



# Care & Health

Hong Kong

2023 Application Form

## Your details ("MAIN INSURED")

Last name \_\_\_\_\_ First name \_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (dd/mmm/yyyy) Nationality \_\_\_\_\_ Gender (M/F) \_\_\_\_\_

Residential address <sup>(1)</sup> \_\_\_\_\_

City \_\_\_\_\_ Country \_\_\_\_\_ Postcode \_\_\_\_\_

Mailing address (if different from above) \_\_\_\_\_

City \_\_\_\_\_ Country \_\_\_\_\_ Postcode \_\_\_\_\_

Phone number \_\_\_\_\_ Mobile <sup>(2)</sup> \_\_\_\_\_ E-mail <sup>(2)</sup> \_\_\_\_\_

Occupation \_\_\_\_\_

## Dependants to be included in the plan

### DEPENDANT 1

Relationship to Main Insured (Spouse/Child): \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ NRIC/Passport Number: \_\_\_\_\_  
(dd/mmm/yyyy)

Nationality: \_\_\_\_\_ Country of Usual Residence <sup>(1)</sup>: \_\_\_\_\_

### DEPENDANT 2

Relationship to Main Insured (Spouse/Child): \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ NRIC/Passport Number: \_\_\_\_\_  
(dd/mmm/yyyy)

Nationality: \_\_\_\_\_ Country of Usual Residence <sup>(1)</sup>: \_\_\_\_\_

### DEPENDANT 3

Relationship to Main Insured (Spouse/Child): \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ NRIC/Passport Number: \_\_\_\_\_  
(dd/mmm/yyyy)

Nationality: \_\_\_\_\_ Country of Usual Residence <sup>(1)</sup>: \_\_\_\_\_

### DEPENDANT 4

Relationship to Main Insured (Spouse/Child): \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ NRIC/Passport Number: \_\_\_\_\_  
(dd/mmm/yyyy)

Nationality: \_\_\_\_\_ Country of Usual Residence <sup>(1)</sup>: \_\_\_\_\_

<sup>(1)</sup> The country in which you and your dependents will reside for at least 6 months of the year is called Country of Usual Residence.

<sup>(2)</sup> We can send you confirmation by SMS of any hospital guarantee we issue if you provide us with your mobile phone number. An email address, however, must be provided as we will send invoices and claim statements by email.

### For Newborn to be included in the plan

For submission of application form to include your newborn child, please advise the following:

**Is your newborn conceived via assisted conception: Yes / No**

If yes, please complete the Health Declaration for full medical underwriting

### Effective date of coverage

When would you like your cover to start?

\_\_\_\_/\_\_\_\_/\_\_\_\_

dd mmm yyyy

Your membership and that of your dependants are effective on the date indicated on your Certificate of Insurance, and at the earliest on the day after we receive the Application Form and Medical Questionnaire Form duly filled and signed, along with all requested additional information, subject to approval by Henner Medical Advisory Board and payment of first premium.

### Payment

How would you like to pay your premium?

☐ Annually ☐ Semi-annual ☐ Quarterly

*(Non annual payment are subject to a 3% loading)*

Select your method of payment:

☐ Visa / MasterCard *(For payment by credit card, upon receipt of your invoice, go to [www.henner.com](http://www.henner.com), log into your secure personal account and register your credit card details online)*

☐ Bank Transfer *(Account details for transfer will be provided with your invoice)*

## ► Choose your plan

Please tick here ☐ if coverage for all Dependants are the same as the Main Insured.

