



Liberty Healthcare

APPLICATION FORM GROUP POLICY

Please write or tick where applicable

New Application

Change

Renewal

PART I – GROUP INFORMATION

Policy Holder/Company Name: _____

Nature of Business: _____

Business Registration No.: _____

Information for Red Invoice (include Name of Company, Address, Tax Code, etc.): _____

Number of Years In Business: _____

Address: _____

Telephone No.: _____ Fax No: _____

Contact person: _____ Job title: _____

Telephone No.: _____ Email Address: _____

PART II – COVER DETAILS

To be insured: Employees only:

Employees and Dependants:

Definition of staff: _____

Plan Enrolled (Please specify, see (*) Guidance for selection of benefits below):

(*) PLAN AVAILABLE

Basic Cover

H1 - Hospital Plan H1 – Classic

H2 - Hospital Plan H2 – Executive

H3 - Hospital Plan H3 – Premier

H4 - Hospital Plan H3 – Premier + Maternity

Optional Cover

O1 - Outpatient

O2 - Outpatient + Dental Benefit

O3 - Outpatient with Deductible (*)

O4 - Outpatient with Deductible (*) + Dental Benefit

Territorial Scope

Zone 1: Worldwide subject to VND44,000,000 deductible for any Disability in USA and Canada

Zone 2: Vietnam, China, Thailand, Singapore, Taiwan, South Korea, Japan, Malaysia, Indonesia and Philippines

Zone 3: Worldwide

Zone 4: Worldwide excluding USA and Canada

(*) Standard Outpatient deductible is VND550,000 per visit

(**) The Company shall not provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Company to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United State of America, including Myanmar, Iran, Sudan, North Korea, Syria, Lybia and Cuba.

Guidance for selection of benefits: H4, O2, Z3 means: You select Hospital Plan H3-Premier + Maternity; Outpatient + Dental Benefit; Worldwide cover.

Requested Effective Date: From: _____ To: _____

Annual Premium: _____

Loading: _____

Mode of Payment

Cash

Cheque

Bank Transfer

Discount: _____
Total: _____

Please note bank charges for remittance will be borne by remitter, please fax or email the bank remittance advice or instruction for reference.

PART III - DECLARATION

WE/I DO HEREBY REPRESENT AND WARRANT that the answers/information given above in every respect are true, complete and correct. We/I agree that the answers/information provided above shall be the basis of the Insurance Policy between the Company and ourselves/myself. We/I have received, read, understand and agree to the Company's applicable HealthCare Insurance policy wording, including but not limitation to, coverage terms, exclusions and conditions expressed therein. We/I hereby agree that the Company can (i) send information on its products and services as well as other customer services' information, to our phone numbers and/or email/mail addresses and (ii) provide all information relating to any third party vendors that provide data processing, back-up and/or storage services to the Company.

MEDICAL RELEASE I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or financial and employment status, to provide such information to Liberty Insurance Ltd.

Signature of Proposer and Company Stamp
Date:

The liability of the Company does not commence until this Application has been accepted by the Company.

Intermediary: _____ Account No.: _____
Tel No.: _____ Fax No.: _____ Email: _____

FOR OFFICE USE ONLY (Underwriting and/or Doctor's Comments):

Full Name	Job title	Date of employment	Gender M/F	Date of Birth (dd/mm/yyyy)	ID No./Passport No.	Usual Country of Residence	Home Country	Height/Weight	Plan Enrolled (Please specify, see (*) below)
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