TheChoice Medical Insurance Application Form
智采醫療保險計劃申請表

	For Company Use only: 公司專用 Effective Date: (DD/MM/YYYY) 生效日期(日/月/年)
▪ One application form for <u>one person to be insured only</u> 每份申請表只跟投保<u>一名受保人</u> ▪ Person to be insured must be applicant himself or his spouse or child 受保人必須是申請人自己或其配偶或子女 ▪ Please tick as appropriated 請選擇並加「✓」號	/ /

Personal Details of Applicant (Applicant must be a HKID cardholder and age 18 or above)
申請人個人資料(申請人年齡必須為18歲以上及持有香港身份證)

Name in English (same as HKID Card) 英文姓名(與香港身份證相同)	Family Name 姓	Given Name 名	Name in Chinese 中文姓名

HKID Card No. 香港身份證號碼 ( )	Sex 性別	☐ Male 男	☐ Female 女

Date of Birth (DD/MM/YYYY) 出生日期(日/月/年) / /	Occupation (Applicable to Applicant who is also the person to be insured) 職業(適用於同時為受保人的申請人)	Nationality (Optional) 國籍(非必要填寫)

Contact Details of Applicant 申請人聯絡資料

Address 地址* (Please complete in ENGLISH 請以英文填寫)

Flat 單位	Room 室	Floor 層數	Block 座

Building / Mansion / House / Estate 大廈/閣/樓/屋苑

Street / Road 街/道

District 地區	☐ HK Island 香港島	☐ Kowloon 九龍	☐ N.T. 新界

Contact No. 聯絡電話	Mobile No. 流動電話號碼	Email Address# 電郵地址#

Details of Person to be insured 受保人資料

Please tick one only 請只選擇一項	☐ Myself (Details as above) 本人(資料與以上相同)	☐ Spouse 配偶	☐ Child 子女

Please provide average stay of the person(s) to be insured in Hong Kong per year 受保人每年平均居港時間: _____ months 月

If the average stay is less than nine months, please provide the place of residence outside Hong Kong:
如受保人之每年平均居港時間少於9個月，請提供海外居住地名稱：_____

Name in English (same as HKID Card) 英文姓名(與香港身份證相同)	Family Name 姓	Given Name 名	Name in Chinese 中文姓名

HKID Card No. 香港身份證號碼 ( )	Sex 性別	☐ Male 男	☐ Female 女

Date of Birth (DD/MM/YYYY) 出生日期(日/月/年) / /	Occupation 職業	Nationality (Optional) 國籍(非必要填寫)

Choice of Cover 投保項目

Core Benefits 主要保障		Optional Outpatient Benefit 自選門診保障	Optional Outpatient and Dental Benefits 自選門診及牙科保障
Plan level 計劃級別	Annual Deductible option 每年自付費	Note: Must be the same as the level of the Hospitalization Benefit 附註:計劃級別必須與住院保障相同	
☐ Standard (Ward) 標準(大房) ☐ Advance (Semi-Private Room) 優選(半私家房) ☐ Prestige (Private Room) 尊尚(私家房)	☐ HK$0 ☐ HK$25,000 ☐ HK$50,000 ☐ HK$80,000	☐	☐
Grand Total Annual Premium (excluding Insurance levy) **每年總保費(不包括保費徵費)**			HK$ 港幣

* P.O. Box, hotel address and overseas address are not acceptable. 不接受信箱、酒店地址和海外地址。
# Please provide email address to enjoy bolttech Insurance eServices app and receive medical claim statement by email.
  請提供電郵地址以享用保特保險eServices應用程式及透過電子郵件收取醫療索償理賠表。

Health Declaration (To be completed by the person to be insured, if the person to be insured is under the age of 18, it can be completed by the applicant) 健康聲明(由受保人填寫，若受保人爲18歲以下，則可由申請人填寫)		
1. 您的身高及體重 Your Height and Weight	Height: m: cm: ft: in: 身高： 米： 厘米： 尺： 寸：	Weight: Kg: lb: 體重： 公斤： 磅：

