APPLICATION FORM
FULL MEDICAL UNDERWRITING

MyHEALTH INDIVIDUAL MEDICAL PLANS

www.april-international.com

PTI insurance
BẢO HIỂM BƯU ĐIỆN

april international

I YOUR DETAILS

IMPORTANT NOTICE:

The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardise coverage or invalidate a claim.

APPLICANT'S DETAILS

Family Name: _____

First Name(s): _____

Date of Birth: DD/MM/YYYY **Gender:** ◯ Male ◯ Female **Height (cm):** **Weight (kg):**

Occupation: (specify nature of duties) _____

Smoker: ◯ Yes ◯ No **Marital Status:** _____

Nationality: _____ **ID/ Passport No.:** _____

Residential Address: _____

_____

Postal Code: _____ **Country:** _____

If you wish to use a different mailing address please advise us

Tel.: _____ **Mobile:** _____

Email: _____

Important: this email will be used for sending your policy documents and claims-related communication which may include sensitive medical information. Your membership card(s) will be posted to you and all policy documents sent by email. If you would prefer to have them printed and sent to you, please check this box ☐

FAMILY MEMBERS TO BE INSURED

	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Family Name				
First Name(s)				
Date of Birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Gender	◯ Female ◯ Male	◯ Female ◯ Male	◯ Female ◯ Male	◯ Female ◯ Male
Marital Status				
Relationship to Applicant				
Nationality				
Smoker	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
ID/Passport No.				
Occupation (specify nature of duties)				
Height and Weight	cm kg	cm kg	cm kg	cm kg

Please use separate sheet if necessary. Please advise us if any Family Members to be insured do not live at the Applicant's Residential Address.

CHOOSE YOUR COVER

Step 1: Select your Core Cover

The following core modules form the base of your policy. Each member has the flexibility to select the cover they want.

If family members will have the same cover as the Applicant, please tick here ☐ and complete cover options for the Applicant only.

CORE OPTIONS	APPLICANT	FAMILY MEMBER			
		1	2	3	4
Hospital and Surgery	☐ Essential $100,000 ☐ Essential $500,000 ☐ Extensive ☐ Elite	☐ Essential $100,000 ☐ Essential $500,000 ☐ Extensive ☐ Elite	☐ Essential $100,000 ☐ Essential $500,000 ☐ Extensive ☐ Elite	☐ Essential $100,000 ☐ Essential $500,000 ☐ Extensive ☐ Elite	☐ Essential $100,000 ☐ Essential $500,000 ☐ Extensive ☐ Elite
Annual Deductible	☐ Nil ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000	☐ Nil ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000	☐ Nil ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000	☐ Nil ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000	☐ Nil ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000
	• Your selected deductible applies to the Hospital and Surgery module only.				
Area of Cover	☐ Worldwide ☐ Worldwide excluding USA ☐ ASEAN excluding Singapore	☐ Worldwide ☐ Worldwide excluding USA ☐ ASEAN excluding Singapore	☐ Worldwide ☐ Worldwide excluding USA ☐ ASEAN excluding Singapore	☐ Worldwide ☐ Worldwide excluding USA ☐ ASEAN excluding Singapore	☐ Worldwide ☐ Worldwide excluding USA ☐ ASEAN excluding Singapore
	• The area of cover chosen will apply to all modules selected. • Services rendered outside of the area of cover are covered up to US$50,000 per period of insurance, only if they are directly caused by sudden illness or injury occurring during the first 30 travel days of any trip outside of your area of cover. • Please refer to Clause 4 of the Policy Terms and Conditions.				

Step 2: Select your Optional Modules

The following modules are optional. Each member has the flexibility to select the cover they want.

If family members will have the same cover as the Applicant, please tick here ☐ and complete cover options for the Applicant only.

OPTIONAL MODULES	APPLICANT	FAMILY MEMBER			
		1	2	3	4
Outpatient	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite
Outpatient Co-Insurance	☐ Nil ☐ 20%	☐ Nil ☐ 20%	☐ Nil ☐ 20%	☐ Nil ☐ 20%	☐ Nil ☐ 20%
Dental and/or Optical Optical included with Elite plan only	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite
Maternity	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite
	• **Important:** Available to women between 19 to 45 years of age who have selected at minimum an Extensive or Elite Hospital and Surgery on a NIL deductible basis, plus an optional Outpatient module.				

