BLUE CROSS VIETNAM

The strength behind your insurance

HEALTHCARE INSURANCE APPLICATION FORM

CLIENT DETAILS

POLICYHOLDER NAME: _____

Billing Address: _____

Tel: _____ Email: _____

PLAN DETAILS

FOUNDATION SERIES

- ☐ Standard – VND 500,000,000
- ☐ Executive – VND 1,000,000,000
- ☐ Premier – VND 2,000,000,000

Optional Outpatient:

(Client can choose any plan)

- ☐ Standard
- ☐ Executive
- ☐ Premier

Optional Benefits

- ☐ Dental Benefit 1
  (VND 5,000,000/year)
- ☐ Dental Benefit 2
  (VND 10,000,000/year)

MASTER SERIES

- ☐ M1+ – VND 5,000,000,000
  Upgrade Benefits
  - ☐ VND 1,000,000,000 Surgeon's Fee
- ☐ M2 – VND 10,000,000,000
- ☐ M3 – VND 20,000,000,000

Optional Benefits:

- ☐ Dental Benefit (VND 20,000,000/year)
- ☐ Personal Accident; *Unit = VND 200,000,000*
  Sum Insured from 1 billion VND to 10 billion VND
  Amount of PA selected: _____
- ☐ Lifestyle Upgrade 1
- ☐ Lifestyle Upgrade 2

Discount:

- ☐ Treatment Area Limit
  (25% discount)
- ☐ Outpatient Exclusion
  (30% discount)
- ☐ 20% Co-payment
  (25% discount)
- ☐ VND 50,000,000 Inpatient Benefits
  Deductible (20% discount)

SENIOR PLAN

- ☐ SM1 – VND 1,500,000,000
- ☐ SM2 – VND 2,000,000,000
- ☐ SM3 – VND 5,000,000,000

Optional Benefits:

- ☐ Dental (VND 20,000,000/year)
- ☐ Personal Accident; *Unit = VND 200,000,000*
  Sum Insured from 1 billion VND to 10 billion VND
  Amount of PA selected: _____

Discount:

- ☐ Treatment Area Limit
  (25% discount)
- ☐ Outpatient Exclusion
  (30% discount)
- ☐ 20% Co-payment
  (25% discount)

GROUP DISCOUNT

- ☐ 3-4 Insured People: 5% discount
- ☐ 5-10 Insured People: 10% discount
- ☐ 11-20 Insured People: 15% discount
- ☐ 21 Insured People or more: 20% discount

PREMIUM PAYMENT

- ☐ Annual
- ☐ Semi-annual (52% annual)

POLICY EFFECTIVE DATE

(dd/mm/yy):

_____

INSURED NAME (last/middle/first): _____

Tel: _____ Email: _____

Relationship to Policyholder: _____

Height: _____ cm Weight: _____ kg Occupation: _____

Date of Birth (dd/mm/yy): _____

Gender: ☐ Male ☐ Female Smoker: ☐ Yes ☐ No

Passport / ID #: _____ Country of Residence: _____ Country of Citizenship: _____

BENEFICIARY INFORMATION (for Personal Accident Benefit only)

Beneficiary Designation: _____ Relationship: _____

MEDICAL QUESTIONAIRE

Please answer the questions below in respect of each proposed insured person (one person, one completed declaration). For each "Yes" answer please provide all necessary details, include hospital and doctor/surgeon's name, address, and contact details if known. In addition please provide the diagnosis, nature and date of treatment, current status, and other relevant information.

