

HEALTHCARE INSURANCE APPLICATION FOR FAMILY

For Health First, Care First

This application form and its contents, as completed by the Insured Person(s), will form a part of and be attached to the policy package:

POLICYHOLDER NAME: _____
BILLING ADDRESS: _____
TEL: _____ **CONTACT EMAIL:** _____
ID NO./TAX CODE: _____

A - INSURED PERSON DETAILS

	INSURED PERSON 1	INSURED PERSON 2	INSURED PERSON 3	INSURED PERSON 4
Full Name	_____	_____	_____	_____
Relationship to Policyholder	_____	_____	_____	_____
Height and Weight	_____ cm _____ kg			
Date of birth (dd/mm/yyyy)	____/____/____	____/____/____	____/____/____	____/____/____
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female			
Occupation	_____	_____	_____	_____
Work description (Ex: office, trading duties, light manual labour, etc.)	_____	_____	_____	_____
Passport/ID No.	_____	_____	_____	_____
Country of Residence	_____	_____	_____	_____
Country of Citizenship	_____	_____	_____	_____
Do you currently smoke or use tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
If you have quit smoking, please state when (mm/yy)	____/____	____/____	____/____	____/____
Tel	_____	_____	_____	_____
Contact Email	_____	_____	_____	_____

For Insured Person under age 03:

	INSURED PERSON 1	INSURED PERSON 2	INSURED PERSON 3	INSURED PERSON 4
In which week of pregnancy was this child born?	_____ Weeks	_____ Weeks	_____ Weeks	_____ Weeks
Height and weight at birth:	_____ cm _____ kg			
Does this child have twin/triplet brother(s) and/or sister(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

B - PLAN SELECTION

HEALTH FIRST	Main Benefit	Medical Benefit						
HF1 - VND 150,000,000	<input type="checkbox"/>							
HF2 - VND 250,000,000	<input type="checkbox"/>							
HF3 - VND 450,000,000	<input type="checkbox"/>							
Dental	<input type="checkbox"/> HF1 <input type="checkbox"/> HF2 <input type="checkbox"/> HF3	<input type="checkbox"/> HF1 <input type="checkbox"/> HF2 <input type="checkbox"/> HF3	<input type="checkbox"/> HF1 <input type="checkbox"/> HF2 <input type="checkbox"/> HF3	<input type="checkbox"/> HF1 <input type="checkbox"/> HF2 <input type="checkbox"/> HF3	<input type="checkbox"/> HF1 <input type="checkbox"/> HF2 <input type="checkbox"/> HF3	<input type="checkbox"/> HF1 <input type="checkbox"/> HF2 <input type="checkbox"/> HF3	<input type="checkbox"/> HF1 <input type="checkbox"/> HF2 <input type="checkbox"/> HF3	<input type="checkbox"/> HF1 <input type="checkbox"/> HF2 <input type="checkbox"/> HF3
Personal Accident	Amount: _____		Amount: _____		Amount: _____		Amount: _____	

CARE FIRST

Inpatient (Main Benefit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CF1 - VND 100,000,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CF2 - VND 250,000,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CF3 - VND 500,000,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Benefit	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3
Outpatient	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3
Maternity	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3	<input type="checkbox"/> CF1 <input type="checkbox"/> CF2 <input type="checkbox"/> CF3
Dental	<input type="checkbox"/> CF3	<input type="checkbox"/> CF3	<input type="checkbox"/> CF3	<input type="checkbox"/> CF3
Personal Accident (PA)	Amount: _____		Amount: _____	
Additional Benefit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20% Co-payment (-25%)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BENEFICIARY INFORMATION

	INSURED PERSON 1	INSURED PERSON 2	INSURED PERSON 3	INSURED PERSON 4
Beneficiary Designation:				
Relationship to Insured Person:				

C - QUESTIONNAIRE

Please answer the questions below (if Insured Person is under 18 years old, parents/ legal guardian are required to complete and sign on behalf of children). We may request additional information based on your response.