|                                                               | MAIN INSURED                                                                                                                                                                                                                                                                                                                                              | DEPENDANTS                                                                                                                                |                                                                                                                                           |                                                                                                                                           |                                                                                                                                           |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                                                                                                                                                                                                                                                                                                                           | DEPENDANT 1                                                                                                                               | DEPENDANT 2                                                                                                                               | DEPENDANT 3                                                                                                                               | DEPENDANT 4                                                                                                                               |
| Plan                                                          | <input type="checkbox"/> Primary <input type="checkbox"/> Vitality<br><input type="checkbox"/> Serenity <input type="checkbox"/> Prestige                                                                                                                                                                                                                 | <input type="checkbox"/> Primary <input type="checkbox"/> Vitality<br><input type="checkbox"/> Serenity <input type="checkbox"/> Prestige | <input type="checkbox"/> Primary <input type="checkbox"/> Vitality<br><input type="checkbox"/> Serenity <input type="checkbox"/> Prestige | <input type="checkbox"/> Primary <input type="checkbox"/> Vitality<br><input type="checkbox"/> Serenity <input type="checkbox"/> Prestige | <input type="checkbox"/> Primary <input type="checkbox"/> Vitality<br><input type="checkbox"/> Serenity <input type="checkbox"/> Prestige |
| Type of Room                                                  | <input type="checkbox"/> Standard private room <input type="checkbox"/> Semi-private room                                                                                                                                                                                                                                                                 |                                                                                                                                           |                                                                                                                                           |                                                                                                                                           |                                                                                                                                           |
| Hospital Network                                              | <input type="checkbox"/> All Hospitals <input type="checkbox"/> Restricted Providers (Tier-1 Hospitals exclusion)                                                                                                                                                                                                                                         |                                                                                                                                           |                                                                                                                                           |                                                                                                                                           |                                                                                                                                           |
| Area of Coverage                                              | <input type="checkbox"/> Worldwide excluding the USA <input type="checkbox"/> ASEAN excluding Singapore<br>(Includes Indonesia, Malaysia, Philippines, Thailand, Brunei, Vietnam, Laos, Myanmar and Cambodia)<br>You will be covered for trips up to 90 consecutive days outside your chosen Area of cover in the event of any accident or sudden illness |                                                                                                                                           |                                                                                                                                           |                                                                                                                                           |                                                                                                                                           |
| Emergency Assistance, Repatriation & Evacuation are included. |                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                           |                                                                                                                                           |                                                                                                                                           |                                                                                                                                           |

## ► Choose to reduce your premium

|                          | MAIN INSURED                                                                                                                                  | DEPENDANTS                                                                                                                                    |                                                                                                                                               |                                                                                                                                               |                                                                                                                                               |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
|                          |                                                                                                                                               | DEPENDANT 1                                                                                                                                   | DEPENDANT 2                                                                                                                                   | DEPENDANT 3                                                                                                                                   | DEPENDANT 4                                                                                                                                   |
| Inpatient Deductible     | <input type="checkbox"/> NIL<br><input type="checkbox"/> USD 2500<br><input type="checkbox"/> USD 5000<br><input type="checkbox"/> USD 10 000 | <input type="checkbox"/> NIL<br><input type="checkbox"/> USD 2500<br><input type="checkbox"/> USD 5000<br><input type="checkbox"/> USD 10 000 | <input type="checkbox"/> NIL<br><input type="checkbox"/> USD 2500<br><input type="checkbox"/> USD 5000<br><input type="checkbox"/> USD 10 000 | <input type="checkbox"/> NIL<br><input type="checkbox"/> USD 2500<br><input type="checkbox"/> USD 5000<br><input type="checkbox"/> USD 10 000 | <input type="checkbox"/> NIL<br><input type="checkbox"/> USD 2500<br><input type="checkbox"/> USD 5000<br><input type="checkbox"/> USD 10 000 |
| Outpatient Co-insurance* | <input type="checkbox"/> NIL<br><input type="checkbox"/> 10%<br><input type="checkbox"/> 20%                                                  | <input type="checkbox"/> NIL<br><input type="checkbox"/> 10%<br><input type="checkbox"/> 20%                                                  | <input type="checkbox"/> NIL<br><input type="checkbox"/> 10%<br><input type="checkbox"/> 20%                                                  | <input type="checkbox"/> NIL<br><input type="checkbox"/> 10%<br><input type="checkbox"/> 20%                                                  | <input type="checkbox"/> NIL<br><input type="checkbox"/> 10%<br><input type="checkbox"/> 20%                                                  |