2. **Have you ever had or been told to have any of the following:** **您有否曾患上或獲悉患上下列疾病：**	Yes 有	No 否
i. Diseases of the Heart 心臟病	☐	☐
ii. Cancer or tumor 癌症或腫瘤	☐	☐
iii. Diabetes or high blood sugar 糖尿病或高血糖	☐	☐
iv. Hepatitis B or C 乙型肝炎或丙型肝炎	☐	☐
v. Kidney Failure 腎功能衰竭	☐	☐
vi. Stroke 中風	☐	☐

3. **In the last 5 years have you received medical advice or been treated for any of the following:** **在過去的5年裡，您有否曾就下列疾病接受過醫療建議或治療：**	Yes 有	No 否
i. Carcinoma insitu, abnormal growth or polyps 原位癌，異常生長或息肉	☐	☐
ii. Asthma, tuberculosis, pneumonia or chronic obstructive lung disease 哮喘，肺結核，肺炎或慢性阻塞性肺病	☐	☐
iii. Stomach ulcer or pancreatitis or gastritis 胃潰瘍或胰腺炎或胃炎	☐	☐
iv. High blood pressure or high cholesterol 高血壓或高膽固醇	☐	☐
v. Abnormal liver function 肝功能異常	☐	☐
vi. Nephritis or abnormal kidney function, prostate enlargement or elevated PSA levels, polycystic ovarian syndrome or endometriosis 腎炎或腎功能異常、前列腺肥大或PSA值高於正常水平、多囊卵巢綜合症或子宮內膜異位	☐	☐
vii. Any injury or disorder of the eyes (excluding vision corrected by prescription lens), ears, bones, joints or spine or physical disability 任何眼睛的受傷或病症(不包括通過處方鏡片矯正視力)，耳朵，骨骼，關節或脊柱或身體殘疾	☐	☐
viii. HIV infection or positive HIV test result 愛滋病感染或愛滋病檢測陽性結果	☐	☐
ix. Depression, mental disorder or intellectual disability 抑鬱症，精神病或智力障礙	☐	☐

4. **For any conditions other than the above: In the last 3 years, have you:** **在過去3年中，除上述病狀外，您有沒有：**	Yes 有	No 否
i. had ongoing follow-up with a doctor or specialist doctor for a period of 6 months or more? 與醫生或專科醫生持續進行6個月或更長時間的跟進？	☐	☐
ii. received medication or treatment, any of which was for a continuous period of 2 weeks or more? 服用禁物或接受治療，當中任何一項持續兩週或更長時間？	☐	☐
iii. had a surgical procedure, or been hospitalized for a continuous period of 6 days or more? (If yes, please provide relevant report(s)) 進行手術或持續住院超過6天？(如有，請提交相關報告)	☐	☐
iv. had an abnormal result or results outside the normal range in a blood test, biopsy, ECG, imaging scan, pap smear, colonoscopy or other investigation? (If yes, please provide relevant report(s)) 在血液測試、活組織檢查、心電圖、影像學掃描、子宮頸抹片檢查、結腸鏡檢查或其他檢驗測試中發現異常或超出正常範圍的結果？(如有，請提交相關報告)	☐	☐

5.	Family Health History 親屬健康狀況	Yes 有	No 沒有
	Amongst your biological parents, brothers or sisters: 您的親生父母，兄弟或姐妹有沒有：		
i.	Two or whom have been diagnosed with breast or ovary cancer (for female person to be insured only), colon cancer or rectal cancer, heart disease or stroke before age 50 兩名或以上在50歲以前被診斷患有乳癌或卵巢癌(女性受保人適用)、結腸癌或直腸癌、心臟病或中風	☐	☐
ii.	One of whom has been diagnosed with Alzheimer's disease, Polycystic Kidney Disease, Motor Neurone Disease, Parkinson^ Disease or Muscular Dystrophy before age 60 在60歲以前被診斷患有阿爾茨海默症(認知障礙症)、多囊腎病、運動神經元病、帕金森症或肌肉營養不良症	☐	☐

6.	(Applicable to female person to be insured only) 只適用於女性受保人	Yes 是	No 否
i.	Are you pregnant now? 您現在是否懷有身孕？	☐	☐
ii.	If Yes: do you have any complications such as high blood pressure, eclampsia or pre-eclampsia, gestational diabetes or risk of premature delivery (excluding reduced iron levels for which you are taking vitamin supplements)? 如是，您曾否患有任何併發症、如高血壓、子癇或子癇前症(妊娠毒血症)、妊娠糖尿病或早產風險(因鐵質水平下降而需要服用維生素補充劑除外)？	☐	☐

