Blue Cross 藍十字
An AIA Company 友邦保險成員公司

收集個人資料聲明
Personal Information Collection Statement

聯絡我們
Contact Us

# 藍十字尊悅自願醫保計劃投保書
# Blue Cross Dynasty VHIS Plan Application Form

**請於投保前閱讀產品小冊子及條款及細則。Please read the product brochure and terms and conditions of the product before applying.**

投保 Apply

Blue Cross HK App

請以中文或英文正楷填寫此份投保書，並連同抬頭為**「藍十字（亞太）保險有限公司」**之劃線支票寄回（如適用）或於第八部分選擇其他付款方法。Please complete this form in Chinese or English BLOCK letters and if applicable, return it together with a crossed cheque payable to **Blue Cross (Asia-Pacific) Insurance Limited** or select other payment methods in part (VIII).

## 醫療保險需求分析（只適用於經代理人／經紀投保的客戶）
## Medical Insurance Needs Assessment (only applicable to customer who submits application via agent/broker)

為確保醫療保險產品能滿足閣下的需求和目標，請回答以下問題以便繼續申請。（註：現有藍十字醫療保險產品並不包括危疾保障計劃即在索償危疾保障時提供一筆過賠償以應付日後健康服務需求和目標。）
In order to ensure the medical insurance product can meet your needs and objectives, please answer the following question before proceeding to the application. (Note: Existing Blue Cross' medical insurance products do not include critical illness protection plans which meet any needs and objectives of offering lump sum payment for future healthcare service upon claims of critical illness.)

閣下是否有意為將來的醫療需要購買醫療保險產品?
Do you intend to purchase a medical insurance product for better planning of your future healthcare needs?

☐ 否 No

☐ 是（請選一項）Yes (Please select one)

- ☐ 本人現正尋找償款型醫療保險產品（例如：報銷醫療開支）以支付醫療費用。
  I am looking for an indemnity medical insurance product (e.g. reimbursement of medical expenses) which serves to settle medical expenses.
- ☐ 本人現正尋找非償款型醫療保險產品（例如：住院現金）以彌補住院期間之收入損失。
  I am looking for a non-indemnity medical insurance product (e.g. hospital cash) which serves to compensate for the loss of income during hospital confinement.
- ☐ 本人現正尋找組合型醫療保險產品（償款但包含非償款現金保障）以支付醫療費用和彌補住院期間之收入損失。
  I am looking for a combo medical insurance product (i.e. indemnity incorporated with non-indemnity cash benefits) which serves to settle medical expenses and compensate for the loss of income during hospital confinement.

## (I) 準保單持有人資料 Details of Proposed Policy Holder

姓名（以香港身份證／護照為準）（姓／名）
Name (as shown on HKID Card/Passport) (Surname/First Name)

☐ 先生 Mr. ☐ 小姐 Miss ☐ 太太 Mrs. ☐ 女士 Ms.

（英文）
(English)

（中文）
(Chinese)

香港身份證／護照號碼
HKID Card/Passport No.

| 出生日期（日／月／年）<br>Date of Birth (dd/mm/yy) | 聯絡電話<br>Contact Telephone No. | 個人電郵地址<br>Personal Email Address |
|---|---|---|
| | | |

通訊地址 Correspondence Address（郵政信箱及酒店地址恕不接納 P.O. Box and hotel address are not acceptable）

室 Flat ____ 樓 Floor ____ 座 Block ____ 大廈 Building ____

屋苑 Estate ____ 期 Phase ____

街道號數 Street No. ____ 街道名稱／地段 Street Name/Lot ____

地區 District ____ ☐香港 HK ☐九龍 KLN ☐新界／離島 NT/Outlying Islands

選擇保單文件及續保資訊之送遞方法（只適用於直接向藍十字投保的客戶）
Delivery method for Policy Documents and Renewal Information (only applicable to customer who submits applications directly to the Company)

☐ 電郵 by email 或 or ☐ 郵寄 by post（如無指明，電郵（如有提供）將被指定為送遞方法。If not specified, email (if provided) will be defaulted as the delivery method.）

☐ 本人欲收取有關保單條款及保障之中文版本(如無指明，有關文件將以英文版本發出)。 I would like to receive the Policy Terms and Benefits in Chinese (if not specified, the related documents will be issued in English).

**醫療賠償選項 Claims Payment Options**

合資格醫療賠償只會支付予保單持有人。Eligible medical claims payment will be payable to Policy Holder only.

☐ 支票付款 By cheque ☐ 銀行戶口自動轉賬（請於下方提供相關資料）By bank account autopay (Please provide the relevant information below)

| 香港銀行戶口號碼⁺ Hong Kong Bank Account No.⁺ | 銀行戶口持有人姓名 Name of Bank Account Holder | 銀行名稱 Bank Name | 分行名稱 Branch Name |
|---|---|---|---|
| 銀行編號 Bank Code / 分行編號 Branch Code / 戶口號碼 Account No. | | | |

+ 只接受15位數字或以下準保單持有人之銀行戶口。Accept proposed Policy Holder's bank account with 15 digits or below only.

