BAOVIET Insurance
BẢO HIỂM BẢO VIỆT

InterCare

APPLICATION FORM

I. POLICYHOLDER

Full name:	Address:
Occupation:	Telephone No.:

II. PERSONAL INFORMATION OF INSURED PERSONS

Full name	Nationality	ID No. (Passport)	Date of Birth	Gender	Height (m)	Weight (kg)	Schooling* (Y/N)
Insured:	.....	.....	.....	.....	.....	.....	.....
Spouse:	.....	.....	.....	.....	.....	.....	.....
Child:	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....

** Children of over 18 years old shall be only covered under their parents' policy until they are 24 years old if they are taking long-term and full time studying courses and still unmarried.*

III. INCEPTION DATE: ……../ ……../ ……..

IV. INSURED BENEFIT OPTIONS

A. CORE BENEFIT (IN-PATIENT TREATMENT & EMERGENCY MEDICAL EVACUATION)

SELECT ☐ **ESSENTIAL** ☐ **CLASSIC** ☐ **GOLD** ☐ **DIAMOND** ☐

B. OPTIONAL BENEFITS

1. Out-patient Treatment (OP)	☐ Yes	☐ No	*Please choose one of the following plans*:	
SELECT ☐	**ESSENTIAL** ☐	**CLASSIC** ☐	**GOLD** ☐	**DIAMOND** ☐
2. Pregnancy & Childbirth (MA)	☐ Yes	☐ No	*Please choose one of the following plans*:	
SELECT ☐	**ESSENTIAL** ☐	**CLASSIC** ☐	**GOLD** ☐	**DIAMOND** ☐
3. Dental Care (DC)	☐ **SELECT**	☐ **DIAMOND**		
4. Personal Accident (PA)	☐ **VIETNAM**	☐ **WORLDWIDE**		
5. Term Life (TL)	☐ **VIETNAM**	☐ **WORLDWIDE**		

V. PREMIUM: .....

Please select one of the following modes of payment:

Cash ☐ Bank Transfer ☐

If bank transfer is applied, please make payment to the following account:

- Bao Viet Insurance – Bao Viet Saigon Branch
- Address: 233 Dong Khoi, Dist. 1, HCMC
- Account: 007.1.00.001232.2 (VND); 007.1.37.008879.6 (USD)
- Vietcombank – HCMC Branch
- Address: 29 Ben Chuong Duong, Dist. 1, HCMC

VI. HEALTH DECLARATION

1. Have you or any of your family members had any congenital diseases, defect or injury? Yes ☐ No ☐
2. For the past five years, have you or any of your family members ever had any surgical operation, been confined or treated in hospital, sanatorium or other institution or other medical institution or do any of the persons to be insured know any circumstances for which hospital treatment may be necessary in the next twelve months? Yes ☐ No ☐
3. For the past five years, have you or any of your family members ever suffered from or been treated for tuberculosis, diabetes, disease of liver (hepatitis), respiratory or lung functional disorder, heart disease, varicose, hypertension, intestine disorder, gall bladder, kidney, pancreas, genital urinary system or venereal disease, cancer or tumors, growth hormone deficiency, Parkinson, epilepsy, mental or psychiatric disorders, bone, joints (bone marrow), ligament, muscle, skin, hernia or gynaecological disease? Yes ☐ No ☐

If any of the above questions is answered "Yes", please provide details:

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……
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VII. PERSONAL INFORMATION OF THE BENEFICIARY

*Full name:*_____ *Relationship with the Insured:* _____
*Address:*_____

PLEASE SIGN AND RETURN THIS FORM AND PAY THE FULL PREMIUM TO THE INSURANCE COMPANY BEFORE COVER CAN BE GRANTED

Declaration: I hereby apply to be enrolled in the insurance policy together with the person(s) to be insured listed above. I declare to the best of my knowledge and belief that the information given in this Application is true and complete. I acknowledge on behalf of all persons to be insured that we are fully understand the policy's terms and conditions including but not limited to all benefits and exclusions. It is agreed that this declaration and information given in this Application shall form the basis of the contract of insurance issued as a result of this application.

Signature of Applicant (For all insured persons)		Date:

FOR AGENTS ONLY

Please provide other information necessary for our underwriting this proposal, if any

Agent: Cong Ty TNHH BML Services (ehealthscanner)