If you answer Yes to any of the above questions, please provide relevant report(s) and details below:
如上述任何問題的回答為「是」，請提供相關報告及詳細資料如下：

Name of condition 病症名稱	Date diagnosed 診斷日期 (DD/MM/YYYY)	What treatment did you have? Please include treatment period, type of treatment and the details (e.g. name of medication, procedure or surgery) 你曾接受何種治療?請註明接受治療的時間，治療種類及其詳情 (如藥物名稱、治療程序或手術之名稱)	Are you Fully Recovered with no ongoing treatment? 您是否已完全康復及沒有正在進行治療？		Date of full recovery (if applicable) 完全康復日期 (如適用) (DD/MM/YYYY)	If not fully covered, please advise stage of recovery, ongoing treatment, etc. 如未完全康復，請提供康復情程、正在進行的治療等。
	/ /		Yes 是 ☐	No 否 ☐	/ /	
	/ /		Yes 是 ☐	No 否 ☐	/ /	
	/ /		Yes 是 ☐	No 否 ☐	/ /	

如您有任何醫療報告或醫療檢查報告，請隨此表格同時附上，並請於空格加「✓」號。 If you have any medical reports or reports of medical investigations, please enclose them and put a tick in the box.	☐ 另有附頁 With Attachment

Bank Name and Account No. for claim reimbursement (Account-Holder must be the Applicant) 理賠時所用之銀行名稱及帳戶號碼 (戶口持有人必須是申請人)		
Personal Bank account (Hong Kong Dollar only) 個人銀行戶口 (只限港元)		
Bank Name 銀行名稱	Branch Code 分行代碼	Bank account no. 銀行帳號

Premium Payment Method 繳付保費方法

Payment Mode 付款期數	☑ Yearly 每年	☐ Monthly 每月
	Note: If payment mode is monthly, the monthly premium is equal to annual premium times 0.09. 註：如選擇每月付款，月費等於年費乘以 0.09.	
Payment Method 付款方法	☑ Cheque 支票	☐ Credit Card (Please complete the below "Credit Card Payment Authorization" section) 信用卡 (請填寫以下 「信用卡付款授權」 部分) （不適用）

If the Cardholder is not the applicant, please fill in the following information. 若信用卡持有人並非申請人，請填寫以下資料。

Relationship with the applicant：————Reason for paying premium and insurance levy on behalf of the applicant ——
與申請人關係：————————代申請人支付保費及保費徵費的原因——

☐ spouse 配偶 ——————————————————————————————————————
☐ parents 父母 —————
☐ children 子女 —————

☐ I hereby confirm to pay the premium and insurance levy in respect of this Application.
本人同意及承擔此申請的全數應繳保費及保費徵費金額。

Credit Card Payment Authorisation 信用卡付款授權

☐ Visa 卡-------------------------------------- --☐ Master Card 萬事達卡-------

Cardholder's Name
持卡人姓名---

Credit Card Account No. 信用卡戶口號碼---	Credit Card Expiry Date (MM/YY) 信用卡到期日 (月 / 年)--------------------------------

☐ I hereby authorise Bolttech Insurance (Hong Kong) Company Limited to charge my above credit card account for the premium and insurance levy (including renewal premium) until further notice.
本人茲授權保特保險 (香港) 有限公司從本人上述之信用卡賬戶支取此保險所應繳之保費及保費徵費 (包括續保保費)，直至另行通知。

不適用 NOT APPLICABLE

X_____
Cardholder's Signature 持卡人簽署----------   Date 日期 (DD/MM/YYYY)---------------

Declaration and Authorisation 聲明及授權

1. I hereby declare that, to the best of my knowledge and belief, all particulars and statements given in this Application are true and complete. I agree that this Application shall be the basis of the contract between me and Bolttech Insurance (Hong Kong) Company Limited ("bolttech Insurance"). I further authorise any physician, hospital, insurance company or organization to furnish part of or all medical history (including but not limited to information in respect of consultations, diagnostic test results, prescriptions or treatment) with respect to any illness or injury of me to bolttech Insurance or its authorised representative. A photocopy of this authorisation shall be considered as effective and valid as the original.