**家庭折扣（如適用）Family Discount (if applicable)**

如合資格家庭成員^為「藍十字尊悅自願醫保計劃」之準受保人（現正另行遞交申請）或為此計劃的現有受保人，該成員將計入您的家庭折扣人數內。
If the eligible family member^ is the Proposed Insured Person (under a separate application concurrently) or is an existing Insured Person of Blue Cross Dynasty VHIS Plan, such member will be counted towards your family discount.

| 請提供所有合資格家庭成員的保單資料<br>Please provide the details of ALL policy(ies) of eligible family member | 與準保單持有人之關係<br>Relationship with proposed Policy Holder |
|---|---|
| 保單號碼 Policy No. :<br>（如未能提供保單號碼，請填上合資格家庭成員的姓名及香港身份證／護照號碼<br>If policy number is not available, please provide eligible family member's name and HKID Card/Passport No.） | |

^ 合資格家庭成員指您（作為保單持有人）、您的配偶／子女、您或配偶的父母／（外）祖父母／兄弟／姊妹。

^ Eligible family members refer to you as the policyholder, your spouse/child, your or your spouse's parent/grandparent/brother/sister.

## (II) 準受保人資料 Details of Proposed Insured Person

| 姓名（姓／名）<br>Name (Surname/First Name) | 香港身份證／護照號碼<br>HKID Card/ Passport No. | 性別<br>Sex | 出生日期<br>（日／月／年）<br>Date of Birth (dd/mm/yy) | 與準保單持有人之關係*<br>Relationship with the proposed Policy Holder* | 居住地▲<br>Place of Residence▲ |
|---|---|---|---|---|---|
| （中文 Chinese）<br>（英文 English） | | | / / | | ☐ 香港 HK<br>☐ 其他 Others<br>（請註明 Please specify） |

| | | |
|---|---|---|
| 準受保人會否在未來12個月內平均於香港或澳門境外地方逗留6個月或以上？如答案為「是」者，請列明確實地點及平均逗留時間。Will the Proposed Insured Person stay outside Hong Kong or Macau for 6 months or more in average in the next 12 months? If the answer is 'Yes', please specify the exact location(s) and the average stay time. | ☐ 是Yes<br>☐ 否No | 地點 Location(s):<br>月 Month(s): |

請問準受保人是否從事高風險職業包括 (i)於建築地盤內從事體力勞動工作；(ii)於離地面或樓面10米以上工作；(iii)職業拳手；(iv)騎師 或 (v)特技人? ☐ 是Yes ☐ 否No
Does the proposed Insured Person engage in high-risk occupation including (i)manual works at construction site; (ii)work at a height (exceeding 10 meters above ground or floor level); (iii)professional boxer; (iv)jockey or (v)stuntman?

* 只接受準保單持有人之受養人。受養人是指準保單持有人的配偶、子女、準保單持有人或其配偶的父母、祖父母、外祖父母或兄弟姊妹。
Only dependant of the proposed Policy Holder is acceptable. Dependant shall mean proposed Policy Holder's spouse, child, proposed Policy Holder's or his/her spouse's parent, grandparent, brother or sister.

▲ 指某人士在法律上擁有居留權的司法管轄區。為免存疑，某人士若對該司法管轄區只有法律上的入境許可，而非居留權（例如留學、工作或旅遊），該司法管轄區並不可被視為該人士的居住地。
Means the jurisdiction(s) in which a person legally has the right of abode. For the avoidance of doubt, a jurisdiction in which a person legally has the right or permission of access only but without the right of abode, such as for the purpose of study, work or vacation, will not be treated as a Place of Residence.

## (III) 保障計劃 Plan Details

| 藍十字尊悦自願醫保計劃 Blue Cross Dynasty VHIS Plan | | |
|---|---|---|
| 計劃級別 Plan Level | ☐ 全球 Worldwide | ☐ 亞洲及澳紐 Asia & Australia-New Zealand |
| 自付費（每保單年度）<br>Deductible (Per policy year) | 港元 HK$ ☐ 0 ☐ 20,000 ☐ 40,000 ☐ 80,000 | |
| 繳費期 Payment Mode | ☐ 年繳 Annual ☐ 半年繳 Semi-annual ☐ 季繳▼ Quarterly▼ ☐ 月繳▼ Monthly▼<br>▼有關付款方法，請填寫第八部分的「信用卡付款指示及授權書」或「直接付款授權書」。<br>Please complete "Credit Card Payment Instruction and Authorisation" or "Direct Debit Authorisation" in part (VIII) for payment method. | |

註：如保單生效日與投保日不同，即以保單生效日決定已屆年齡。本公司將根據此計劃之保費表計算應繳金額。
Note: Policy Effective Date will be used to determine the age attained if it is different from the application date. The total amount payable will be calculated according to the premium table of this plan.

