Chubb Assurance Vietnam Limited
Floor 18, Vincom Building,
45A Ly Tu Trong, Sai Gon Ward,
Ho Chi Minh City, Vietnam
Tax code: 0304732887
Hotline: 1800 599 998
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HealthCare – Application Form – Group Insurance Policy

Please write or tick ☐ where applicable

☐ New Application ☐ Change ☐ Renewal

Part I – GROUP INFORMATION

Policyholder (*) _____	Name of business _____	Business Registration No. _____
Number of Years in Business _____	Address _____	
Telephone No. _____	Email address _____	Fax No. _____
Information for VAT Invoice (include name of company, address, tax code, etc.) _____		
Contact person _____	Job title _____	Telephone No. _____

(*) Information of other policyholders (if any) is listed in the Appendix of this Application Form.

Part II – COVER DETAILS

Insured Objectives	☐ Employees/Members of a Sponsoring Organization only	☐ Employees/Members of a Sponsoring Organization and Dependants
Benefit Plan ("Plan Enrolled") (Please specify, see (*) Guidance for selection of Plan Enrolled below): _____		

(*) 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")

Chubb Assurance Vietnam 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.

Guidance for enrollment of Plan Enrolled: H4, O2, Z3 means: You select Hospital Plan H3-Premier + Maternity; 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 III – DECLARATION

We do hereby represent and warrant:

1. The answers and the Insured's information that We provided the Company in every respect are true, complete and correct;
2. The answers and the Insured's information that We provided the Company shall be the basis of the Insurance Policy between Us and the Company for the insurance of the Insured;

3. We and the Insured have received, read, understood and confirmed that the Insured(s)/We 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 the Insured(s)'/Our 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 the Insured(s)'/Our 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.

The Insured(s)/We have carefully read, understood and agreed to the Company's privacy policy posted at: https://www.chubb.com/vn-vn/footer/assurance-privacy-notice.html or accessed by QR code:

The Insured(s)/We 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.chubb.com/vn-vn/footer/assurance-regulations-governing-the-provision-of-insurance-services-and-products-online.html

AUTHORIZATION OF THE INSURED(S)

We, as the Employer (or the Sponsoring Organization) (as defined in the Chubb HealthCare Insurance Policy Wording), hereby irrevocably confirm that We have been duly authorized by the Insured(s) to act on behalf of the Insured(s) in:

1. Paying the premium for the Insurance Policy;
2. Terminating the Insurance Policy when any Insured is no longer considered as "Working" for Us; and
3. Receiving the remaining premium (if any) after the Insurance Policy terminates in accordance with the Insurance Policy.

MEDICAL INFORMATION RELEASE

We have been consented by the Insured(s) about allowing 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 the Insured(s)' 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, Company Stamp

HealthCare – Application Form – Group Insurance 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)		
_____		

Full name	Job title	Date of employment/ Member of Sponsoring Organization (dd/mm/yyyy)	Gender (Male/ Female)	Date of Birth (dd/mm/yyyy)	ID No./ Passport No.	Usual Country of Residence	Home Country	Height/ Weight	Plan enrolled (Please specify, see (*) above)