Indemnity Form Declaration

Policy #: _____ ("the Policy")

Policyholder: _____ ("the Policyholder")

Hospital: _____ ("the Hospital")

The undersigned ("the Claimant") acknowledges and agrees that:-

1. Subject to the provisions below, GlobalHealth Asia Limited ("GlobalHealth") as the authorized administrator of AIG Vietnam Insurance Company Limited ("AIG VN") in respect of any claim(s) made by the Claimant under the Policy ("the Claim"), is or will be arranging for a guarantee in favour of the Hospital ("the Guarantee") for the medical expenses to be incurred therein by :

   Name of Patient: _____ ("the Patient")

   ID/Passport No.: _____

2. The Guarantee is or will be arranged so as to enable and not to delay any medically necessary treatment of the Patient.

3. In light of the foregoing, it is the intention of the parties that if at any time after the date hereof, the Claim shall for any reason be found to be invalid or not effective (whether due to lack of proof; or being excluded from or outside scope of the Policy; or the relevant insurance with AIG VN is not in force; or for any other reason whatsoever), the Guarantee shall be automatically revoked or terminated forthwith and become null and void with immediate effect.

4. In the event the Guarantee is revoked as aforesaid, the Claimant shall (or if the Claimant shall be more than one person, each of them shall jointly and severally) indemnify and reimburse AIG VN (or on its behalf, GlobalHealth) on demand on a full indemnity basis all costs or expenses paid by GlobalHealth on behalf of AIG VN in connection with the Patient's treatments at the Hospital. For avoidance of doubt, without limiting the generality of the foregoing, AIG VN (or on its behalf, GlobalHealth) shall not be liable or have any further obligation to settle for any of the Patient's medical costs or expenses and the Claimant shall be responsible to settle all of the Patient's medical costs or expenses subsequent to the Guarantee being revoked as aforesaid.

Signature of the Claimant: _____

Name: _____

ID/Passport No.: _____

Claimant's Relationship with the Patient: _____

Date: _____