Liberty Insurance Limited
18th Floor, Vincom Building
45A Ly Tu Trong, District 1, Ho Chi Minh City
18th Floor, Vincom Building
45A Ly Tu Trong, Saigon Ward, Ho Chi Minh City (due to merger)
MST: 0304732887
Hotline: 1800 599 998
www.libertyinsurance.com.vn

Liberty HealthCare - Employee/Member of a Sponsoring Organization Application Form - Group Insurance Policy

Please write or tick ☐ where applicable

☐ New Application ☐ Change ☐ Renewal

Part I – GROUP INFORMATION

Policyholder	Name of Employee/Member of a Sponsoring Organization	Date of employment/Member of Sponsoring Organization
_____	_____	_____
Contact Address/	Job title/Occupation *Please provide short description of working environment and daily job./*	
_____	_____	
Telephone No.	Email address	
_____	_____	

Please enter the names and details of Employee/Member of a Sponsoring Organization (Employee) and Dependants for whom coverages are required.

Personal details	Employee		Dependant 1		Dependant 2		Dependant 3	
Full Name								
Relationship with Policyholder								
Gender	☐ Male	☐ Female	☐ Male	☐ Female	☐ Male	☐ Female	☐ Male	☐ Female
Date of Birth (dd/mm/yyyy)								
ID/Passport No. Số								
Usual Country of Residence (*)								
Home Country								

Height/Weight (cm/kg)				
Benefit Plan ("Plan Enrolled")				
Occupation of Spouse (if any) Please provide short description of working environment and daily job.				
Coverage for Dependants must be under the same Plan Enrolled as the principal Insured, excluding territorial scope. For Dependant who are children aged 18 to 23, please indicate the name and address of the college or university and number of hours enrolled, supporting documents may be required.				

(*) Usual Country of Residence
With respect to a person, the country in which such person is living at the date of commencement of cover under the Insurance Policy and which is declared in the Application Form.
Expatriate(s) residing in Vietnam with tourist visa is/are not considered having usual country of residence in Vietnam.

(*) PLAN ENROLLED AVAILABLE

Basic Cover

- H1 - Hospital Plan H1 – Classic
- H2 - Hospital Plan H2 – Executive
- H3 - Hospital Plan H3 – Premier

Optional Cover

- Outpatient 1 - Outpatient VND 110 million
- Outpatient 2 - Outpatient VND 110 million + Dental Benefit
- Outpatient 3 - Outpatient VND 110 million with Deductible (*)
- Outpatient 4 - Outpatient VND 110 million with Deductible (*) + Dental Benefit
- Outpatient 5 - Outpatient VND 24 billion
- Outpatient 6 - Outpatient VND 24 billion + Dental Benefit
- Outpatient 7 - Outpatient VND 24 billion with Deductible (*)
- Outpatient 8 - Outpatient VND 24 billion with Deductible (*) + Dental Benefit

Territorial Scope

- Z1 - Zone 1: Worldwide subject to VND48,000,000 deductible for any Sickness/Disease/Injury in USA and Canada
- Z2 - Zone 2: Vietnam, China, Thailand, Taiwan, South Korea, Japan, Malaysia, Indonesia and Philippines
- Z3 - Zone 3: Worldwide
- Z4 - Zone 4: Worldwide excluding USA and Canada

(*) Standard Outpatient deductible is VND690,000 per Doctor's Visit ("Visit")

Liberty Insurance Limited (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, Vietnamese law.

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Guidance for selection of Plan Enrolled: H1, O2, Z3 means: You select Plan H1 - Classic, Outpatient, Dental Benefit, Worldwide cover.

Requested Effective Date	From	To
Payment method		
☐ Cash	☐ Cheque	☐ Bank Transfer
Please note bank charges for remittance will be borne by remitter, please fax or email the bank remittance advice or instruction for the Company's reference.		

PART II (A)– MEDICAL QUESTIONNAIRE

The questions below must be answered for the Insured and Dependant(s) included on the Application Form. For any question that has been answered"✓ YES" please provide complete details of the medical condition in the text box below in Part II (B) including the name, address and telephone number of all attending physicians, diagnosis, all treatment dates, types of treatment, prognosis, and present course of treatment. The Company reserves the right to request additional medical information.

