Liberty International

# Individual Medical Insurance Application Form
# 個人醫療保險計劃申請表

## Part A Policyholder & Insured's Information 保單持有人及投保人資料

Name of Policyholder 保單持有人名稱 : _____ 香港身份證號碼 HKID No. : _____

Name of Insured (If other than Policyholder)投保人名稱(如非保單持有人): _____

Policyholder's Relationship to Insured 保單持有人與投保人關係: _____

Insured's Marital Status 投保人婚姻狀況: _____ Nationality 國籍: _____ Occupation 職位: _____

e-mail 電郵地址: _____ Fax 傳真號碼: _____ Home/Mobile 家居/流動電話: _____

Residential Address 住址: _____

Name of Company 公司名稱 : _____ Business Nature 公司性質: _____

Company as Policyholder 公司爲保單持有人 : ☐ Yes 是* ☐ No 否

* no premium refund nor replacement enrollment allowed upon staff termination of services with the Employer
中途斷保將不被退回保費或更換新投保人

Tel. No. 電話: _____ Contact Person 聯絡人: _____

Company Address 公司地址 : _____

| **Plan Name 投保計劃** | **Plan Cover 投保福利** | **Plan No. 計劃編號** (Tick as appropriate ✓ 如適用請✓) |
|---|---|---|
| | Basic Hospital Benefits 基本住院保障 | ☐ Plan 計劃_____ |
| | Supplementary Major Medical Benefit 附加重症醫療保障 | ☐ Plan 計劃_____ 必須與基本住院保障同級 Must be same as basic hospital benefit |
| | Outpatient Benefits 門診保障 | ☐ Plan 計劃_____ |
| Total Premium 總保費 | | HKD$ |

## Part B Insured & Insured Dependents' Information 投保人及投保家屬資料

| Surname / Other name 姓 / 名 | Relationship 關係 | HKID No. 香港身份證號碼 | Sex 男/女 | Date of Birth (M/D/Y) 出生日期 (月/日/年) | Country of Residence 現居地 | Height / Weight 身高 / 體重 | Exact Duties 工作範圍 |
|---|---|---|---|---|---|---|---|
| | SELF 本人 | ( ) | | | | | |
| | SPOUSE 配偶 | ( ) | | | | | |
| | CHILD 子女 | ( ) | | | | | |
| | CHILD 子女 | ( ) | | | | | |

## Part C Health Statement 病歷聲明

| | Yes 是 | No 否 |
|---|---|---|
| 1. Have you or any of the Insured has any congenital, acquired physical defect / impairment or now pregnant? 閣下及家屬是否有任何先天或後天肢體缺損，或現正懷孕？ | ☐ | ☐ |
| 2. Have you or any of the Insured ever been refused enrolment or renewal of life or medical insurance, or subject to special terms and conditions or additional premium? 閣下及投保家屬是否於投保或續保任何人壽或醫療保險時被拒或附加條件或增加保費始被接納? | ☐ | ☐ |
| 3. In the last three years, have you or any of the Insured had any surgical operation, been confined or treated in hospital, sanatorium or other medical institution or do any of the Insured know any circumstances for which medical treatment may be necessary in the next twelve months? 在過去三年內，閣下及投保家屬曾否接受任何手術或曾經在醫院，療養院或其他醫療機構接受治療或可有投保人知道在未來十二個月內需要進院接受任何治療？ | ☐ | ☐ |
| 4. In the last three years, have you or any of the Insured ever suffered from, aware of or been treated for tuberculosis, diabetes mellitus, rheumatic fever, hepatitis, respiratory or lung disorder, heart condition, varicose veins, high blood pressure, hyperlipidaemia, disorder of thyroid gland, disorder of the alimentary canal bowel, liver or gall bladder, kidney, genito-urinary system or venereal disease, cancer or tumors, lumps or fibroids, epilepsy, mental or psychiatric disorders, bone, joint, ligament, muscle, skin, hernia or gynaecological disorders? 在過去三年內，閣下及投保家屬曾否患有、已知道存在或曾經接受治療肺結核、糖尿、風濕性熱、肝炎、呼吸及肺功能不正常、心臟疾病、曲張靜脈、高血壓、高血脂、甲狀腺不正常、消化器官不正常、肝臟或膽囊、腎臟、生殖泌尿功能失調、性病、癌症或腫瘤、腫塊或纖維瘤、癲癇、心智或精神功能失調、骨骼、關節、韌帶、肌肉、皮膚、疝氣或婦科病？ | ☐ | ☐ |

