APPLICATION FORM
FULL MEDICAL UNDERWRITING

MyHEALTH INDIVIDUAL MEDICAL PLANS

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Please print only if necessary

Liberty Insurance

april International

YOUR APPLICATION, STEP BY STEP.

This is your application form. Complete it, sign it, send it.

WANT TO SAVE TIME?

The submit button at the end of this form allows you
to send a soft copy for us to start the process.
We will arrange for the signing of the form at a later stage.

An underwriting offer will be provided in **3 working days or less**.

ONCE OUR OFFER HAS BEEN ACCEPTED, IN 5 WORKING DAYS, YOU WILL RECEIVE:

- ☑ Your full member's pack (by email)
  This includes relevant documentation such as claim forms, instructions, terms and conditions, and benefit schedules.
- ☑ You will be able to download your member card containing emergency contact numbers for requesting assistance services or before admission to hospital on our Easy Claim app.

Should you wish to have your member's pack printed and posted to you, please tick here ☐

1. 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 : _____

Usual Country of Residence : _____

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.

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	Male ◯ Female ◯	Male ◯ Female ◯	Male ◯ Female ◯	Male ◯ Female ◯
Marital Status				
Relationship to Applicant				
Nationality				
Smoker	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
ID/Passport No.				
Occupation (Specify nature of duties)				
Height & 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.

2. YOUR COVER

STEP 1	**SELECT YOUR COVER** The following modules form the base of your policy. Each member has the flexibility to select the cover they want. All limits and monetary amounts shall in all instances be in thousands of VNĐ If dependants will have the same cover as the Applicant, please tick here ○ and complete cover options for the Applicant only.				
MODULES	**APPLICANT**	**FAMILY MEMBER 1**	**FAMILY MEMBER 2**	**FAMILY MEMBER 3**	**FAMILY MEMBER 4**
Hospital & Surgery	○ Essential 2,320,000 VNĐ ○ Essential 11,600,000 VNĐ ○ Extensive ○ Elite	○ Essential 2,320,000 VNĐ ○ Essential 11,600,000 VNĐ ○ Extensive ○ Elite	○ Essential 2,320,000 VNĐ ○ Essential 11,600,000 VNĐ ○ Extensive ○ Elite	○ Essential 2,320,000 VNĐ ○ Essential 11,600,000 VNĐ ○ Extensive ○ Elite	○ Essential 2,320,000 VNĐ ○ Essential 11,600,000 VNĐ ○ Extensive ○ Elite
Annual Deductible	○ Nil ○ 11,600 VNĐ ○ 23,500 VNĐ ○ 58,000 VNĐ ○ 116,000 VNĐ ○ 230,000 VNĐ	○ Nil ○ 11,600 VNĐ ○ 23,500 VNĐ ○ 58,000 VNĐ ○ 116,000 VNĐ ○ 230,000 VNĐ	○ Nil ○ 11,600 VNĐ ○ 23,500 VNĐ ○ 58,000 VNĐ ○ 116,000 VNĐ ○ 230,000 VNĐ	○ Nil ○ 11,600 VNĐ ○ 23,500 VNĐ ○ 58,000 VNĐ ○ 116,000 VNĐ ○ 230,000 VNĐ	○ Nil ○ 11,600 VNĐ ○ 23,500 VNĐ ○ 58,000 VNĐ ○ 116,000 VNĐ ○ 230,000 VNĐ
	• Your selected deductible applies to the Hospital and Surgery module only.				
Area of Cover	○ Worldwide ○ Worldwide excluding USA ○ Europe and ASEAN Excluding Singapore	○ Worldwide ○ Worldwide excluding USA ○ Europe and ASEAN Excluding Singapore	○ Worldwide ○ Worldwide excluding USA ○ Europe and ASEAN Excluding Singapore	○ Worldwide ○ Worldwide excluding USA ○ Europe and ASEAN Excluding Singapore	○ Worldwide ○ Worldwide excluding USA ○ Europe and 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 2,320,000 VNĐ 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 ANY OPTIONAL MODULES THAT YOU WISH** The following modules are optional. Each member has the flexibility to select the cover they want. If dependants will have the same cover as the Applicant, please tick here ○ and complete cover options for the Applicant only.				
MODULES	**APPLICANT**	**FAMILY MEMBER 1**	**FAMILY MEMBER 2**	**FAMILY MEMBER 3**	**FAMILY MEMBER 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.				