## (IV) 健康相關資料問卷 Questionnaire on Health-Related Information

準受保人必須回答下列問題以作核保之用：Proposed Insured Person is required to answer the following questions for underwriting purpose:

**資料收集聲明**

(i) 此問卷收集與健康相關的資料僅作為核保之用途，而核保是本公司評估申請人之健康風險及決定申請結果的程序。本公司採用的核保程序應為公平合理，並會因應客戶要求解釋申請結果。

(ii) 作為申請人，閣下需要盡其所知所信，按本問卷中要求向本公司提供完整及準確的資料。本公司根據閣下提供的資料，可能會提出跟進問題或查詢而需要閣下進一步提供資料以作核保之用。

(iii) 若閣下在提交本申請表後至閣下收到保單前的期間就本問卷中提供的資料有任何改變或更新，閣下需要及早通知本公司。

(iv) 即使已成功投保並獲簽發保單，若閣下未按（ii）所述盡其所知所信向本公司提供完整及準確的資料，或未按（iii）所述就資料的任何改變或更新而及早通知本公司，閣下的保險保障可能會受到影響，本公司亦可能因此終止、作廢或撤銷有關保單，或拒絕賠償。

**Statement for Collection of Information**

(i) This questionnaire collects health-related information solely for the purpose of underwriting which is a process for the Company to evaluate the health risk of the applicants and decide the application results. The underwriting process that the Company adopts should be fair and reasonable, and the Company should explain the application results if requested by the customers.

(ii) As the applicant, you are required to provide the Company with complete and accurate information requested in this questionnaire to the best of your knowledge and belief. Based on the information provided, the Company may have follow-up questions or enquiries that require you to provide further information for underwriting purpose.

(iii) If there are any changes to or updates of the information provided in this questionnaire after the time of submission of this application and before you receive the Policy, you are required to notify the Company in a timely manner.

(iv) Even after an insurance policy has been issued upon successful application, the insurance coverage for you may be affected or the policy may be terminated, voided or rescinded, or claims may be repudiated by the Company, if you have not provided the Company with complete and accurate information to the best of your knowledge and belief according to (ii), or if you have not notified the Company on any changes to or updates of the information in time according to (iii).

## 甲部 Part A – 基本資料 General Information

| | | | | | |
|---|---|---|---|---|---|
| 1. 身高 Height | 厘米 centimetres (cm) | | 或OR | | 呎／吋 feet/inches |
| 2. 體重 Weight | 公斤 kilogrammes (kg) | | 或OR | | 磅 pounds (lbs) |

## 乙部 Part B – 健康資料 Health Information

申請人須知：無需於乙部問題披露以下健康狀況或治療。
Note for applicant(s): Questions of Part B do not require the applicant(s) to disclose information regarding the medical conditions or treatments below.

傷風／感冒／喉嚨痛、腸胃炎／食物中毒（已痊癒）、消化不良（無需檢查）、痤瘡、肌肉扭傷（已痊癒）、鵝口瘡、常規產前掃描／血液檢驗（檢驗結果正常）、常規子宮頸細胞塗片檢驗（檢驗結果正常）、常規健康檢查（檢查結果正常）、預防疫苗、荷爾蒙補充治療（更年期）、不育治療或胎兒生長情況正常的懷孕、近視／遠視／散光／老花。
Cold / flu / sore throat, gastroenteritis / food poisoning (fully recovered), indigestions (no investigations required), acne, muscle sprained (fully recovered), thrush, routine scan / blood test for pregnancy (normal result), routine cervical smear (normal result), routine health check (normal result), preventive vaccination, Hormonal Replacement Therapy (menopause), infertility treatment or uncomplicated pregnancy, myopia / hyperopia / astigmatism / presbyopia.

若以下第1至8項任何一項問題之答案為「是」者，請於丙部回答相關的跟進問題。
If your answer to any of the questions 1 - 8 below is "Yes", please proceed to answer the relevant follow-up questions in Part C.

