PACIFIC CROSS VIETNAM

The strength behind your insurance

HEALTHCARE INSURANCE APPLICATION FORM

CLIENT DETAILS

POLICYHOLDER NAME Mark Edward Jerome

Billing Address 5b-6b, Ngo 21, Van Bao, Ba Dinh, Hanoi, Vietnam

Telephone: +84975325759 Email: markjerome1959@gmail.com

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	☐ M2 VND 10,000,000,000	☐ M3 VND 20,000,000,000
	☐ **Upgrade Benefits** *(VND 1,000,000,000 Surgeon's Fee)*		
OPTIONAL BENEFITS	☐ Dental Benefit 1 *(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 SERIES	☐ SM1 VND 1,500,000,000	☐ SM2 VND 2,000,000,000	☐ SM3 VND 5,000,000,000
OPTIONAL BENEFITS	☐ Dental Benefit 1 *(VND 20,000,000/year)*	☐ Personal Accident; *Unit = VND 20,000,000* *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	PREMIUM PAYMENT	POLICY EFFECTIVE DATE
☐ 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	☐ Annual ☒ Semi-annual (52% annual)	(dd/mm/yy): 24/11/2016

INSURED NAME(last/middle/first) Jerome Edward Mark

Telephone: +84975325759 Email: markjerome1959@gmail.com

Relationship to Policyholder I am the Policyholder

Height 175 cm Weight 90 kg Occupation Consultant

Date of Birth (dd/mm/yy) 02/07/1959

Gender Male Smoker No

Passport / ID #	Country of Residence	Country of Citizenship
511801065	UNITED KINGDOM	VIETNAM

BENEFICIARY INFORMATION (for Personal Accident Benefit only)

Beneficiary Designation: Cat Thi Thuy Hien

Relationship to Insured Person: Wife

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?	☒	☐
a. Speech defect, paralysis, hearing loss, sight loss, physical defects, congenital or chronic illness related to your sight, hearing or speech?	☐	☒
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?	☐	☒

3. Are you currently taking or have any medications or treatments been recommended or prescribed? (please list) ☒ ☐

1. Until recently, I was taking Avodart for my enlarged prostate. I am currently taking Xatral. 2. In the past I have been prescribed statins to help reduce my cholesterol. I came off the prescription a few months ago.

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? ☒ ☐

(1) I had a couple of cases of chest pains and was admitted to a hospital overnight for observation. The last occurrence was in 2009. (2) In 2011, I had influenza while traveling and was in hospital for 3 nights. (3) in 2013, I was admitted to hospital with kidney stones and was there for 1.5 days.

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 when?	☐	☒
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?	☐	☒
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? 2		
e.Do you drink mainly beer, wine or distilled alcohol? 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.

My prostate has been enlarged for about 5-6 years. I am having it monitored regularly and have been prescribed medicine for the last year (Avodart, and now Xatral).
My cholesterol levels have been on the margin between safe and unsafe for some years. I am having them monitored regularly; following medical advice, I have changed my diet and occasionally been prescribed statins to bring my cholesterol levels down.

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 Pacific Cross Vietnam any such information. A photographic copy of this authorization shall be valid as the original.

Applicant signature		Date	24/11/2016
Applicant Name	Mark Edward Jerome	Broker	Adam Stevens

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

HÙNG VƯƠNG ASSURANCE

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