

# TheChoice Medical Insurance Application Form

## 智采醫療保險計劃申請表

<ul style="list-style-type: none"> <li>One application form for <u>one person to be insured only</u> 每份申請表只跟投保一名受保人</li> <li>Person to be insured must be applicant himself or his spouse or child 受保人必須是申請人自己或其配偶或子女</li> <li>Please tick as appropriated 請選擇並加「✓」號</li> </ul>		For Company Use only: 公司專用 Effective Date: (DD/MM/YYYY) 生效日期(日/月/年) / /	
<b>Personal Details of Applicant (Applicant must be a HKID cardholder and age 18 or above)</b> 申請人個人資料(申請人年齡必須為18歲以上及持有香港身份證)			
Name in English (same as HKID Card) 英文姓名(與香港身份證相同)	Family Name 姓 Given Name 名	Name in Chinese 中文姓名	
HKID Card No. 香港身份證號碼 ( )	Sex 性別 <input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女		
Date of Birth (DD/MM/YYYY) 出生日期(日/月/年) / /	Occupation (Applicable to Applicant who is also the person to be insured) 職業(適用於同時為受保人的申請人)	Nationality (Optional) 國籍(非必要填寫)	
<b>Contact Details of Applicant 申請人聯絡資料</b>			
Address 地址* (Please complete in ENGLISH 請以英文填寫)			
Flat 單位	Room 室	Floor 層數	
Block 座			
Building / Mansion / House / Estate 大廈/閣/樓/屋苑			
Street / Road 街/道			
District 地區 <input type="checkbox"/> HK Island 香港島 <input type="checkbox"/> Kowloon 九龍 <input type="checkbox"/> N.T. 新界			
Contact No. 聯絡電話	Mobile No. 流動電話號碼	Email Address# 電郵地址#	
<b>Details of Person to be insured 受保人資料</b>			
Please tick one only 請只選擇一項	<input type="checkbox"/> Myself (Details as above) 本人(資料與以上相同)	<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Child 子女	
Please provide average stay of the person(s) to be insured in Hong Kong per year 受保人每年平均居港時間: _____ months 月 If the average stay is less than nine months, please provide the place of residence outside Hong Kong: 如受保人之每年平均居港時間少於9個月,請提供海外居住地名稱: _____			
Name in English (same as HKID Card) 英文姓名(與香港身份證相同)	Family Name 姓 Given Name 名	Name in Chinese 中文姓名	
HKID Card No. 香港身份證號碼 ( )	Sex 性別 <input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女		
Date of Birth (DD/MM/YYYY) 出生日期(日/月/年) / /	Occupation 職業	Nationality (Optional) 國籍(非必要填寫)	
<b>Choice of Cover 投保項目</b>			
<b>Core Benefits 主要保障</b>		<b>Optional Outpatient Benefit 自選門診保障</b>	<b>Optional Outpatient and Dental Benefits 自選門診及牙科保障</b>
Plan level 計劃級別	Annual Deductible option 每年自付費	Note: Must be the same as the level of the Hospitalization Benefit 附註: 計劃級別必須與住院保障相同	
<input type="checkbox"/> Standard (Ward) 標準(大房)	<input type="checkbox"/> HK\$0	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Advance (Semi-Private Room) 優選(半私家房)	<input type="checkbox"/> HK\$25,000	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prestige (Private Room) 尊尚(私家房)	<input type="checkbox"/> HK\$50,000 <input type="checkbox"/> HK\$80,000	<input type="checkbox"/>	<input type="checkbox"/>
<b>Grand Total Annual Premium (excluding Insurance levy)</b> 每年總保費(不包括保費徵費)			HKS 港幣

\* P.O. Box, hotel address and overseas address are not acceptable. 不接受信箱、酒店地址和海外地址。

# Please provide email address to enjoy bolttech Insurance eServices app and receive medical claim statement by email.  
請提供電郵地址以享用保特保險eServices應用程式及透過電子郵件收取醫療索償理賠表。

