



Application No.:

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PDF Form Version

Insurance Application Form (Insurance Broker Version)

Important Notes:

- You have to disclose fully and truthfully in this application ALL material facts, which shall form the basis of our contract; otherwise the policy issued may be void or voidable. If in doubt whether a fact is material, please disclose it below. In case the space provided is insufficient, please indicate the section and question number, and provide the details in a separate supplement to application form.
- Please complete this application form in Block Letters and put a "✓" in the appropriate box(es) or delete as appropriate.
- This form is also applicable for investment-linked assurance scheme with sum insured.
- The original of this form and supporting documents submitted will not be returned.
- This form is also available in Chinese/ 本申請書有中文版本供選擇。

Financial Consultant's Code	Financial Consultant's Name
1.	1.
2.	2.

A1. Personal Details of Proposed Insured/Proposed Owner

	Proposed Insured	Proposed Owner (Leave blank if Proposed Owner is the Proposed Insured)
1. Name (as shown on H.K.I.D. Card/ Passport/Birth Certificate)	In English Surname Given Name In Chinese (If applicable)	In English Surname Given Name In Chinese (If applicable)
2. Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
3. Date of Birth	YYYY MM DD	YYYY MM DD
4. Place of Birth	Country City/Town	Country City/Town
5. Nationality		
6. H.K.I.D. Card/Passport/ Birth Certificate/Business Registration No. (Please attach copy)	<input type="checkbox"/> HK Permanent Resident: H.K.I.D. Card/Birth Certificate No.* <input type="checkbox"/> Non-HK Permanent Resident: H.K.I.D. Card No.® (if any) Passport No./Birth Certificate No.*	<input type="checkbox"/> HK Permanent Resident: H.K.I.D. Card No. <input type="checkbox"/> Non-HK Permanent Resident: H.K.I.D. Card No.® (if any) Passport No. <input type="checkbox"/> Corporate Customer#: Business Registration No.
Notes: * If Proposed Insured's Age is Below 18. ® For Non-HK Permanent Resident, please submit nationality proof. # For corporate entity as Proposed Owner, please complete and submit "Supplement to Application – for Corporate Proposed Owner" together with this application form.		
7. Relationship to Proposed Insured	Not Applicable	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Others
8. Name of Employer		
9. Office Address	Room/Flat Floor Block Name of Building/Estate Street No. & Name City/District Postal Code Country	Room/Flat Floor Block Name of Building/Estate Street No. & Name City/District Postal Code Country
10. Employer's Business Nature		
11. Occupation	Title Main Duties	Title Main Duties
12. Monthly Earned Income (HK\$)		

Signature of Proposed Owner

A1. Personal Details (Cont'd)	Proposed Insured	Proposed Owner																														
13. Is your income a regular source of earnings?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No																														
14. Education	<input type="checkbox"/> Primary or below <input type="checkbox"/> Secondary/Advanced Level <input type="checkbox"/> Tertiary or above	<input type="checkbox"/> Primary or below <input type="checkbox"/> Secondary/Advanced Level <input type="checkbox"/> Tertiary or above																														
15a. Residential Address Note: i. Please attach address proof issued within 3 months from the date of submission. ii. Please complete the address in English if residing in Hong Kong; address in Mainland China or Taiwan please complete in English or Chinese. iii. If the address is located in the Mainland China, please complete Section J of this form.	<table border="1"> <tr> <td>Room/Flat</td> <td>Floor</td> <td>Block</td> </tr> <tr> <td colspan="3">Name of Building/Estate</td> </tr> <tr> <td colspan="3">Street No. & Name</td> </tr> <tr> <td colspan="3">City/District</td> </tr> <tr> <td>Postal Code</td> <td colspan="2">Country</td> </tr> </table>	Room/Flat	Floor	Block	Name of Building/Estate			Street No. & Name			City/District			Postal Code	Country		<table border="1"> <tr> <td>Room/Flat</td> <td>Floor</td> <td>Block</td> </tr> <tr> <td colspan="3">Name of Building/Estate</td> </tr> <tr> <td colspan="3">Street No. & Name</td> </tr> <tr> <td colspan="3">City/District</td> </tr> <tr> <td>Postal Code</td> <td colspan="2">Country</td> </tr> </table>	Room/Flat	Floor	Block	Name of Building/Estate			Street No. & Name			City/District			Postal Code	Country	
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15b. Have you resided outside the country/city of the provided Residential Address for more than 6 months during the last 12 months?	<input type="checkbox"/> Yes (Please provide the country and city): <input type="checkbox"/> No	<input type="checkbox"/> Yes (Please provide the country and city): <input type="checkbox"/> No																														
16. Correspondence Address of Proposed Owner (Leave blank if same as Residential Address & see Note ii. in Item 15a) Note: If the address is located in the Mainland China, please complete Section J of this form.	<table border="1"> <tr> <td>Room/Flat</td> <td>Floor</td> <td>Block</td> <td>Name of Building/Estate</td> </tr> <tr> <td colspan="2">Street No. & Name</td> <td>City/District</td> <td>Postal Code</td> </tr> <tr> <td colspan="4">Country</td> </tr> </table>	Room/Flat	Floor	Block	Name of Building/Estate	Street No. & Name		City/District	Postal Code	Country				<table border="1"> <tr> <td>Room/Flat</td> <td>Floor</td> <td>Block</td> <td>Name of Building/Estate</td> </tr> <tr> <td colspan="2">Street No. & Name</td> <td>City/District</td> <td>Postal Code</td> </tr> <tr> <td colspan="4">Country</td> </tr> </table>	Room/Flat	Floor	Block	Name of Building/Estate	Street No. & Name		City/District	Postal Code	Country									
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Street No. & Name		City/District	Postal Code																													
Country																																
17. Contact No. Country Code Hong Kong: 852 China: 86 Others: Please specify	<table border="1"> <tr> <td>Mobile:</td> <td>(Country Code)</td> </tr> <tr> <td>Residence:</td> <td>(Country Code) (Area Code)</td> </tr> <tr> <td>Office:</td> <td>(Country Code) (Area Code)</td> </tr> </table>	Mobile:	(Country Code)	Residence:	(Country Code) (Area Code)	Office:	(Country Code) (Area Code)	<table border="1"> <tr> <td>Mobile:</td> <td>(Country Code)</td> </tr> <tr> <td>Residence:</td> <td>(Country Code) (Area Code)</td> </tr> <tr> <td>Office:</td> <td>(Country Code) (Area Code)</td> </tr> </table>	Mobile:	(Country Code)	Residence:	(Country Code) (Area Code)	Office:	(Country Code) (Area Code)																		
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18. Email Address																																

To reduce paper use and provide you with a better digital experience, if you have provided your mobile number or email address on this form, you will automatically be enrolled in "ePolicy Service" and "eStatement/eAdvice Service". You will not receive paper copies of relevant documents for this policy.

After your policy is issued, an email/SMS will be sent to you. You will be able to register for Emma by AXA to enjoy "ePolicy" and "eStatement/eAdvice" services via the app or portal. Please activate or login to your account to view and download your policy documents anytime online. For details, please visit www.axa.com.hk/en/emma-by-axa.

If you would like to receive paper copies of relevant documents, please mark "✓" in the applicable box(es) below:

Policy contract – I request to receive a paper copy of my policy contract

Statement/Advice – I do not wish to enroll to eStatement/eAdvice Service and request to receive paper copies of my policy statements/advices

Terms and conditions of "ePolicy Service" and "eStatement/eAdvice Service" apply, please refer to section F of this form. You may also refer to our website www.axa.com.hk for the latest terms and conditions for "eStatement/eAdvice Service". AXA reserves the right to revise the relevant terms and conditions from time to time.

