Liberty Insurance

Liberty Healthcare

APPLICATION FORM

Please write or tick ☐ where applicable

New Application ☐ Change ☐ Renewal ☐

PART I – PERSONAL INFORMATION

Policy Holder Full Name: _____ (e.g Applicant)

Occupation: _____

Contact Address: _____

_____

Telephone No.: _____ Email Address: _____

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

Full Name	Relationship with Policyholder	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)
	P/H						/	
	Spouse						/	
	Child						/	
	Child						/	

Occupation of Spouse (if any): _____

Dependants' cover must be the same plan as the Applicant. 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 ENROLLED

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

Zone 1: Worldwide subject to VND44,000,000 deductibe for any Disability in USA and Canada
Zone 2: Vietnam, China, Thailand, Singapore, Taiwan, South Korea, Japan, Malaysia, Indonesia and Philippines
Zone 3: Worldwide
Zone 4: Worldwide excluding USA and Canada

(*) Standard Outpatient deductible is VND550,000 per visit

(**) The Company shall not provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Company to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United State of America, including Myanmar, Iran, North Korea, Sudan, Syria, Lybia and Cuba.

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: _____

Mode of Payment

☐ Cash ☐ Cheque ☐ Bank Transfer

Loading: _____

Discount: _____

Total: _____

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

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.	**Policyholder**		Name		Name		Name	
	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?	☐	☐	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐	☐	☐
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:	☐	☐	☐	☐	☐	☐	☐	☐
a. I, cardiac, cardiovascular or circulatory condition?	☐	☐	☐	☐	☐	☐	☐	☐
b. Blood Vessels, Arteries, Blood Pressure or Anaemia?	☐	☐	☐	☐	☐	☐	☐	☐
c. Migraines, Chronic Headache, Epilepsy or Stroke?	☐	☐	☐	☐	☐	☐	☐	☐
d. Diabetes?	☐	☐	☐	☐	☐	☐	☐	☐
e. Cancer, Tumour, Cyst, Polyp, Lump or Abnormal Growth of any kind?	☐	☐	☐	☐	☐	☐	☐	☐
f. Liver, Stomach, Gall Bladder, Colon, Intestines or Hepatitis?	☐	☐	☐	☐	☐	☐	☐	☐
g. Kidney, Prostate, Urinary System?	☐	☐	☐	☐	☐	☐	☐	☐
h. Lung, Respiratory System, Asthma or Deviated Nasal Septum?	☐	☐	☐	☐	☐	☐	☐	☐
i. Mental, Nervous, Depress, Anxiety or Neurological? Drug abuse or alcoholism?	☐	☐	☐	☐	☐	☐	☐	☐
j. Bone or Skeletal, including any disorder of Knee, Hip or Back?	☐	☐	☐	☐	☐	☐	☐	☐
k. Reproductive systems, including Maternity?	☐	☐	☐	☐	☐	☐	☐	☐
4. Any other illness, injury, impairment or condition of any kind not stated above?	☐	☐	☐	☐	☐	☐	☐	☐

5. Address and Telephone of usual doctor.

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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 VND55,000,000 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

WE/I DO HEREBY REPRESENT AND WARRANT that the answers/information given above in every respect are true, complete and correct. We/I agree that the answers/information provided above shall be the basis of the Insurance Policy between the Company and ourselves/myself. We/I have received, read, understand and agree to the Company's applicable HealthCare Insurance policy wording, including but not limitation to, coverage terms, exclusions and conditions expressed therein. We/I hereby agree that the Company can (i) send information on its products and services as well as other customer services' information, to our phone numbers and/or email/mail addresses and (ii) provide all information relating to any third party vendors that provide data processing, back-up and/or storage services to the Company.

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 Applicant:
Date:

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

Intermediary: TNHH BML Services Account No.: _____
Tel No.: +84 8 2220 2201 Fax No.: _____ Email: _____

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

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