| 請在適當方格上填上「✓」。 Please tick "✓" the appropriate boxes. | 是 Yes | 否 No |
|---|---|---|
| 1. 您是否曾被確診下列疾病或健康狀況？<br>Have you ever been diagnosed with any of the following diseases or medical conditions? | | |
| (a) 癌症或原位癌<br>Cancer or carcinoma in situ | ☐ | ☐ |
| (b) 腦部腫瘤<br>Brain tumor | ☐ | ☐ |
| (c) 心臟疾病<br>Heart disease | ☐ | ☐ |
| (d) 中風（包括短暫性腦缺血，俗稱「小中風」）<br>Stroke (including transient ischemic attack (TIA)) | ☐ | ☐ |
| (e) 高血壓<br>Hypertension | ☐ | ☐ |
| (f) 糖尿病或葡萄糖耐量異常<br>Diabetes mellitus or impaired glucose tolerance | ☐ | ☐ |
| (g) 腎病<br>Kidney disease | ☐ | ☐ |
| (h) 椎間盤突出或脊椎退化性疾病<br>Prolapsed intervertebral disc or degenerative spine conditions | ☐ | ☐ |
| (i) 需要植入醫療儀器或義肢的疾病或健康狀況<br>Diseases or medical conditions requiring a medical device or prosthesis to be implanted within the body | ☐ | ☐ |
| (j) 人體免疫力缺乏病毒（愛滋病病毒）感染<br>Human immunodeficiency virus ("HIV") infection | ☐ | ☐ |
| (k) 先天性疾病（指於出生時或之前已存在的醫學、生理或精神上的異常）<br>Congenital conditions (medical, physical or mental abnormalities that existed at the time of or before birth) | ☐ | ☐ |
| (l) 身體缺陷、不健全、畸形，及／或影響活動能力、視力、說話能力或聽力的狀況<br>Physical defects, impairments, deformities, and / or conditions affecting mobility, sight, speech or hearing | ☐ | ☐ |
| (m) 精神健康狀況（例如抑鬱、焦慮、精神分裂、飲食失調或躁狂抑鬱症）<br>Mental health conditions (such as depression, anxiety, schizophrenia, eating disorders, or bipolar disorders) | ☐ | ☐ |
| (n) 高膽固醇症或高血脂症<br>Hypercholesterolemia or Hyperlipidemia | ☐ | ☐ |
| (o) 肝臟疾病（例如乙型或丙型肝炎（包括測試呈陽性反應）、脂肪肝或肝硬化）<br>Liver disorder (such as hepatitis B or hepatitis C (including tested positive), fatty liver or cirrhosis of liver) | ☐ | ☐ |
| (p) 多發性硬化症<br>Multiple sclerosis | ☐ | ☐ |
| 2. 您目前是否患有下列疾病或健康狀況？<br>Do you currently have any of the following diseases or medical conditions? | | |
| (a) 疝氣（俗稱「小腸氣」）<br>Hernia | ☐ | ☐ |
| (b) 乳房病變（腫瘤／硬塊／腫塊／囊腫／結節／增生）<br>Breast lesion (tumour / mass / lump / cyst / nodule / growth) | ☐ | ☐ |
| (c) 子宮或卵巢病變（腫瘤／硬塊／腫塊／囊腫／瘜肉／結節／增生）<br>Uterine or ovarian lesion (tumour / mass / lump / cyst / polyp / nodule / growth) | ☐ | ☐ |
| (d) 良性前列腺肥大<br>Benign prostatic hypertrophy | ☐ | ☐ |
| (e) 膽結石或泌尿道結石（腎結石、輸尿管結石或膀胱結石）<br>Gall bladder stone or urinary stone (renal stone, ureteric stones or urinary bladder stone) | ☐ | ☐ |
| (f) 白內障、青光眼或視網膜病變<br>Cataract, glaucoma or retinopathy | ☐ | ☐ |
| (g) 關節炎或其他關節疾病<br>Arthritis or other joint disorder | ☐ | ☐ |
| 3. 在過去五年內，您是否曾經或被建議定期或持續（例如每月、每兩個月、每半年、每年）為任何疾病或健康狀況接受專業醫護人員（例如專科醫生、物理治療師、精神科醫生）的跟進診治或醫療護理？<br>In the last 5 years, have you ever had or been advised to have any regular or ongoing (such as monthly, every 2 months, half-yearly, annually) follow-up consultations or medical care with a healthcare professional (such as specialist doctor, physiotherapist, psychiatrist) for any disease or medical condition? | ☐ | ☐ |
| 4. 在過去五年內，您是否曾被醫生建議定期（例如按醫生指示每日／每週一次／有需要時）服用為期超過一個月的處方藥物？<br>In the last 5 years, have you been advised by your doctor to take any medications (such as to be taken daily / once per week / as needed as directed by doctor) for a continuous period of more than one (1) month? | ☐ | ☐ |
| 5. 在過去五年內，您是否曾入住醫院？<br>In the last 5 years, have you been admitted into a hospital? | ☐ | ☐ |
| 6. 在過去五年內，您是否曾在非住院情況下接受外科程序（包括內窺鏡檢查或活組織化驗）？<br>In the last 5 years, have you undergone a surgical procedure (including endoscopy or biopsy) without being admitted into a hospital? | ☐ | ☐ |

## 乙部 Part B – 健康資料 Health Information

| 請在適當方格上填上「✓」。 Please tick "✓" the appropriate boxes. | 是 Yes | 否 No |
|---|---|---|
| 7. 在過去五年內，您是否曾接受或曾被建議接受檢查（例如驗血、驗尿、心電圖、X光、超聲波、電腦掃描、磁力共振、正電子掃描、愛滋病測試、乙型肝炎測試、丙型肝炎測試）？<br>In the last 5 years, have you ever had or been advised to undergo investigations (such as blood or urine test, ECG, X-ray, ultrasound, CT scan, MRI, PET scan, HIV test, Hepatitis B test, Hepatitis C test)? | ☐ | ☐ |
| 如果答案屬「是」，您的檢查結果是否包括下列情況？<br>If the answer is "Yes", do your investigation result(s) include the followings? | | |
| (a) 檢驗結果正常<br>Normal test result is advised | ☐ | ☐ |
| (b) 檢驗結果異常<br>Abnormal test result is advised | ☐ | ☐ |
| (c) 您正等候檢驗或檢驗結果<br>You are still awaiting test / test result | ☐ | ☐ |
| (d) 檢驗結果為無定論或不確定（需要重新或進一步檢驗）<br>Test result is inconclusive or uncertain (retesting or follow up test is required) | ☐ | ☐ |
| (e) 就檢驗結果已尋求醫療意見或需要接受治療（例如一些未必需要即時治療的情況如肝囊腫／腦囊腫／關節退化或鈣化／於成像檢測中發現肺部或乳房或甲狀腺出現鈣化）<br>Medical advice has been sought or treatment is required for the test result (such as liver cyst / brain cyst / joint degeneration or calcification / lung or breast or thyroid calcification discovered on imaging test, that may not require immediate treatment) | ☐ | ☐ |
| 8. 除了您在第1至7項問題中已披露的資料外，您是否有下列情況?<br>Apart from anything you have already disclosed in Questions 1 - 7, do you have any of the following conditions? | | |
| (a) 在過去一年內，體重無故地減少了5公斤（11磅）以上<br>Unintentional weight loss by more than 5 kg (11 lbs) over past 1 year | ☐ | ☐ |
| (b) 不正常出血（例如陰道出血、便血、流鼻血或咳血）至少一個月<br>Abnormal bleeding (such as vaginal bleeding, rectal bleeding, nose bleeding or coughing up of blood) for at least one month | ☐ | ☐ |
| (c) 在過去一年內，您有任何健康狀況或病徵及症狀曾經接受或需要接受專業醫護人員（例如專科醫生、物理治療師、精神科醫生）的跟進診治<br>In the last 1 year, you had or have been required to have follow-up consultation with a healthcare professional (such as specialist doctor, physiotherapist, psychiatrist) for any medical condition or sign and symptom | ☐ | ☐ |
| (d) 其他健康狀況或病徵及症狀（例如腫塊、頭痛、持續咳嗽、胸痛或上腹痛）而正在或打算尋求醫療意見<br>Other medical conditions or sign and symptom (such as lump, headache, persistent coughing, chest pain or epigastric pain) that you are seeking or intend to seek medical advice | ☐ | ☐ |