19. Self-Certification of Tax Residency (Foreign Account Tax Compliance Act (FATCA) and Common Reporting Standard (CRS))	<p>Tax regulations require the Company to collect information about the tax residence(s) of our customers. Depending on your tax residence, the Company may be obliged to pass on information on this form and information related to the policy to the relevant tax authorities. If you have any questions about how to determine your tax residency status you should consult your tax adviser.</p> <p>Please note that it may be an offence under the laws of the jurisdiction(s) where the Company is regulated, for a person who makes a statement that is misleading, false or incorrect in a particular material, and such person may be liable to penalties.</p>
<p>19a. FATCA Declaration of U.S. Tax Residency</p> <p>[Applicable to individual as Proposed Owner]</p> <p>Is Proposed Owner a US citizen or US tax resident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please submit "Supplement – Tax Residency Self-Certification for Individual".</p> <p>If No, you must notify us if you become a US citizen or US tax resident immediately (and in any event within 30 days of you becoming a US citizen or US tax resident).</p> <p>[Applicable to non-individual as Proposed Owner]</p> <p>Is Proposed Owner an entity or trust? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please submit "Supplement – Tax Residency Self-Certification for Non-Individual", and provide (a) IRS Form W-8 (for Entities) if you are a non-US entity or trust; or (b) IRS Form W-9 if you are a US entity or trust.</p> <p>For information on the definition of US citizen, US tax resident, US entity or US trust, please refer to US Internal Revenue Service website www.irs.gov. If you are in any doubt, you should consult your personal professional adviser.</p> <p>Please declare all your other tax residency in the following section 19b.</p>	

Signature of Proposed Owner

A1. Personal Details (Cont'd)

19b. CRS Declaration of Non-U.S. Tax Residency (Including Hong Kong and/or Macau)

Regulations based on the Organisation for Economic Co-operation and Development (“OECD”) CRS require financial institutions to collect and report certain required information based on an account holder’s tax residence. Each jurisdiction has its own rules for defining tax residence. In general, tax residence is the country in which you live. Special circumstances (such as studying abroad, working overseas, or extended travel) may cause you to be resident elsewhere or resident in more than one country at the same time (multiple residency). The country(ies)/jurisdiction(s) in which you pay income tax are likely to be your country(ies)/jurisdiction(s) of tax residence. For more information on tax residence, please consult your tax adviser or the information at the following OECD Automatic Exchange of Financial Account Information (“AEOI”) link: <http://www.oecd.org/tax/automatic-exchange/crs-implementation-and-assistance/>

The Company must comply with the following requirements of the Inland Revenue Ordinance to facilitate the Inland Revenue Department of Hong Kong automatically exchanging certain financial account information as provided for thereunder:

(i) to identify certain accounts as “non-excluded financial accounts” (“NEFAs”); (ii) to identify the jurisdiction(s) in which NEFA-holding individuals and certain NEFA-holding entities reside for tax purposes; (iii) to determine the status of certain NEFA-holding entities as “passive NFEs” and identify the jurisdiction(s) in which their “controlling persons” reside for tax purposes; (iv) to collect certain information on NEFAs (“Required Information”); and (v) to furnish certain Required Information to the Inland Revenue Department of Hong Kong (collectively, the “AEOI requirements”).

The Proposed Owner agrees to comply with requests made by the Company to comply with the AEOI requirements.

[Applicable to individual as Proposed Owner]

Please indicate your country/jurisdiction of tax residence (please list all countries of tax residence, including Hong Kong and/or Macau, and associated taxpayer identification numbers (“TIN”). Please refer to the OECD AEOI Portal for more information on tax residency and TIN.

If a TIN is unavailable, please provide the appropriate reason A or B where indicated below:

Reason A – The country/jurisdiction where you are resident in does not issue TINs to its residents
Reason B – You are unable to obtain a TIN or equivalent number.

Country/Jurisdiction of Tax Residence	TIN or equivalent number (Please write “N/A” if TIN is not available)	If no TIN is available, enter Reason A or B
1.*		<input type="checkbox"/> Reason A <input type="checkbox"/> Reason B
2.		<input type="checkbox"/> Reason A <input type="checkbox"/> Reason B
3.		<input type="checkbox"/> Reason A <input type="checkbox"/> Reason B
4.		<input type="checkbox"/> Reason A <input type="checkbox"/> Reason B

* Please put “NIL” in the first box if you have no Tax Residency other than U.S.

Please explain in the following boxes why you are unable to obtain a TIN if you selected **Reason B** above.

1.

2.

3.

4.

I/We undertake to advise the Company and provide a duly updated “Supplement – Tax Residency Self-Certification for Individual” within 30 days of the occurrence of any change in circumstance which causes any of the information contained in this form to be incorrect.

[Applicable to non-individual as Proposed Owner]

Please complete and submit “Supplement – Tax Residency Self-Certification for Non-Individual”.

A2. Source of Funds & Supplementary Question

20. Are you acting on behalf of another person in connection with this insurance application? Yes No
If Yes, please submit “Supplement to Application – Declaration of Acting on Behalf of Another Person in Connection with Insurance Application/Policy Service”.

21. What are your sources of funds for insurance premiums? (Tick one or more)

Salary Income/Bonus Rental Income Accumulated Savings Investment return/ongoing investment income

Pension Fund/Ongoing pension Income & previous occupation Loan Business earning

Others (If financially depends on others, please provide relationship, occupation & title)

22. What is your rationale for purchasing insurance policy in Hong Kong? (Applicable to non-H.K.I.D. card holder only)

Product Variety Risk Diversification Others (Please specify):

A3. Beneficiary Details

23. Death proceeds of this policy shall be payable to beneficiaries in equal shares unless specified otherwise. If no beneficiary is designated, the death proceeds shall be payable according to the policy contracts of your policy.

Beneficiary Name	H.K.I.D. Card/Passport No.	Relationship to Proposed Insured	Share (%)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TOTAL:			100%

