PJICO

# PROPOSAL FORM

## CARE PLUS

*(For Individual and Family Members)*

***Important Note:***

*1. Under Law on Insurance Business of Vietnam or any subsequent amendment, you are required to disclose fully and faithfully all the facts you know or ought to know in respect of the risk that is being applied for the person(s) to be insured, otherwise, policy issued here shall be void.*

*2. Please inform us immediately if any member changes the Principal Country of Residence (**). We reserve the right to adjust the premium or not to continue the cover.*

*3. Please provide a copy of the valid passport/identification (ID) of the applicant/policyholder and the person(s) to be insured.*

### PART 1: PARTICULARS OF THE APPLICANT/POLICYHOLDER

*(Please keep us informed if there is any change in your address or personal details)*

**Family name/Surname:** _____ **First name/Given name:** _____

**Gender:** Male ☐ Female ☐ **Date of birth** *(dd/mm/yyyy)*: _____

**Principal country of residence**:** _____ **Nationality:** _____

**Passport or ID no.:** _____ **Marital status:** Married ☐ Single ☐

**Occupation/Job title:** _____ **Industry:** _____

**E-mail:** _____ **Cell phone:** _____ **Alternative contact number:** _____

**City:** _____ **Province:** _____ **Postal code:** _____

**Residential address in Vietnam*:** _____

**Correspondence address :** _____

*(*) All correspondences will be sent to the residential address unless you have completed the correspondence address.*

### PART 2: FAMILY MEMBERS TO BE COVERED

*(Please complete this section if your family member is eligible for coverage under this policy)*

**Total no. of family members to be covered: (  )**

| | Family Member 1 | Family Member 2 | Family Member 3 | Family Member 4 |
|---|---|---|---|---|
| **Family name/Surname:** | | | | |
| **First name/Given name:** | | | | |
| **Passport or ID no.:** | | | | |
| **Gender:** | Male ☐ Female ☐ | Male ☐ Female ☐ | Male ☐ Female ☐ | Male ☐ Female ☐ |
| **Relationship to the applicant/policyholder:** | Spouse ☐ Child ☐ | Spouse ☐ Child ☐ | Spouse ☐ Child ☐ | Spouse ☐ Child ☐ |
| **Date of birth** *(dd/mm/yyyy)*: | | | | |
| **Nationality:** | | | | |
| **Principal country of residence**:** | | | | |
| **Occupation/Job title:** | | | | |

*(**) The country where the person to be insured lives or intend to live for most of the year being 185 days or more and which will be shown as the address and place of residence in our records.*

## PART 3: CHOICE OF PLAN

When choosing a family plan, the family member must be insured on the same plan with the applicant/policyholder.

**Plan:** A1 ☐ A2 ☐ B1 ☐ B2 ☐ C1 ☐ C2 ☐ D1 ☐ D2 ☐

## PART 4: COVER START DATE

Your cover will begin when you have submitted completed application form and accepted the terms offered by us. If you wish your cover start at a later date, please indicate this below. This date cannot be more than 14 days after the date you complete this form. We cannot backdate cover under any circumstances.

**Preferred cover start date:** _____

*(dd/mm/yyyy)*

## PART 5: EXISTING OR PREVIOUS HEALTH AND OTHER INSURANCE

5.1. Does any of the person to be insured has a current health cover or previously had a health cover with any insurer? Yes ☐ No ☐

5.2. Has any of the person to be insured ever made a claim against any insurer in respect of illness or injury? Yes ☐ No ☐

5.3. Has any of the person to be insured ever had an application, reinstatement or renewal of a Health, Critical Illness, Life or Disability insurance been deferred, declined, rejected, cancelled or accepted on special terms by an insurer? Yes ☐ No ☐

If the answers to Part 5.1, 5.2 and 5.3 is "Yes", please provide details below (including name of the insurance company, scheme/plan name, period of insurance, name of person to be insured and membership number, if available).

