

# Voluntary Health Insurance Scheme Certified Plans enrollment form 自願醫療保障計劃認可產品投保表格

For internal use only  
只供內部使用

Agent name  
代理人姓名: \_\_\_\_\_

Agent no.  
代理人編號: \_\_\_\_\_

Please ✓ the appropriate box and \* delete where inappropriate. 請 ✓ 適用方格及於\*號刪去不適用者。  
All fields are mandatory, Please complete in BLOCK LETTERS. 所有項目必須填報，請以英文正楷大寫填報。

## 1. Applicant's information 投保人資料

Mr. 先生  Mrs. 太太  Ms. 女士 Last name 姓 \_\_\_\_\_ First name 名 \_\_\_\_\_

Chinese name 中文姓名 \_\_\_\_\_ Date of birth 出生日期 Day日 Month月 Year年  
□□□□□□□□

HKID card no. /Passport no. 香港身份證號碼 / 護照號碼\* \_\_\_\_\_ Mobile phone no. 手提電話號碼 \_\_\_\_\_

Correspondence address 通訊地址	Flat/Room 室 / 單位	Floor 樓	Block 座	Building 大廈
Estate name/No. & name of street/Lot no. 屋苑名稱 / 街名及門牌 / 地段			District 地區	HK/KLN/NT* 香港 / 九龍 / 新界*

Usual place of residence 慣常居住地  Hong Kong 香港  Other, please specify 其他，請註明 \_\_\_\_\_

Marital status 婚姻狀況 \_\_\_\_\_ Nationality 國籍 \_\_\_\_\_

Email address 電郵地址 \_\_\_\_\_

Industry 行業 \_\_\_\_\_ Occupation and position 職業及職位 \_\_\_\_\_

## 2. Application details 投保詳情

Insured person 受保人 1 <input type="checkbox"/> Same as applicant 與投保人相同	Insured person 受保人 2	Insured person 受保人 3	Insured person 受保人 4
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Insured person's information 受保人資料				
Last name 姓				
First name 名				
Chinese name 中文姓名				
Gender 性別	<input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女	<input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女	<input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女	<input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女

## 2. Application details (continued) 投保詳情 (續)

	Insured person 受保人 1	Insured person 受保人 2	Insured person 受保人 3	Insured person 受保人 4
HKID card no./Passport no./ Birth certificate no. 香港身份證號碼 / 護照號碼 / 出世紙號碼				
Date of birth 出生日期	Day日 Month月 Year年 □□□□□□□□	Day日 Month月 Year年 □□□□□□□□	Day日 Month月 Year年 □□□□□□□□	Day日 Month月 Year年 □□□□□□□□
Relationship with applicant 與投保人關係	The insured person must be the policyholder him/herself, his/her spouse, child(ren), parent(s) or parent(s)-in-law. 受保人須為保單持有人本人、其配偶、子女、父母或配偶的父母。			
Usual place of residence 慣常居住地				
Industry 行業				
Occupation and position 職業及職位				
<b>Choice of plan 計劃選擇</b>				
(A) HealthSure Voluntary Health Insurance Plan 「智選守護」自願醫療 保障計劃	<input type="checkbox"/> Standard plan 標準計劃	<input type="checkbox"/> Standard plan 標準計劃	<input type="checkbox"/> Standard plan 標準計劃	<input type="checkbox"/> Standard plan 標準計劃
(B) HealthFlexi Voluntary Health Insurance Plan 「智選無憂」自願醫療 保障計劃	<input type="checkbox"/> Essential 精選 <input type="checkbox"/> Essential with SMM 精選附帶附加醫療保障 <input type="checkbox"/> Advanced 特選 <input type="checkbox"/> Advanced with SMM 特選附帶附加醫療保障	<input type="checkbox"/> Essential 精選 <input type="checkbox"/> Essential with SMM 精選附帶附加醫療保障 <input type="checkbox"/> Advanced 特選 <input type="checkbox"/> Advanced with SMM 特選附帶附加醫療保障	<input type="checkbox"/> Essential 精選 <input type="checkbox"/> Essential with SMM 精選附帶附加醫療保障 <input type="checkbox"/> Advanced 特選 <input type="checkbox"/> Advanced with SMM 特選附帶附加醫療保障	<input type="checkbox"/> Essential 精選 <input type="checkbox"/> Essential with SMM 精選附帶附加醫療保障 <input type="checkbox"/> Advanced 特選 <input type="checkbox"/> Advanced with SMM 特選附帶附加醫療保障
(C) HealthFlexi Plus Voluntary Health 「智選無憂+」自願醫療 保障計劃	Deductible (HKD) 自付費 (港元)			
	<input type="checkbox"/> 0 <input type="checkbox"/> 60,000 <input type="checkbox"/> 90,000 <input type="checkbox"/> 150,000	<input type="checkbox"/> 0 <input type="checkbox"/> 60,000 <input type="checkbox"/> 90,000 <input type="checkbox"/> 150,000	<input type="checkbox"/> 0 <input type="checkbox"/> 60,000 <input type="checkbox"/> 90,000 <input type="checkbox"/> 150,000	<input type="checkbox"/> 0 <input type="checkbox"/> 60,000 <input type="checkbox"/> 90,000 <input type="checkbox"/> 150,000
	Territorial scope of cover 保障地域範圍			
	<input type="checkbox"/> Asia 亞洲 <input type="checkbox"/> Worldwide excluding US 環球但不包括美國	<input type="checkbox"/> Asia 亞洲 <input type="checkbox"/> Worldwide excluding US 環球但不包括美國	<input type="checkbox"/> Asia 亞洲 <input type="checkbox"/> Worldwide excluding US 環球但不包括美國	<input type="checkbox"/> Asia 亞洲 <input type="checkbox"/> Worldwide excluding US 環球但不包括美國
<b>Premium payment 保費支付</b>				
Payment frequency 繳付保費形式	<input type="checkbox"/> Annual 年繳 <input type="checkbox"/> Monthly 月繳	<input type="checkbox"/> Annual 年繳 <input type="checkbox"/> Monthly 月繳	<input type="checkbox"/> Annual 年繳 <input type="checkbox"/> Monthly 月繳	<input type="checkbox"/> Annual 年繳 <input type="checkbox"/> Monthly 月繳
Premium payable (HKD) (excluding levy collected by the Insurance Authority) 應付保費 (港元) (不包括保險 業監管局徵收的保費徵費)				