Signature of Proposed Owner

B1. Details of Plan

24. Policy Contract Language <input type="checkbox"/> English <input type="checkbox"/> Chinese		25. <input type="checkbox"/> Term Conversion Policy No.: _____		26. <input type="checkbox"/> Replacement of Healthpak Plan (For Smart Start) Policy No.: _____	
27. Policy Currency <input type="checkbox"/> USD <input type="checkbox"/> HKD <input type="checkbox"/> Others (Please specify): _____					
28. Payment Mode <input type="checkbox"/> Monthly (must pay via autopay) <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Single Premium					
29. Renewal Premium Payment Method (For non-autopay, direct billing will be assigned)		<input type="checkbox"/> Autopay by Bank Account (Please complete Direct Debit Authorisation) <input type="checkbox"/> Autopay by ICBC AXA Credit Card (Please complete ICBC AXA Credit Card Payment Authorisation)			
30. Basic Plan Annuity Start Age (For annuity product): _____		31. Sum Insured/ Protection Amount/ Notional Amount			
Benefit Type	Supplement				Sum Insured/ Protection Amount
32a. Waiver of Premium	<input type="checkbox"/> Waiver of Premium (On Basic Plan & Term Supplement) <input type="checkbox"/> Applicant's Waiver of Premium at Death up to insured's Age 18 <input type="checkbox"/> Applicant's Waiver of Premium at Death up to insured's Age 21 <input type="checkbox"/> Applicant's Waiver of Premium at Death or Disability up to insured's Age 18 <input type="checkbox"/> Applicant's Waiver of Premium at Death or Disability up to insured's Age 21				
32b. Accident Benefit	<input type="checkbox"/> Extra CARE				
	<input type="checkbox"/> Accident Protector				
	<input type="checkbox"/> Child Accident Protector Plan 1		<input type="checkbox"/> Child Accident Protector Plan 2		
	<input type="checkbox"/> Fortune Guard Accident Protector (For Fortune Guard Life Insurance only) (Premium payment term: <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years <input type="checkbox"/> To age 85)				
	<input type="checkbox"/> Ever Care Accident Protector (Premium payment term: <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years <input type="checkbox"/> To age 85)				
	<input type="checkbox"/> Accident Protector First (1st) Year Free Supplement <input type="checkbox"/> Accident Protector First 3 Years Free Supplement				
32c. Critical Illness	<input type="checkbox"/> HealthVital II Multiple Benefit Supplement <input type="checkbox"/> HealthVital II Multiple Benefit (Enhancer) Supplement (Premium payment term: <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years <input type="checkbox"/> 25 years <input type="checkbox"/> To age 85)				
	<input type="checkbox"/> Multiple Benefit III Supplement <input type="checkbox"/> Multiple Benefit III (Enhancer) Supplement (Premium payment term: <input type="checkbox"/> 20 years <input type="checkbox"/> 25 years <input type="checkbox"/> To age 85)				
	<input type="checkbox"/> HealthVital II Early Stage Major Illness Benefit Supplement (Premium payment term: <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years <input type="checkbox"/> 25 years <input type="checkbox"/> To age 85)				
	<input type="checkbox"/> Early Stage Major Illness Benefit III Supplement (Premium payment term: <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years <input type="checkbox"/> 25 years <input type="checkbox"/> To age 85)				
	<input type="checkbox"/> Smart Living Insurance II (On Basic Plan)		<input type="checkbox"/> Living Insurance Plus II (On Basic Plan)		
	<input type="checkbox"/> Extra Living Insurance II		<input type="checkbox"/> Smart Lady		
32d. Term	<input type="checkbox"/> Living Insurance Plus II (On Term)				
	<input type="checkbox"/> Smart Elite Term Supplement/Smart Term Supplement (Renewal Period: <input type="checkbox"/> Yearly <input type="checkbox"/> 5 years <input type="checkbox"/> 10 years <input type="checkbox"/> To age 75)				
32e. Medical	<input type="checkbox"/> Smart Elite 10-Year Term First (1st) Year Free Supplement/ Smart 10-Year Term First (1st) Year Free Supplement				
	<input type="checkbox"/> AXA WiseGuard Medical Insurance Plan				
	<input type="checkbox"/> Smart Start Medical Insurance		<input type="checkbox"/> With Supplementary Major Medical Coverage		
	<input type="checkbox"/> Smart Medicare		<input type="checkbox"/> Regular <input type="checkbox"/> Superior <input type="checkbox"/> Premier <input type="checkbox"/> With Supplementary Major Medical Coverage		
	<input type="checkbox"/> AXA WiseGuard Pro Medical Insurance Plan		<input type="checkbox"/> Regular <input type="checkbox"/> Enhance <input type="checkbox"/> Premier <input type="checkbox"/> Noble Deductible: <input type="checkbox"/> HKD 0/ USD 0 <input type="checkbox"/> HKD 20,000/ USD 2,500 <input type="checkbox"/> HKD 50,000/ USD 6,250		
	<input type="checkbox"/> Smart Medimoney		<input type="checkbox"/> Economy <input type="checkbox"/> Regular <input type="checkbox"/> Superior <input type="checkbox"/> Premier		
	<input type="checkbox"/> Cancer Therapy Insurance II		<input type="checkbox"/> Regular <input type="checkbox"/> Superior		
	<input type="checkbox"/> Cancer and Stroke Therapy Insurance		<input type="checkbox"/> Regular <input type="checkbox"/> Superior		
	<input type="checkbox"/> Pink Medical Insurance Plan				
	<input type="checkbox"/> CareForAll Hospital Cash Plan		<input type="checkbox"/> CareForAll Hospital Cash – First Year \$1 Supplement		
32f. Disability Benefit	<input type="checkbox"/> Disability Income Protection <input type="checkbox"/> Disability Income Protection Plus Max Benefit Period: <input type="checkbox"/> 2 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> Age 65 Waiting Period: <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days				
	<input type="checkbox"/> Lifelong Care Partner Insurance Supplement				
32g. Long-term Care					
32h. Others					

Signature of Proposed Owner

B1. Details of Plan (Cont'd)

33a. Dividend Option (If applicable)	<input type="checkbox"/> Cash	<input type="checkbox"/> Reduce Premium (Please submit Premium Offset Supplementary Illustration)	<input type="checkbox"/> Accumulated	<input type="checkbox"/> Paid-up Addition
33b. Annuity Payment Option (If applicable)	<input type="checkbox"/> Cash	<input type="checkbox"/> Accumulate		

B2. Details of Investment-Linked Assurance Scheme (If Applicable)

34. Death Benefit Option (If applicable) Level Death Benefit Increasing Death Benefit Others

35. Lump Sum Premium (In policy currency) \$ Top-up Premium (per payment mode) (In policy currency) \$

36. Investment Option Allocation Instruction
 Please refer to Investment Options Leaflet of the relevant plan for the full list of investment options currently available for the investment-linked assurance scheme applying for. You can choose up to a maximum of 10 investment options. Allocation shall be at least 10% for each investment option chosen.

Investment Option	Allocation %
	%
	%
	%
	%
	%
	%
	%
	%
	%
	%
	%
TOTAL	100%

C1. Personal Statement: Other Insurance Information

37. Insurance in force and amount (including currently applied for) on Proposed Insured. Please complete the table below if applicable.

Insurance Company Name	Sum Insured/Protection Amount/Notional Amount/Benefit (HK\$)					Date of Issuance (YYYY/MM)
	Life Insurance (Including Lifetime Annuity)	Disability Income	Critical Illness Insurance	Personal Accident	Hospital Cash/Income	

Attention: Please read the below statement carefully before completing the sections C2 and C3.

Statement for Collection of Information

- (i) This questionnaire collects health-related information solely for the purpose of underwriting which is a process for the Company to evaluate the health risk of the applicants and decide the application results. The underwriting process that the Company adopts should be fair and reasonable, and the Company should explain the application results if requested by the customers.
- (ii) As the applicant, you are required to provide the Company with complete and accurate information requested in this questionnaire to the best of your knowledge and belief. Based on the information provided, the Company may have follow-up questions or enquiries that require you to provide further information for underwriting purpose.
- (iii) If there are any changes to or updates of the information provided in this questionnaire after the time of submission of this application and before you receive the Policy, you are required to notify the Company in a timely manner.
- (iv) Even after an insurance policy has been issued upon successful application, the insurance coverage for you may be affected or the policy may be terminated, voided or rescinded, or claims may be repudiated by the Company, if you have not provided the Company with complete and accurate information to the best of your knowledge and belief according to (ii), or if you have not notified the Company on any changes to or updates of the information in time according to (iii).

 Signature of Proposed Owner

C2. Personal Statement: Health-Related Information (Part I)

(For Individual Indemnity Hospital Insurance Plans, please complete the Information in C3 - Personal Statement: Health-Related Information (Part II). For all other products including Cancer Therapy series and Cancer And Stroke Therapy series please complete the information in C2 and C3.)

The “you” and “your” under this section shall refer to Proposed Insured in this application. If Applicant’s Waiver of Premium is applied, Proposed Owner is also required to complete this section.

If your answer to any of the questions 38, 39, or 41, 42 below is “Yes”, please complete the Supplementary Health Information form. Any disclosures made to questions 38-43 below, will not be used in the assessment of any Individual Indemnity Hospital Insurance Plans.

General Information	Proposed Insured		Proposed Owner	
	Yes	No	Yes	No
38. Have you ever been declined, postponed, or accepted with an increased premium or an exclusion applied in any Life, Critical Illness, Medical or Disability insurance application, reinstatement or renewal due to health/medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Have you ever taken habit forming drugs or narcotics, or been treated or counselled for a drug or alcohol problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Do you participate or intend to participate in any hazardous activities such as diving, mountaineering, skydiving, parachuting, hang gliding, motor sports or aviation (excluding flying as a passenger on a regular scheduled airline)? <i>If Yes, please complete the appropriate questionnaire/Personal Statement.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Information

Applicant(s) are not required to disclose information regarding the medical conditions or treatments below – Cold/flu/sore throat, gastroenteritis/food poisoning (fully recovered), indigestions (no investigations required), acne, muscle sprained (fully recovered), thrush, routine scan/blood test for pregnancy (normal result), routine cervical smear (normal result), routine health check (normal result), preventive vaccination, Hormonal Replacement Therapy (menopause), infertility treatment or uncomplicated pregnancy, myopia/hyperopia/astigmatism/presbyopia.

