Application Form

Full Medical Underwriting

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

PVI 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 invalidate a claim, impact premium or entitle the insurer to declare the insurance contract void.

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 : _____

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 USD 100,000 Essential USD 500,000 Extensive Elite	Essential USD 100,000 Essential USD 500,000 Extensive Elite	Essential USD 100,000 Essential USD 500,000 Extensive Elite	Essential USD 100,000 Essential USD 500,000 Extensive Elite	Essential USD 100,000 Essential USD 500,000 Extensive Elite
	• The Hospital & Surgery Essential $100,000 module is exclusively available as a standalone option and cannot be combined with other modules. • 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 5 of the Policy Terms and Conditions.				
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 5 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	○ 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.

	BANK CARD (Debit/Credit/ATM cards issued in Vietnam)	BANK TRANSFER
Annual (No Surcharge)	◎	◎
Semi-Annually (5% Surcharge)	◎	◎
Quarterly (5% Surcharge)	◎	◎

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.

Please note that installment payments by card are not automatic. For each payment installment, PVI Insurance will send you a debit note detailing the payment information for bank transfers and card payments, or a payment link for direct card payments.

BANK TRANSFER

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

Vietnamese Dong (VND) Account

Beneficiary :	TCT BAO HIEM PVI - CHI NHANH BAO HIEM PVI DONG KHOI
Beneficiary Address:	8th floor, HMC Building, No. 193, Dinh Tien Hoang Street, Da Kao Ward, District 1, Ho Chi Minh City
Account Number :	666 888 79798
Bank Name :	Asia Commercial Bank - Thong Nhat Sub -Branch
Bank address :	No. 529, Thong Nhat Street, Ward 16, Go Vap District, Ho Chi Minh City
Swift Code :	ASCBVNVX

US Dollar (USD) Account

Beneficiary :	TCT BH PVI – CN BAO HIEM PVI DONG KHOI
Beneficiary Address:	8th floor, HMC Building, No. 193, Dinh Tien Hoang Street, Da Kao Ward, District 1, Ho Chi Minh City
Account Number :	105 059 9037
Bank Name :	Joint Stock Commercial Bank for Foreign Trade of Vietnam – Tan Dinh Branch
Bank address :	72 Pham Ngoc Thach Street, Vo Thi Sau Ward, District 3, Ho Chi Minh City, Vietnam
Swift Code :	BFTVVNVX037
Bank Code:	79203009

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.
3. Please fax (028) 36 223 283 or email globalhealthcare@pvi.com.vn the bank remittance advice or instruction slip with your Policy Number to PVI for our accounting records and to issue an Official Receipt.

VAT INVOICE REQUEST

Please complete the information below if you would like to request a VAT invoice to pay your premiums.

Name:	
Address:	
Tax code: (not applicable for Individual):	

5. NOTICE TO CUSTOMERS RELATING TO THE PERSONAL DATA ORDINANCE

PERSONAL DATA PROTECTION STATEMENT

I give consent to PVI Insurance, April Vietnam Company Limited, and their third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data (general personal data and sensitive personal data) relating to myself or other individuals that I have furnished via any means for one or more of the purposes and in the manners described in **PVI Insurance Privacy Policy** and **APRIL Vietnam Limited Privacy Notice**.The Company has explained, and I have understood clearly the obligations of data subjects stated in Article 10 and the rights of personal data subjects stated in Article 9 of Decree 13/2023/ND-CP and other legislation documents amend/ supplement Decree 13/2023/ND-CP (if any). If there is any personal data relating not to myself but to other individuals that I have furnished via any means in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for PVI Insurance and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform PVI Insurance of any changes to the personal data to my knowledge as soon as practicable.

CUSTOMER DECLARATIONS

1. I/We hereby confirm this declaration is correct and consent to disclose personal data to APRIL and the Insurer.
2. I/We (and my dependents where applicable) have read, understand, and agree with **PVI Insurance Privacy Policy** and **APRIL Vietnam Limited Privacy Notice**, and if my dependents are minors, I am providing such consent as parent or legal guardian of such minors.
3. I/We (and my dependents where applicable) have read, understand, and agree to the Brochure, Policy Terms and Conditions, and Benefits Schedule.
4. I/We am/are aware that I/We can seek advice from a qualified advisor before I/We sign this 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.
5. I/We hereby agree to the use and validity of electronics signature as well as electronic means to receive information and conduct certain electronic transactions concerning and as described in this application.

☐ I/We do not wish to receive any marketing communications from APRIL or its affiliates.

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.

Insured by:

PVI Insurance Dong Khoi Branch
8th floor, HMC Building,
193 Dinh Tien Hoang Street, Da Kao Ward, District 1
Ho Chi Minh City, Vietnam
Email: globalhealthcare@pvi.com.vn
Tel: (028) 36 223 289
Fax: (028) 36 223 283

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
Email: contact.vn@april.com
Tel: (+84) 28 7307 7984

MH VN 2024/11

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