

Personal Accident – Application Form – Individual Policy

Please write or tick ☐ where applicable

New Application

Change

Renewal

1. PERSONAL INFORMATION

Policyholder	Contact Address	Telephone No.
Email address	Job title/Occupation <i>Please provide short description of working environment and daily job.</i>	
Information of VAT Invoice (Address, ID No./Tax code)		
Requested Effective Date	From	To

2. INSURANCE TYPE

Individual	Family
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3. BENEFIT PLAN AND PREMIUM (Unit: VND)

A – INDIVIDUAL Please select 1 among 4 below plans				
Insurance Benefits	Classic	Executive	Premier	Super Premier
Death and Permanent Disablement	200,000,000 /Adult (*)	300,000,000 /Adult (*)	400,000,000 /Adult (*)	500,000,000 /Adult (*)

Personal Accident – Application Form – Individual Policy

Educational Support (Maximum two (2) legal children)	5,000,000 /Minor Child	5,000,000 /Minor Child	5,000,000 /Minor Child	5,000,000 /Minor Child
Tribute Cost	2,000,000 /Insured	2,000,000 /Insured	2,000,000 /Insured	2,000,000 /Insured
Daily Cash Allowances	200,000/Day (Maximum 30 days/Accident, 180 days/Annual Policy)	400,000/Day (Maximum 30 days/Accident, 180 days/Annual Policy)	600,000/Day (Maximum 30 days/Accident, 180 days/Annual Policy)	800,000/Day (Maximum 30 days/Accident, 180 days/Annual Policy)
Medical Expense/Occurrence	20,000,000 /Insured	40,000,000 /Insured	60,000,000 /Insured	80,000,000 /Insured
PREMIUM	651,000	1,201,000	1,889,000	2,696,000

B – FAMILY | Please select 1 among 4 below plans

Insurance Benefits	Classic	Executive	Premier	Super Premier
Death and Permanent Disablement	200,000,000 /Adult (*) 20,000,000 /Dependants (unmarried children)	300,000,000 /Adult (*) 30,000,000 /Dependants (unmarried children)	400,000,000 /Adult (*) 40,000,000 /Dependants (unmarried children)	500,000,000 /Adult (*) 50,000,000 /Dependants (unmarried children)
Educational Support (Maximum two (2) legal children)	5,000,000 /Minor Child	5,000,000 /Minor Child	5,000,000 /Minor Child	5,000,000 /Minor Child
Tribute Cost	2,000,000 /Insured	2,000,000 /Insured	2,000,000 /Insured	2,000,000 /Insured
Daily Cash Allowances (Not applicable for Dependants (unmarried children))	200,000/Day (Maximum 30 days/Accident, 180 days/Annual Policy)	400,000/Day (Maximum 30 days/Accident, 180 days/Annual Policy)	600,000/Day (Maximum 30 days/Accident, 180 days/Annual Policy)	800,000/Day (Maximum 30 days/Accident, 180 days/Annual Policy)
Medical Expense/Occurrence	20,000,000 /Family	40,000,000 /Family	60,000,000 /Family	80,000,000 /Family
PREMIUM	1,356,000	2,483,000	3,885,000	5,526,000

(*) Note: Adult is Individual from 18 years of age and above (except Dependants (unmarried children))

4. INSURED LIST

Personal details	Policyholder		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)								

Personal Accident – Application Form – Individual Policy

ID/Passport No.				
Occupation				
Usual Country of Residence (**)				
Home Country				

Coverage for Dependants must be under the same plan as the principal Insured. For Dependants 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 Vietnam as their Usual Country of Residence.

5. BENEFICIARY INFORMATION (Applicable in case of Death of the Insured)

Personal details	Policyholder	Dependant 1	Dependant 2	Dependant 3
Beneficiary Name				
Relationship with Insured				
ID/Passport No.				
Contact Address				

6. 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.		

7. ACCIDENT HISTORY

Please give particulars of all accidents during the last 3 years		
Date of Accident	Nature of Accident	Amount of Loss (VND)

Personal Accident – Application Form – Individual Policy

8. 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:



We/I also confirm that We/I 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>.

9. 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.

10. MEDICAL INFORMATION RELEASE

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.

Date

Signature and Name of Policyholder

Personal Accident – Application Form – Individual Policy

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)		