

Policy Number: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_  
 Job Title: \_\_\_\_\_  
 Date of Birth (dd/mm/yyyy): \_\_\_\_\_ Gender:  Male  Female  
 Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_  
 Email Address: \_\_\_\_\_

## Dependants

Name	Date of Birth (dd / mm / yyyy)	Gender (M/F)	Height (cm)	Weight (kg)	Occupation

- Have you or any of your dependants consulted a physician in the past 2 years?  No  Yes (explain)  
 \_\_\_\_\_
- Are you or any of your dependants under treatment, special diet, or medication for any illness, injury, or medical condition?  No  Yes (explain)  
 \_\_\_\_\_
- Have you or any of your dependants been advised to undergo any test, treatment, special diet, medication, procedure, checkup, or hospitalisation?  No  Yes (explain)  
 \_\_\_\_\_
- Have you or any of your dependants incurred any medical expense (or other expense covered by the policy) during the past two years which has not been reported to the Company?  No  Yes (explain & state amount)  
 \_\_\_\_\_

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete, and true. I agree that the answers in this form shall be incorporated into the policy and shall, along with statements made in connection with my application and any renewals, form the basis of the reinstated policy.

\_\_\_\_\_  
 Signature of the Insured / Main Applicant  
 (Signature by Policyholder if the insured person is a Minor)

\_\_\_\_\_  
 Date

## Please send completed form to APRIL Vietnam Company Limited

**APRIL Vietnam Company Limited**  
 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 7984  
 Email: ops.vn@april.com