\*Co-insurance selected will be applicable to the chosen Add on benefits

## ► Choose your Add on benefits

You are free to customize your base plan by adding optional modules, as long as they are within the same level or lower. Please tick accordingly to opt in for additional benefits plan below.

|                                                                                                                            | MAIN INSURED                                                                                                                                       | DEPENDANTS                                                                                                  |                                                                                                             |                                                                                                             |                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
|                                                                                                                            |                                                                                                                                                    | DEPENDANT 1                                                                                                 | DEPENDANT 2                                                                                                 | DEPENDANT 3                                                                                                 | DEPENDANT 4                                                                                                 |
| DEPENDENTS MAY PURCHASE ADD ON BENEFITS (WELLNESS, DENTAL OR VISION) ONLY IF THE MAIN INSURED HAS OPTED FOR THESE BENEFITS |                                                                                                                                                    |                                                                                                             |                                                                                                             |                                                                                                             |                                                                                                             |
| Wellness                                                                                                                   | <input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                                                             | <input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                      | <input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                      | <input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                      | <input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                      |
| Dental                                                                                                                     | <input type="checkbox"/> Vitality<br><input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                        | <input type="checkbox"/> Vitality<br><input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige | <input type="checkbox"/> Vitality<br><input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige | <input type="checkbox"/> Vitality<br><input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige | <input type="checkbox"/> Vitality<br><input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige |
| Dental is available for Vitality (with 20% co-insurance), Serenity and Prestige                                            |                                                                                                                                                    |                                                                                                             |                                                                                                             |                                                                                                             |                                                                                                             |
| Vision                                                                                                                     | <input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                                                             | <input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                      | <input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                      | <input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                      | <input type="checkbox"/> Serenity<br><input type="checkbox"/> Prestige                                      |
| Vision is available only if Dental has been selected.                                                                      |                                                                                                                                                    |                                                                                                             |                                                                                                             |                                                                                                             |                                                                                                             |
| Maternity                                                                                                                  | <input type="checkbox"/> Serenity <input type="checkbox"/> Prestige<br>Only available if spouse is also enrolled in Vitality, Serenity or Prestige |                                                                                                             |                                                                                                             |                                                                                                             |                                                                                                             |

**Total annual premium including all dependants: USD \_\_\_\_\_/year**

Levy collected by the Insurance Authority of Hong Kong is not included in the above amount and will be imposed on this policy at the applicable rate and is remitted to the Authority accordingly. For more information regarding the levy, please do refer to the webpage of the Insurance Authority of Hong Kong at [https://www.ia.org.hk/en/aboutus/role/financial\\_arrangements.html](https://www.ia.org.hk/en/aboutus/role/financial_arrangements.html)

## Your declaration

I, the undersigned, certify that the information filled in this Application Form is accurate and true. I certify having provided full disclosure and not having withheld any information which might affect the risk assessment. I understand and have taken note that any false declaration or non-disclosure will void coverage under this policy, and that in this case the insurer will retain paid premiums as civil damages and that I shall have to reimburse benefits paid for all beneficiaries.

I hereby apply for cover under the Care & Health plan, designed by Henner, administered by GMC Services Asia Pacific and insured by AXA General Insurance Hong Kong Limited. I acknowledge that I have read and understood the coverage described in the table of benefits and the General Conditions of the Care & Health plan for which I am applying.

I have duly noted that my enrollment under the Care & Health policy shall be effective subject to:

- Approval by the Henner Medical Advisory Board of the enclosed Medical Questionnaire duly filled
- Payment of premium

### **For Telemedicine**

I note that all material displayed on the MyDoc Website and/or Portal are provided without any guarantees, conditions or warranties to its accuracy. Unless expressly stated to the contrary to the fullest extent permitted by law, Post and Telecommunication Joint Stock Insurance Corporation, Henner and its subsidiaries.