## 丙部 Part C – 健康資料補充 Supplementary Health Information

若乙部第1至8項任何一項問題之答案為「是」者，請在適用的問題提供更多資料。請盡量提供齊全資料（例如在未能回憶確實日期的情況下提供年份及月份）以便作出公平核保決定。
If the answer to any of the questions 1-8 in Part B is "Yes", please provide additional information as applicable. Please provide information as detailed as possible (e.g. provide year and month if exact date could not be recalled) for the sake of fair assessment in underwriting.

| **題號 Question No.**<br>題號1-8每題適用之跟進問題<br>Follow-up questions to each of Q1-8 as applicable | 疾病／健康狀況／病徵及症狀<br>Disease / medical condition / sign and symptom | 首次出現病徵及症狀的日期<br>Date of first occurrence of sign and symptom | a) 已進行的治療／檢查／測試／掃描<br>Treatment / investigations / tests / scans that have been performed<br>b) 有關治療／檢查／測試／掃描日期<br>Date of such treatment / investigation / tests /scan | 現況（例如是否已完全康復、有否跟進／服用跟進藥物／下次覆診日期）<br>Present condition (such as whether fully recovered, follow up action / medication / next follow up date) | 最後覆診／治療日期<br>Date of last follow-up medical consultation / treatment | 治療有關疾病／不適／健康狀況／病徵及症狀的醫生姓名※<br>Name of doctor who treated the disease / sickness / medical condition / sign and symptom※<br>醫院名稱（如適用）※<br>Name of Hospital, where applicable※ |
|---|---|---|---|---|---|---|
| | | | | | | |

※（注意：在保險公司聯絡申請人的醫生及／或醫院以獲取其醫療記錄前，需獲得申請人的書面同意。）
(Note: written consents from applicant are needed before an insurance company may approach the applicant's doctor and/or hospital for access to his/her medical records.)

## (V) 選擇拒絕在直接促銷中使用個人資料 Opt-out from Use of Personal Data in Direct Marketing

為向你提供最新消息、優惠及推廣活動的資訊，以及進行直接促銷活動，藍十字（亞太）保險有限公司（「藍十字」）可能會按「收集個人資料聲明」（「該聲明」）所述使用你的個人資料作直接促銷及把閣下的個人資料提供予該聲明第(4)(iii)段的聯盟計劃合作夥伴作直接促銷，但在未經你同意的情況下，藍十字不能就此目的使用及提供你的個人資料。若你不希望藍十字在直接促銷中使用及提供你的個人資料，請在下列空格內劃上「✓」號。

1. **使用個人資料直接促銷**
   - ☐ 我不同意藍十字根據該聲明第(4)段使用我的個人資料作直接促銷（例如通過向我提供最新消息、優惠及推廣活動的資訊）。
2. **把個人資料提供聯盟計劃合作夥伴**
   - ☐ 我不同意藍十字根據該聲明第(4)段把我的個人資料提供予聯盟計劃合作夥伴作直接促銷（例如通過向我提供最新消息、優惠及推廣活動的資訊），不論藍十字會否獲得金錢或其他財產的回報。

**以上代表你目前就是否希望接受藍十字及聯盟計劃合作夥伴直接促銷的聯繫或資訊的選擇，並取代你在本申請前可能曾給予藍十字的任何選擇。請注意，你以上的選擇將適用於列在該聲明內作直接促銷的產品、服務、建議及／或標的。請同時參閱該聲明以知悉可能用作直接促銷的個人資料種類以及可能轉移有關個人資料作直接促銷的資料轉承人類別。**

In order to provide you with the latest news, offers and promotions and to conduct direct marketing activities, Blue Cross (Asia-Pacific) Insurance Limited (Blue Cross) may use your personal data according to Blue Cross' Personal Information Collection Statement (the "Statement") and provide your personal data to its alliance program partners as set out in paragraph 4(iii) of the Statement for direct marketing but Blue Cross cannot use and provide your personal data for such purpose without your consent. Please tick "✓" in the box below if you do not wish Blue Cross to use and provide your personal data for direct marketing.