### Remarks 備註

- Separate policy will be issued for each insured person. 每位受保人會各自獲發出一份獨立保單。
- SMM: supplementary major medical 附加醫療保障
- VHIS Certification Number 自願醫療保認可產品編號

### HealthSure Voluntary Health Insurance Plan 「智選守護」自願醫療保障計劃 S00024-01-000-02

#### HealthFlexi Voluntary Health Insurance Plan 「智選無憂」自願醫療保障計劃

Essential 精選	F00044-01-000-02
Essential with supplementary major medical 精選附帶附加醫療保障	F00044-01-001-02
Advanced 特選	F00044-02-000-02
Advanced with supplementary major medical 特選附帶附加醫療保障	F00044-02-001-02

### HealthFlexi Plus Voluntary Health Insurance Plan 「智選無憂+」自願醫療保障計劃

Asia, Deductible HKD 0 亞洲·自付費 0 港元	F00036-01-000-02
Asia, Deductible HKD 60,000 亞洲·自付費 60,000 港元	F00036-02-000-02
Asia, Deductible HKD 90,000 亞洲·自付費 90,000 港元	F00036-03-000-02
Asia, Deductible HKD 150,000 亞洲·自付費 150,000 港元	F00036-04-000-02
Worldwide excluding the United States, Deductible HKD 0 環球但不包括美國·自付費 0 港元	F00036-05-000-02
Worldwide excluding the United States, Deductible HKD 60,000 環球但不包括美國·自付費 60,000 港元	F00036-06-000-02
Worldwide excluding the United States, Deductible HKD 90,000 環球但不包括美國·自付費 90,000 港元	F00036-07-000-02
Worldwide excluding the United States, Deductible HKD 150,000 環球但不包括美國·自付費 150,000 港元	F00036-08-000-02

### 3. Health questionnaire 醫療問卷

Each insured person must complete one health questionnaire. If more than one insured person applies for this plan, please photocopy and complete this section for each additional insured person(s). 每一位受保人必須填寫一份醫療問卷。如多於一位受保人申請此計劃，請複印此醫療問卷並為每位額外的受保人填寫。

Insured person name 受保人姓名

\_\_\_\_\_

Yes 是 No 否

#### Part A: General Information 甲部：基本資料

##### 1. Please provide your height and weight measurements.

請提供您的身高及體重資料。

Height 身高 \_\_\_\_\_ m 米 Weight 體重 \_\_\_\_\_ kg 公斤

##### 2. Smoking habit 吸煙習慣

Do you smoke or have you smoked in the last five years? 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).

您有沒有吸煙或在過去五年內曾否吸煙？「吸煙」在此問題的含義包括但不限於香煙、雪茄、煙斗、嚼煙及使用尼古丁補充劑產品（例如電子煙）。

If "Yes", please provide the following information

如「是」，請提供以下資料：

(a) Type of tobacco product:  cigarettes,  cigars,  tobacco pipes,  others:  
煙草產品種類：香煙 雪茄 煙斗 其他：\_\_\_\_\_

(b) \_\_\_\_\_ pieces per day 支 / 每日 · for 達 \_\_\_\_\_ years 年。

(c) If you no longer smoke now, 若您現時已沒有吸煙 ·

(i) when did you quit smoking?

