

Application Form

Full Medical Underwriting

MyHEALTH Individual Medical Plans

Download our Easy Claim mobile app
for quicker claims reimbursement!



 april-international.com

Please print only if necessary



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.

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 | <u>DD / MM / YYYY</u> | <u>DD / MM / YYYY</u> | <u>DD / MM / YYYY</u> | <u>DD / MM / YYYY</u> |
| Gender | Male <input type="radio"/> Female <input type="radio"/> | Male <input type="radio"/> Female <input type="radio"/> | Male <input type="radio"/> Female <input type="radio"/> | Male <input type="radio"/> Female <input type="radio"/> |
| Marital Status | | | | |
| Relationship to Applicant | | | | |
| Nationality | | | | |
| Smoker | Yes <input type="radio"/> No <input type="radio"/> | Yes <input type="radio"/> No <input type="radio"/> | Yes <input type="radio"/> No <input type="radio"/> | Yes <input type="radio"/> No <input type="radio"/> |
| 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 <input type="radio"/> and complete cover options for the Applicant only. | | | | | |
| MODULES | APPLICANT | FAMILY MEMBER 1 | FAMILY MEMBER 2 | FAMILY MEMBER 3 | FAMILY MEMBER 4 |
| Hospital & Surgery | <input type="radio"/> Essential \$100,000 <input type="radio"/> Essential \$500,000 <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential \$100,000 <input type="radio"/> Essential \$500,000 <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential \$100,000 <input type="radio"/> Essential \$500,000 <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential \$100,000 <input type="radio"/> Essential \$500,000 <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential \$100,000 <input type="radio"/> Essential \$500,000 <input type="radio"/> Extensive <input type="radio"/> Elite |
| Annual Deductible | <input type="radio"/> Nil <input type="radio"/> USD 500 <input type="radio"/> USD 1,000 <input type="radio"/> USD 2,500 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 | <input type="radio"/> Nil <input type="radio"/> USD 500 <input type="radio"/> USD 1,000 <input type="radio"/> USD 2,500 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 | <input type="radio"/> Nil <input type="radio"/> USD 500 <input type="radio"/> USD 1,000 <input type="radio"/> USD 2,500 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 | <input type="radio"/> Nil <input type="radio"/> USD 500 <input type="radio"/> USD 1,000 <input type="radio"/> USD 2,500 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 | <input type="radio"/> Nil <input type="radio"/> USD 500 <input type="radio"/> USD 1,000 <input type="radio"/> USD 2,500 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 |
| <ul style="list-style-type: none"> Your selected deductible applies to the Hospital and Surgery module only. | | | | | |
| Area of Cover | <input type="radio"/> Worldwide <input type="radio"/> Worldwide excluding USA <input type="radio"/> Europe and ASEAN Excluding Singapore | <input type="radio"/> Worldwide <input type="radio"/> Worldwide excluding USA <input type="radio"/> Europe and ASEAN Excluding Singapore | <input type="radio"/> Worldwide <input type="radio"/> Worldwide excluding USA <input type="radio"/> Europe and ASEAN Excluding Singapore | <input type="radio"/> Worldwide <input type="radio"/> Worldwide excluding USA <input type="radio"/> Europe and ASEAN Excluding Singapore | <input type="radio"/> Worldwide <input type="radio"/> Worldwide excluding USA <input type="radio"/> Europe and ASEAN Excluding Singapore |
| <ul style="list-style-type: none"> 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 <input type="radio"/> and complete cover options for the Applicant only. | | | | | |
| MODULES | APPLICANT | FAMILY MEMBER 1 | FAMILY MEMBER 2 | FAMILY MEMBER 3 | FAMILY MEMBER 4 |
| Outpatient | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite |
| Outpatient Co-Insurance | <input type="radio"/> Nil <input type="radio"/> 20% | <input type="radio"/> Nil <input type="radio"/> 20% | <input type="radio"/> Nil <input type="radio"/> 20% | <input type="radio"/> Nil <input type="radio"/> 20% | <input type="radio"/> Nil <input type="radio"/> 20% |
| Dental and/or Optical <small>Optical included with Elite plan only</small> | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite |
| Maternity | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite |
| <ul style="list-style-type: none"> 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 | | |
|---|---|--|
| <p>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.</p> | | |
| | | Yes <input type="radio"/> No <input type="radio"/> |
| <p>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).</p> | | |
| | | Yes <input type="radio"/> No <input type="radio"/> |
| <p>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.</p> | | |
| | | Yes <input type="radio"/> No <input type="radio"/> |
| MEDICAL DETAILS AND HISTORY | Please indicate if you or any person to be insured <u>have or have ever had</u> 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 <input type="radio"/> No <input type="radio"/> |
| 2 | Respiratory system: Asthma, bronchitis, allergies, rhinitis or sinusitis, tuberculosis, or other disorder of the respiratory system | Yes <input type="radio"/> No <input type="radio"/> |
| 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 <input type="radio"/> No <input type="radio"/> |
| 4 | Gastrointestinal system: Indigestion, gastric reflux, gastric ulcer, hemorrhoids, hernia, or other disorder of the gastrointestinal system | Yes <input type="radio"/> No <input type="radio"/> |
| 5 | Musculoskeletal: Bone fracture, joint injury, arthritis, back, neck or muscle pain, or other disorder of the spine | Yes <input type="radio"/> No <input type="radio"/> |
| 6 | Tropical illness: Malaria, dengue fever | Yes <input type="radio"/> No <input type="radio"/> |
| 7 | HIV/AIDS | Yes <input type="radio"/> No <input type="radio"/> |
| 8 | Urinary system: Kidney stones or other disorder of the urinary system or prostate | Yes <input type="radio"/> No <input type="radio"/> |
| 9 | Liver: Diabetes, hepatitis, fatty liver, or other disorder of the liver | Yes <input type="radio"/> No <input type="radio"/> |
| 10 | Thyroid: Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid | Yes <input type="radio"/> No <input type="radio"/> |
| 11 | Brain and nervous system: Stroke, aneurysm, seizures, chronic headache, migraine, or other disorder of the brain or nervous system | Yes <input type="radio"/> No <input type="radio"/> |
| 12 | Anxiety, depression, stress, addiction, or other mental, behavioral, developmental disorder | Yes <input type="radio"/> No <input type="radio"/> |
| 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 <input type="radio"/> No <input type="radio"/> |
| 14 | Skin: Eczema, dermatitis, psoriasis, wart, or other disorder of skin | Yes <input type="radio"/> No <input type="radio"/> |
| 15 | Eyes and ears: Cataract, glaucoma, otitis, hearing loss, or other disorder of eyes or ears | Yes <input type="radio"/> No <input type="radio"/> |
| 16 | Congenital, hereditary conditions, birth defects, deformities, or conditions affecting mobility | Yes <input type="radio"/> No <input type="radio"/> |
| 17 | Any other disorder/ injury | Yes <input type="radio"/> No <input type="radio"/> |