	Proposed Insured		Proposed Owner	
	Yes	No	Yes	No
41. Do you currently have or have you ever been diagnosed with any of the following diseases or medical conditions?				
a. Cancer or carcinoma in situ (CIS), tumour, melanoma, cyst, nodule, polyp, lump or growth of any kind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart disease including chest pain, angina, heart rhythm disorder or structural heart abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Stroke including transient ischemic attack (TIA) or cerebral aneurysm/subarachnoid haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Hypertension/high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Thyroid disorders including hypothyroidism or hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes mellitus, impaired glucose tolerance or diseases of the kidney, genitourinary system (including bladder or prostate) or the reproductive organs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Prolapsed intervertebral disc, degenerative spine conditions, arthritis or other joint disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Medical conditions requiring a medical device or prosthesis to be implanted within the body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Congenital conditions (medical, physical or mental abnormalities that existed at the time of or before birth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Physical defects, impairments, deformities, and/or conditions affecting mobility, sight, speech and/or hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Mental health conditions (such as depression, anxiety disorders, schizophrenia, eating disorders or bipolar disorders)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Hypercholesterolemia or hyperlipidaemia (elevated cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Human immunodeficiency virus (“HIV”) infection, liver disorders (example Hepatitis B or Hepatitis C (including tested positive), fatty liver or cirrhosis of liver)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Multiple sclerosis or neurological disorders (example Alzheimer’s disease, Epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Respiratory diseases, blood or vascular disorders, auto-immune diseases (example Myasthenia gravis), sleep disorders (example Obstructive sleep apnoea)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Gallbladder or any gastrointestinal diseases (including gastric/duodenal ulcer, ulcerative colitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Only for juvenile applicant (under age 18): Have you ever been diagnosed with or had signs or symptoms of physical, mental or neurodevelopment problems such as Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD) and/or developmental delay?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Has your biological mother, father, or any sister or brother been diagnosed prior to age 60 with any of the following?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Cancer, heart disease, stroke, diabetes, Huntington’s disease, polycystic kidney disease, multiple sclerosis, Alzheimer’s disease or any other inherited conditions. <i>If Yes, please complete the table below with exact nature of the illness e.g. breast cancer, colon cancer or heart attack etc.</i>	<input type="checkbox"/>	I am adopted	<input type="checkbox"/>	I am adopted

Proposed Insured			Proposed Owner		
Relative	Diagnosis/Condition	Onset Age	Relative	Diagnosis/Condition	Onset Age

Signature of Proposed Owner

C3. Personal Statement: Health-Related Information (Part II)

(Please complete for ALL Individual Indemnity Hospital Insurance Plans PLUS all other insurance products where applicable)

The “you” and “your” under this section shall refer to Proposed Insured in this application. If Applicant’s Waiver of Premium is applied, Proposed Owner is also required to complete this section.

If your answer to any of the questions 46 - 51 below is “Yes”, please complete the Supplementary Health Information form.

General Information

44.	Proposed Insured			Proposed Owner		
a. Height	cm Or	ft	in	cm Or	ft	in
b. Weight	kg Or		lbs	kg Or		lbs

	Proposed Insured		Proposed Owner	
	Yes	No	Yes	No
45. Do you smoke or have you smoked in the last 12 months? For the purpose of this question, the meaning of “smoking” includes but is not limited to cigarettes, cigars, tobacco pipes, chewing tobacco and the use of nicotine replacement products (such as e-cigarettes). If “Yes”, please provide types of tobacco product, frequency and quantity of consumption.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Cigarettes	<input type="checkbox"/>	<input type="text"/> pcs/day	<input type="checkbox"/>	<input type="text"/> pcs/day
b. Others (Please specify): <input type="text"/>	<input type="checkbox"/>	<input type="text"/> pcs/day	<input type="checkbox"/>	<input type="text"/> pcs/day

Health Information

Applicant(s) are not required to disclose information regarding the medical conditions or treatments below – Cold/flu/sore throat, gastroenteritis/food poisoning (fully recovered), indigestions (no investigations required), acne, muscle sprained (fully recovered), thrush, routine scan/blood test for pregnancy (normal result), routine cervical smear (normal result), routine health check (normal result), preventive vaccination, Hormonal Replacement Therapy (menopause), infertility treatment or uncomplicated pregnancy, myopia/hyperopia/astigmatism/presbyopia.

	Proposed Insured		Proposed Owner	
	Yes	No	Yes	No
46. In the last 5 years, have you ever had or been advised to have any regular or ongoing (such as monthly, every 2 months, half-yearly, annually) follow-up consultations or medical care with a healthcare professional (such as specialist doctor, physiotherapist, psychiatrist) for any disease or medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. In the last 5 years, have you been advised by your doctor to take any medications (such as to be taken daily/once per week/as needed as directed by doctor) for a continuous period of more than 1 month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. In the last 5 years, have you been admitted into a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. In the last 5 years, have you undergone a surgical procedure (including endoscopy or biopsy) without being admitted into a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. In the last 5 years, have you ever had or been advised to undergo investigations (such as blood or urine test, ECG, X-ray, ultrasound, CT scan, MRI, PET scan, HIV test, Hepatitis B test, Hepatitis C test)? If the answer is “Yes”, do your investigation result(s) include the followings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Normal test result is advised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Abnormal test result is advised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. You are still awaiting test/test result	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Test result is inconclusive or uncertain (retesting or follow up test is required)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Medical advice has been sought or treatment is required for the test result (such as liver cyst/brain cyst/ joint degeneration or calcification/lung or breast or thyroid calcification discovered on imaging test, that may not require immediate treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Do you have any other medical conditions or sign and symptom (such as lump, headache, persistent coughing, chest pain or epigastric pain) that you are seeking or intend to seek medical advice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. [For children aged 2 or below only] Was the insured child born before 37th week of pregnancy and/or born with body weight less than 2.5 kg (5.51 lbs)? If the answer is “Yes”, please provide body weight at birth:	<input type="checkbox"/>	<input type="checkbox"/>		
a. more than 2.50 kg/5.51 lbs	<input type="checkbox"/>			
b. 1.51 - 2.50 kg/3.32 - 5.51 lbs	<input type="checkbox"/>			
c. 1.00 - 1.50 kg/2.20 - 3.31 lbs	<input type="checkbox"/>			
d. less than 1.00 kg/2.20 lbs	<input type="checkbox"/>			

D. Remarks or Special Requests

- Date back Policy Date to a day before Birthday with a maximum of 6 months. If the day falls on 29th to 31st, 28th will be assigned. (Date back Policy Date is not applicable to some products, e.g. Investment-Linked Assurance Scheme, Medical products and Disability Income applied as basic plan, any application with Medical products under the Voluntary Health Insurance Scheme, etc. Details refer to Product Handbook)
- Others:

Signature of Proposed Owner

E. Replacement Declaration

In order to fund the purchase of your new life and/or medical insurance policy, are you using, or do you intend to use some or all of the funds arising from your existing life and/or medical insurance policy, or any savings made by reducing the premium payable under your existing life and/or medical insurance policy?

For example, such funds or savings may arise from:

- a) surrendering/partially surrendering your existing life and/or medical insurance policy to obtain its surrender value
- b) taking out a policy loan (including automatic premium loan) from your existing life and/or medical insurance policy
- c) withdrawing policy values from your existing life and/or medical insurance policy (e.g. cash out dividends or redeem fund units etc.)
- d) lapsation of your existing life and/or medical insurance policy (e.g. by non-payment of premium)
- e) exercising the right to a premium holiday under your existing life and/or medical insurance policy

Yes Not yet decided No *Please check one appropriate box only*

Warning: Please answer the above question carefully. Making changes on your existing life and/or medical insurance policy may not be in your best interest. Your licensed insurance intermediary must explain to you the financial implications, insurability implications and claims eligibility implications of such changes. For this purpose, your licensed insurance intermediary may require certain information on your existing life and/or medical insurance policy. You may need to approach the insurer of your existing life and/or medical insurance policy to obtain accurate and up to date information on your existing policy.