If the answer to any of the above questions is yes, please provide details 如以上問題之答案爲是，請提供詳細資料：
(Please use separate sheet if the space is insufficient, 如空位不足，請另頁書寫。)

| Question No. 問題題號 | Insured Name 投保人姓名 | Name of diagnosis 病症名稱 | Medical History / Date of Occurrence 過往病歷紀錄 / 發生日期 | Treatment Received 所需之治療 | Present Condition 現時情況 |
|---|---|---|---|---|---|
| | | | | | |

Name and Address of Family physician: 閣下／家庭常診的醫生姓名或地址： _____

_____ Tel 電話: _____

## Personal Data Collection Statement 個人資料須知聲明

**Part I (applicable to Insured)** The information you provide to us is collected to enable us to administer any insurance product or service applied for, or any alternations, variations, cancellation or renewal; any claim or investigation or analysis of such claim; and exercising right of subrogation. The said information may be transferred to any other company carrying on insurance or reinsurance related business or an intermediary or a claim or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes and our direct marketing; or any association, federation or similar organization of insurance companies (Federation) that exists or is formed from time to time.

**Part II (applicable to Company as Policyholder)** The Company understands that (a) it is duly authorized to release the information of its being the Insured and their Insured Dependants Member and will fully indemnify Liberty for any losses, damages, or claims that might result from the release of such information; (b) Liberty may not process this Application if it fails to obtain any information requested in this Application; and (c) it has the right to obtain access to and to request amendments of any personal information held by Liberty concerning the Insured Members and to inform all Members regarding this contract before submitting their personal information to Liberty. Liberty shall not accept any liability for uninformed Members. You may contact Liberty's personal data privacy officer at the address below for any request to access and/or correct any information supplied to us. Moreover, Liberty International Insurance Ltd is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance Industry.

甲: (投保人適用): 閣下所提供的資料，爲本公司提供保險產品/服務之行政業務所需，或該類產品或服務的任何更改、變更、取消、或續期、任何索償及有關之調查或分析；行使任何代位權。以上資料，可轉移於任何其它從事與保險或再保險業務有關的公司；或與保險業務有關的中介人或索償或調查或其它服務提供者，以達到任何上述或有關目的或用作直銷; 或現存或不時成立的任何保險公司協會或聯會或類同組織「聯會」，以達到任何上述或有關目的。

乙: (投保公司適用): 本公司明白(a)本公司獲得正式授權，可以提供其僱員及其家屬的資料予利寶，並全面保障利寶免因提供該資料而遭受任何損失、損害或索償; (b)倘若申請人未能提供本申請所需的資料，利寶可能未能處理本申請;及(c)申請人有權查閱及要求更正利寶持有有關投保人的所有個人資料及在遞交所需之個人資料予利寶前，須就有關合約通知所有投保人。利寶不會就投保人未獲通知而負上任何責任。閣下可聯絡本公司個人資料私隱主任，地址如下，要求查閱/更改任何交予本公司閣下的個人資料。此外，在此授權利寶國際保險有限公司由「聯會」從保險業內收集的資料中查閱及/或核對閣下的任何資料。

## Part D Method of Payment 付款方法

☐ Yearly by Cheque 以支票年繳

Please make cheque payable to "Liberty International Insurance Limited". Post dated cheque will not be accepted

請提供劃線支票，抬頭請註明「利寶國際保險有限公司」。期票將不予接受。

☐ Yearly by Credit Card 以信用咭繳付

I hereby authorize and request Liberty International Insurance Limited to debit the initial premiums and subsequent premiums from my VISA/Master Card Account for the premium stated on the proposal form and subsequent renewal invitation.