	YES	NO
1. Have you had any medical insurance application or policy declined, loaded premium, restricted, or cancelled, at any time in the past? If YES, please state the reason: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had diseases of or been diagnosed with, treated for any conditions related to brain, cancer, heart, blood vessels, liver, lung, kidney and urinary tract, gynecology, stomach, musculoskeletal system, autoimmune diseases, diabetes, orthopedic or psychiatric conditions?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been hospitalized or had any inpatient treatment within the last 03-years?	<input type="checkbox"/>	<input type="checkbox"/>
4. In past 03 years, have you seen a physician, undergone any medical tests or check-ups, taken any medication, or had any other procedures no mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>

D - SUPPLEMENT

If you answered "YES" to any of the above questions 2, 3, 4 in Part C, please give complete the attached "General Questions" form.

INSURED PERSON 1

INSURED PERSON 2

INSURED PERSON 3

INSURED PERSON 4

We hereby declare that

1. The answers and information which I/ We given to Hung Vuong Insurance Corporation and its third party administrator - Pacific Cross Vietnam (hereinafter referred to as "the Company") are true, complete, and correct. I/ We agree and confirm that the answers/ information provided above shall be the basis of the Insurance Policy between the Company and myself/ ourselves. I/ We understand that untruthful information, concealment, or misrepresentation of any significant condition will result in the voiding the Insurance Policy.

2. I/ We have provided complete and accurate personal information to the Company. I/ We know the type of personal data that will be processed as well as the rights and obligations of the data subject in accordance with the law on protection of personal data. I/ We voluntarily and completely agree and allow the Company to process our personal data for the purposes related to this Insurance Policy.

Regarding the information and personal data of relevant data subject which I/ We provided to the Company, I/ We warrant that I/ We have the full approval and consent of the data subject to provide the Company and are fully responsible for providing this information and personal data.

3. I/ We have received, read, understood, and agreed to the Company's Insurance Policy wordings, including coverage terms, exclusions and related conditions.

I/We do confirm that I have received a clear and complete explanation of insurance benefits, be aware of the characteristics of the selected product.

I/ We further understand that the premium is based on the Insured Person residency in Vietnam.

4. I/ We do hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Company any such information. A photographic copy of this authorization shall be valid as the original.

5. I/ We agree to receive any information relating to the Insurance Policy and insurance benefits from Company via Email/ SMS/ MMS/ USSD/ Zalo/ Whatsapp/ Viber and other electronic means.

6. I/ We hereby agree that the Company can:

a. Send information on its products and services as well as other information relating to customer services, to our phone numbers and/or email/mail addresses and

b. Send and store all information related to this Insurance Policy at relevant third-party vendors that provide data processing, storage and/or back-up services to the Company.

SIGNATURE AND NAME:**Policyholder:****Date(dd/mm/yyyy):**

_____/_____/_____

Insured Person 1:**Date(dd/mm/yyyy):**

_____/_____/_____

Insured Person 2:**Date(dd/mm/yyyy):**

_____/_____/_____

Insured Person 3:**Date(dd/mm/yyyy):**

_____/_____/_____

Insured Person 4:**Date(dd/mm/yyyy):**

_____/_____/_____

Agent/Broker:**Date(dd/mm/yyyy):**

_____/_____/_____

Please note:

(i) We will not be able to process your application if any sections are left incomplete or any necessary questions left unanswered.

(ii) Please submit the completed Healthcare insurance application form with your original signature to Company. If the Healthcare insurance application form is not bound at the spine, please sign in each page. We accept the submitting of color images and color scanned files of the Healthcare insurance application form sending by above registered email of each Insured Person.

(iii) Please submit the copy of the Passport/ID, this identifying information is the basis for us to issue the Insurance Policy as well as settle the healthcare insurance benefits to you.