Please also sign and submit the “Important Facts Statement – Policy Replacement” as appropriate, and your licensed insurance intermediary must explain the relevant to you.

IMPORTANT: PLEASE DO NOT SIGN ON BLANK FORM

Signature of Proposed Owner	Date Signed in Hong Kong (YYYY/MM/DD)
Signature of Financial Consultant	Date Signed in Hong Kong (YYYY/MM/DD)
Full Name of Financial Consultant	Type of License and License No.

F. Declaration and Authorisation

“The Company”: AXA China Region Insurance Company (Hong Kong) Limited/AXA China Region Insurance Company Limited
 I HEREBY CONFIRM that I am not acting on behalf of any other person for this insurance application unless otherwise expressly indicated in this application form or any other documents provided to the Company for this application.

I HEREBY DECLARE AND AGREE on behalf of myself and other persons referred to in this application (hereinafter referred to as “Relevant Persons”, “We”, “Our” or “Us”) for the avoidance of doubt, the expressions “Relevant Persons”, “We”, “Our” or “Us” include myself and such other persons that

1. all statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true;
2. all answers to such questions, together with this application, shall form the basis and become a part of the policy;
3. I have read and fully understood the relevant offering/promotional documents, including but not limited to (where applicable) Principal Brochure (in the case of an investment-linked plan), proposal (including the illustration document), product leaflet and promotional leaflet for the plan(s) and/or additional benefit(s) applied for in this application form;
4. where I have provided the personal data of other persons (including but not limited to the beneficiary) (“**Such Other Persons**”) to the Company in this application form or in any ways provided to the Company for or relating to this application, or for or relating to the future services in connection with this application, (a) I have obtained the personal data from Such Other Persons lawfully; (b) I have notified Such Other Persons of the Company’s Privacy Policy[#] and the relevant data collection document (being this application form or any other documents provided to the Company for this application) and obtained all necessary consent from Such Other Persons for the data processing (including provision of personal data to the Company) as set out in the Company’s Privacy Policy[#]; (c) I will assist the Company to obtain all necessary consent from Such Other Persons if the processing of personal data of Such Other Persons goes beyond the original scope of consent provided by them; (d) I acknowledge and understand that a minor is a person under 14 (in Mainland China) or 18 years old (in Hong Kong) under applicable data protection law, and I am (or I have been authorised by) the guardian of Such Other Person who is a minor, or I have been authorised by Such Other Person who is not a minor (e.g. individuals aged 14-17 years old located in Mainland China) to give necessary consent on his/her behalf; and (e) I have taken reasonably practicable measures to ensure that the personal data I provide to the Company is accurate and complete;
5. in the case of an investment-linked plan, my investment option allocation instruction is based on my own judgment and I have not relied on any advice provided by the financial consultant or other person acting on behalf of the Company. I fully understand that investment in investment-linked plan involves risks. Value of units in investment options may rise or fall. The benefits payable under such plan are, depending on the policy features, in whole or in part, linked to the performance of the investment options in my investment option allocation instruction;
6. I confirm that neither the financial consultant nor anyone else acting on behalf of the Company has provided me with any investment advice in connection with any investment-linked plan or discussed with me or provided me with any information concerning any of the securities or other assets underlying any investment-linked plan other than to provide me with factual information about the securities or other assets upon which the value of particular investment options is based;
7. I understand and accept that I have to reimburse the fees as charged by medical service providers if I apply to obtain the results of any Medical Examination Report/Laboratory Tests;
8. I shall disclose to the Company any change in health and/or medical consultation and/or material facts of all Relevant Person(s) that occur after signing this application form but before the policy is issued;
9. the policy shall not become effective until it is issued with initial premium paid in full, the Relevant Person(s) being still living, and all applicable requirements being met;
10. the Company is not bound by and is not required to rely on any statement which I may have made to any person if not written or printed here.

[#] The Privacy policy is available here: <https://www.axa.com.hk/en/legal>

If We fail to provide any information requested in this application, it may result in the Company’s inability to accept or process this application.

I HEREBY REPRESENT, WARRANT AND CERTIFY on behalf of the Relevant Persons that

1. (i) all funds to be invested in the policy have been or will be declared to relevant tax authorities in the jurisdiction of my/Our habitual residence for the purposes of taxation and/or any other jurisdictions as necessary or appropriate in accordance with applicable laws and regulations, and (ii) none of the funds derive, directly or indirectly, from illegal activities or sources and/or tax evasion;
2. the AXA Group and the Company have a longstanding policy of cooperating with tax and other governmental authorities to combat money laundering, tax evasion or other illegal activities. In cases where I am/We are not a tax resident of the jurisdiction in which this policy is issued (a “Cross-Border Transaction”) the AXA Group may, in accordance with applicable laws and regulations, disclose to the pertinent tax and/or other governmental authorities the identity of myself/ourselves and certain information concerning the policy that is the subject of this application and I/We hereby consent and agree that the Company may, in its discretion, make such disclosure;
3. in the event of a violation of the foregoing representation and warranty, I/We hereby jointly and severally expressly acknowledge and agree that the Company shall, to the fullest extent permitted by applicable law and regulation, have the right to (i) terminate the policy immediately, (ii) notwithstanding the actual date of termination pursuant to clause (i) of this paragraph, impose the maximum surrender and any other charges imposable on me/Us under the policy, as if the policy had been surrendered immediately after issuance, (iii) notify relevant governmental authorities and furnish all information deemed necessary or appropriate in the entire discretion of the Company concerning any of Us and/or the policy; and (iv) if deemed appropriate after consultation with governmental authorities and legal counsel, either (a) refund to me premiums and other amounts paid to the Company through the date of such termination less applicable surrender and other charges in accordance with clause (ii) of this paragraph

 Signature of Proposed Owner

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(the "Refund Amount"), or (b) if requested or required to do so by competent governmental authorities, freeze or pay over to relevant governmental authorities all or a portion of the Refund Amount or take such other actions as competent governmental authorities may request or require.

I HEREBY AUTHORISE on behalf of the Relevant Persons

1. any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of me/the Relevant Persons and/or who has attended or may hereafter attend to me/the Relevant Persons to disclose such information to the Company as the Company may request;
2. the Company or any of its appointed medical examiners, paramedical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/the Relevant Persons in relation to this application and any claim arising therefrom.
3. the Company to give either the Insurance Authority or other parties, as required for relevant records or information.

This authorisation shall bind the successors and assignees of the Relevant Persons and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.

Terms and Conditions of "ePolicy Service" and "eStatement/eAdvice Service" (if applicable)

I acknowledge and agree that:

