PACIFIC CROSS VIETNAM

The strength behind your insurance

APPLICATION FOR CHANGE OF BENEFIT (FOR OPTIONAL)

(not applicable for upgrade of benefit)

Policy No.: _____

Name of Policyholder: _____

Address: _____

_____

Name(s) of Insured Person(s): _____

_____

Telephone No.: _____ (H) _____ (O)

Fax No.: _____

Email: _____

New Benefit Requested: _____

Effective Date for Proposed Changes: _____

Remarks: _____

_____

I/We hereby declare that, to the best of my knowledge and belief, all answers to the foregoing questions are correctly and accurately recorded, and that they are full, complete and true. I/We further declare that all persons covered by this request are in good health except as declared herein.

Signature of Policyholder: _____ Date (day/month/year): _____

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