APPLICATION FOR CHANGING OF PRODUCT

Name of Policyholder: _____

Policy No.: _____

Name of Insured Person 1*: _____

Name of Insured Person 2*: _____

Name of Insured Person 3*: _____

Current Plan: _____

Request to change product as below:

CARE ELITE	CE1 - VND 10,000,000,000	CE2 - VND 20,000,000,000
Inpatient	☐	☐
Outpatient	☐	☐
Maternity	☐	☐
Dental	☐	☐
Personal Accident (PA)	Sum Insured Amount: _____	
Discount Options	☐ 20% Co-payment (-25%)	☐ Asia coverage area (-10%)** ☐ Southeast Asia coverage area (-20%)***

CARE CROSS	CC1 - VND 1,000,000,000	CC2 - VND 2,000,000,000	CC3 - VND 5,000,000,000
Inpatient	☐	☐	☐
Outpatient	☐	☐	☐
Maternity	☐	☐	☐
Dental	☐	☐	☐
Personal Accident (PA)	Sum Insured Amount: _____		
Discount Options	☐ 20% Co-payment (-25%)	☐ Asia coverage area (-10%)** ☐ Southeast Asia coverage area (-20%)***	

CARE FIRST	CF1 - VND 100,000,000	CF2 - VND 250,000,000	CF3 - VND 500,000,000
Inpatient	☐	☐	☐
Outpatient	☐	☐	☐
Maternity	☐	☐	☐
Dental			☐
Personal Accident (PA)	Sum Insured Amount: _____		
Discount Options	☐ 20% Co-payment (-25%)		

This application and all attachments will be part of the Healthcare Insurance Policy Package.

Signature & name of Insured Person 1: _____ Date: _____
(day/month/year)

Signature & name of Insured Person 2: _____ Date: _____
(day/month/year)

Signature & name of Insured Person 3: _____ Date: _____
(day/month/year)

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

(*): Please attach the list in case the policy has multiple Insured Persons.
(**): Exclude for Hong Kong, Singapore, and Japan;
(***): Exclude for Singapore.

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