Liberty Insurance
Member of Liberty Mutual Group

Liberty Healthcare

APPLICATION FORM GROUP POLICY

Please write or tick ☐ where applicable

New Application ☐ Change ☐ Renewal ☐

PART I – GROUP INFORMATION

Policy Holder/Company Name: _____

Nature of Business: _____

Business Registration No.: _____

Number of Years In Business: _____

Address: _____

_____

Telephone No.: _____ Fax No: _____

Contact person: _____ Job title: _____

Telephone No.: _____ Email Address: _____

PART II – COVER DETAILS

To be insured: Employees only: ☐ Employees and Dependants: ☐

Definition of staff: _____

Plan Enrolled (Please specify, see (*) Guidance for selection of benefits below):

(*) PLAN AVAILABLE

Basic Cover

H1 - Hospital Plan H1 – Classic
H2 - Hospital Plan H2 – Executive
H3 - Hospital Plan H3 – Premier
H4 - Hospital Plan H3 – Premier **+** Maternity

Optional Cover

O1 - Outpatient
O2 - Outpatient + Dental Benefit

Territorial Scope

Z1 - Zone 1: Worldwide (US$2,000 deductible for treatment in USA/Canada)
Z2 - Zone 2: Vietnam, China, Thailand, Singapore, Taiwan, South Korea, Japan, Malaysia, Indonesia and Philippines
Z3 - Worldwide

Guidance for selection of benefits: H4, O2, Z3 means: You select Hospital Plan H3-Premier + Maternity; Outpatient + Dental Benefit; Worldwide cover.

Requested Effective Date: From: _____ To: _____

Annual Premium: _____

Loading: _____

Discount: _____

Total: _____

Mode of Payment

☐ Cash ☐ Cheque ☐ Bank Transfer

Please note bank charges for remittance will be borne by remitter, please fax or email the bank remittance advice or instruction for reference.

PART III - DECLARATION

DECLARATION I/We understand and agree:

(i) that any misrepresentation or omission contained herein will void the insurance, and any and all claims and benefits there under will be forfeited and waived,

(ii) that Liberty Insurance Ltd will rely on the accuracy and completeness of the information provided herein,

(iii) that no coverage will be effective until this application has been duly accepted in writing by the Company,

(iv) that no modification or waiver relating to this application or the coverage applied for will be binding upon the Company unless approved in writing by an officer of the Company, and

(v) that the Master Policy is issued in Vietnam, and is governed by its laws.

MEDICAL RELEASE I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or financial and employment status, to provide such information to Liberty Insurance Ltd.

_____

Signature of Proposer and Company Stamp
Date:

The liability of the Company does not commence until this Application has been accepted by the Company.

Intermediary: _____ Account No.:_____

Tel No.: _____Fax No.: _____ Email: _____

FOR OFFICE USE ONLY (Underwriting and/or Doctor's Comments):

_____

_____

_____

_____

_____

Full Name	Job title	Date of employment	Gender M/F	Date of Birth (dd/mm/yyyy)	ID No./ Passport No.	Usual Country of Residence	Home Country	Height/ Weight	Plan Enrolled (Please specify, see (*) below)
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