Please answer each question by clearly ticking one of the corresponding Yes/No boxes	Policyholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
1. Do you or the Dependants have any permanent disablement (**), congenital diseases/malformations, or physical defects?	☐	☐	☐	☐	☐	☐	☐	☐
2. Have you or the Dependants ever tested positive for, been diagnosed with, or been treated for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	☐	☐	☐	☐	☐	☐	☐	☐
3. During the last three years, have you or the Dependants been diagnosed or had treatments or sought of medical consultations or been consulted to do medical examination/treatment/surgery or medical screening tests, or had any signal, symptom to one of the following Sicknesses/Diseases/Injuries:								
a. Heart disease, heart and vascular system? Blood vessels, artery, blood pressure or anemia?	☐	☐	☐	☐	☐	☐	☐	☐

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Please answer each question by clearly ticking one of the corresponding Yes/No boxes	Policyholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
E.g. high/low blood pressure, angina/chest pain, heart attack or heart failure, coronary, anemia, deep vein thrombosis, varicose veins, stroke, etc.								
b. Conditions/diseases of brain or nervous system? E.g. migraine, chronic headache, stroke/Transient Ischemic Attack (TIA), faint, seizure/epilepsy, multiple sclerosis, meningitis, neuritis, etc.	☐	☐	☐	☐	☐	☐	☐	☐
c. Diabetes, thyroid gland, Metabolic syndrome or other endocrine disorders? E.g. hypothyroidism or hyperthyroidism, dyslipidemia, diseases and disorders of pituitary or adrenal gland, etc.	☐	☐	☐	☐	☐	☐	☐	☐
d. Cancer or hyperplasia, tumors, cysts, polyps, oncology or abnormal development of any kind of tumors? E.g. benign hyperplasia or cysts, lymphoma, any kind of cancer or pre-cancer, carcinoma in situ, etc.	☐	☐	☐	☐	☐	☐	☐	☐
e. Liver and hepatitis, stomach, gallbladder, pancreas, colon, intestine or digestive system? E.g. gastritis, Gastroesophageal reflux disease (GERD), liver stenosis, gallbladder stones, pancreatitis, irritable bowel syndrome, colitis, hemorrhoids, chronic diarrhea, Crohn's disease, gastric ulcer, tummy ache, gastrointestinal bleeding, all kinds of herniation, etc.	☐	☐	☐	☐	☐	☐	☐	☐
f. Kidney, bladder, prostate gland, urinary tract, ureter, urethra or Sexual Transmitted Diseases (STD)? E.g. infectious diseases, renal stones, nephritis, renal failure, prostate enlargement, etc.	☐	☐	☐	☐	☐	☐	☐	☐
g. Respiratory system, lung, ears, nose, throat? E.g. pneumonia, bronchitis, tuberculosis, asthma, chronic obstructive pulmonary disease	☐	☐	☐	☐	☐	☐	☐	☐

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Please answer each question by clearly ticking one of the corresponding Yes/No boxes	Policyholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
(COPD), pulmonary alveolus, short of breath, nasal septum deviation, all kinds of respiratory tract allergies, Coronavirus Infection (including Covid-19), hearing impairment/hearing loss, recurrent otitis media, tonsilitis, sinusitis, etc.								
h. Psychiatric or mental conditions, mental illness, insomnia, alcohol and drug addiction or abuse of medications and/or stimulants? E.g. Parkinson, Alzheimer, autism, hydrocephalus, cerebral palsy, paralysis syndrome, schizophrenia, schizotypal disorders, delusional disorders, mental disorders, dementia, intellectual disability, Down syndrome, depression, anxiety, worry, stress, etc.	☐	☐	☐	☐	☐	☐	☐	☐
i. Musculoskeletal and Joints? E.g. cervical pain, back pain, joint pain, disc hernia, sciatica, arthritis, spinal degeneration, knee osteoarthritis, gout, joint replacement, bone fracture, all kinds of meniscus and ligaments, etc.	☐	☐	☐	☐	☐	☐	☐	☐
j. Reproductive system including birth delivery, pregnancy, gynecological or breast conditions/diseases? E.g. irregular menstruation, pelvic organ prolapse, endometriosis, abnormal Pap Smear test results, HPV Infection, diseases and disorders of cervix, uterus, ovaries or fallopian tube, etc.	☐	☐	☐	☐	☐	☐	☐	☐
k. Conditions/diseases/disorders of skin? E.g. eczema, dermatitis, psoriasis, or skin allergy, etc.	☐	☐	☐	☐	☐	☐	☐	☐
l. Conditions/diseases/disorders of eyes? E.g. glaucoma, cataract, retinal detachment, macular degeneration, etc.	☐	☐	☐	☐	☐	☐	☐	☐
4. Any Sickness/Disease/Injury, impairment, deterioration or	☐	☐	☐	☐	☐	☐	☐	☐

Please answer each question by clearly ticking one of the corresponding Yes/No boxes	Policyholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
condition in any form, medical diagnosis or treatment, or having sought or been advised to undergo tests/treatments/surgery or screening tests which have not been mentioned above?								
5. If you have any of the following at present or during the past 21 days (until the date of entry/exit/transit): fever, cough, hard to breathe, sore throat, vomiting, diarrhea, skin hemorrhage, rash?	☐	☐	☐	☐	☐	☐	☐	☐
6. Have you or any Dependants ever undergone gender transition, are currently undergoing gender transition, or plan to gender transition within the next 5 years?	☐	☐	☐	☐	☐	☐	☐	☐
7. Address and Telephone of usual physician _____								

(**)"Permanent Disablement" means the percentage of bodily injury or health damage from 50% and above in accordance with law/managing government in forensic examination, forensic psychiatric examination (or other similar regulations issued by or managing government of health).

