

智采醫療保險計劃申請表

* 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。

TheChoice Medical Insurance 智采醫療計劃

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·若受保人為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	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>

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 <input type="checkbox"/>	No 否 <input type="checkbox"/>		
			Yes 是 <input type="checkbox"/>	No 否 <input type="checkbox"/>		
			Yes 是 <input type="checkbox"/>	No 否 <input type="checkbox"/>		
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.						<input type="checkbox"/> 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	<input type="checkbox"/> Yearly 每年 <input type="checkbox"/> 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	<input type="checkbox"/> Cheque 支票	<input type="checkbox"/> 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)
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 與申請人關係: <input type="checkbox"/> spouse 配偶 <input type="checkbox"/> parents 父母 <input type="checkbox"/> children 子女	Reason for paying premium and insurance levy on behalf of the applicant 代申請人支付保費及保費徵費的原因 _____	
<input type="checkbox"/> 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		
<input type="checkbox"/> Visa 卡	<input type="checkbox"/> 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)
<input type="checkbox"/> 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。		
X _____ Cardholder's Signature 持卡人簽署 Date 日期 (DD/MM/YYYY)		

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貴料將根據保特保險(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：

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

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

3) Critical illness insurance 危疾保險

4) 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

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Classified as C2 - General Business

Step 2: Insurance intermediary product recommendation after product suitability assessment
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: 保險中介人之產品建議：

Step 3: Customer selected product after product suitability assessment
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 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/我們已細閱及明瞭本人/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資料聲明予以處理。
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瞭此表格之內容，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
申請人姓名

Proposed insured's name
(if different from the Applicant)
準受保人姓名(如跟申請人不同)

Name of Agent / Broker
經紀姓名

Applicant's Signature
申請人簽署

Proposed insured's Signature
準受保人簽署

Agent's / Broker's Code
經紀編號

Date (DD / MM / YYYY)
日期(日/月/年)

Date (DD / MM / YYYY)
日期(日/月/年)

Agent's / Broker's signature
經紀簽署

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