II UNDERWRITING QUESTIONNAIRE

INSURANCE DETAILS

Have you or any person to be insured ever applied for, been covered under, or held a policy administered by APRIL International / GlobalHealth? If Yes, please give details.	◯ Yes ◯ No
Do you or any person to be insured currently have health insurance with another company? If Yes, please give details and indicate if it will be continued (and if not, as of what date).	◯ Yes ◯ No
Have you or any person to be insured ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused or cancelled, or had any special terms imposed? If Yes, please give details.	◯ Yes ◯ No

MEDICAL DETAILS AND HISTORY

Please indicate if you or any person to be insured have or have ever had any of the **signs, symptoms, illnesses or disorders** below by ticking the appropriate box.

1	Cancer, leukaemia, tumour or neoplasm (including benign growths), cysts including fibrocystic breast disorder, or any blood disorder	◯ Yes ◯ No
2	Asthma, chronic bronchitis, allergies, chronic rhinitis or sinusitis, tuberculosis, any disease or disorder of the lungs	◯ Yes ◯ No
3	Chest pain, raised blood pressure, heart condition, circulatory disorder	◯ Yes ◯ No
4	Indigestion, gastric reflux, gastric ulcer, haemorrhoids	◯ Yes ◯ No
5	Spinal condition, bone fracture, joint injury, back, neck or muscle pain	◯ Yes ◯ No
6	Malaria, dengue fever, other tropical illness	◯ Yes ◯ No
7	HIV/AIDS	◯ Yes ◯ No
8	Kidney Stones, kidney disorder, disorder of the urinary bladder or tract	◯ Yes ◯ No
9	Diabetes, liver disorder, hepatitis	◯ Yes ◯ No
10	Disorder of the brain or nervous system, stroke, aneurysm	◯ Yes ◯ No
11	Mental health problem, anxiety, addiction	◯ Yes ◯ No
12	Gynaecological disorders including pregnancy, irregular periods or bleeding, menstrual pain, complicated pregnancy, HPV infection, or an abnormal smear test result	◯ Yes ◯ No
13	Eczema, dermatitis, disorder of eyes, ears	◯ Yes ◯ No
14	Congenital conditions	◯ Yes ◯ No
15	Any other disorder/injury	◯ Yes ◯ No

If you answered “Yes” in the Medical Details and History section, please provide more information in the table below. You may be required to complete additional questionnaires or provide medical reports, depending on the severity and nature of the condition declared.

Person to be insured	Question no.	Date of first consultation	Details of Medical condition, including nature of treatment, results, date of last consultation,and whether you have fully recovered	Name & Address of doctor, Hospital or health professional consulted	Do you require any follow up treatment or consultation, if so when?
		D D / M M / Y Y Y Y			◯ Yes ◯ No D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y			◯ Yes ◯ No D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y			◯ Yes ◯ No D D / M M / Y Y Y Y

Please provide more details on a separate sheet if required.

16	Except as disclosed elsewhere in this form, have you or any person to be insured ever been admitted to hospital as an inpatient, or (within the last five years) undergone any procedures, scans, or diagnostic tests whether as an inpatient or outpatient? If Yes, please give details.	◯ Yes ◯ No
17	Are you or any person to be insured under medication? If Yes, please state the medicine name, dosage and the approximate cost.	◯ Yes ◯ No
18	Please enter the following details about the usual/family doctor for each person to be insured. If you do not have a usual/family doctor, please provide the names, addresses and contact information of medical providers you and your family members to be insured have seen in the last 3 years. Use a separate sheet if necessary. If you have never seen a doctor in the past 3 years, please indicate that below. Name: _____ Address: _____ _____ Telephone: _____ Fax: _____ Email: _____	

Please provide more details on a separate sheet if required.

ADDITIONAL SPACE FOR FURTHER REMARKS

You may use this space for any further comments about any medical conditions you have or have suffered from. Please remember to enclose any supporting documents with your application.

COMMENCEMENT DATE

☐ On Acceptance
☐ Another date D D / M M / Y Y Y Y
(We cannot backdate cover to a date earlier than the Offer Acceptance Date)

Important: This Individual and Family Application Form is valid for 14 calendar days from date of application signature to date of receipt by APRIL International.

INTERMEDIARY ACCESS

Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account?

◯ Yes ◯ No

Do you authorise us to discuss and/or share claims and medical information with your insurance intermediary?