_____

_____

_____

_____

## PART 6: CONFIDENTIAL MEDICAL HISTORY *(only applicable to person(s) to be insured)*

| | Applicant/policyholder | Family Member 1 | Family Member 2 | Family Member 3 | Family Member 4 |
|---|---|---|---|---|---|
| **Height (m)** | | | | | |
| **Weight (kg)** | | | | | |

### Medical Questionnaire

*Only person(s) to be insured to complete all the questions. If any of the answer is "Yes", please provide details in Part 7.*

| | Applicant/ policyholder | Family Member 1 | Family Member 2 | Family Member 3 | Family Member 4 |
|---|---|---|---|---|---|
| 6.1. On an average, do/have you smoked more than 30 sticks of cigarettes or tobacco per day? | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 6.2. On an average, do/have you consume more than 15 units of alcoholic drinks per week? 1 unit = 1 can of beer (355ml)/1 glass of wine (125ml)/1 single shot of Spirits (30ml)? | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 6.3. Have you ever been diagnosed or had treatment or has been told to have any health condition (regardless whether a medical practitioner has been consulted) relating to: | | | | | |
| a) Diabetes, kidney failure; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| b) Transient ischaemic attack, stroke, coma; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| c) Autoimmune disorder such as systemic lupus erythematosus (SLE), rheumatoid arthritis, multiple sclerosis; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| d) High blood pressure, raised cholesterol, heart attack, coronary artery disease, ischaemic heart disease, heart murmur, palpitations, heart enlargement, abnormal heart rate, heart failure, or any other heart or heart valvular or blood vessels; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| e) Cancer, leukaemia, brain tumour, any form of cyst, tumour or growth of any kind; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| f) Thyroid disorders; organ transplant e.g. kidneys, bone marrow, cornea; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| g) Asthma, bronchitis, chronic obstructive pulmonary disease, pneumonia or any other breathing or lung disease; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |

| | | | | | |
|---|---|---|---|---|---|
| h) Drug or alcohol addiction or abuse; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| i) Gastritis, gastric or duodenal ulcer, gastro-esophageal reflux disease, heartburn, Crohn's disease, ulcerative colitis; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| j) Epilepsy, fits, paralysis or weakness of limb, head injury or the brain or neurological system; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| k) Depression, anxiety, nervous breakdown, or any form of psychiatric or psychological disorder; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| l) Arthritis, gout, slipped disc, cervical spondylosis, osteoarthritis, osteoporosis or pain/injury to the muscles, limbs, joints, spine, neck; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| m) Anaemia, thalassaemia, blood clot, varicose veins or deep vein thrombosis or any other disorder of the blood; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| n) Hepatitis B(including hepatitis B carrier) or hepatitis C, fatty liver, liver cirrhosis, liver failure, gallstones or any other disorder of the liver or gallbladder; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| o) Kidney stones, kidney infection, recurrent urinary tract infection - i.e. more than 3 times per year; or any other disorder of the kidney, bladder, prostate; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| p) Psoriasis, eczema or any other disorder of the skin; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| q) Ear discharge, otitis media, tonsillitis, cataract, glaucoma, retinal detachment, sinusitis, rhinitis or any disorder of the eye, ear, nose or throat; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| r) Congenital abnormalities, either anatomical or function, premature birth, developmental delay (whether behavioral or psychological); | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| s) **For female person(s) to be insured only** Abnormal pap smear/mammogram/ultrasound, breast lump, fibrocystic disease of the breast, fibroadenoma, breast cyst, ovarian cyst, endometriosis, uterine fibroid, hysterectomy, abnormal pap smear/ mammogram/ ultrasound, cervical/ endometrial polyp, or any other disorder of the breast or female reproductive system; | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 6.4. During the past five (5) years, have you ever had any illness or injury, not mentioned above? | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 6.5. Do you in the coming 12 months have any planned visit with a doctor or a health professional for follow up consultation or to undergo further investigations? (This excludes vaccinations) | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |

## PART 7: ADDITIONAL INFORMATION

If you have answered 'Yes' to any of the questions in Part 6 - Confidential medical history, please provide us more information in the following table. Please complete on a separate page if there is not enough space.