MyDoc and its suppliers, content providers and advertisers hereby expressly exclude all conditions, warranties and other terms which might otherwise be implied by statute, common law or the law of equity and shall not be liable for any damages whatsoever, including but without limitation to any direct, indirect, special, consequential, punitive or incidental damages or damages of loss of use, profits, data or other intangibles, damage to goodwill or reputation, or the cost of procurement of substitute goods and services, arising out of or related to the use, inability to use, performance or failures of the Website or any materials posted thereon, irrespective of whether such damages were foreseeable or arise in contract, tort, equity, restitution, by statute, at common law or otherwise.

## Personal Information Collection Statement

AXA General Insurance Hong Kong Limited (referred to hereinafter as the “Company”) recognises its responsibilities in relation to the collection, holding, processing, use and/or transfer of personal data under the Personal Data (Privacy) Ordinance (Cap. 486) (“**PDPO**”). Personal data will be collected only for lawful and relevant purposes and all practicable steps will be taken to ensure that personal data held by the Company is accurate. The Company will take all practicable steps to ensure security of the personal data and to avoid unauthorised or accidental access, erasure or other use.

Please note that if you do not provide us with your personal data, we may not be able to provide the information, products or services you need or process your request.

**Purpose:** From time to time it is necessary for the Company to collect your personal data (including credit information and claims history) which may be used, stored, processed, transferred, disclosed or shared by us for purposes (“**Purposes**”), including:

1. offering, providing and marketing to you the products/services of the Company, other companies of the AXA Group (“**our affiliates**”) or our business partners (see “**Use and provision of personal data in direct marketing**” below), and administering, maintaining, managing and operating such products/services;
2. processing and evaluating any applications or requests made by you for products/services offered by the Company and our affiliates;
3. providing subsequent services to you, including but not limited to administering the policies issued;
4. any purposes in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Company and/or our affiliates, including investigation of claims;
5. detecting and preventing fraud (whether or not relating to the products/services provided by the Company and/or our affiliates);

6. evaluating your financial needs;
7. designing products/services for customers;
8. conducting market research for statistical or other purposes;
9. matching any data held which relates to you from time to time for any of the purposes listed herein;
10. making disclosure as required by any applicable law, rules, regulations, codes of practice or guidelines or to assist in law enforcement purposes, investigations by police or other government or regulatory authorities in Hong Kong or elsewhere;
11. conducting identity and/or credit checks and/or debt collection;
12. complying with the laws of any applicable jurisdiction;
13. carrying out other services in connection with the operation of the Company's business; and
14. other purposes directly relating to any of the above.

**Transfer of personal data:** Personal data will be kept confidential but, subject to the provisions of any applicable law, may be provided to:

1. any of our affiliates, any person associated with the Company, any reinsurance company, claims investigation company, your broker, industry association or federation, fund management company or financial institution in Hong Kong or elsewhere and in this regard you consent to the transfer of your data outside of Hong Kong;
2. any person (including private investigators) in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Company and/or our affiliates;
3. any agent, contractor or third party who provides administrative, technology or other services (including direct marketing services) to the Company and/or our affiliates in Hong Kong or elsewhere and who has a duty of confidentiality to the same;
4. credit reference agencies or, in the event of default, debt collection agencies;
5. any actual or proposed assignee, transferee, participant or sub-participant of our rights or business;
6. any government department or other appropriate governmental or regulatory authority in Hong Kong or elsewhere; and
7. the following persons who may collect and use the data only as reasonably necessary to carry out any of the purposes described in paragraphs nos. 2, 3, 4 and 5 of the Purposes specified above: insurance adjusters, agents and brokers, employers, health care professionals, hospitals, accountants, financial advisors, solicitors, organisations that consolidate claims and underwriting information for the insurance industry, fraud prevention organisations, other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check data provided against existing data.

For our policy on using your personal data for marketing purposes, please see the section below **“Use and provision of personal data in direct marketing”**.

Transfer of your personal data will only be made for one or more of the Purposes specified above.