   本人謹此聲明在本申請表內填報之一切，就本人之所知所信，全部真實無訛。本人同意此申請表為本人與保特保險(香港)有限公司(「保特保險」)之間所訂立合約之依據。本人進一步授權任何醫生、醫院、保險公司或機構，可以將部分或全部有關本人傷患之病歷(包括但不限於診症、診斷性檢驗結果、藥方或治療資料)給予保特保險或其已獲授權之代理人。此授權之副本與正本具同等效力。

2. I undertake that I will inform/have informed my spouse or child to be Insured (if applicable) about this Policy and the Personal Information Collection Statement (BPICS") of bolttech Insurance (whether contained herein or otherwise obtained) before transferring his/her personal data to bolttech Insurance. bolttech Insurance shall not accept any liability for the person to be insured not having been so informed. I further undertake that I will comply with the Personal Data (Privacy) Ordinance and confirm I have obtained the consent from the person to be insured for the transfer of his/her personal data to bolttech Insurance for the purpose of enrolling him/ her in the TheChoice Medical Insurance plan.

   本人承諾於遞交所需之個人資料予保特保險前，須已通知本人的受保配偶或子女(如適用)有關本保單及保特保險之收集個人資料聲明(不論是否載於此申請表或由其他途徑取得)。保特保險將不會就受保人未被通知的情況承擔任何責任。本人承諾會遵守個人資料(私隱)條例，並確認已獲得受保人的同意，將其個人資料移交保特保險以作申請智采醫療計劃之用。

3. I have read, understand and accept the PICS of bolttech Insurance.

   本人已細閱、明白及接受保特保險之收集個人資料聲明。

bolttech Insurance intends to send you marketing communications or materials and use Your Personal Data in accordance with paragraphs 8 & 9 of PICS. If you do not agree to receive such marketing communications or bolttech Insurance's intended use of Your Personal Data, please tick below to exercise your right to opt-out

保特保險有意向閣下發送推廣訊息或資料及根據收集個人資料聲明第8及第9段使用閣下的個人資料。如閣下不同意接收有關的推廣訊息或不同意保特保險就該目的使用閣下的個人資料，請在以下有關方格內加上(√)號，藉以行使閣下不同意此項安排的權利。

☐ Opt-out marketing communications or materials and bolttech Insurance's intend use of my personal data.
　 拒絕接收推廣訊息或資料及保特保險就該目的使用本人的個人資料。

Applicable to Insurance Broker only:

The applicant understands, acknowledges and agrees that, as a result of the applicant purchasing and taking up the policy to be issued by bolttech Insurance, bolttech Insurance will pay the authorised insurance broker commission during the continuance of the policy including renewals, for arranging the said policy. Where the applicant is a body corporate, the authorised person who signs on behalf of the applicant further confirms to bolttech Insurance that he or she is authorised to do so. The applicant further understands that the above agreement is necessary for bolttech Insurance to proceed with the application.

只適用於保險經紀：

申請人明白、確知及同意，保特保險會就申請人購買及接受其簽發的保單，於保單有效期內(包括續保期)向負責安排有關保單的獲授權保險經紀支付佣金。如申請人為法人團體，則代表申請人簽署的獲授權人員在此向保特保險確認他/她已獲該法人團體授權。申請人亦明白保特保險必須取得申請人的同意，才可以處理其保單申請。

X _____　　　_____ / _____ / _____

Applicant's Signature 申請人簽署　　　　　　　　Signed in Hong Kong on (DD/MM/YYYY) 於香港簽署之日期(日/月/年)

Advisor/Broker's Information 代理人/經紀資料

Advisor / Broker/Technical Representative's Name 代理人/經紀/業務代表名稱 Union Faith Insurance Agency Limited	Email Address 電郵地址　service@unionfaith.com.hk
Account Code 帳戶號碼　UFOAPH	Contact No. 聯絡電話

Personal Information Collection Statement ("PICS")
收集個人資料聲明

Please scan the following QR code for review of Bolttech Insurance (Hong Kong) Company Limited's (the "Company") PICS. You can also request a copy of the PICS by calling the Company's Customer Service Hotline at 3123 3344.

