Application Form

Continuous Personal Medical Exclusions

MyHEALTH Individual Medical Plans

Download our Easy Claim mobile app for quicker claims reimbursement!

Available on the App Store

GET IT ON Google play

april-international.com

Please print only if necessary

pti Insurance

april International
INSURANCE MADE EASY

YOUR APPLICATION, STEP BY STEP.

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

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.

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. You are applying for **Continuous Personal Medical Exclusions (CPME)**, which means that any special terms, exclusions or loadings on your current/expiring health insurance policy will be carried over and applied to your new MyHEALTH policy.

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. 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 $100,000 ○ Essential $500,000 ○ Extensive ○ Elite	○ Essential $100,000 ○ Essential $500,000 ○ Extensive ○ Elite	○ Essential $100,000 ○ Essential $500,000 ○ Extensive ○ Elite	○ Essential $100,000 ○ Essential $500,000 ○ Extensive ○ Elite	○ Essential $100,000 ○ Essential $500,000 ○ Extensive ○ Elite
Annual Deductible	○ Nil ○ USD 500 ○ USD 1,000 ○ USD 2,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,000 ○ USD 2,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,000 ○ USD 2,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,000 ○ USD 2,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,000 ○ USD 2,500 ○ USD 5,000 ○ USD 10,000
	• 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 US$100,000 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 AND MEDICAL DETAILS	If the answer is Yes to any of the following questions, please provide full details.

Do you or any person to be insured currently have health insurance with another company?
If Yes, please provide details and attach all existing insurance certificates, schedules and endorsement relating to all persons to be insured. CPME is only available to persons currently covered by an equivalent international medical insurance policy.

Yes ○ No ○

Do you and any person to be insured have or have ever had any signs, symptoms, treatments, consultations, investigations, diagnostic tests for cancer?

Yes ○ No ○

Have you or any person to be insured been suffering from chronic conditions such as but not limited to polyps, cysts, asthma, heart conditions, cerebral infarction/stroke, brain multiple sclerosis, renal failure, liver cirrhosis, autoimmune disease, joint replacement, severe mental illness/Alzheimer's, Parkinson, Epilepsy, Down syndrome? Or ever made a claim against your insurance in relation to chronic conditions?

Yes ○ No ○

Chronic condition : A disease, illness or injury that has one or more of the following characteristics:
a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests; or
b. it needs ongoing or long-term control or relief of symptoms; or
c. you need to be rehabilitated or specially trained to cope with it; or
d. it continues indefinitely; or
e. it has no known cure; or
f. it comes back or is likely to come back.

Do you or any person to be insured have any recent (12 months) hospitalisations or plan of surgery or treatment/consultation for cancer and/or chronic conditions?

Yes ○ No ○

Is anyone to be covered on this plan currently pregnant?

Yes ○ No ○

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

Date : DD / MM / YYYY

We cannot backdate cover to a date earlier than the date you accept our final offer.

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 ○
Producer Name		Producer 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	○ VND ○ 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. PAYMENT METHODS

PREMIUM PAYMENT FREQUENCY

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

	CREDIT CARD (Visa / Mastercard)	BANK TRANSFER
Annual (No Surcharge)	○	○
Semi-Annually (5% Surcharge)	○	Not Available
Quarterly (5% Surcharge)	○	Not Available

Important Notice for Semi-Annual & Quarterly 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. The credit card you authorise below must be valid for at least 15 months and will be used to automatically collect instalment premiums when due.

CREDIT CARD AUTHORISATION (ANNUAL, SEMI-ANNUALLY AND QUARTERLY)

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

I/we, the undersigned, authorise PTI/April International to charge my credit card for premiums due, unless I advise otherwise in writing.

SIGNATURE	
	Note: The actual processed deduction by the credit card centre will be considered as valid payment. **For existing policyholders:** If your prior authorisation to **PTI/April International** to charge your credit card for renewals and the credit card details are still valid, you do not need to complete this form. We will rely on your credit card details on file.
Date :	

Please send the completed credit card authorisation 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
Tel: (+84) 28 7307 7984
Email: contact.vn@april.com

4. PAYMENT METHODS - CONTINUED

BANK TRANSFER (ANNUAL PAYMENT ONLY)

- Please send full payment (inclusive of all bank charges) to

Vietnamese Dong (VND) Account

Beneficiary :	TONG CONG TY CO PHAN BAO HIEM BUU DIEN
Beneficiary Address:	95 Tran Thai Tong Street, Dich Vong Ward, Cau Giay District, Hanoi City, Vietnam
Account Number :	011-01-01-666868-6
Bank Name :	Vietnam Maritime Commercial Joint Stock Bank
Bank address :	No. 54A, Nguyen Chi Thanh Street, Lang Thuong, Dong Da, Hanoi
Swift Code :	MCOBVNVX

US Dollar (USD) Account

Beneficiary :	PTI
Beneficiary Address:	8th Floor, Harec Building, 4A Lang Ha,Hanoi, Vietnam
Account Number :	030-01-37-022340-7
Bank Name :	Vietnam Maritime Commercial Joint Stock Bank
Bank address :	88 Lang Ha Street, Dong Da, Hanoi, Vietnam
Swift Code :	MCOBVNVX

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 ban .
3. Please fax +84 28 3841 0577 or email bhcn_saigon@pti.com.vn the bank remittance advice or instruction slip with your Policy Number to PTI for our accounting records and to issue an Official Receipt.

PRODUCER DETAILS (FOR OFFICIAL USE ONLY)

Producer Name			
Company Name			
Telephone		Email	

5. 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 PTI/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 PTI. 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 PTI/APRIL International (whether contained in the Application or otherwise obtained) may be used and disclosed by PTI/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 PTI/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 PTI/APRIL International to release the names, dates of birth, sex, passport and/or identification number, any information provided on the application and any records PTI/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 PTI/APRIL International for a claim which is not covered under this Policy or when the limit of liability for this insurance is exceeded, PTI/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 PTI/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.

Underwritten by:

Post Telecommunication Joint Stock Insurance Corporation (PTI)
No. 95 Tran Thai Tong Street, Dich Vong Ward, Cau Giay District,
Hanoi, Vietnam
Tel: (+84) 28 3 841 0576
Fax: (+84) 28 3 841 0577

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

MH VN 2024/07

SUBMIT YOUR APPLICATION

SUBMIT ELECTRONICALLY

SUBMIT

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