1. In respect of policy document for which I have subscribed for the "ePolicy Service", paper copies will no longer be provided to me by AXA China Region Insurance Company Limited or AXA China Region Insurance Company (Hong Kong) Limited (collectively "AXA"). Only electronic copies of policy document ("ePolicy") will be provided and shall be available on my Emma by AXA account. I understand and accept that I am required to activate my Emma by AXA account to get the ePolicy.
2. In respect of any document type ("Specified Document") for which I have subscribed for the "eStatement/eAdvice Service", paper copies of such document will no longer be provided to me by AXA for relevant policy unless AXA receives my written instruction to resume the delivery of such paper copies. Only electronic copies ("eStatements/eAdvices") of the Specified Documents will be provided and such eStatements/eAdvices shall be available on my Emma by AXA account.
3. A notification email and/or SMS (if I have provided a mobile phone number) eAlert (as defined in paragraph 6 below) will be sent to my designated email address and/or mobile phone number (if I have provided a mobile phone number) when a new ePolicy or eStatement/eAdvice is available for viewing on my Emma by AXA account. I should promptly check my ePolicy or eStatement/eAdvice. Should the ePolicy or eStatement/eAdvice not be available for viewing, I should promptly contact AXA.
4. Latest version of ePolicy will be retained and available on my Emma by AXA account and old version of ePolicy will be replaced. Each eStatement/eAdvice will be retained on my Emma by AXA account for **3 years** from the issue date. All eStatements/eAdvices will be deleted automatically after the said retention period. I may save an electronic copy of the ePolicy or eStatements/eAdvices in my own computer storage or print a hard copy of the ePolicy or eStatements/eAdvices for my future reference. I may be required to pay a reasonable charge for obtaining a hard copy of any Specified Document that is no longer available for access and downloading through my Emma by AXA account.
5. Appropriate computer equipment and software, internet access and a specific email address provided and designated by me are required for viewing **ePolicy or eStatements/eAdvices**. I will need Adobe Acrobat Reader installed in my computer to view the PDF (Portable Document File) file of ePolicy or eStatements/eAdvices. I am recommended to upgrade the Adobe Acrobat Reader to the latest version from time to time to view my ePolicy or eStatements/eAdvices.
6. I understand and accept that email (and SMS (if applicable)) will be the only notice (i.e. the "eAlert") that ePolicy or eStatements/eAdvices have been posted on my Emma by AXA account, and I should check my designated email address (and SMS (if applicable)) regularly for such notice. I am obliged to provide a valid and up-to-date email address (and mobile phone number (if applicable)) that has sufficient capacity at all relevant times to receive an eAlert, and inform AXA as soon as practicable upon a change in my designated e-mail address (and mobile phone number (if applicable)) or termination or suspension of my electronic communication devices or services.
7. I understand and accept that should I want to cancel the eStatement/eAdvice Service and resume receiving paper copies of the Specified Documents, I have to give written instruction to AXA not less than **fifteen working days** before the intended cancellation.
8. I understand and accept that internet and email services (and SMS (if applicable)) may be subject to certain IT risks and disruption.
9. I understand and accept that I may incur additional costs (e.g. internet service and mobile telephone service costs) for using the ePolicy Service or eStatement/eAdvice Service.
10. I will need to promptly review any ePolicy or eStatements/eAdvices posted on my Emma by AXA account upon receiving an eAlert from AXA to ensure that any errors are detected and reported to AXA as soon as practicable.
11. AXA has the discretion from time to time to modify, restrict, withdraw, cancel, suspend or discontinue the ePolicy Service or eStatement/eAdvice Service without giving any reason and I understand that by using the ePolicy Service or eStatement/eAdvice Service after any modification has been effected, I shall be deemed to have agreed to such modification.
12. I understand and accept that AXA reserves the right to add to, delete and/or vary any of these Terms and Conditions upon notice to me using such means of notification as AXA shall deem appropriate. By continuing to use the eStatement/eAdvice Service from the date upon which any changes to these Terms and Conditions are to take effect (as specified in AXA's notice), I shall be deemed to have agreed to such changes. If I do not agree to any change(s), I must cancel or terminate the eStatement/eAdvice Service prior to the date upon which such change(s) are to take effect.

I HEREBY DECLARE that I understand that the Company may deduct any outstanding amount applicable from the payout and/or sum received by the Company under the Policy according to the applicable statutory and/or regulatory requirement(s), including levy collected by the Insurance Authority.

I ACKNOWLEDGE that the terms, "Insured", "Owner", "Policy Anniversary", "Policy Date" and "Issue Date" mentioned in the forms, letters and any communication means shall bear the same meaning as "Insured Person", "Policy Holder", "Renewal Date", "Policy Effective Date" and "Policy Issuance Date" stated in the terms and benefits of the relevant certified plan under the Voluntary Health Insurance Scheme ("VHIS") respectively.

I HEREBY DECLARE AND AGREE that I have the full authority from and consent of the Relevant Persons to make the above declarations, agreements and authorisations.

Important Notes:

1. For an investment-linked assurance scheme, this application form should only be issued in conjunction with the Principal Brochure and the proposal (including illustration document) of the plan that you are applying for.
2. The Proposed Insured shall be deemed to be the Proposed Owner unless otherwise indicated in this application form.
3. This form is only for use in Hong Kong Special Administrative Region.
4. Please visit www.axa.com.hk or contact the Company for the latest version of the "eStatement/eAdvice Service" introduction.

G. Appointment of Broker Declaration

I/We acknowledge and agree that the insurance broker through whom this application is submitted is appointed and authorized as my/Our insurance broker regarding the new policy (the "Policy"). The Company is authorized to release from time to time information pertaining to me/Us as actual or proposed owner/insured and/or the Policy to the insurance broker. This appointment and authorization shall remain in effect unless I/We write to the Company to revoke the same, in which event the Company shall give effect to the written revocation within 30 days after its actual receipt of the same. This rule equally applies to future replacement broker(s), if any, appointed by me/Us.

H. Personal Information Collection Statement

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;

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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
AXA China Region Insurance Company Limited
Suite 2001, 20/F, Tower Two, Times Square, 1 Matheson Street, Causeway Bay, 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/Our 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. Commission Disclosure Declaration

I/We understand, acknowledge and agree that, as a result of my/Our purchasing and taking up the policy to be issued by the Company, the Company will pay the authorised insurance broker commission during the continuance of the policy including renewals, for arranging the said policy. Where I/We am/are a body corporate, the authorised person who signs on my/Our behalf further confirms to the Company that he or she is authorised to do so. I/We further understand that the above agreement is necessary for the Company to proceed with the application.

**J. Consents to Data Processing Pursuant to AXA Privacy Policy
(Applicable to individual signatory(ies) with any declared address in the Mainland China only)**

Please sign below to ACKNOWLEDGE and CONFIRM you agree to the following statements and grant **each** of the separate consents below. If you do not agree to grant any one of the consents below, the Company and/or other companies of the AXA Group may not be able to provide the information, products or services you need or process your request.

- I/We have read and consent to the [Privacy Policy](#)[#]; and
- I/We agree to the processing and/or management of my/Our personal data, sensitive personal data, and that of minors under my/Our guardianship (if applicable) outside of Mainland China as prescribed in the Privacy Policy.

In the case that the Proposed Insured is aged below 18, I/We grant **each** of the above separate consents on behalf of the Proposed Insured as his/her guardian or authorised person (as the case may be).

[#] The Privacy policy is available here: <https://www.axa.com.hk/en/legal>

Signature of Proposed Insured (If aged 18 or above)/ the Guardian or authorised person of Proposed Insured (If Proposed Insured is aged below 18)	Signature of Proposed Owner (If other than Proposed Insured)

K. Cancellation Right and Refund of Premium and Levy

I understand that I have the right to cancel this new policy and obtain a refund of any premium(s) (in the case of an investment-linked assurance schemes policy and/or single premium policy (if applicable), less any market value adjustment (if applicable)) and any levy paid by returning the policy (if applicable) by giving a written notice to the Company. I understand that to exercise this right, the notice of cancellation must be signed by me and received directly by the Customer Service of the Company at Suite 2001, 20/F, Tower Two, Times Square, 1 Matheson Street, Causeway Bay, Hong Kong within the Cooling-off Period. I understand that the Cooling-off Period is the period of 21 calendar days immediately following either the day of delivery of the policy or the Notice of Policy Issuance to me or my nominated representative (whichever is the earlier). I understand that the Notice of Policy Issuance is a notice that will be sent to me or my nominated representative by the Company to notify me of the Cooling-off Period around the time the policy is delivered.

The Cancellation Right and Refund of Premium do not apply to any non-investment-linked policy issued from term conversion.