請掃描以下二維碼查看保特保險(香港)有限公司 (「 本公司」) 的收集個人資料聲明。您亦可致電本公司的客戶服務熱線 3123 3344 索取收集個人資料聲明副本。

English   中文

Important Notes

The Applicant (i.e. You are) is required to disclose all material facts which you know Bolttech Insurance (Hong Kong) Company Limited (the "Company") as an insurer would regard them as likely to influence the acceptance and assessment of this proposal. If you are in doubt whether certain facts are material you should disclose them. We recommend you to keep a record (including a copy of completed proposal) for your future reference of all information given. Providing correct answers and making sure we are informed is for your own protection, as failure to disclose such information may mean that your policy will not provide with the cover you require and may even invalidate the policy altogether.

重要事項

申請人(即你)必須提供所有可能影響保特保險(香港)有限公司(「本公司」)接受承保及評估之重要事實,如未能確定這項事實是否具有實質性的關係,應將該等事實填報,我們建議你將有關的資料(包括此投保書副本作紀錄),以備日後作參考之用。為確保你的利益,你應如實呈報所有有關資料,否則此保單將可能無法提供你所需的保障,甚至可能會導致此保單無效。

Product Suitability Assessment Form
產品合適性評估表

Please provide the personal information in this Suitability Assessment Form in order for us to analyse your medical, financial, and coverage needs to make suitable medical coverage recommendations for you. By providing the information below, you understand and agree that the information provided in this form will be handled in accordance with the Personal Information Collection Statement ("PICS") of Bolttech Insurance (Hong Kong) Company Limited.
請根據此產品合適性評估表提供個人資料以助我們分析您在醫療、財務及保障上的需要，以便提供合適的醫療保障建議。客戶在填寫此分析表時，即表示您明白及同意有關資料將根據保特保險(香港)有限公司之個人資料收集聲明予以處理。

Applicant's name: 申請人姓名：	Proposed insured's name: 準受保人姓名：	Proposed Insured's Age: 準受保人年齡：	Proposed insured's Sex: 準受保人性別：	Proposed insured's relationship to applicant: 準受保人與申請人關係：

Step 1:   Customer's medical insurance needs and objectives: 第一步：客戶醫療保險需求及目標：

1)   Are you able to to pay medical insurance premium every year to enjoy the benefits and services as stated in the medical insurance policy for future illnesses or injuries?
您確定每年都能支付醫療保險保費，以享用醫療保險保單中所指定的保障項目和服務來保障未來可能出現之疾病或傷患嗎？
☐ a) Yes 確定
☐ b) No 不確定

2)   What is your annual budget for medical insurance protection?
您的每年醫療保障費用預算為？

HK$ 港幣 _____

3)   Do you have any existing personal medical insurance(s)?
您有現有的個人醫療保險嗎？

☐ a) Yes 有 _____
(If yes, please indicate no. of in-force policy)
如有，請寫出生效之保單數目：

   i)   Medical expense reimbursement insurance 醫療費用實報實銷保險 _____

   ii)   Daily cash for hospitalization insurance 每日住院現金保險 _____

   iii) Critical illness insurance 危疾保險 _____

   iv)   Personal accident insurance 個人意外保險 _____

☐ b) No 沒有

4)   Why do you want to purchase a new medical insurance？
您為什麼想購買一份新的醫療保險？
☐ a) For insurance protection of the increasing medical treatment costs 為日益增加的醫療費用提供保險保障
☐ b) For income protection during sickness 用於疾病期間的收入保障
☐ c) My existing medical insurance cover is insufficient 我的現有醫療保險保障不足
☐ d) To enjoy tax allowance of VHIS compliant product ("Voluntary Health Insurance Scheme") 我希望享受「自願醫保」所提供的免稅額
☐ e) Others, please specify 其他，請註明 : _____