本人茲授權並要求利寶國際保險有限公司從本人下列之VISA/萬事達咭戶口內支付本申請書或續保通知書所註明之首年及其後應繳之保費。

Name of Policyholder/Cardholder保單/信用咭持有人姓名: _____ Expiry Date屆滿日期: _____/_____ (M月/Y年)

VISA/MasterCard Account No. 帳戶號碼: _____-_____-_____-_____

Cardholder's Signature 持咭人簽署 _____ Date 日期 _____

Relationship with Policyholder (if the Cardholder is other than Policyholder) 與保單持有人的關係 (如持咭人非保單持有人)_____

## Declaration & Authorization 投保人聲明/授權

**Declaration**: I/We hereby apply to be enrolled in the Plan together with the Insured(s) listed overleaf. I declare to the best of my knowledge and belief that the information given in this Application is true and complete. I acknowledge on behalf of all Insured that benefits will not apply to treatment arising from any existing diseases, injuries, ailments or conditions which have been diagnosed, aware of and/or treated prior to the first day of this insurance. It is agreed that this declaration and information given in this Application shall form the basis of the contract between the Insured and the Insurer. I/We have read and agreed to be bound by the Policy and I accept them to be part of the contract of insurance issued as a result of this application. I/we understand this insurance is unavailable to permanent residents outside Hong Kong. Purchase of this insurance by permanent residents outside Hong Kong will render the policy null and void.

**Authorization**: I/We authorize Liberty International Insurance Ltd to provide and collect information about me/us in connection with this application and subsequent assessment of any insurance claim under the policy that may be issued pursuant to this application from other organizations, institutions or other persons, including other insurance companies/medical service provider, and to compare such information with my personal data, and to use the results for taking of any actions that may be adverse to my/our interests (including declining this application). This authorization shall survive me and shall be irrevocable and photocopy of this authorization shall be as valid as original.

**投保人聲明**：本人及申請書內各人現向貴公司投購醫療保險謹聲明已就實情完整地將本人及各投保人的資料填報於投保書內。本人謹代表所有投保人同意，凡因原患之疾病、損傷或其他知道情況而引致之醫療需要，一律不予賠償。本人已細讀並同意遵守本計劃之各條例並同意這份聲明及投保書將被用作投保／受保雙方合約的基礎，及同意長期在香港以外居留之人仕，均不獲接受投購本醫療計劃，上述人仕在本港購買後如需離港定居海外，此保單即屬無效。

**授權**：本人(等)授權利寶國際保險有限公司向 / 從其他組織或機構(包括其他保險公司/醫療提供者)收集關於本人(等)的必須投保資料及其後索償申請之資料並與本人(等)的個人資料作出比較並利用比較結果採取任何行動，包括不符合本人(等)利益者(包括不接納此申請)；此授權不能推翻，即使本人(等)去世，此授權仍然有效。此授權書之影印本與正本具同等效力。

I/we understand that the effective date shall be the date when this application is accepted by Liberty International Insurance Ltd.

本人(等)明白有效日期須爲利寶國際有限公司接受此申請之日期

| Name of Insured 投保人姓名 | Signature of Insured 投保人簽署 (on behalf of all Insured Members 代表各投保人) | Date 日期 |
|---|---|---|
| Name of Policyholder 保單持有人姓名 (if other than the Insured 如非投保人) | Signature of Policyholder 保單持有人簽署 (if other than the Insured 如非投保人) Note: If Company, Authorized Signature with Company chop is required 註: 如公司爲保單持有人則公司授權人簽署加公司蓋章 | Date 日期 |
| Trans-Pacific Insurance Brokers Ltd<br>Name of Agent/Broker 保險顧問公司/代理人姓名 | Signature of Agent/Broker with Company chop 保險顧問公司/代理人簽署及公司蓋章 | Date 日期 |