**Use and provision of personal data in direct marketing:** The Company intends to:

1. use your name, contact details, products and services portfolio information, transaction pattern and behaviour, financial background and demographic data held by the Company from time to time for direct marketing;
2. conduct direct marketing (including but not limited to providing reward, loyalty or privileges programmes) in relation to the following classes of products and services that the Company, our affiliates, our co-branding partners and our business partners may offer:
  - a) insurance, banking, provident fund or scheme, financial services, securities and related products and services;
  - b) products and services on health, wellness and medical, food and beverage, sporting activities and membership, entertainment, spa and similar relaxation activities, travel and transportation, household, apparel, education, social networking, media and high-end consumer products;
3. the above products and services may be provided by the Company and/or:
  - a) any of our affiliates;
  - b) third party financial institutions;

- c) the business partners or co-branding partners of the Company and/or affiliates providing the products and services set out in (2) above;
  - d) third party reward, loyalty or privileges programme providers supporting the Company or any of the above listed entities
4. in addition to marketing the above products and services, the Company also intends to provide the data described in (1) above to all or any of the persons described in (3) above for use by them in marketing those products and services, and the Company requires your written consent (which includes an indication of no objection) for that purpose;

Before using your personal data for the purposes and providing to the transferees set out above, the Company must obtain your written consent, and only after having obtained such written consent, may use and provide your personal data for any promotional or marketing purpose.

You may in future withdraw your consent to the use and provision of your personal data for direct marketing.

If you wish to withdraw your consent, please inform us in writing to the address in the section on “**Access and correction of personal data**”. The Company shall, without charge to you, ensure that you are not included in future direct marketing activities.

**Access and correction of personal data:** Under the PDPO, you have the right to ascertain whether the Company holds your personal data, to obtain a copy of the data, and to correct any data that is inaccurate. You may also request the Company to inform you of the type of personal data held by it.

Requests for access and correction or for information regarding policies and practices and kinds of data held by the Company should be addressed in writing to: Data Privacy Officer of AXA General Insurance Hong Kong Limited, 10 - 11/F, Vertical Square, 28 Heung Yip Road, Wong Chuk Hang, Hong Kong. A reasonable fee may be charged to offset the Company’s administrative and actual costs incurred in complying with your data access requests.

I/WE ACKNOWLEDGE AND CONFIRM that I/we have read and understood the Personal Information Collection Statement (“**PICS**”). I/We confirm that I/we have been advised to read carefully the PICS, and I/we have read it carefully its effect and impact in respect of my/our personal data collected or held by the Company (whether contained in this application or otherwise). Based on the foregoing, I/we hereby give my/our acknowledgement and agree to the use and transfer of my/our personal data by the Company in accordance with the PICS, including the use and provision of my/our personal data for the purpose of direct marketing. **[Important: If you do not agree to the use and provision of your personal data for direct marketing as set out in the section “Use and provision of personal data in direct marketing”, please tick the box below and we will not use your personal data for direct marketing.]**

☐ I/ we do not agree with the use and provision of my personal data for direct marketing purposes as set out above in the Personal Information Collection Statement (see “**Use and provision of personal data in direct marketing**”) and do not wish to receive any promotional and direct marketing materials.

*I hereby apply for the above listed persons to be enrolled in the Care and Health medical scheme as indicated. I declare that to the best of my knowledge and belief the statements contained in this application are true and complete.*

*No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America*

#### **COMMISSION DISCLOSURE DECLARATION**

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

### Your signature

Please tick the box if you want your intermediary (if any) to be your official representative for medical questions:

☐ I, the undersigned, authorize the Medical Advisory Board or the insurer to provide and request to my intermediary any medical information that is required

By signing below, I acknowledge that I have read and understand the content, terms and conditions of the insurance plan applied for and this application form:

Name: \_\_\_\_\_ On (date) \_\_\_\_/\_\_\_\_/\_\_\_\_ (dd/mmm/yyyy)

### Your representative

Broker firm (if any): \_\_\_\_\_ Consultant name: \_\_\_\_\_

Email address: \_\_\_\_\_ Signature: \_\_\_\_\_

On (date) \_\_\_\_/\_\_\_\_/\_\_\_\_ (dd/mmm/yyyy)

