PACIFIC CROSS

HEALTHCARE INSURANCE APPLICATION
For Care Student

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./ PERSONAL IDENTIFICATION NUMBER/ TAX CODE: _____

A - INSURED PERSON DETAILS

Full Name : _____

Relationship to Policyholder: _____ Height: _____ cm Weight: _____ kg

Date of birth (dd/mm/yyyy): _____/_____/_____ Gender: ☐ Male ☐ Female

ID No./ Personal Identification Number/ Tax Code: _____

Country of Residence: _____ Country of Citizenship: _____

Tel: _____ Contact Email: _____

B - PLAN SELECTION

BENEFIT	☐ STANDARD CARE	☐ PREMIER CARE
Inpatient Benefit:	100 million VND/Policy Year	100 million VND/Policy Year
Personal Accident Benefit (PA):	100 million VND/Policy Year	100 million VND/Policy Year
Outpatient Benefit:	Not Applicable	10 million VND/Policy Year

Beneficiary information:

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 Insured Person). 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: _____	☐	☐
2.	Have you ever had diseases of or been diagnosed with, treated for any conditions related to brain, cancer, heart, blood vessels, liver, respiratory diseases and lungs, kidney and urinary tract, gynecology, digestive diseases and stomach, musculoskeletal system, autoimmune diseases, diabetes, orthopedic or psychiatric conditions?	☐	☐
3.	In past 03 years, have you seen a physician, undergone any medical tests or check-ups, taken any medication, inpatient care or had any other procedures no mentioned above?	☐	☐

D - SUPPLEMENT

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

_____

_____

E - DECLARATION

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.

Name and Signature of Insured Person: _____ Date(dd/mm/yyyy): _____/_____/_____
Name and Signature of Policyholder: _____ Date(dd/mm/yyyy): _____/_____/_____
Broker/ Agent: _____

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 or the Policyholder in case the Insured Person is under 18 years old.
(iii) Please submit the copy/photo of the Passport/ ID/ Personal Identification Number, this identifying information is the basis for us to issue the Insurance Policy as well as settle the healthcare insurance benefits to you.