◯ Yes ◯ No

Intermediary Name: _____ Intermediary Code: _____

Company Name: _____

Telephone: _____ Email: _____

ANNUAL PAYMENT

Currency ◯ VND ◯ USD

Bank Transfer
Please send full payment (inclusive of all bank charges and surcharges) to:

Vietnamese Dong (VND) Account		**US Dollar (USD) Account**	
Beneficiary:	Cong Ty Bao Hiem Buu Dien Sai Gon	Beneficiary:	PTI
Beneficiary Address:	Room 3-2, 3rd Floor, 24C Phan Dang Luu Street,Ward 6, Binh Thanh District, HCMC, Vietnam	Beneficiary Address:	8th Floor, Harec Building, 4A Lang Ha, Hanoi, Vietnam
Account No.	007 100 300 3042	Account No.	030-01-37-022340-7
Bank Name:	Vietcombank – HCM	Bank Name:	Vietnam Maritime Commercial Joint Stock Bank
Bank Address:	M Floor, Vietcombank Tower, No 5 Cong Truong Me Linh, Dist 1, HCM City	Bank Address:	88 Lang Ha Street, Dong Da, Hanoi, Vietnam
Swift Code	BFTVVNVX007	Swift Code	MCOBVNVX

Note:
1. All bank charges will be borne by the remitter.
2. Please indicate your Policy Number as a payment detail to your banker.
3. Please fax +84 28 3841 0577 or email bhcn_saigon@pti.com.vn the bank remittance advice or instruction slip with your Policy Number to PTI for our accounting records and to issue an Official Receipt.

PRODUCER DETAILS (FOR OFFICIAL USE ONLY)

Producer Name

Company Name

Telephone

Email

CLAIM REIMBURSEMENT

Please provide your banking details for claim reimbursement.

Bank Name: _____

Bank Address: _____

A/C Name: _____ A/C No.: _____

Currency: ◯ VND ◯ USD

For all other currencies, please check with APRIL International. For international transfers to a foreign bank, note that your bank may charge you fees for each transaction which will be your responsibility to bear.

The following information must be provided for bank accounts outside Vietnam:

Sort Code: _____

BIC (Swift) Code: _____

Corresponding Bank Details (if applicable): _____

IV DECLARATION BY PROPOSER

I/We declare that the statements contained in this application form are correctly recorded, and that they are full, complete and true. I/We further declare that I have not withheld any material fact and that except as declared herein, all persons to be insured are currently in good health. I/We will notify PTI/APRIL International immediately if after signing this application and before a policy is issued I/We become aware of material facts not disclosed in this form, or if the health of any person to be insured changes such that any answer on this form is not full complete, and true. If a policy is issued to me, this proposal and the statements made herein shall form the basis of the policy between me/us and PTI. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

I/We agree that any information collected or held by PTI/APRIL International (whether contained in the Application or otherwise obtained) may be used and disclosed by PTI/APRIL International Asia to its associated individuals/companies or any independent third parties (within or outside Vietnam) for any matters relating to this application, any policy issued and to provide advice or information concerning products and services which PTI/APRIL International believes may be of interest to me/us and to communicate with me/us for any purpose.

I/We hereby declare that I/We have received, read and understood, or have been advised of and understand, the contents of the brochure and any information material relating to this insurance product.

I/We am/are aware that I/We can seek advice from a qualified advisor before I/We sign this enrolment form. Should I/We choose not to, I/We take sole responsibility to ensure that this product is appropriate to my financial needs and insurance objectives.

I/We authorise PTI/APRIL International to release the names, dates of birth, sex, passport and/or identification number, any information provided on the application and any records PTI/APRIL International may have regarding the Insured person(s) shown on the Namelist to hospitals, clinics, laboratories, physicians, specialists, dentists, chiropractors, acupuncturists, physiotherapists, or other medical practitioners for the purpose of providing direct bill paying services for the insured person(s). By signing this Authority and Release Form, I/We also acknowledge the specific Policy term listed below:

Right of Recovery: In the event of authorisation of payment and/or payment is made by PTI/APRIL International for a claim which is not covered under this Policy or when the limit of liability for this insurance is exceeded, PTI/APRIL International reserves the right to recover the said sum or excess from you. This recovery includes but is not limited to deducting the payments owed from other claims made by you during the policy period. If the amount owed remains outstanding for more than 90 days, then PTI/APRIL International reserves the right to suspend the direct billing service to you without further notice.

Name & Title	Signature	DD/MM/YYYY Date

Important: *The application form must be sent to us within 14 days from this date for your application to be valid.*

Underwritten by:

Saigon Post & Telecommunication Insurance Company
Room 3-2, 3/F, Dali Tower
24C Phan Dang Luu Street, Ward 6, Binh Thanh District,
Ho Chi Minh City, Vietnam
Tel: (+84) 28 3 841 0576 | Fax: (+84) 28 3 841 0577

Arranged and administered by:

GlobalHealth Vietnam Company Limited
An APRIL COMPANY
Unit 201, 2nd Floor, Lafayette Building
8 Phung Khac Khoan Street, Da Kao Ward, District 1
Ho Chi Minh City, Vietnam
Tel: (+84) 28 7307 7985 | Fax: (+84) 28 7307 7987
Email: ops.vn@april.com

PTI insurance
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