| Question No. | Name of the person(s) to be insured | Nature of illness, disability, diagnostic test with result and reason and treatment received | When did it start? *(mm/yyyy)* | How long did it last? | Need for further treatment? If Yes, please provide more details. | What is the outcome of treatment? *(E.g. still on follow up, still on review, fully discharged by the doctor - no follow up required etc)* |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## PART 8: MEDICAL PRACTITIONER(S) MOST FREQUENTLY VISITED IN THE LAST 5 YEARS

**Medical practitioner(s) name:** _____

**Clinic/Hospital name:** _____

**Address:** _____

**Telephone:** _____ **Fax:** _____ **E-mail:** _____

## PART 9: MODE OF ANNUAL PREMIUM PAYMENT

Please tick one of the following:

Credit Card Payment:

☐ Type of Card: Visa ☐ Master Card ☐ American Express ☐

Card Number: _____

Expiry Date: _____ *(mm/yyyy)*

☐ Bank Transfer: _____

☐ Cheque:

Amount Issued: _____ payable to PJICO.

Cheque no.: _____

Issuing Bank: _____

## PART 10: YOUR SIGNATURE AND DECLARATION

1. I/We hereby apply for Care Plus Policy underwritten by **Petrolimex Insurance Corporation (PJICO).**

2. I/We hereby declare that to the best of my/our knowledge and belief that the statements and answers given in this Proposal Form are true and complete and that I/we have not withheld any material facts, that is, facts likely to influence the assessment and acceptance of this application by PJICO. I/We understand that any mis-statement of facts, whether by commission or by omission may be grounds for PJICO in its absolute and sole discretion to decline to pay any benefit under the Policy and also, to void the Policy. I/We agree that this application, together with any additional statements signed by me/us which shall be deemed to be part of this declaration, shall be the basis of the contract of insurance.

3. I/We agree that if the health status of any of the above mentioned person(s) to be insured changes after this Proposal Form is signed and before PJICO issues the Policy, I/we shall immediately notify PJICO of the changes, otherwise, PJICO reserves the right to void the Policy.

4. I/We have carefully read the Care Plus Policy terms and conditions. I/We agree to accept the terms, conditions, exclusions and limitations stated in the Policy contract.

5. I/We understand and agree that PJICO has the right to accept or decline this application. If PJICO accepts my/our application, I/we agree to let PJICO issue the formal Policy documents.

6. I/We understand that my/our application for this Policy is subject to the acceptance and approval of this application by PJICO.

7. I/We also agree that in case of any claims, I/we authorize any hospital, physician or other person who has attended to us, or has examined us or who is authorized to maintain medical records to disclose, when requested to do so by PJICO, any and all information with respect to any illness or injury, medical history or treatment. A photocopy of this authorization shall be considered as effective and valid as the original.

8. I/We also understand that the membership cards issued for this Policy are to be used only for admissions to hospitals for treatments within the Policy terms and conditions. In the event that charges incurred are not claimable from the Policy for any reason, I/we shall undertake to pay PJICO within 30 days from the receipt of all expenses that are not claimable under the Policy. I/We further agree to return the membership card upon request from PJICO or on termination of the Policy or member.

9. I/We understand that PJICO reserves the right to request for a copy of the latest medical report from me/us at my/our own expense should further medical information is required.

10. I/We confirm that my/our principal county of residence is stated correctly in Part 1 or Part 2 of this form. I/We understand and agree to inform PJICO immediately if any of the member changes the Principal Country of Residence and PJICO reserves the right to revise the premium or to decline to continue the cover.

| **Applicant/Policyholder on and behalf of the person(s) to be insured (Signature and full name)** |
|---|
| Signature: _____<br>Full name: _____<br>Date (dd/mm/yyyy): |

## PART 11: INSURANCE INTERMEDIARY INFORMATION

**Name of Insurance Intermediary:** _____ **Account number** *(if applicable)*: _____

**Company Name** *(where applicable)*: _____

**Telephone:** _____ **Cell phone:** _____ **E-mail:** _____