### Administered by:



GMC SERVICES ASIA PACIFIC PTE.LTD. (wholly owned subsidiary of Henner SAS), Private Company Limited by Shares, registered in Singapore under number 1999 01918D, having its Registered office at 137 Telok Ayer Street #07-01/02/03 - Singapore 068602

### Insured by:



AXA General Insurance Hong Kong Limited is the insurance underwriter of this policy and is solely responsible for all coverage and benefit payment of the plan. AXA General Insurance Hong Kong Limited is an authorized insurer in Hong Kong with its Hong Kong office at 20/F, Vertical Sq, 28 Heung Yip Road, Wong Chuk Hang, Hong Kong

# MEDICAL QUESTIONNAIRE – HONG KONG

## SECTION 1

It is important to disclose accurate and complete information in this medical questionnaire. Kindly complete the following questions carefully for all persons that are to be covered under the policy and send us the completed form to the address/email provided at the end of this form. We will not be able to process your application until we receive this form. Should there be any changes in the health status of the persons to be covered between the date of submission of this form and the start date of your policy, please notify us immediately. Please note that this medical questionnaire forms part of your insurance contract and is valid for 30 days from the date of submission. Thereafter, a new declaration may be required.

**If your answer is ‘yes’ to any of the following questions, please provide further details in the document titled “Medical Questionnaire - Section 2”. [Click here to download the Medical Questionnaire – Section 2.](#)**

If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information which you may have given to the adviser but is not written in this document. Please check to make sure you are fully satisfied with the information stated in this document before signing.

**This document must be submitted in English only. Application submitted in other languages will not be taken into consideration. In the event of inconsistency or discrepancy between the English version and any of the other linguistic versions of this document, the English language version shall prevail.**

### KINDLY COMPLETE YOUR HEALTH DECLARATION

|    |                                                                                                                                                                                                    | Main Insured                                                                     | Spouse                                                                           | Child 1                                                                          | Child 2                                                                          | Child 3                                                                          |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| 1  | Last name (family name/surname)                                                                                                                                                                    |                                                                                  |                                                                                  |                                                                                  |                                                                                  |                                                                                  |
| 2  | First name                                                                                                                                                                                         |                                                                                  |                                                                                  |                                                                                  |                                                                                  |                                                                                  |
| 3  | Date of birth (DD/MMM/YYYY)                                                                                                                                                                        |                                                                                  |                                                                                  |                                                                                  |                                                                                  |                                                                                  |
| 4  | Height <input type="checkbox"/> Cm <input type="checkbox"/> Inches                                                                                                                                 |                                                                                  |                                                                                  |                                                                                  |                                                                                  |                                                                                  |
| 5  | Weight <input type="checkbox"/> Kg <input type="checkbox"/> lbs                                                                                                                                    |                                                                                  |                                                                                  |                                                                                  |                                                                                  |                                                                                  |
| 6  | Gender                                                                                                                                                                                             | <input type="checkbox"/> M <input type="checkbox"/> F                            | <input type="checkbox"/> M <input type="checkbox"/> F                            | <input type="checkbox"/> M <input type="checkbox"/> F                            | <input type="checkbox"/> M <input type="checkbox"/> F                            | <input type="checkbox"/> M <input type="checkbox"/> F                            |
| 7  | Do you smoke?<br><i>If yes, kindly indicate the average number of cigarettes smoked per day.</i>                                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="text"/> |
| 8  | Are you currently on medical/sick leave?                                                                                                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 9  | In the last 10 years, have you been on medical/sick leave for more than 10 consecutive days?                                                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 10 | Are you currently suffering from any physical disability, medical incapacity or have you been diagnosed for any chronic medical condition(s)?                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 11 | Are you suffering from a congenital or hereditary condition? (For example: cleft lips/palate, heart defects, spina bifida, Down’s syndrome, or any other congenital/hereditary condition)          | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 12 | In the past 10 years, have you had an accidental injury that required medical treatment or has lingering aftereffects (stiffness, numbness or pain, etc.)                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 13 | Are you currently undergoing any medical treatment, whether prescribed or performed by a doctor or therapist? (For example: physiotherapy, speech therapy, osteopathy, acupuncture, psychotherapy) | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                         |