**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)

1. 您的身高及體重 Your Height and Weight	Height: 身高:	m: 米:	cm: 厘米:	ft: 尺:	in: 寸:	Weight: 體重:	Kg: 公斤:	lb: 磅:	
<b>2. Have you ever had or been told to have any of the following: 您有否曾患上或獲悉患上下列疾病:</b>								<b>Yes 有</b>	<b>No 否</b>
i. Diseases of the Heart 心臟病								<input type="checkbox"/>	<input type="checkbox"/>
ii. Cancer or tumor 癌症或腫瘤								<input type="checkbox"/>	<input type="checkbox"/>
iii. Diabetes or high blood sugar 糖尿病或高血糖								<input type="checkbox"/>	<input type="checkbox"/>
iv. Hepatitis B or C 乙型肝炎或丙型肝炎								<input type="checkbox"/>	<input type="checkbox"/>
v. Kidney Failure 腎功能衰竭								<input type="checkbox"/>	<input type="checkbox"/>
vi. Stroke 中風								<input type="checkbox"/>	<input type="checkbox"/>
<b>3. In the last 5 years have you received medical advice or been treated for any of the following: 在過去的5年裡,您有否曾就下列疾病接受過醫療建議或治療:</b>								<b>Yes 有</b>	<b>No 否</b>
i. Carcinoma insitu, abnormal growth or polyps 原位癌,異常生長或息肉								<input type="checkbox"/>	<input type="checkbox"/>
ii. Asthma, tuberculosis, pneumonia or chronic obstructive lung disease 哮喘,肺結核,肺炎或慢性阻塞性肺病								<input type="checkbox"/>	<input type="checkbox"/>
iii. Stomach ulcer or pancreatitis or gastritis 胃潰瘍或胰腺炎或胃炎								<input type="checkbox"/>	<input type="checkbox"/>
iv. High blood pressure or high cholesterol 高血壓或高膽固醇								<input type="checkbox"/>	<input type="checkbox"/>
v. Abnormal liver function 肝功能異常								<input type="checkbox"/>	<input type="checkbox"/>
vi. Nephritis or abnormal kidney function, prostate enlargement or elevated PSA levels, polycystic ovarian syndrome or endometriosis 腎炎或腎功能異常、前列腺肥大或PSA值高於正常水平、多囊卵巢綜合症或子宮內膜異位								<input type="checkbox"/>	<input type="checkbox"/>
vii. Any injury or disorder of the eyes (excluding vision corrected by prescription lens), ears, bones, joints or spine or physical disability 任何眼睛的受傷或病症(不包括通過處方鏡片矯正視力)、耳朵、骨骼、關節或脊柱或身體殘疾								<input type="checkbox"/>	<input type="checkbox"/>
viii. HIV infection or positive HIV test result 愛滋病感染或愛滋病檢測陽性結果								<input type="checkbox"/>	<input type="checkbox"/>
ix. Depression, mental disorder or intellectual disability 抑鬱症,精神病或智力障礙								<input type="checkbox"/>	<input type="checkbox"/>
<b>4. For any conditions other than the above: In the last 3 years, have you: 在過去3年中,除上述病狀外,您有沒有:</b>								<b>Yes 有</b>	<b>No 否</b>
i. had ongoing follow-up with a doctor or specialist doctor for a period of 6 months or more? 與醫生或專科醫生持續進行6個月或更長時間的跟進?								<input type="checkbox"/>	<input type="checkbox"/>
ii. received medication or treatment, any of which was for a continuous period of 2 weeks or more? 服用藥物或接受治療,當中任何一項持續兩週或更長時間?								<input type="checkbox"/>	<input type="checkbox"/>
iii. had a surgical procedure, or been hospitalized for a continuous period of 6 days or more? (If yes, please provide relevant report(s)) 進行手術或持續住院超過6天?(如有,請提交相關報告)								<input type="checkbox"/>	<input type="checkbox"/>
iv. had an abnormal result or results outside the normal range in a blood test, biopsy, ECG, imaging scan, pap smear, colonoscopy or other investigation? (If yes, please provide relevant report(s)) 在血液測試、活組織檢查、心電圖、影像學掃描、子宮頸抹片檢查、結腸鏡檢查或其他檢驗測試中發現異常或超出正常範圍的結果?(如有,請提交相關報告)								<input type="checkbox"/>	<input type="checkbox"/>

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)		
<b>5. Family Health History 親屬健康狀況</b>	<b>Yes 有</b>	<b>No 沒有</b>
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's 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"/>
<b>6. (Applicable to female person to be insured only) 只適用於女性受保人</b>	<b>Yes 是</b>	<b>No 否</b>
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、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)

## Declaration and Authorisation 聲明及授權

1. I hereby declare that, to the best of my knowledge and belief, all particulars and statements given in this Application are true and complete. I agree that this Application shall be the basis of the contract between me and Bolttech Insurance (Hong Kong) Company Limited ("bolttech Insurance"). I further authorise any physician, hospital, insurance company or organization to furnish part of or all medical history (including but not limited to information in respect of consultations, diagnostic test results, prescriptions or treatment) with respect to any illness or injury of me to bolttech Insurance or its authorised representative. A photocopy of this authorisation shall be considered as effective and valid as the original.

