

APPLICATION FORM - INTERCARE

This Application form is an integral part of the Policy. Please read carefully the information below and completing this Application form. The information declared in this Application form will be applied as a basis to implement the rights and obligations of all parties in all Insurance Policies (including Policy issued under this Application form and the next renewal policies, excluding information refilled in case of renewal).

Please note that your signing of this application form is the evidence that you you have fully acknowledged and agreed to all terms and conditions of this Application form and the whole package of related Insurance wording.

1. DETAILS OF PROPOSER (POLICYHOLDER)

Full name:		ID No./Passport No./Tax code:	
Date of birth:		Tel:	
		Email:	
Address:			

2. DETAILS OF THE INSURED PERSONS

No.	Full name	Gender	Date of birth	ID No./Passport No.	Relationship to the Proposer
1					
2					
3					
4					
5					

3. INSURANCE PERIOD: from / / to / /

4. DETAILS OF INSURANCE BENEFITS

Unit: VND

INSURANCE BENEFITS		THE INSURED (Based on the order number in the list of Insured Persons)				
		1	2	3	4	5
CORE PLAN: In-patient treatment due to illness/disease and accident (IP)	Plan					
OPTIONAL PLAN(S):						
1. Out-patient treatment due to illness/disease/accident (OP)	Plan					
2. Maternity care (MA)	Plan					
3. Dental care (DC)	Plan					
4. Personal accident (PA)	Plan					
	Sum Insured					
5. Term life (TL)	Plan					
	Sum Insured					
6. Overseas student protection (OSP)	Plan					

Note: If you choose Optional benefit No.6, please provide Bao Viet the following information:

Major and overseas school name:.....
School address:

Guardian information:

Full name:	
D.O.B:	
Relationship to the Student:	

Gender:	
ID No./Passport No.:	

5. MEDICAL QUESTIONNAIRE

1	During the last three (03) years, has any The Insured listed above been medical examined/medical consulted/indicated treatment/treated (*) at a clinic/hospital/nursing home/medical facilities or other similar facilities? (*) medical examined/medical indication/treatment due to the following diseases/conditions that may not need to be declared, including: digestive disorders, acute diarrhea, constipation, food poisoning, common cold, influenza, viral fever, otitis externa, acute rhinitis/pharyngitis, upper respiratory tract infections (excluding: sinusitis, tonsillitis, adenoiditis, otitis media, and other chronic conditions), hand, foot and mouth disease, chickenpox, conjunctivitis, sty/chalazion, allergies, prenatal check-ups, contraception, appendectomy, childbirth, dental treatment, gingivitis, vaccination, and fully recovered injuries that no longer require follow-up or further treatment.	☐ Yes ☐ No
2	Is any The Insured listed above being monitored or treated for an injury, illness, or unstable health symptoms or indicated treatment within the next 12 months?	☐ Yes ☐ No
3	During the last three (03) years, has any The Insured listed above ever suffered from, and/or been treated for any of the following diseases/conditions: Inflammatory diseases of the central nervous system (brain); Parkinson; Other degenerative diseases of the nervous system; Amnesia, Coma, Cerebral palsy, Poliomyelitis (polio); Diabetes; Lung failure, Pneumothorax/ pleural effusion, Chronic respiratory failure; Cerebrovascular diseases, Stroke (brain hemorrhage/ Atherosclerosis); Heart failure, heart attack, heart surgery; Hepatitis, liver cirrhosis; Kidney failure, renal atrophy, kidney stones, hemodialysis; Pancreatitis; Bone marrow transplant; Lupus erythematosus; Tuberculosis of any kinds; Leprosy; Tumors of any kinds; Cancers of any kinds; Bone marrow failure; Leukemia; Sexual transmitted Diseases (STDs); Immunodeficiency Syndrome; Congenital diseases, genetic diseases, genetic deformities; Body disability; Down?	☐ Yes ☐ No
4	Has any The Insured listed above ever been reimbursed by Baoviet under a similar health insurance policy; or be refused by any Insurance company/refused to renew a similar health insurance policy; or agreed to be covered with exclusion/special clauses?	☐ Yes ☐ No

In case of answer "Yes" to any question above, please provide details (For question no.1,2,3 please provide full name of The Insured, diagnosis, date of diagnosis/treatment, details of treatment, current condition, name and address of hospital/clinic; For question no.4, please provide full name of The Insured, name of the Insurance company, refusal/acceptance of insurance with special clause and reason...)

Full name	Details

6. DETAILS OF BENEFICIARY (Applicable in case the Insured is deceased)

Full name:		ID No./Passport No.:	
Relationship to the Insured:		Date of birth:	
Notes:			

7. DETAILS OF NOMINATED RECEIVER (Applicable in case the Insured nominates another person to receive his/her payments of benefit)

Full name:		ID No./Passport No.:	
Relationship to the Insured:		Date of birth:	

8. FORM OF INSURANCE CARD☐ Physical card☐ Electronic card**DECLARATION**

- I/We declare that I/We are in good mental and physical health; not suffer from mental illness, leprosy; not under treatment of any illness/disease/disability; not suffer more than 50% permanent disabilities.
- I/We declare that the information given above are full, true and complete to the best of my/our knowledge and belief; and agree to notify BaoViet of any changes. I/We confirm that I/We have received all product documents (application form, insurance wording, insurance benefits table, insurance contract form, product summary) and been consulted by the sales representative and fully understood the information of the Application form, and agree that this Application form and full payment of premium shall constitute the basis for the insurance contract between me/us and BaoViet..
- I/We agree that any failure to disclose fully and truthfully all relevant information shall entitle Bao Viet to disclaim its liability, in whole or in part, for any claim arising under this Insurance Contract. In the event that such non-disclosure is determined to have been made with the intent to commit insurance fraud, Bao Viet shall be entitled to rescind this Insurance Policy ab initio.
- I/we agree to BaoViet's General Terms and Conditions on Protection and Processing of Personal Data as set out on BaoViet's website (<https://baovietonline.com.vn/en/chinh-sach-bao-mat-thong-tin.html>), and authorize BaoViet and/or Bao Viet's representative shall have the rights to collect, process and store Personal data in order to exercise rights and obligations set forth in Insurance Policy and other related tasks according to the law; on behalf of the Insured to approach third parties including but not limited to medical staff, doctors to collect necessary information in assessing the Insured's health condition.

....., Date ... month ... year

The Insurance Application Form is valid for issuance within 30 days from the date of declaration.

Signed by the Proposer (Signature and full name)	Signed by the Insured (Signature and full name, in order)				
	1	2	3	4	5

TO BE FILLED OUT BY BAOVIET AGENT/SALES REPRESENTATIVE

Unit: VND

PREMIUM CALCULATED TABLE		THE INSURED				
		1	2	3	4	5
CORE PLAN: In-patient treatment due to illness/disease and accident (IP)	[1]					
OPTIONAL PLAN(S):						
Out-patient treatment due to illness/disease/accident (OP)	[2]					
Maternity care (MA)	[3]					
Dental care (DC)	[4]					
Personal accident (PA)	[5]					
Term life (TL)	[6]					
Overseas student protection (OSP)	[7]					
Premium Loading (+)/Discount(-)	[8]					
TOTAL PREMIUM =[1]+[2]+[3]+[4]+[5]+[6]+[7]+[8]						

....., Date ... month ... year

Commitment of Agent/Sales Representative <i>I commit that I have consulted and guided Clients all information in this Application form. Clients have understood, self declared and signed in this Application form.</i>	Information of Agent/Sales Representative	
Note:	Full name:	Signature
	Code:.....	
	Branch name:	