TheChoice Medical Insurance Application Form

智采醫療保險計劃申請表

 One application form for <u>one pers</u> Person to be insured must be appl Please tick as appropriated 請選擇 	icant himself or his spouse or			For Company Use only: 公司專用 Effective Date: (DD/MM/YYYY) 生效日期(日/月/年) / / /
Personal Details of Applicant (App 申請人個人資料(申請人年龄必須為		nolder and age 18 or ab	ove)	
Name in English (same as HKID Car 英文姓名(與香港身份證相同)		Given 1	Name 名	Name in Chinese 中文姓名
HKID Card No. 香港身份證號碼	()	Sex □ Male 性別 男	e □ Female 女
Date of Birth (DD/MM/YYYY) 出生日期(日/月/年)	Occupation (Applicable to / 職業(適用於同時為受保人的		e person to be insured)	Nationality (Optional) 國籍(非必要填寫)
Contact Details of Applicant 申請 Address 地址* (Please complete in)				
				dr.
Flat 單位 Building / Mansion / House / Estate 大廈/閣/樓/屋苑	Room 室	Floor 層數	Block /	¥
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 受作	呆人資料			
Please tick one only 請只選擇一項	 Myself (Details as above 本人(資料與以上相同) 	配偶	□ Child 子女	
Please provide average stay of the If the average stay is less than nine 如受保人之每年平均居港時間少於94	months, please provide the	e place of residence ou		months 月
Name in English (same as HKID Car 英文姓名(與香港身份證相同)			Name 名	Name in Chinese 中文姓名
HKID Card No. 香港身份證號碼	()	Sex □ Male 性別 男	e □ 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 Bene 主要保障			utpatient Benefit 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 le 附註:計劃級別必须	vel of the Hospitalization Benefit 頁與住院保障相同
 □ 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 (exc 每年總保費(不包括保費徵費)	luding Insurance levy)	1		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。

	alth Declaration (To be con 康聲明(由受保人填寫,若受係				the person	to be insur	ed is und	er the age of 18,	it can be comp	pleted by the a	pplicant)
١.	您的身高及體重 Your Height and Weight		Height: 身高:	m: 米:	cm: 厘米 :	fc 尺:	in: 寸:	Weight: 體重:	Kg: 公斤:	lb: 磅 :	
2.	Have you ever had or beer 您有否曾患上或獲悉患上下	-	f the follow	ring:						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 糖尿病或高血糖 	l sugar									
	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 在過去的5年裡,您有否曾說				ated for any	of the fol	lowing:			Yes 有	No 否
	 Carcinoma insitu, abno 原位癌, 異常生長或息 	o 1	yps								
	 Asthma, tuberculosis, 哮喘,肺結核,肺炎或, 		onic obstruct	tive lung	disease						
	iii. Stomach ulcer or pand 胃潰瘍或胰腺炎或胃炎	-									
	iv. High blood pressure o 高血壓或高膽固醇	r high cholesterol									
	v. Abnormal liver function 肝功能異常	n									
	vi. Nephritis or abnormal endometriosis 腎炎或腎功能異常、前			-				c ovarian syndro	me or		
	vii. Any injury or disorder disability 任何眼睛的受傷或病症		-			,		es, joints or spine	or physical		
	viii. HIV infection or positiv 愛滋病感染或愛滋病核										
	ix. Depression, mental dis 抑鬱症 · 精神病或智力		l disability								
4.	For any conditions other t 在過去3年中,除上述病狀外		he last 3 ye	ars, have	e you:					Yes 有	No 否
	 had ongoing follow-up 與醫生或專科醫生持續 				period of 6	months or	more?				
	ii. received medication c 服用禁物或接受治療,				tinuous peri	od of 2 we	eks or mo	pre?			
	 iii. had a surgical procedu report(s)) 進行手術或持縝住院超 				us period of	6 days or	more? (lf	yes, please provi	de relevant		
	iv. had an abnormal result colonoscopy or other 在血液測試、活組織檢 結果?(如有,請提交;	• investigation? (If y 查、心電圖、影像學	es, please pi	rovide re	elevant repo	ort(s))					

	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)					
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)?					

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 with no ongo treatment? 您是否已完当 正在進行治療	bing ≧康復及沒有	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 口	No 否		
			Yes 是	No 否		
			Yes 是 口	No 否		

個人銀行戶口 (只限)			
Bank Name 銀行名稱			Branch Code 分行
Premium Payment M	lethod 繳付保費方	法	
Payment Mode 付款期數	□ Yearly 每年	□ Monthly 每月	
	97	Note: If pa	ayment mode is m 睪每月付款,月費
Payment Method 付款方法	□ Cheque 支票		□ Credit Card 信用卡 (請り
If the Cardholder is r	not the applicant, p	lease fill in the follow	ing information. 若
Relationship with the 與申請人關係: □ spouse 配偶	e applicant	Reason for paying 代申請人支付保費	•
口 parents 父母 口 children 子女			
,		um and insurance lev 改保費及保費徵費金額	
Credit Card Paymen	t Authorisation 信	「用卡付款授權	
□ Visa 卡			Master Car
Cardholder's Name 持卡人姓名			
Credit Card Account 信用卡戶口號碼	No.		
	n) until further no	nce (Hong Kong) Col tice. 公司從本人上述之信	
×			

the	An	plic	ant)
une	×μ	plica	ant)

Bank account no. 銀行帳

thly, the monthly premium is equal to annual premium times 0.09. 诊年費乘以 0.09.

ease complete the below "Credit Card Payment Authorization" section) 引以下「信用卡付款授權」部分)

用卡持有人並非申請人,請填寫以下資料。

nce levy on behalf of the applicant

plication.