1. **Use of Personal Data in Direct Marketing**
   - ☐ I do not agree to Blue Cross' use of my personal data for direct marketing (such as by way of providing me updates on latest news, offers and promotions) as set out in paragraph (4) of the Statement.
2. **Provision of Personal Data in Direct Marketing to Alliance Program Partners**
   - ☐ I do not agree to Blue Cross' provision of my personal data to its alliance program partners for direct marketing (such as by way of providing me updates on latest news, offers and promotions) as set out in paragraph (4) of the Statement, whether or not for money or other property.

**The above represents your present choice of whether or not to receive direct marketing contact or information from Blue Cross and its alliance program partners. This shall replace any choice you may have given to Blue Cross prior to this application. Please note that your above choice shall apply to the direct marketing of the products, services, advice and/or subjects as set out in the Statement. Please also refer to the Statement for the kinds of personal data which may be used for direct marketing and the classes of persons to which your personal data may be provided for them to use in direct marketing.**

## (VI) 聲明及授權 Declaration and Authorisation

**本人／我們，謹此聲明並同意：**

1. 上述所有問題的答案包括所有資料及細節均是準確無誤，真實及為事實之全部，並且是盡本人／我們所知及所信而作答的。本人／我們並沒有隱瞞任何重要資料及同意此投保書之內容及聲明將成為此項保險合約之承保根據。本人／我們在此確認，如未能提供真實及準確無誤之資料或通知藍十字（亞太）保險有限公司（「貴公司」）任何有關此保險申請之重要資料，將可能導致貴公司不能接受或處理此保險申請或令本保單失效。在本人／我們簽署本申請書後直至收到保單前，本人／我們必須向貴公司披露有關本人／我們（包括準受保人）的健康狀況的任何改變。
2. 本人／我們確認貴公司有權要求本人／我們提供更多有關本人／我們之健康狀況，一切費用由本人／我們支付。本人／我們現授權任何知悉或持有本人／我們健康情況資料之註冊醫生、醫療從業員、醫院、診所或其他與醫療有關的機構、保險公司、組織、機構或人士提供本人／我們的健康或個人資料予貴公司及其授權代表／再保險公司，作為審核此投保書或處理根據此投保書所簽發之保單的相關索償之用。此授權書不可撤銷。本授權書之副本與正本具同等效力。
3. 本人／我們明白就有關本申請所作出的付款，並不保證可立刻批准所申請的承保範圍。承保範圍將於交妥第一期保費並發出有關保單後方能生效。一概保險賠償必須在本申請獲接納後並已將首次應付保費繳交予貴公司後始可生效。
4. 保單持有人將有權就一切有關於受保人的索償或按本申請所簽發之保單的相關事宜，與貴公司進行交涉，並向其接收或索取與受保人有關之資料。本人／我們並同意所有由貴公司給予保單持有人或受保人之賠償款項將會存入本投保書第一部分所指定之戶口內或於該戶口不存在時以支票支付，並完全解除貴公司就該些索償之一切承保責任。
5. 除本人／我們另有指明外，此乃自願醫保計劃的獨立新申請，並非從本人／我們在貴公司簽發的現有醫療保險計劃（如有）中轉移出來。
6. 接受貴公司醫療卡之條款（如適用），並於要求下即時償還任何不在承保範圍內的醫療費用及超出保障之外的醫療費用＜賠償差額＞。
7. **本人／我們明白及確認貴公司會就本人／我們購買及接受貴公司簽發的保單及其後續保該保單，向負責安排有關保單的獲授權保險經紀（如有）支付佣金。本人／我們若在此代表法人團體簽署，即同時確認本人／我們已獲該法人團體授權。本人／我們亦明白貴公司必須取得上述的同意，才可以處理有關保險申請事宜。**
8. 本人／我們確認已閱讀及明白產品小冊子、產品條款及細則，同意第四部分的資料收集聲明和隨本表格附上有關貴公司的收集個人資料聲明。
9. #在投保此計劃時，準保單持有人正身處香港。（#如不適用，請刪除）