本人謹此聲明在本申請表內填報之一切，就本人之所知所信，全部真實無訛。本人同意此申請表為本人與保特保險(香港)有限公司(「保特保險」)之間所訂立合約之依據。本人進一步授權任何醫生、醫院、保險公司或機構，可以將部分或全部有關本人傷患之病歷(包括但不限於診症、診斷性檢驗結果、藥方或治療資料)給予保特保險或其已獲授權之代理人。此授權之副本與正本具同等效力。

2. I undertake that I will inform/have informed my spouse or child to be Insured (if applicable) about this Policy and the Personal Information Collection Statement (BPICS) of bolttech Insurance (whether contained herein or otherwise obtained) before transferring his/her personal data to bolttech Insurance. bolttech Insurance shall not accept any liability for the person to be insured not having been so informed. I further undertake that I will comply with the Personal Data (Privacy) Ordinance and confirm I have obtained the consent from the person to be insured for the transfer of his/her personal data to bolttech Insurance for the purpose of enrolling him/ her in the TheChoice Medical Insurance plan.

本人承諾於遞交所需之個人資料予保特保險前，須/已通知本人的受保配偶或子女(如適用)有關本保單及保特保險之收集個人資料聲明(不論是否載於此申請表或由其他途徑取得)。保特保險將不會就受保人未被通知的情況承擔任何責任。本人承諾會遵守個人資料(私隱)條例，並確認已獲得受保人的同意，將其個人資料移交保特保險以作申請智采醫療計劃之用。

3. I have read, understand and accept the PICS of bolttech Insurance.

本人已細閱、明白及接受保特保險之收集個人資料聲明。

bolttech Insurance intends to send you marketing communications or materials and use Your Personal Data in accordance with paragraphs 8 & 9 of PICS. If you do not agree to receive such marketing communications or bolttech Insurance's intended use of Your Personal Data, please tick below to exercise your right to opt-out

保特保險有意向閣下發送推廣訊息或資料及根據收集個人資料聲明第8及第9段使用閣下的個人資料。如閣下不同意接收有關的推廣訊息或不同意保特保險就該目的使用閣下的個人資料，請在以下有關方格內加上(√)號，藉以行使閣下不同意此項安排的權利。

Opt-out marketing communications or materials and bolttech Insurance's intend use of my personal data.

拒絕接收推廣訊息或資料及保特保險就該目的使用本人的個人資料。

### Applicable to Insurance Broker only:

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

### 只適用於保險經紀:

申請人明白、確知及同意，保特保險會就申請人購買及接受其簽發的保單，於保單有效期內(包括續保期)向負責安排有關保單的獲授權保險經紀支付佣金。如申請人為法人團體，則代表申請人簽署的獲授權人員在此向保特保險確認他/她已獲該法人團體授權。申請人亦明白保特保險必須取得申請人的同意，才可以處理其保單申請。

X

Applicant's Signature 申請人簽署

Signed in Hong Kong on (DD/MM/YYYY) 於香港簽署之日期(日/月/年)

## Advisor/Broker's Information 代理人/經紀資料

Advisor / Broker/Technical Representative's Name 代理人/經紀/業務代表名稱	Email Address 電郵地址
Account Code 帳戶號碼	Contact No. 聯絡電話

# Personal Information Collection Statement ("PICS") 收集個人資料聲明

Please scan the following QR code for review of Bolttech Insurance (Hong Kong) Company Limited's (the "Company") PICS. You can also request a copy of the PICS by calling the Company's Customer Service Hotline at 2603 9435.

請掃描以下二維碼查看保特保險(香港)有限公司(「本公司」)的收集個人資料聲明。您亦可致電本公司的客戶服務熱線 2603 9435 索取收集個人資料聲明副本。



English



中文

## Important Notes

The Applicant (i.e. You are) is required to disclose all material facts which you know Bolttech Insurance (Hong Kong) Company Limited (the "Company") as an insurer would regard them as likely to influence the acceptance and assessment of this proposal. If you are in doubt whether certain facts are material you should disclose them. We recommend you to keep a record (including a copy of completed proposal) for your future reference of all information given. Providing correct answers and making sure we are informed is for your own protection, as failure to disclose such information may mean that your policy will not provide with the cover you require and may even invalidate the policy altogether.

## 重要事項

申請人(即你)必須提供所有可能影響保特保險(香港)有限公司(「本公司」)接受承保及評估之重要事實，如未能確定這項事實是否具有實質性的關係，應將該等事實填報，我們建議你將有關的資料(包括此投保書副本作紀錄)，以備日後作參考之用。為確保你的利益，你應如實呈報所有有關資料，否則此保單將可能無法提供你所需的保障，甚至可能會導致此保單無效。