

PROPOSAL FORM

CARE PLUS

(For Individual and Family Members)

Important Note:

- 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.
- 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.
- 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 <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Relationship to the applicant/policyholder:	Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Spouse <input type="checkbox"/> Child <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Transient ischaemic attack, stroke, coma;	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Autoimmune disorder such as systemic lupus erythematosus (SLE), rheumatoid arthritis, multiple sclerosis;	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Cancer, leukaemia, brain tumour, any form of cyst, tumour or growth of any kind;	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Thyroid disorders; organ transplant e.g. kidneys, bone marrow, cornea;	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) Asthma, bronchitis, chronic obstructive pulmonary disease, pneumonia or any other breathing or lung disease;	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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:

Card Number: _____

Type of Card: Visa Master Card American Express Expiry Date: _____
(mm/yyyy)

Bank Transfer: _____

Cheque: _____ Cheque no.: _____
Amount Issued: _____ payable to PJICO. 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: _____

Full name: _____

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: _____