

## TERMINATION REQUEST OF HEALTHCARE INSURANCE

**Policyholder name:** \_\_\_\_\_

**Policy No.:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Request to terminate healthcare insurance for:**

All Insured persons of this policy

Insured person (including member no.)

1. ....
2. ....
3. ....
4. ....
5. ....

**Termination date (\*):**.....

**Beneficiary name (in case a refund is available):**.....

**Bank account:** .....

**Beneficiary bank name:** .....

**Branch:** .....

**If designating an Account Holder's Name other than the Policyholder/ Insured's account, please specify the reason**

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In case I designate an Account Holder's Name to receive the refund of insured premium that is not the account of the Policyholder/ Insured under the Policy, I undertake to: be solely responsible for and bear legal liability; undertake not to dispute, claim any content related to the payment by the Company under my appointment under this Form.

**Important note:**

(\*) The termination date written on the endorsement is based on:

(a) The termination date is filled in this request, OR

(b) The date when Pacific Cross Viet Nam receives this request, whichever is later.

The termination date is one of the facts for calculating a refund (if eligible).

**Policyholder**  
(Sign and write your full name)

**Date (dd/mm/yyyy)**