|    |                                                                                                                                                                                                                                                                                  |                                                          |                                                          |                                                          |                                                          |                                                          |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| 14 | <b>In the last 10 years, have you been treated by a doctor or therapist for more than 8 consecutive days? (For example: medicine, speech therapy, physiotherapy, acupuncture, psychotherapy, laser treatment)</b>                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15 | <b>In the last 10 years, have you been treated in a medical facility (i.e. public or private hospital, clinic, psychiatric institution) concerning:</b>                                                                                                                          |                                                          |                                                          |                                                          |                                                          |                                                          |
| a. | A surgical procedure (including endoscopy, biopsy, arthroscopy, angioplasty)?                                                                                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. | Specialised investigations (colonoscopy, radiology and laboratory tests, etc)                                                                                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. | Treatment?                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. | Rehab?                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|    | <i>Note: No declaration is required for this question if it is a yes for removal of wisdom teeth, tonsils and adenoids, appendicitis</i>                                                                                                                                         |                                                          |                                                          |                                                          |                                                          |                                                          |
| 16 | <b>In the past 10 years, have you undergone lab tests (blood, urine, stools), cardiac explorations (ultrasound, electrocardiogram, Doppler, Holter), medical imaging (ultrasound, TDM, PET scan, scintigraphy, MRI, endoscopy, colonoscopy, gastroscopy, X-rays, mammogram)?</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17 | <b>In the past 10 years, have you suffered from:</b>                                                                                                                                                                                                                             |                                                          |                                                          |                                                          |                                                          |                                                          |
| a. | A respiratory condition (e.g. asthma, chronic bronchitis, tuberculosis, or any other respiratory condition)?                                                                                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. | A cardiovascular condition (e.g. high blood pressure, phlebitis, myocardial infarction, stroke, rhythm disorder, or any other cardiovascular condition)?                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. | Eye/ ENT condition (e.g. glaucoma, cataract, blindness, repeated episodes of sinusitis or any other eye/ENT condition)?                                                                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. | Osteoarticular or musculoskeletal condition (For example: cervicalgia, herniated disc, sciatic pain, back pain, polyarthritis, or any other osteoarticular condition)?                                                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. | Skin condition (e.g. eczema, psoriasis, lupus, or any other skin condition)?                                                                                                                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. | Digestive condition (e.g. Crohn's disease, ulcerative colitis, oesophageal varices, liver condition, pancreas condition, or any other digestive condition)?                                                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

|    |                                                                                                                                                                                                                        |                                                          |                                                          |                                                          |                                                          |                                                          |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| g. | Neuromuscular condition (e.g. epilepsy, myopathy, multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia, repeated or treatment resistant headaches, migraines, or any other neuromuscular condition)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|

|    |                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |                                                                         |                                                                         |                                                                         |                                                                         |
|----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------|
| h. | Endocrine/metabolic condition (e.g. thyroid condition, diabetes, cholesterol condition, pituitary gland condition, or any other endocrine/metabolic condition)?                                                                                                                                                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| i. | Kidney/urinary system condition (e.g. kidney stone, repeated urinary tract infection, or any other kidney/urinary system condition)?                                                                                                                                                                                                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| j. | Genital condition (e.g. endometriosis, ovarian cyst, prostate condition, or any other urogenital or gynaecological condition)?                                                                                                                                                                                                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| k. | Are you currently pregnant? If not, are you currently being or have you previously been treated for any fertility/pregnancy condition?                                                                                                                                                                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><div></div> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><div></div> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><div></div> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><div></div> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><div></div> |
| l. | Psychiatric/psychological condition (e.g. depression, anxiety, stress disorder, fibromyalgia, psychosis, eating disorder, behavioural disorder, alcohol or drug addiction or any other psychiatric/psychological condition)?                                                                                                                                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| m. | Tumour/Cancer (e.g. breast disorders, abnormal cervical smear, leukemia, Hodgkin's disease, lymphoma, benign/malignant tumour, or any other tumour/cancer disease)?                                                                                                                                                                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| n. | Any other condition (e.g. infectious disease, viral, parasitosis, blood related, malaria, hepatitis, any affection requiring medical follow-up)                                                                                                                                                                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| 18 | <b>In the last 10 years, have you taken serology tests, such as hepatitis B and C or HIV, with a positive result?</b>                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| 19 | <b>In the last 10 years, have you consulted a specialist (For example: a cardiologist, a surgeon, a psychiatrist, or any other medical or surgical specialist?</b>                                                                                                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| 20 | <b>Are any of the persons named in this application aware of any illness, symptoms or conditions not already mentioned? If yes, please give details of any known or suspected issues regardless if medical advice has been sought or a diagnosis reached.</b>                                                                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                | <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| 21 | <b>Have you or any of the persons to be insured been advised to have or intend to seek any medical advice, test, investigation, surgical procedure, hospitalization, treatment in the future or expect a review or follow up for any current or past medical issues not already mentioned? If yes, please provide the medical condition attending physician and recommended treatment.</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><div></div> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><div></div> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><div></div> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><div></div> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><div></div> |

