shall continue to be kept at the old benefit which is lower benefit level within the 12 months from the effective date of the upgrade;
2. Upgrade from the old plan which does not have maternity benefit to the new plan which has maternity benefit:
   - 2.1. The maternity benefit shall NOT be qualified for if the insured person:
     - a.) Gives birth within 270 days from the effective date of the upgrade; or
     - b.) Has a miscarriage or therapeutic abortion within 90-days from the effective date of the upgrade.
   - 2.2. If a child of an Insured Person is delivered within 270 days of the upgrade, such child does not qualify for the free New Born Cover benefit under the insurance of this Insured Person.
3. Upgrade from a plan which has maternity benefit to a new plan which has a higher maternity benefit: new plan is applied from the effective date of upgrading.

FOR THE UPGRADE OF INPATIENT AND/ OR OUTPATIENT BENEFIT; ADDITION OF OUTPATIENT BENEFIT

Please advise if any person covered by this request:	YES	NO
1. has undergone any tests, investigations or taken any medications or received any form of treatment recommended or prescribed during the last 12 months?	☐	☐
2. is currently under treatment or observation for any medical condition?	☐	☐
3. has been advised to have any diagnostic test or medical procedure which has not been completed?	☐	☐
4. has incurred any medical expenses which have not yet been fully disclosed to Pacific Cross Vietnam?	☐	☐
5. has exhibited any symptoms in a repeated/ persistent way?	☐	☐

I hereby declare that, to the best of my knowledge and belief, all answers to the foregoing questions are accurate and true. This application and all attachments will be part of the Healthcare Insurance Policy Package.

Signature & name of Insured Person: _____ Date (day/month/year): _____

Signature & name of Policyholder: _____ Date (day/month/year): _____
(if Policyholder is different with Insured Person)