**I/WE, HEREBY DECLARE AND AGREE THAT:**

1. The answers to all the above questions including all information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief. I/We have not withheld any material information and accept that this application and declaration shall form the basis of the contract between Blue Cross (Asia-Pacific) Insurance Limited ("the Company") and me/us. I/We hereby acknowledge that failure to supply true and accurate answers to this application or inform the Company of all material information about my/our application may render the Company unable to accept or process this application or the insurance policy void. I/We shall disclose to the Company any change in my/our/the proposed Insured Person's health after signing this application until I/we receive the policy.
2. I/We acknowledge that the Company reserves the right to ask for submission of more details of health status of me/us at my/our own cost. I/We hereby authorise any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organisation, institution or person, that has any records, knowledge or health information of me/us, to give to the Company, its authorised representatives/reinsurers any such information for the purpose of assessment of this application or subsequent assessment of any insurance claim under the insurance policy that may be issued pursuant to this application, such authorisation shall be irrevocable. A photographic copy of this authorisation shall be as valid as the original.
3. I/We understand that any payment made in connection with this application does not guarantee immediate approval of the coverage applied for. The insurance coverage applied for shall only take effect when the relevant policy is issued and the first premium is paid in full. The insurance coverage applied for shall only take effect when this application has been accepted by and the first premium has been paid to the Company.
4. The Policy Holder shall have the authority to deal with, receive or request for information from the Company concerning the Insured Person in relation to any claims or matters arising from the policy issued pursuant to this application. I/We further agree that payment of any benefits hereunder to the Policy Holder or Insured Person by the Company in relation to all medical claims shall be credited to the bank account as specified in part (I) of this application or made by cheque in the absence of such an account, which shall constitute a full discharge on the part of the Company in relation to such claims.
5. Unless otherwise specified by me/us, this is an independent new application on VHIS plan which is not migrated from my/our existing medical insurance plan (if any) issued under the Company.
6. To accept the terms and conditions for the usage of the medical card (if applicable) and reimburse the Company for non-eligible medical expenses or expenses exceeding the benefit limit (claim charge back) immediately upon demand.
7. **I/We understand and acknowledge that the Company shall pay the authorised insurance broker (if any) a commission for arranging the insurance policy, as a result of purchasing and taking up the policy issued by the Company as well as renewing the said policy thereafter. If I/we sign herein on behalf of a body corporate, I/we further confirm that I/we am/are authorised to do so. I/We further understand that the above agreement is necessary for the Company to proceed with the application.**
8. I/We confirm having read and understood the product brochure, terms and conditions of the product, agree Statement for Collection of Information in part (IV) and the Company's Personal Information Collection Statement as accompanied with this form.
9. #The proposed Policy Holder is physically present in Hong Kong as at the date of this application. (#delete if not applicable)

***冷靜期內取消保單的權利及退還保費***

本人明白本人有權以書面通知要求藍十字（亞太）保險有限公司取消保單並獲退還所有已繳保費及保費徵費。本人明白為行使這項權利，該取消保單的通知必須由本人簽署並由藍十字（亞太）保險有限公司在香港灣仔皇后大道東183號合和中心54樓之總辦事處於冷靜期內直接收到。本人明白冷靜期為緊接保單或冷靜期通知書交付予本人或本人的指定代表之日起計的21天的期間（以較早者為準）。本人明白冷靜期通知書是由藍十字（亞太）保險有限公司在交付保單時致予本人或本人的指定代表的一份通知書，以就冷靜期一事通知本人。

***Cancellation Rights and Refund of Premium(s) within Cooling-off Period***

I understand that I have the right to cancel the policy and obtain a refund of any premium(s) and levy paid by giving a written notice to Blue Cross (Asia-Pacific) Insurance Limited. I understand that to exercise this right, the notice of cancellation must be signed by me and received directly by Blue Cross (Asia-Pacific) Insurance Limited at 54/F Hopewell Centre,183 Queen's Road East, Wanchai, Hong Kong within the cooling-off period. I understand that the cooling-off period is the period of 21 days immediately following either the day of delivery of the policy or the cooling-off notice to me or my nominated representative (whichever is the earlier). I understand that the cooling-off notice is a notice that will be sent to me or my nominated representative by Blue Cross (Asia-Pacific) Insurance Limited to notify me of the cooling-off period around the time the policy is delivered.

| 日期（日／月／年）<br>Date at Hong Kong (dd/mm/yy) | 準保單持有人簽署<br>Signature of Proposed Policy Holder | 準受保人簽署<br>Signature of Proposed Insured Person |
|---|---|---|
| | | |

## (VII) 代理人／經紀專用 For Agent/Broker Use Only

| 代理人／經紀姓名<br>Agent/Broker Name | 代理人／經紀編號<br>Agent/Broker Code | 代理人／經紀電話<br>Agent/Broker Tel | 代理人／經紀傳真<br>Agent/Broker Fax |
|---|---|---|---|
| | | | |

## (VIII) 付款方法 Payment Method

**請選擇付款方法並且填寫適當部分。Please select a payment method and complete the appropriate section accordingly.**

☐ 支票付款（劃線支票抬頭**「藍十字（亞太）保險有限公司」**）（不適用於季繳及月繳）
By cheque (please make your crossed cheque payable to **Blue Cross (Asia-Pacific) Insurance Limited**) (Not applicable to quarterly and monthly payment)

☐ 信用卡付款（請填寫以下(a)部分）By credit card (please complete section (a) below)

☐ 銀行戶口自動轉賬（請填寫以下(b)部分）By bank account autopay (please complete section (b) below)

### (a) 信用卡付款指示及授權書 Credit Card Payment Instruction and Authorisation

（只接受準保單持有人之港元信用卡。Accept proposed Policy Holder's credit card in HK currency only.）

| | |
|---|---|
| ☐ Visa ☐ Mastercard | 信用卡戶口號碼<br>Credit Card Account No. |
| 持卡人姓名（姓／名）<br>Name of Cardholder (Surname/First Name) | 信用卡到期日（月／年）<br>Expiry Date (mm/yy) |