|           |                                                                        |                                                          |                                                          |                                                          |                                                          |                                                          |
|-----------|------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| <b>22</b> | <b>Within the past 10 years, have you been:</b>                        |                                                          |                                                          |                                                          |                                                          |                                                          |
| <b>a.</b> | Accepted with exclusions or loadings                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>b.</b> | Denied or cancelled by an insurer for health or life insurance policy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

## DECLARATION

I declare that the information given in this form (including both section 1 and 2) is true and complete with respect to all persons mentioned herein. Where I have provided information on behalf of any other person to be covered under the policy, I confirm that I have checked with them that the information is correct before completing this form and I have their express agreement to submit this form on their behalf, or I am their legal representative.

I understand and acknowledge that any incomplete or false declaration could result, at your discretion and depending on the facts, in the rejection of my claims, the cancellation of my cover retroactively to its inception date in which case the premiums paid will be retained as damages or/and special terms may be applied retroactively.

Main insured's name (compulsory): .....

Signature:

Date (dd/mmm/yy): .....

## DATA PROTECTION PRIVACY

I agree and consent that Insurer may collect, use, process and disclose the personal data disclosed by me with respect to myself and/or the persons named in this form in accordance with the terms and conditions stated in the insurance application form (if applicable) which I have read, understood and agreed to the same.

The information concerning your personal life and health collected in this medical questionnaire (both section 1 and 2) are required to process your application. We collect and process this information in a confidential manner and in strict compliance with the rules and regulations regarding medical and professional secrecy.

Main insured's name (compulsory): .....

Signature:

Date (dd/mmm/yy): .....

## How to apply?

Check list of documents required for your application:

### FOR YOU:

- ☐ Copy of identity card or passport
- ☐ Application form & Medical Questionnaire (including section 2 if applicable) duly completed and signed, together with the necessary supporting documents
- ☐ Certificate of your current insurance (and Table of Benefits) for us to consider waiving the 6-month waiting period.

### FOR YOUR FAMILY:

- ☐ Copy of identity card or passport
- ☐ Certificate of full-time attendance at school for your children from 19 to 28 years old

If your Application request is accepted, we will send you a notification and your Policy will be effective upon receipt of premium payment. We look forward to welcome you to Henner.

### Administered by:



GMC SERVICES ASIA PACIFIC PTE.LTD. (wholly owned subsidiary of Henner SAS), Private Company Limited by Shares, registered in Singapore under number 1999 01918D, having its Registered office at 137 Telok Ayer Street #07-01/02/03 - Singapore 068602

### Insured by:



AXA General Insurance Hong Kong Limited is the insurance underwriter of this policy and is solely responsible for all coverage and benefit payment of the plan. AXA General Insurance Hong Kong Limited is an authorized insurer in Hong Kong with its Hong Kong office at 20/F, Vertical Sq, 28 Heung Yip Road, Wong Chuk Hang, Hong Kong