

Personal Accident – Application Form – Group Policy

Please write or tick ☐ where applicable

☐ New Application

☐ Change

☐ Renewal

1. GROUP INFORMATION

Policyholder (*)	Name of business	Business Registration No.
Number of Years in Business	Contact Address	
Telephone No.	Email address	Fax No.
Information for VAT Invoice (include 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.

2. COVER DETAILS

Insured Objectives	☐ Employees/Members of a Sponsoring Organization only		☐ Employees/Members of a Sponsoring Organization and Dependants
	Declare Increase/Decrease of Employees/Members of a Sponsoring Organization and Dependants quarterly ☐ Yes ☐ No		
	If Yes, please provide list of Insured as per No.13		
Requested Effective Date	From	To	

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3. THE PREMISES TO BE INSURED

Location:
Use of Premises: <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 48%;"> ☐ Office Building ☐ Hotel ☐ Shop ☐ Dwelling ☐ Manufacturing </div> <div style="width: 48%;"> ☐ Apartment Building ☐ Commercial Centre ☐ Restaurant ☐ Warehouse ☐ Engineering </div> </div> <div style="margin-top: 10px;">Others, please specify</div>

4. BENEFIT PLAN (Unit: VND)

Group	Group Description	No. of Insured	Sums Insured					
			Death/ Permanent Disablement	Temporary Disablement		Medical Expenses	Daily Cash Allowances	
				Month Limit	Number of months		Sums Insured/Day	No of days

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5. EXTENSIONS

Worldwide	☐ Yes	☐ No
Food Poisoning	☐ Yes	☐ No

6. PAYMENT METHOD

☐ Cash	☐ Cheque	☐ Bank Transfer
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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)

8. INSURANCE HISTORY

Has any insurance company ever		
Declined your Personal Accident Proposal?	☐ Yes	☐ No
Required special terms to insure you?	☐ Yes	☐ No
Canceled or refused to renew your Personal Accident Policy?	☐ Yes	☐ No

9. DETAILS OF EXPIRING INSURANCE

Please provide the following information		
Insurer	Sum Insured (VND)	Annual Premium (VND)
Deductible	Special Terms and Conditions	Expiry Date

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10. 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-en/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>

11. AUTHORIZATION OF THE INSURED(S)

We, as the Employer (or the Sponsoring Organization) (as defined in the Personal Accident 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.

12. 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

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.

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Intermediary		Account No.
Tel No.	Fax No.	Email
FOR OFFICE USE ONLY (Underwriting and/or Doctor's Comments)		

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13. INSURED LIST (Please attach separate list if the space is not sufficient)

No	Full name	Date of Birth (dd/mm/yyyy)	ID/Passport No.	Occupation	Usual Country of Residence	Home Country	Sum Insured					
							Death/ Permanent Disablement	Temporary Disablement		Medical Expenses	Daily Cash Allowances	
								Month Limit	Number of months		Sum Insured/Day	No of days
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