PACIFIC CROSS VIETNAM

The strength behind your insurance

APPLICATION FOR CHANGE OF BENEFIT

(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: _____

_____

_____

Please advise if any person covered by this request:	YES	NO
1. has undergone any tests, investigations or taken any medications or received any form of treatment recommended or prescribed during the last 12 months?	❑	❑
2. is currently under treatment or observation for any medical condition?	❑	❑
3. has been advised to have any diagnostic test or medical procedure which has not been completed?	❑	❑
4. has incurred any medical expenses which have not yet been fully disclosed to **Pacific Cross Vietnam**?	❑	❑
5. has exhibited any symptoms in a repeated/persistent way?	❑	❑

If you answered "Yes" to any of the above questions 1 to 5, please give complete details on a separate sheet.

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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