PACIFIC CROSS

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	_____ cm _____ kg	_____ cm _____ kg	_____ cm _____ kg
Date of birth (dd/mm/yyyy)	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If you have quit smoking, please state when (mm/yy)	_____/_____	_____/_____	_____/_____	_____/_____
Tel				
Contact Email				

For Insured Person under age 03:

In which week of pregnancy was this child born?	_____ Weeks	_____ Weeks	_____ Weeks	_____ Weeks
Height and weight at birth:	_____cm _____kg	_____cm _____kg	_____cm _____kg	_____cm _____kg
Does this child have twin/triplet brother(s) and/or sister(s)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

B - PLAN SELECTION

HEALTH FIRST

	Main Benefit	Medical Benefit	Main Benefit	Medical Benefit	Main Benefit	Medical Benefit	Main Benefit	Medical Benefit
HF1 - VND 150,000,000 HF2 - VND 250,000,000 HF3 - VND 450,000,000	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Dental	☐ HF1 ☐ HF2 ☐ HF3		☐ HF1 ☐ HF2 ☐ HF3		☐ HF1 ☐ HF2 ☐ HF3		☐ HF1 ☐ HF2 ☐ HF3	
Personal Accident	Amount: _____		Amount: _____		Amount: _____		Amount: _____	

CARE FIRST

Inpatient (Main Benefit) CF1 - VND 100,000,000 CF2 - VND 250,000,000 CF3 - VND 500,000,000	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Additional Benefit Outpatient Maternity Dental Personal Accident (PA)	☐ CF1 ☐ CF2 ☐ CF3 ☐ CF1 ☐ CF2 ☐ CF3 ☐ CF3 ☐ Amount: _____	☐ CF1 ☐ CF2 ☐ CF3 ☐ CF1 ☐ CF2 ☐ CF3 ☐ CF3 ☐ Amount: _____	☐ CF1 ☐ CF2 ☐ CF3 ☐ CF1 ☐ CF2 ☐ CF3 ☐ CF3 ☐ Amount: _____	☐ CF1 ☐ CF2 ☐ CF3 ☐ CF1 ☐ CF2 ☐ CF3 ☐ CF3 ☐ Amount: _____
Additional Benefit 20% Co-payment (-25%)	☐	☐	☐	☐

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.

		IP* 1		IP* 2		IP* 3		IP* 4	
		Yes	No	Yes	No	Yes	No	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, lung, kidney and urinary tract, gynecology, stomach, musculoskeletal system, autoimmune diseases, diabetes, orthopedic or psychiatric conditions?	☐	☐	☐	☐	☐	☐	☐	☐
3.	Have you been hospitalized or had any inpatient treatment within the last 03-years?	☐	☐	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐	☐	☐

(*) Insured Person

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.

NSURED PERSON 1

NSURED PERSON 2

NSURED PERSON 3

NSURED PERSON 4

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.

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.