Liberty Insurance
Member of Liberty Mutual Group

Liberty Healthcare

EMPLOYEE APPLICATION FORM
GROUP POLICY

Please write or tick ☐ where applicable

New Application ☐ Change ☐ Renewal ☐

PART I – PERSONAL INFORMATION

Policy Holder/Company Name: AUSTRALIAN CENTRE FOR EDUCATION AND TRAINING

Employee Name: Stephen Tucker

Date of employment: 15th Sep 2009

Job title/Occupation: Teacher

Contact Address: 26 Bich Cau, Dong Da, Hanoi

Telephone No.: +84-936123456 Email Address: stephent@hotmail.com

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

Please enter the names and details of employee and dependants for whom cover is required.

Full Name	Relationship with Employee	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)
Stephen Tucker	Employee	M	30/04/1981	B123456	**Vietnam**	Australia	180cm/76 kg	H1, O1, Z4
Mary James	Wife	F	25/08/1982	B736917	**Vietnam**	Australia	172cm/65 kg	H1, O1, Z4
							/	
							/	

Occupation of Spouse (if any): Housewife

Dependants' cover must be the same plan as the Employee. For dependant children aged 18 to 23, please indicate the name and address of the college or university and number of hours enrolled, supporting document may be required.

(*) 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
O3 - Outpatient with Deductible (*)
O4 - Outpatient with Deductible (*) + Dental Benefit

Territorial Scope

Option 1: Worldwide excluding USA and Canada
Option 2: Vietnam, China, Thailand, Singapore, Taiwan, South Korea, Japan, Malaysia, Indonesia and Philippines

(*) Standard Outpatient deductible is VND500,000 per visit

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: 1st June 2012 To: 31st May 2013

PART II (A) – MEDICAL QUESTIONNAIRE

The questions below must be answered for the applicant and every family member included on the Application. For any question that has been answered "✓ YES" please provide complete details of the medical condition at issue in the text box below this section of the form including the name, address and telephone number of all attending physicians, diagnosis, all treatment dates, types of treatment, prognosis, and present course of treatment. Liberty Insurance Ltd. Reserves the right to request additional medical information.

Please answer each question by clearly ticking one of the corresponding Yes/No boxes.	**Employee** Stephen Tucker		Dependant Mary James		Dependant		Dependant	
	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?	☐	☐x	☐	☐x	☐	☐	☐	☐
2. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	☐	☐x	☐	☐x	☐	☐	☐	☐
3. During the last three years, have you or any applicants been diagnosed of any medical condition or received treatment or have been seeking advice or has been advised to have investigation test, treatment or surgery or do you anticipate testing for any of the following:	☐	☐x	☐	☐x	☐	☐	☐	☐
a. I, cardiac, cardiovascular or circulatory condition?	☐	☐x	☐	☐x	☐	☐	☐	☐
b. Blood Vessels, Arteries, Blood Pressure or Anaemia?	☐	☐x	☐	☐x	☐	☐	☐	☐
c. Migraines, Chronic Headache, Epilepsy or Stroke?	☐	☐x	☐	☐x	☐	☐	☐	☐
d. Diabetes?	☐	☐x	☐	☐x	☐	☐	☐	☐
e. Cancer, Tumour, Cyst, Polyp, Lump or Abnormal Growth of any kind?	☐	☐x	☐	☐x	☐	☐	☐	☐
f. Liver, Stomach, Gall Bladder, Colon, Intestines or Hepatitis?	☐	☐x	☐	☐x	☐	☐	☐	☐
g. Kidney, Prostate, Urinary System?	☐	☐x	☐	☐x	☐	☐	☐	☐
h. Lung, Respiratory System, Asthma or Deviated Nasal Septum?	☐	☐x	☐	☐x	☐	☐	☐	☐
i. Mental, Nervous, Depress, Anxiety or Neurological? Drug abuse or alcoholism?	☐	☐x	☐	☐x	☐	☐	☐	☐
j. Bone or Skeletal, including any disorder of Knee, Hip or Back?	☐	☐x	☐	☐x	☐	☐	☐	☐
k. Reproductive systems, including Maternity?	☐	☐x	☐	☐x	☐	☐	☐	☐
4. Any other illness, injury, impairment or condition of any kind not stated above?	☐	☐x	☐	☐x	☐	☐	☐	☐

5. Address and Telephone of usual doctor.

_____

_____

PART II (B) – MEDICAL QUESTIONNAIRE

This part applies if you have indicated any "Yes" replies in Part II (A). Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply. Use column 3 to list them separately and give the further detailed information required by Column 4 to 6.

1. Name	**2. Relevant Box No.**	**3. Medical Conditions**	**4. Treatment and Conditions received (with date)**	**5. Need for further treatment or consultation**	**6. Present state of Health**

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking this box. ☐

PART III - INSURANCE HISTORY

1. Do you or any family member have any other medical/healthcare insurance in force? Yes ☐ No☐×

   If Yes, please give details:

   (i) Name of Insurer: _____

   (ii) Sum Insured: _____ (iii) Insurance Period: _____

2. Have you ever made a major claim exceeding US$2,500 against any insurer in respect of bodily injury or sickness during the last 3 years? Yes ☐ No☐×

   If Yes, please give details:

   Name of Insurer | Year of Claim | Nature of Claim | Claim Amount

   _____

   _____

   _____

   _____

   _____

3. Have medical/health insurance application or policy for you or any family member ever been declined or accepted with special terms? If Yes, please give details:

   (i) Application declined? Yes ☐ No☐×

   Reason: _____

   (ii) Special terms to insure required? Yes ☐ No☐×

   Reason: _____

   (iii) Renewal cancelled or refused? Yes ☐ No☐×

   Reason: _____

PART IV - DECLARATION

DECLARATION I 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.

CERTIFICATION I hereby certify, represent and warrant:

(i) that I have read the above questions or they have been read to me, and I understand them,

(ii) that my responses to the questions are true, accurate and complete in all respects,

(iii) that I am (we are) currently in good health and, except for the conditions and other information disclosed herein, have not been diagnosed with, treated for, and do not suffer from any pre-existing condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance.

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
Name of Employee: Stephen Tucker
Date: 25th May 2010

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