聲明：

（一） 本人現授權貴公司從本人所指定之信用卡戶口內扣除保單之任何保費（包括續保保費）、保險業監管局徵費及賠償差額（如適用），直至本人另行發出書面通知為止。

（二） 本人明白本人可隨時通知貴公司取消此授權，並同意該取消或更改本授權書通知，須於取消／更改生效日最少一個月之前交予貴公司及／或信用卡中心。

（三） 如選擇月繳，於投保時貴公司將預先收取首兩個月保費及保險業監管局徵費。

（四） 本人確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。

Declaration:

1. I hereby authorise the Company to effect debit of any premium (including renewal premium), levy to the Insurance Authority and claims charge back (if applicable) from the Credit Card Account specified herewith for the insurance policy, until further written notice is given by me.
2. I understand that I have the right to cancel this authorisation at any time and agree that any notice of cancellation or variation of this authorisation shall be given to the Company and/or Credit Card Centre at least 1 month prior to the effective date of such cancellation/variation.
3. If monthly payment mode is selected, the Company will charge 2-month premium and levy to the Insurance Authority in advance at the time of application.
4. I confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form.

| | |
|---|---|
| 持卡人簽署<br>Signature of Cardholder | 日期（日／月／年）<br>Date (dd/mm/yy) |

### (b) 直接付款授權書 Direct Debit Authorisation

（只接受15位數字或以下準保單持有人之香港銀行戶口。Accept proposed Policy Holder's Hong Kong bank account with 15 digits or below only.）

| 收款人名稱 Name of Party to be credited | 銀行編號 Bank Code | 分行編號 Branch Code | 貸方戶口號碼 Account No. to be credited |
|---|---|---|---|
| **Blue Cross (Asia-Pacific) Insurance Limited** | **0 1 5** | **5 2 1** | **4 0 0 5 0 1 2 4** |

聲明：

（一）本人／我們現授權下述銀行，由本人／我們之賬戶轉賬保單之任何保費（包括續保保費）及保險業監管局徵費予貴公司（根據貴公司不時給予本人／我們銀行之指示），直至本人／我們另行發出通知為止。

（二）本人／我們同意本人／我們之銀行毋須證實該等轉賬通知是否已交予本人／我們。

（三）如因該等轉賬而令本人／我們之戶口出現透支（或令現時的透支增加），本人／我們願共同及個別承擔全部責任。

（四）本人／我們同意如本人／我們之戶口並無足夠款項支付該等授權轉賬，本人／我們之銀行將有權不予轉賬，且銀行可收取慣常之收費。

（五）本人／我們明白本人／我們可隨時通知貴公司取消此授權，並同意該取消或更改本授權書之通知，須於取消／更改生效日最少7個工作天之前交予貴公司及／或本人／我們之銀行。

（六）本人／我們確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。

Declaration:

1. I/We hereby authorise the below named Bank to effect transfer of any premium (including renewal premium) and levy to the Insurance Authority from my/our account to the Company (in accordance with such instructions as my/our Bank may receive from the Company from time to time) for the policy, until further written notice is given by me/us.
2. I/We agree that my/our Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me/us.
3. I/We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our account which may arise as a result of any such transfer(s).
4. I/We agree that should there be insufficient funds in my/our account to meet any transfer hereby authorised, my/our Bank shall be entitled, in its discretion, not to effect such transfer and impose usual service charges on me/us.
5. I/We understand that I/we have the right to cancel this authorisation at any time and agree that any notice of cancellation or variation of this authorisation shall be given to the Company and/or my/our Bank at least seven (7) working days prior to the effective date of such cancellation/variation.
6. I/We confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form.

| 銀行名稱 Bank Name | 分行名稱 Branch Name | 銀行編號 Bank Code | 分行編號 Branch Code | 戶口號碼 Account No. |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| 戶口持有人姓名<br>Name of Account Holder(s) | 戶口持有人身份證號碼<br>HKID Card No. of Account Holder(s) |
| 戶口持有人簽署<br>Signature of Account Holder(s) | 日期（日／月／年）<br>Date (dd/mm/yy) |

請注意：

（一） 所有款項均以港元作出扣除。如須貨幣轉換，兑換率將由東亞銀行以該自動轉賬日所釐訂之兑換率為準。

（二） 此授權書內之簽名必須與閣下銀行戶口之簽名樣式完全相同。

（三） 設定直接付款授權指示需時，如選擇年繳、半年繳或季繳，請以劃線支票方式預先繳交全年、半年或一季之保費及保險業監管局徵費。如選擇月繳，請繳交首2個月之保費及保險業監管局徵費。

Please note:

1. All debits will be made in Hong Kong dollars. If currency conversion is required, the exchange rate will be determined by The Bank of East Asia, Limited as at the date of processing the direct debit transaction.
2. Please ensure that your signature(s) on this authorisation is/are the same as the specimen signature(s) on your Bank Account.
3. To allow sufficient time for the set-up of the direct debit authorisation, if annual, semi-annual or quarterly payment mode is selected, please arrange for submission of the annual, semi-annual or quarterly premium and levy to the Insurance Authority in advance by crossed cheque. If monthly payment mode is selected, please submit the first 2-month premium and levy to the Insurance Authority.