5)   What are your preferred benefits and coverages for your newly applied medical insurance?
在您新投保的醫療保險中，您首要考慮的保障項目和保險範圍是什麼？
☐ a) Basic hospitalization and surgical benefits 基本住院及手術保障之項目
☐ b) Comprehensive medical insurance protection 全面的醫療保險保障
☐ c) Income protection during sickness 疾病期間的收入保障
☐ d) Annual deductible or co-insurance options to lower the annual premium 每年以自付費或共付保險形式投保之選項，以降低每年的保費

Insurance intermediary product recommendations: 保險中介人之產品建議 :

_____
_____
_____

I / we confirm that I have gone through the above product suitability assessment and confirm the below medical insurance product is selected by my / our own decision.
本人/我們確認本人/我們已進行上述之產品合適性評估並確認以下之醫療保險產品選擇是本人/我們自己所決定的。

Plan name計劃名稱: _____

Annual Deductible option (if applicable) 每年自付費選擇(如有): HK$ _____

Optional benefit (if applicable) 自選保障(如有) : _____

客戶聲明 Customer Declaration:

1)   I / We have read and understood the product brochure, information sheet and policy provision of the medical insurance product I / we selected. 本人/我們已細閱及明暸本人/我們所選擇之醫療保險產品的產品小冊子、資訊單張及保單條款之內容。

2)   I / We confirm the medical insurance product I / we selected (in respect of any type of indemnity, non-indemnity, or combo product) is suitable for my / our insurance needs and my / our objectives for purchasing a medical insurance product (including but not limited to (i) income protection during hospital confinement; (ii) preparation for the hospitalization and medical treatment expenses due to illness or injury), and I / we can afford to pay the required premium. 本人/我們確認本人/我們所選擇之醫療保險產品（包括任何種類之賠償、非賠償、或組合產品）符合本人/我們的保險需要及購買醫療保險產品的目標(包括但不限於(i)住院期間的收入保障；(ii)為疾病或受傷之住院及其醫療費用作準備)，及本人/我們有能力支付其所需的保費。

3)   I/ We confirm the medical insurance product I/we selected is my / our own decision with no forced pressure from any third parties. 本人/我們確認本人/我們所選擇之醫療保險產品是在沒有受第三者壓力下由本人/我們自行決定的。

4)   I / We understand the information contained in this form was used to analyse my / our medical insurance needs and provided as reference only for my choice of medical insurance product and premium amount. I / We also understand and agree that the information contained in this form will be handled in accordance with the Personal information Collection Statement ("PICS") of Bolttech Insurance (Hong Kong) Company Limited. 本人/我們明白此表格內所提供之資料乃用作分析本人/我們的醫療保險需求，並為本人/我們在選擇保險計劃及保費金額時作參考。本人/我們亦明白此表格內之資料會根據保特保險(香港)有限公司的收集個人責料聲明予以處理。

5)   We understand that the analysis and choices made in this form were based upon the information provided and it does not create any liability to Bolttech Insurance (Hong Kong) Company Limited. 本人/我們明白此表格之分析及選擇乃基於本人/我們所提供之資料而作出的，當中並不構成保特保險(香港)有限公司之任何責任。

6)   I / We understand that I /We am required to inform Bolttech Insurance (Hong Kong) Company Limited if there are any substantial changes to the information provided in this form prior to the insurance policy being issued. 本人/我們明白，如本人/我們就此表格內的資料有任何重大更改，本人/我們需在保單生效前通知保特保險(香港)有限公司。

I / We, as the Applicant, confirm that I / we have read and understood all the contents in this form and provided all the correct information for the above on behalf of the proposed insured / existing insured listed in this application. 本人/我們作為申請人確認已細閱及明暸此表格之內容，並代表此計劃之準受保人/現有受保人就以上問題提供正確無誤之資料。

_____   _____   ____ / ____ / _____
Applicant's name   Applicant's Signature   Date (DD / MM / YYYY)
申請人姓名   申請人簽署   日期（日/月/年）

_____   _____   ____ / ____ / _____
Proposed insured's name   Proposed insured's Signature   Date (DD / MM / YYYY)
(if different from the Applicant)   準受保人簽署   日期（日/月/年）
準受保人姓名(如跟申請人不同)

Union Faith Insurance Agency Limited   UFOAPH
_____   _____   _____
Name of Agent / Broker   Agent's / Broker's Code   Agent's / Broker's signature
經紀姓名   經紀編號   經紀簽署