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 | <p>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.</p> | | | Yes <input type="radio"/> | No <input type="radio"/> |
| | | | | | |
| 19 | <p>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.)</p> | | | Yes <input type="radio"/> | No <input type="radio"/> |
| | | | | | |
| 20 | <p>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.</p> | | | Yes <input type="radio"/> | No <input type="radio"/> |
| | | | | | |
| 21 | <p>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.</p> | | | | |
| | 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 <input type="radio"/> | No <input type="radio"/> |
| Do you authorise us to discuss and/or share claims and medical information with your insurance intermediary? | | Yes <input type="radio"/> | No <input type="radio"/> |
| 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 | <input type="radio"/> VND <input type="radio"/> 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) | <input type="radio"/> | <input type="radio"/> |
| Semi-Annually (5% Surcharge) | <input type="radio"/> | Not Available |
| Quarterly (5% Surcharge) | <input type="radio"/> | 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 | Fax: (+84) 28 7307 7987
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 : Cong Ty Bao Hiem Buu Dien Sai Gon
Beneficiary Address: Room 3-2, 3rd Floor, 24C Phan Dang Luu Street, Ward 6, Binh Thanh District, HCMC, Vietnam
Account Number : 007 100 300 3042
Bank Name : Vietcombank – HCM
Bank address : M Floor, Vietcombank Tower, No 5 Cong Truong Me Linh, Dist 1, HCM City
Swift Code : BFTVNVX007

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 : MCOB NVX

- All bank charges will be borne by the remitter.
- Please indicate your Policy Number and Debit Note number as a payment detail to your banker.
- 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:

Saigon Post & Telecommunication Insurance Company
Room 3-2, 3/F, Dali Tower
24C Phan Dang Luu Street, Ward 6, Binh Thanh District,
Ho Chi Minh City, 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 | Fax: (+84) 28 7307 7987
Email: contact.vn@april.com



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