3. 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? 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, leukemia, tumor or neoplasm, cysts, fibrocystic breast disorder, polyp or growths of any kind	Yes ◯ No ◯
2	Respiratory system: Asthma, bronchitis, allergies, rhinitis or sinusitis, tuberculosis, or other disorder of the respiratory system	Yes ◯ No ◯
3	Circulatory system and blood disorder: Chest pain, raised blood pressure, raised cholesterol, heart condition, or other disorder of the circulatory system or blood	Yes ◯ No ◯
4	Gastrointestinal system: Indigestion, gastric reflux, gastric ulcer, hemorrhoids, hernia, or other disorder of the gastrointestinal system	Yes ◯ No ◯
5	Musculoskeletal: Bone fracture, joint injury, arthritis, back, neck or muscle pain, or other disorder of the spine	Yes ◯ No ◯
6	Tropical illness: Malaria, dengue fever	Yes ◯ No ◯
7	HIV/AIDS	Yes ◯ No ◯
8	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes ◯ No ◯
9	Liver: Diabetes, hepatitis, fatty liver, or other disorder of the liver	Yes ◯ No ◯
10	Thyroid: Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid	Yes ◯ No ◯
11	Brain and nervous system: Stroke, aneurysm, seizures, chronic headache, migraine, or other disorder of the brain or nervous system	Yes ◯ No ◯
12	Anxiety, depression, stress, addiction, or other mental, behavioral, developmental disorder	Yes ◯ No ◯
13	Gynecological system: Pregnancy (including any complication), fibroid, endometriosis, irregular periods or bleeding, menstrual pain, HPV infection, or an abnormal smear test result, or other disorder of the gynecological system	Yes ◯ No ◯
14	Skin: Eczema, dermatitis, psoriasis, wart, or other disorder of skin	Yes ◯ No ◯
15	Eyes and ears: Cataract, glaucoma, otitis, hearing loss, or other disorder of eyes or ears	Yes ◯ No ◯
16	Congenital, hereditary conditions, birth defects, deformities, or conditions affecting mobility	Yes ◯ No ◯
17	Any other disorder/ injury	Yes ◯ No ◯

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

If you answered "Yes" to any of the above, please provide details in the table below. You may be required to provide a further medical questionnaire or medical reports, depending on the severity and nature of the condition declared.

Person to be insured			
Question No.			
Disease/ Medical Condition/ Sign & Symptom			
Date of first occurrence of sign & symptom	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Frequency of sign & symptom			
Treatment Details (including name, date, duration of medication, surgery etc.)			
Date of last follow-up medical consultation/ treatment	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Any on-going, regular, planned or preventive treatment required?			
Any on-going sign or symptom?			

MEDICAL DETAILS AND HISTORY - CONTINUED

18 **Except as disclosed elsewhere in this form, have you or any person to be insured ever been admitted to hospital as an inpatient, or undergone any procedures including endoscopy, biopsy whether as an inpatient or outpatient?**
If Yes, please give details.

Yes ◯ No ◯

19 **In the last five years, have you or any person to be insured been notified of any abnormal test results or awaiting results for any scans or tests performed (e.g. blood or urine test, ECG, endoscopy, X-ray, ultrasound, CT scan, MRI, PET scan etc.)?** Please also answer "yes" if there are any inconclusive or uncertain results (retesting or follow up test required) and abnormal findings that may not require treatment at present (e.g. cyst, joint degeneration, calcification, etc.)