L. Signature

IMPORTANT: PLEASE DO NOT SIGN ON BLANK FORM

Signature of Proposed Insured (If aged 18 or above)	Signature of Proposed Owner (If other than Proposed Insured)
Signature of Financial Consultant as Witness	Date Signed in Hong Kong (YYYY/MM/DD)
Full Name of Financial Consultant as Witness	

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Questions for Proposed Insured and Proposed Owner

Application number		Proposed Insured	Proposed Owner
1. How long have you known him/her?		Years	Years
2. If he/she is not gainfully employed, please state details of supporter's insurance coverage. (Amount and name of Insurance company)			
3. Initial Premium submitted with this application	HK\$	by	<input type="checkbox"/> Cash <input type="checkbox"/> Cheque <input type="checkbox"/> Credit Card <input type="checkbox"/> Others
4. What is the purpose of Insurance?	<input type="checkbox"/> Family Protection <input type="checkbox"/> Keyman Insurance <input type="checkbox"/> Mortgage Redemption <input type="checkbox"/> Employee Benefit <input type="checkbox"/> Others (please specify):		
5. Underwriting notification language (If unspecified, the underwriting notification language will be CHINESE by default)	<input type="checkbox"/> English <input type="checkbox"/> Chinese		

Mandatory Checklist for Insurance Application Form (For Financial Consultants) – For Priority Processing

When you submit the application, please put “✓” in tick box after checking to ensure applicable items are fully completed.

✓	Compulsory			
SPECIAL ATTENTION is Required for the Following:		Section No.	Q. No.	Specific Details Required
<input type="checkbox"/>	Employment & Occupation Information	A1	8-11	<ul style="list-style-type: none"> Full name of employer must be completed Employer's office address must be completed Nature of employer's business must be stated Occupation Title & Main Duties must be completed
<input type="checkbox"/>	Monthly Earned Income (HK\$)	A1	12-13	<ul style="list-style-type: none"> Monthly Income and regular source of income must be completed
<input type="checkbox"/>	Education	A1	14	<ul style="list-style-type: none"> Education must be completed
<input type="checkbox"/>	Residential Address	A1	15	<ul style="list-style-type: none"> Residential Address must be completed Residential Address must match with the supporting Address Proof
<input type="checkbox"/>	Self-Certification of Tax Residency (FATCA and CRS)	A1	19	<ul style="list-style-type: none"> Must complete both 19a and 19b
<input type="checkbox"/>	Plan Name/Plan Code/Sum Insured/Protection Amount/Notional Amount	B1	30-32	<ul style="list-style-type: none"> Must match Proposal Illustration
<input type="checkbox"/>	Other Insurance Information	C1	37	<ul style="list-style-type: none"> Provide details if applicable
<input type="checkbox"/>	Personal Statement – Health-Related Information (Part I)	C2	38-43	<ul style="list-style-type: none"> This part is NOT applicable to Individual Indemnity Hospital Insurance Plans (Except Cancer Therapy Insurance series and Cancer And Stroke Therapy Insurance series) All questions must be completed with “✓” in either the ‘Yes’ or ‘No’ box Full details to any ‘Yes’ answers must be completed in the “Supplement to Application – Supplementary Health Information” form for medical condition Information
<input type="checkbox"/>	Personal Statement – Health-Related Information (Part II)	C3	44-52	<ul style="list-style-type: none"> All questions must be completed with “✓” in either the ‘Yes’ or ‘No’ box Height & weight must be completed Full details to any ‘Yes’ answers must be completed in the Q45 for relevant smoking habit information or/and “Supplement to Application – Supplementary Health Information” form for medical condition Information
<input type="checkbox"/>	Consents to Data Processing Pursuant to AXA Privacy Policy (Applicable to individual signatory(ies) with any declared address in the Mainland China only)	J	—	<ul style="list-style-type: none"> Fully Signed by Owner/Insured (if any declared address is in the Mainland China)
<input type="checkbox"/>	Application Form Sign Date & Signature	L	—	<ul style="list-style-type: none"> Fully Signed & Dated by Owner/Insured & Financial Consultant

Other Documents Required to Complete the Application (If Applicable)

- Residential Address Proof (Owner) – Issued within 3 months from the date of submission – Verified by Financial Consultant
- Copy of Birth Certificate if Child under age 18 years – Verified by Financial Consultant
- Section of “Term Policy Conversion” under “Policy Service Application Form II” – For Term Conversion
Remarks: Please also submit “Supplement to Application for Term Conversion to Major Illness Insurance/Critical Illness Insurance” if Term Conversion to HealthVital II/HealthSelect II/LoveAssure/LoveAssure Plus
- Important Facts Statement – Policy Replacement
- Client Needs Analysis (CNA)
- Proposal/Illustration Summary Forms – Signed & Dated
- Direct Debit Authorisation – Payment mode monthly/Payment by Autopay for Renewal Premium
- Large Amount Supplement – Sum Insured > HKD12,000,000/
Annual Premium > HKD500,000/Single Premium > HKD3,000,000

Additional Requirements For Investment Linked Assurance Scheme (ILAS) – Fully Completed Signed & Dated

- Important Facts Statement and Applicant's Declarations (IFS and AD)

Additional Requirements For Non-Hong Kong Residents

- Copy of Passport & Copy of Entry Proof – Verified by Financial Consultant
- Copy of Passport & Copy of Entry Proof of MCV – Face-to-face verification by authorized staff/via Mobile Electronic MCV Verification
- Declaration of Insurance – Fully Completed, Signed & Dated

Other Applicable to Mainland Chinese Visitors Only (additional to above) – Fully Completed Signed and Dated:

- 重要資料聲明書 – 內地人士在港投購人身/壽險保單 (MCV-IFS)

Financial Consultant's Declaration

I HEREBY CERTIFY that I have personally asked all the questions (including all health questions in case of a non-medical application) on the application form, verified the identity of the Proposed Insured and Proposed Owner against their original identification documents, and witnessed their signatures on the application.

Name of Financial Consultant	Signature of Financial Consultant	Contact Number	Date (YYYY/MM/DD)
Name of Financial Consultant's Manager	Signature of Financial Consultant's Manager	Contact Number	Date (YYYY/MM/DD)

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Policy Number 保單編號：

 New Application
新生意 Existing Policy
現有保單

Important Facts Statement – Policy Replacement 重要資料聲明書 – 轉保

Important Notes:

1. This form is to be filled in BLOCK LETTERS and signed by the Proposed Owner/Owner, please ensure the signature matches with the one provided in the policy file.
2. Please read carefully before signing.
3. Please do not sign on blank form.
4. The original of this form and supporting documents submitted will not be returned.

重要事項：

1. 此聲明書應由建議持有人/持有人以正楷填寫及簽名，簽名式樣須與保單上的記錄相符。
2. 請先行詳細閱讀方可簽署。
3. 請勿在空白聲明書上簽署。
4. 所遞交之正本申請書及所需文件將不獲退還。

Full Name of Proposed Owner/Owner:
建議持有人/持有人姓名：

This “Important Facts Statement – Policy Replacement” (“IFS-PR”) aims to help you understand the factors to be considered and the risks involved in replacing your existing life insurance policy with a new life insurance policy. Your licensed insurance intermediary should explain to you the implications and associated risks involved in replacing your existing life insurance policy.

If you do not understand any of the following paragraphs or the advice or information provided to you by your licensed insurance intermediary is different from the information in this IFS-PR, please **do not sign** this IFS-PR and **do not proceed** with replacing your existing Life Policy.

此《重要資料聲明書—轉保》(《聲明書》)旨在協助您了解以新的人壽保險保單取代現有人壽保險保單所需要考慮的因素及相關風險。您的持牌保險中介人必須向您解釋取代現有人壽保險保單的影響及相關風險。

若您並非完全明白下文任何段落之內容，或您的持牌保險中介人向您提供的意見或資料與本《聲明書》所載的資料有差異，則您**請勿簽署**本《聲明書》，以及**不應取代**現有人壽保險保單。

SOME IMPORTANT FACTS YOU SHOULD KNOW
Please read carefully before signing.
Your insurance intermediary shall explain the content to you.
您應知道之重要事項
於您簽署前請務必細閱。
您的保險中介人必須向您詳細解釋的內容。

Financial Implications 財務影響

- (1) **Informed Decision** – Life insurance policies usually lasts for a long period of time. If you surrender/take out policy loan from/withdraw policy values from/suspend or stop paying premium/reduce the premium payable on your existing life insurance policy, particularly during the early years of the policy period, you will usually suffer loss, including by way of having to pay charges. You should carefully compare your existing life insurance policy against the new life insurance policy you intend to purchase, and assess whether replacing your existing life insurance policy is in your best interests before you make a final decision.