事達卡

Credit Card Expiry Date (MM/YY) 信用卡到期日 (月 / 年)

rge my above credit card account for the premium and insurance levy (including

所應繳之保費及保費徵費(包括續保保費)·直至另行通知。

1/YYYY)

Declaration and Authorisation 聲明及授權



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 2603 9435.

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 2603 9435 索取收集個人資料聲明副本。





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責料將根據保特保險(香港)有限公司之個人責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:

	b 1:Customer's medical insurance needs and objectives: 步:客戶醫療保險需求及目標:
- 第一	
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」
	□ 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

Step 2: Insurance intermediary product recommendation afte 第二步:產品合適性評估後,保險中介人之產品建議

Insurance intermediary product recommendations: 保險中介人之

Step 3: Customer selected product after product suitability 第三步:產品合適性評估後客戶選擇之產品

I / we confirm that I have gone through the above product suita 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

Plan name計劃名稱: _

Annual Deductible option (if applicable) 每年自付費選擇(如有): Optional benefit (if applicable) 自選保障(如有):_____

客戶聲明 Customer Declaration:

- I / We have read and understood the product brochure, in insurance product I / we selected. 本人/我們已細閱及明瞭本 及保單條款之內容。
- I / We confirm the medical insurance product I / we select combo product) is suitable for my / our insurance needs a product (including but not limited to (i) income protection hospitalization and medical treatment expenses due to illn premium. 本人/我們確認本人/我們所選擇之醫療保險產品 (1 的保險需要及購買醫療保險產品的目標(包括但不限於(i)住所 準備),及本人/我們有能力支付其所需的保費。
- I/ We confirm the medical insurance product I/we selected third parties. 本人/我們確認本人/我們所選擇之醫療保險產品
- 4) I / We understand the information contained in this form provided as reference only for my choice of medical insura and agree that the information contained in this form will Collection Statement ("PICS") of Bolttech Insurance (Hong 資料乃用作分析本人/我們的醫療保險需求,並為本人/我們 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
- 5) We understand that the analysis and choices made in this does not create any liability to Bolttech Insurance (Hong K 乃基於本人/我們所提供之資料而作出的,當中並不構成保報
- I / We understand that I /We am required to inform Bolted substantial changes to the information provided in this form 白·如本人/我們就此表格內的資料有任何重大更改·本人/

I / We, as the Applicant, confirm that I / we have read and correct information for the above on behalf of the propos 我們作為申請人確認已細閱及明瞭此表格之內容,並代表此料。

Applicant's name 申請人姓名	Applicant's 申請人簽署
Proposed insured's name (if different from the Applicant) 準受保人姓名(如跟申請人不同)	Proposed i 準受保人資
Name of Agent / Broker 經紀姓名	Agent's / Br 經紀編號

r product suitability ass	essment
2產品建議:	
ssessment	
bility assessment and c	onfirm the below medical insurance
下之醫療保險產品選擇	是本人/我們自己所決定的。
НК\$	
nformation sheet and po 人/我們所選擇之醫療例	blicy provision of the medical R險產品的產品小冊子、資訊單張
nd my / our objectives during hospital confine ness or injury), and I / w 包括任何種類之賠償、	pe of indemnity, non-indemnity, or for purchasing a medical insurance ment; (ii) preparation for the re can afford to pay the required 非賠償、或組合產品)符合本人/我們 為疾病或受傷之住院及其醫療費用作
was used to analyse my ance product and premi be handled in accordar Kong) Company Limite	on with no forced pressure from any 力下由本人/我們自行決定的。 y / our medical insurance needs and um amount. I / We also understand nee with the Personal information d. 本人/我們明白此表格內所提供之 金額時作參考。本人/我們亦明白此
form were based upon	the information provided and it 本人/我們明白此表格之分析及選擇 2任何責任。
ch Insurance (Hong Kor m prior to the insurance	g) Company Limited if there are any ce policy being issued. 本人/我們明 知保特保險(香港)有限公司。
sed insured / existing ins	ents in this form and provided all the sured listed in this application. 本人/ 受保人就以上問題提供正確無誤之資
ignature	<mark>///</mark> Date (DD / MM / YYYY) 日期(日/月/年)
sured's Signature 署	/ / Date (DD / MM / YYYY) 日期(日/月/年)
ker's Code	Agent's / Broker's signature 經紀簽署