PART II (B) - MEDICAL QUESTIONNAIRE

This part applies if you have indicated any “Yes” replies in Part II (A). Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply. Use column 3 to list them separately and give the further detailed information required in columns 4 to 6.

Name (1)	Relevant Box No. (2)	Medical Conditions (3)	Treatment and Conditions received (with date) (4)	Need for further treatment or consultation (5)	Present state of Health (6)

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking this box ☐

PART III – INSURANCE HISTORY

Have you and the Dependants currently been covered under any health/personal accident/life insurance contract (if YES, please provide copy of insurance contracts and benefit table to us).

Have you and the Dependants had any health/personal accident/life insurance application or contracts having been declined, increased premium, limited benefit or cancelled by any insurer? If YES, please provide information.

Have you and Dependants had any claims under health/personal accident/life insurance contract? If YES, please provide information.

PART IV – DECLARATION

We/I do hereby represent and warrant:

1. Our/My answers and information that We/I provided the Company in every respect are true, complete and correct;
2. Our/My answers and information that We/I provided the Company shall be the basis of the Insurance Policy between Us/Me and the Company;
3. We/I have received, read, understood and confirmed that We/I have been advised, explained by and agreed with the Company on all the terms and conditions set out in this Application Form and other documents of the Insurance Policy; and
4. The Company is entitled to process Our/My data, which may include but not limited to basic and sensitive personal data, as follows:

   i. Call to introduce/send information on its products and services as well as other customer services' information, to Our/My phone numbers and/or email/mail addresses; and

   ii. Provide, store and process all information relating to the Insurance Policy to any third-party vendors that provide data processing, back-up, storage and/or services to the Company.

We/I have carefully read, understood and agreed to the Company's privacy policy posted at: https://www.libertyinsurance.com.vn/chinh-sach-rieng-tu; or accessed by QR code:

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We/I also confirm that we have carefully read, understood and agreed to the Regulations on the provision of insurance services and products on the network environment posted at: https://www.libertyinsurance.com.vn/quy-che-cung-cap-san-pham-moi-truong-mang.

AUTHORIZATION OF THE INSURED(S)

We/I hereby irrevocably confirm that Our/My Employer (or the Sponsoring Organization) (as defined in the Liberty HealthCare Insurance Policy Wording) has been duly authorized by Us/Me to act on Our/My behalf in:

1. Paying the premium for the Insurance Policy;
2. Terminating the Insurance Policy when We/I are/am no longer considered as "Actively at Work" for the Employer (or the Sponsoring Organization); and
3. Receiving the remaining premium (if any) after the Insurance Policy terminates in accordance with the Insurance Policy.

CERTIFICATION

We/I hereby certify, represent and commit

1. That We/I have read the above questions or such questions have been read for Us/Me and We/I have understood them,
2. That Our/My answers in every respect are true, complete and correct,
3. That We/I have good health conditions, except the health conditions and other information as declared in this Application Form, have no diagnosis, treatment, and have no illness/pre- existing condition that We/I can foresee requiring medical treatment in the future or We/I intend to lodge a claim under this Insurance Policy.

MEDICAL INFORMATION RELEASE

1. We/I hereby irrevocably agree that We/I have consented 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 Our/My care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or financial and employment status, to provide such information to the Company.
2. BY TICKING THE BOX BELOW, We/I expressly consent that any record or knowledge with reference to my accident, health and/or medical history and/or information of Ours/Mine collected and/or held by the Company (whether contained in this Application Form or otherwise obtained), may be used by and/or disclosed to my current Employer (or Sponsoring Organization), whose name is as below, for the sole purpose of the negotiation between the Company and my current Employer (or Sponsoring Organization) regarding the renewal of the insurance policy under which We are/I am insured.

☐ Name of the Policyholder:

_____

_____ _____

Date

Signature and Name of Employee/ Member of a Sponsoring Organization

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The liability of the Company does not commence until this Application Form has been accepted and an effective Insurance Policy has been entered into by the Company and the Policyholder.

Intermediary _____		Account No. _____
Tel No. _____	Fax No. _____	Email _____
FOR OFFICE USE ONLY (Underwriting and/or Doctor's Comments) _____		