知情的決定 – 人壽保險保單通常具較長年期。若您退保/從現有人壽保險保單中提取保單抵押貸款/提取保單價值/暫停或終止支付保費/減少應付保費，您通常會蒙受損失(尤其是在保單早期的時期)，包括因需要支付收費而蒙受損失。您應仔細比較現有人壽保險保單與擬購買的新的人壽保險保單，並在作出最終決定前評估取代現有人壽保險保單是否最為符合您之最佳利益。

- (2) **Difference between cash value from Surrender/Lapse and total premium paid under your existing Life Policy** – The cash value that you may receive from surrendering your existing life insurance policy or allowing your existing life insurance policy to lapse, may be less than your total premium paid. This means that you may suffer a loss. Further, you may incur surrender charges if you surrender your existing life insurance policy or allow it to lapse.

您現有人壽保險保單的退保/失效所得的現金價值與已支付的總保費之差額 – 就現有人壽保險保單退保或允許其失效所得的現金價值可能會少於您已支付的總保費，即您可能會蒙受損失。此外，您或需承擔因退保或允許保單失效而衍生的退保費用。

- (3) **Policy Loan Interest** – The issuing insurer of your existing life insurance policy may charge you interest starting from the loan drawdown date. You should carefully review your regular statements to understand the opening and ending loan balance as well as the interest amount charged in the relevant period. Your existing life insurance policy may be terminated if the accumulated loan amount (and interest) exceeds a specified level of the account value/cash value of your existing life insurance policy.

保單貸款的利息 – 發出您現有人壽保險保單的保險公司可能會自您提取保單貸款當日起收取利息。您應該仔細檢閱定期報表，以了解於有關時期的期初和期末貸款餘額，以及該期間收取的利息金額。如果累計貸款金額(及利息)超出現有人壽保險保單的賬戶價值/現金價值的指定水平，則您的現有人壽保險保單可能會被終止。

- (4) **Withdrawal/Partial Surrender Charges** – You may be subject to withdrawal charges or partial surrender charges within a prescribed period before the end of the policy term of your existing life insurance policy. For the new life insurance policy you intended to purchase, you may be subject to other early surrender/withdrawal charges within a prescribed period before the end of the term of the new life insurance policy.

提取保單款項/部分退保費用 – 若您於現有人壽保險保單的保單有效期前的訂明期限內，提取保單價值或部分退保，您或需支付相關費用。就您打算購買的新的人壽保險保單而言，您或需於新的人壽保險保單的保單有效期前的訂明期限內，支付其他提前退保/提取保單價值的費用。

- (5) **Policy Set-up Cost and Remuneration for licensed insurance intermediaries** – If you purchase a new life insurance policy, a substantial part of the initial premium may be used to pay for policy administration costs incurred by insurers and remuneration for the licensed insurance intermediaries. As a result, you may incur additional cost for replacing your existing life insurance policy.
開立保單費用及持牌保險中介人的酬勞 – 若您購買新的人壽保險保單，大部分最初所支付的保費可能會用於繳付保險公司的保單行政費及持牌保險中介人的酬勞。因此，您可能需要為取代現有人壽保險保單而承擔額外開支。
- (6) **Higher Premium** – You may have to pay higher premium under the new life insurance policy in view of the difference in age, changes of health conditions, occupation, lifestyle/habit, and recreational activities (as compared with when you purchased your existing life insurance policy).
較高的保費 – 因您的年齡增長，及健康狀況、職業、生活方式/習慣及所參與的康樂活動有所改變（與您購買現有人壽保險保單時相比），您或需為新的人壽保險保單支付較高的保費。
- (7) **Loss of Financial Benefit under the existing life insurance policy** – You may lose the financial benefit accumulated over the years (e.g. loyalty bonus or dividends) or to which you may be entitled (e.g. terminal bonus or dividends) under the existing life insurance policy.
現有人壽保險保單下財務利益的損失 – 您或會損失現有人壽保險保單多年來累積的財務利益（例如：長期客戶獎賞或紅利）或損失有權從現有人壽保險保單獲得的財務利益（例如：終期紅利或保單紅利）。
- (8) **Financial Benefits under the New Life Insurance Policy Not Guaranteed** – The illustrated benefits of a new life insurance policy may NOT be guaranteed and whether they can be achieved depend on the performance of the issuing insurer of the new life insurance policy. If the new life insurance policy is an investment-linked assurance scheme policy, the illustrated benefits are based on assumed rates of return only.
新的人壽保險保單的財務利益並非保證 – 新的人壽保險保單的說明所述利益可能並非屬保證利益，並會受發出新的人壽保險保單的保險公司的表現所影響。若新的人壽保險保單為投資相連壽險計劃保單，則其說明所述利益的計算只基於假設回報率。

Insurability Implications 受保資格的影響

- (9) **Changes in Coverage** – If you purchase a new life insurance policy and use it to replace an existing life insurance policy, some benefits, which are the policy features of the existing life insurance policy, may not be covered under the new life insurance policy due to changes in age, health conditions, occupation, lifestyle/habit or recreational activities. Also, riders/supplementary benefits under your existing life insurance policy may not be available under the new life insurance policy.
保障範圍的轉變 – 若您購買新的人壽保險保單，並以其取代現有人壽保險保單，則現有人壽保險保單的部分保障，可能會因您年齡、健康狀況、職業、生活方式/習慣及參與的康樂活動有所轉變，而不包括在新的人壽保險保單的受保範圍內。此外，新的人壽保險保單可能並不會包括您現有人壽保險保單的附加保障利益。

Claims Eligibility Implications 索償資格的影响

- (10) Benefits under the existing life insurance policy will no longer be payable to you if you surrender the policy or allow it to lapse. Besides, you may need to start a new waiting period in respect of certain benefits (e.g. medical, critical illness, suicide or incontestability) under the terms and conditions of the new life insurance policy.
若您就現有人壽保險保單退保或允許其失效，則現有人壽保險保單將不再為您提供保障。此外，視乎新的人壽保險保單的條款及細則，某些保障的等候期或需重新計算（例如：醫療、危疾、自殺或不可爭議的情況）。

Declaration 聲明

By the Insurance Intermediary 保險中介人聲明

I declare that I have discussed and explained the implications and associated risks (including the above listed items) to the Applicant/Proposer regarding his/her decision to replace his/her existing life insurance policy with a new life insurance policy. I further declare that I have not made any inaccurate or misleading statements or comparisons, or withheld any information which may affect the decision of the Applicant/Proposer.

本人聲明，本人已經與申請人/投保人討論並解釋申請人/投保人就以新的人壽保險保單取代現有人壽保險保單的決定對其的影響及相關風險（包括上述各項）；本人亦聲明，本人並無作出任何不準確或誤導的陳述或比較，或隱瞞任何可能影響申請人/投保人的決定的資料。

Signature of the Licensed Insurance Intermediary 持牌保險中介人簽署	Full Name of the Licensed Insurance Intermediary 持牌保險中介人姓名
Type of License and Licensed No. 牌照類別及牌照號碼	Date (YYYY/MM/DD) 日期(年/月/日)

By the Proposed Owner/Owner 建議持有人/持有人聲明：

I understand the content of the above listed items (1) – (10).
本人明白上述(1) – (10)各項之內容。

Warning: you must read all items carefully and check that the licensed insurance intermediary has explained all the information on this IFS-PR before you sign this IFS-PR.

忠告：您必須細閱所有項目，以及確保在簽署本《聲明書》前，持牌保險中介人已經向您解釋本《聲明書》上所有資料。

Signature of the Proposed Owner/Owner 建議持有人/持有人簽署	Full Name of the Proposed Owner/Owner 建議持有人/持有人姓名	Date (YYYY/MM/DD) 日期(年/月/日)
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