	YES	NO
1. a. Are you currently covered by a medical policy? (include a copy of the policy and benefit schedule)	☐	☐
b. Has any medical or life insurance application been declined, rated, restricted, or cancelled, at any time in the past?	☐	☐
c. Are you currently applying for health, life, or accident insurance with any other company?	☐	☐
2. Have you ever had symptoms of or been diagnosed or treated for any of the following? If yes, please specify by circling or underlining those impairments		
a. Speech defect, paralysis, hearing loss, sight loss, physical defects, congenital or chronic illness related to your sight, hearing or speech?	☐	☐
b. Respiratory or allergic condition, asthma, emphysema, chronic obstructive pulmonary disease, pneumonia, or bronchitis or other breathing problems or disorder of the eyes, ears, nose, or throat?	☐	☐
c. Psychiatric or mental disorder, fainting, black-out, mood change, drug or alcohol addiction, seizure or epilepsy?	☐	☐
d. High/low blood pressure, hypertension, chest pain, heart attack, angina, irregular heart rate, cholesterol problem, dizziness, heart, or circulatory disorder?	☐	☐
e. Kidney stones, veneral disease, or disorder of the bladder, prostate, kidney or genitor-urinary tract?	☐	☐
f. Gastritis, GERD, dyspepsia, stomach or intestinal ulcers, intestinal bleeding, anemia, intestinal polyps, colitis, irritable or inflammatory bowel disorder, persistent or recurrent diarrhea or abdominal pain, gallbladder disease, gallstones, hemorrhoids, hernias, hepatitis, pancreatitis or any other stomach, liver or bowel disorder?	☐	☐
g. Gout, sciatica, neck or back pain, joint pain or rheumatic, arthritis, muscle, joint or bone disease or condition?	☐	☐
h. HIV, AIDS, AIDS Related Complex, or any blood or immune system disease or condition?	☐	☐
i. Skin, hormone, gland disease or condition, diabetes?	☐	☐
j. Injury, illness, disease, or birth defect or condition other than as noted above?	☐	☐

	YES	NO
3. Are you currently taking or have any medications or treatments been recommended or prescribed? (please list)	☐	☐
Do you take:		
a. Insulin or any other blood sugar lowering medicines	☐	☐
b. Blood pressure medicines	☐	☐
c. Blood thinning medicines (anticoagulants), heart medicines	☐	☐
d. Nitro-glycerine or other heart medications	☐	☐
e. Cholesterol lowering medicines	☐	☐
f. Prednisone or breathing medicines (inhaler, nebulizers)	☐	☐
4. Have you been admitted to a hospital, medical centre, clinic, or sanatorium in the past? If so, for what? And for how long, when?	☐	☐
5. Have you been advised to have any medical test or procedure other than as noted in this document? If so, please specify.	☐	☐
6. Have you ever had cancer, tumour, or cyst, or been treated for suspected to have cancer or tumour? If so, please specify.	☐	☐
7. Have you ever had problems with your veins? Arteries? Or nerves? In your legs?	☐	☐
8. Have you ever had a stroke? A mini stroke (TIA)? Or dizzy spells, lost consciousness within the past 10 years? If so, please specify.	☐	☐
9. Have you ever had any surgical operations? If so, for what? And then?	☐	☐
10. Did your parents or siblings (brothers/sisters) die at less than 60 years of age? If yes, what was the cause of death, at what age?	☐	☐
11. WOMEN ONLY: Have you in the past 10 years had a breast disorder, diseases of uterus, ovaries, fallopian tubes, or cervix, menstruation disorder, gynaecological disorder, or pregnancy related disease or complication? If so, please explain.	☐	☐

	YES	NO
12. LIFESTYLE		
a. Do you currently smoke pipes, cigar, or cigarettes, and how many do you smoke per day?	☐	☐
b. Have you ever smoked? If so for how many years?	☐	☐
c. When did you quit? Date:		
d. How many alcohol drinks do you consume in an average week?		
e. Do you drink mainly beer, wine or distilled alcohol?	☐	☐
f. Do you play any sports? Organized?	☐	☐
g. How often? What kind?		
h. Do you wear any equipment? If so please indicate type?	☐	☐
i. Have you ever had any sports injuries? What part of your body? How long ago? What was the treatment?	☐	☐
13. I would like to see if my pre-existing conditions can be covered (additional information may be required).	☐	☐

When you answered "YES" to any of the questions above, please use the space below to provide the necessary detail.

DECLARATION

All the above statements are true and complete, and I understand that the Company, believing them to be such, will rely on them. I further understand that the premium quoted for the plan benefits selected, unless otherwise advised by the Insurance Company or its appointed Administrator, is quoted based on my family and I being resident of Vietnam. I do hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give to Blue Cross Vietnam any such information. A photographic copy of this authorization shall be valid as the original.

Applicant signature: _____ Date: _____

Applicant Name: _____ Broker: _____

Provided by: HUNG VUONG ASSURANCE CORPORATION
Administered by: BLUE CROSS VIETNAM

BHVAssurance
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