Yes ◯ No ◯

20 **In the last five years, have you or any person to be insured currently taking or been prescribed any medications for a continuous period of more than one month?** If Yes, please state the medicine name, dosage and the approximate cost.

Yes ◯ No ◯

21 **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.

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

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 : DD / MM / YYYY
(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			

CLAIM REIMBURSEMENT

Please provide your banking details for claim reimbursement.

Bank Name			
Bank Address			
A/C Name		A/C No.	
Currency	◯ VNĐ ◯ 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 of Vietnam:			
Sort Code		BIC (Swift) Code	
Corresponding Bank Details (if applicable)			

4. NOTICE TO CUSTOMERS RELATING TO THE PERSONAL DATA ORDINANCE

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 Liberty/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 Liberty. 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 Liberty/APRIL International (whether contained in the Application or otherwise obtained) may be used and disclosed by Liberty/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 Liberty/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 Liberty/APRIL International to release the names, dates of birth, sex, passport and/or identification number, any information provided on the application and any records Liberty/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 Liberty/APRIL International for a claim which is not covered under this Policy or when the limit of liability for this insurance is exceeded, Liberty/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 Liberty/APRIL International reserves the right to suspend the direct billing service to you without further notice.

SIGNATURE

Name : _____

Title : _____

Date : _____

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

5. PAYMENT METHODS

PREMIUM PAYMENT FREQUENCY

Please select the frequency in which you wish to pay your premiums.

	BANK TRANSFER	CREDIT CARD (Visa / Mastercard)
Annual (No Surcharge)	○	○
Semi-Annually (5% Surcharge)	○	○

Important Notice for Semi-Annual Payments: This is an annual policy. You are responsible for the entire annual premium even if you choose to pay by instalments. The premium payment frequency cannot be changed during the policy year, only at renewal provided you notify us in writing. Installments are available for premiums in excess of 70 million VNĐ.

BANK TRANSFER

1. If you have Vietcombank account, please use Insurance Billing Payment

Beneficiary :	Liberty Insurance Limited
Beneficiary Address:	18F, Vincom Office Building, 45A Ly Tu Trong Street, Ward Ben Nghe,District 1, HCMC, Vietnam
Account Number :	044.100.370.8222 (VNĐ) 044.137.370.8250 (USD)
Bank Name :	Vietcombank – Tan Binh Branch
Bank address :	364 Cong Hoa Tan Binh Dist, HCMC,Vietnam
Swift Code :	BFTVVNVX007

2. If you have another bank account, please send full payment to:

Beneficiary :	Liberty Insurance Limited
Beneficiary Address:	18F, Vincom Office Building, 45A Ly Tu Trong Street, Ward Ben Nghe, District 1, HCMC, Vietnam
Account Number :	0301581017 (VNĐ) 0301581009 (USD)
Bank Name :	Citibank – HCM Branch
Bank address :	115 Nguyen Hue, Dist 1, HCMC,Vietnam
Swift Code :	CITIVNVX

1. All bank charges will be borne by the remitter.
2. Please indicate your Policy Number and Debit Note number as a payment detail to your banker.

PAYMENT ONLINE

If you choose to pay your premiums by Online method, you will receive a payment link by email sent to the address you provided on this form.

Underwritten by:

Liberty Insurance Vietnam
Floor 18, Vincom Office Center
45A Ly Tu Trong Street, District 1, Ho Chi Minh City, Vietnam
Hotline 24/7: *1122 or 1800-599-998
Website: www.libertyinsurance.com.vn

Arranged and administered by:

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: contact.vn@april.com

Liberty Insurance

April International

MH VN LVIN 2022/02

SUBMIT YOUR APPLICATION

SUBMIT ELECTRONICALLY

SUBMIT

Click **SUBMIT**
if you want your default email
program to send this document to us.

Alternatively,
save this file and send it to
asia.app@april.com

OR

PRINT, SIGN, EMAIL

PRINT

Send the scanned copy to
asia.app@april.com

Mail to **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