請問您是何時戒煙？ \_\_\_\_\_

(ii) are you advised by doctor to quit smoking and for what reason?

是否醫生建議戒煙及原因為何？ \_\_\_\_\_

##### 3. Alcohol consumption 飲酒

In the last 12 months, on average do you drink alcoholic beverages for more than three times in a week?

在過去12個月內，您是否平均每週飲用酒精飲品超過三次？

If "Yes", please state the following:

如「是」，請提供以下資料

(a) Type of alcoholic beverages

酒精飲品種 \_\_\_\_\_

(b) Duration of drinking habit, frequency and quantity of consumption:

飲酒習慣的持續時間、頻密度及飲用份量：

\_\_\_\_\_ times per week 次 / 每週 · each consumption 每次數量 \_\_\_\_\_ ml 毫升

(c) If you no longer drink now,

若您現時已沒有飲酒 ·

(i) when did you quit drinking?

請問您是何時戒酒的？ \_\_\_\_\_

(ii) Are you advised by doctor to quit drinking and for what reason?

是否醫生建議戒酒及原因為何？ \_\_\_\_\_

##### 4. Have you engaged in the following activities within the last 12 months or will you engage/intend to engage in the following activities within the next 12 months? 您曾否在過去12個月內或會否在未來12個月內參與以下活動？

(a) any hazardous sports or activities (such as diving, motor racing, mountaineering or rock climbing, parachuting, sky diving, hang gliding)

任何危險性運動或活動（例如：潛水、賽車、攀山或攀石、跳傘、高空跳傘、懸掛滑翔飛行）

(b) flying activities other than as a fare-paying passenger of a licensed air service operating within recognized scheduled routes

飛行活動（不包括以付費乘客身份乘搭由商業性民航客機提供並獲認可的定期航班服務）

If "Yes", please state the following information

如「是」，請提供以下資料

Type of activity

活動種類 \_\_\_\_\_

Duration and frequency of engagement in the activity 參與活動的持續時間及頻密度：

\_\_\_\_\_ times per month 次 / 每月 · each duration 每次活動時間 \_\_\_\_\_ hours 小時

### 3. Health questionnaire (continued) 醫療問卷 (續)

#### Part B: Health Information 乙部: 健康資料

Note: Questions of Part B does not require the proposed insured person 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.

請注意: 準受保人無需於乙部問題披露以下健康狀況或治療: 傷風/感冒/喉嚨痛、腸胃炎/食物中毒(已痊癒)、消化不良(無需檢查)、瘰癧、肌肉扭傷(已痊癒)、鵝口瘡、常規產前掃描/血液檢驗(檢驗結果正常)、常規子宮頸細胞塗片檢驗(檢驗結果正常)、常規健康檢查(檢查結果正常)、預防疫苗、荷爾蒙補充治療(更年期)、不育治療或胎兒生長情況正常的懷孕、近視/遠視/散光/老花。

If your answer to any of the questions 5–12 below is “Yes”, please proceed to answer the relevant follow-up questions in Part C.  
若以下第5至12項任何一項問題之答案為「是」者，請於丙部回答相關的跟進問題。

	Yes 是	No 否
5. Have you ever been diagnosed with any of the following diseases or medical conditions? 您是否曾被確診下列疾病或健康狀況?		
(a) Cancer or carcinoma in situ 癌症或原位癌	<input type="checkbox"/>	<input type="checkbox"/>
(b) Brain tumor 腦部腫瘤	<input type="checkbox"/>	<input type="checkbox"/>
(c) Heart disease 心臟疾病	<input type="checkbox"/>	<input type="checkbox"/>
(d) Stroke (including transient ischemic attack (TIA)) 中風(包括短暫性腦缺血·俗稱「小中風」)	<input type="checkbox"/>	<input type="checkbox"/>
(e) Hypertension 高血壓	<input type="checkbox"/>	<input type="checkbox"/>
(f) Diabetes mellitus or impaired glucose tolerance 糖尿病或葡萄糖耐量異常	<input type="checkbox"/>	<input type="checkbox"/>
(g) Kidney disease 腎病	<input type="checkbox"/>	<input type="checkbox"/>
(h) Prolapsed intervertebral disc or degenerative spine conditions 椎間盤突出或脊椎退化性疾病	<input type="checkbox"/>	<input type="checkbox"/>
(i) Diseases or medical conditions requiring a medical device or prosthesis to be implanted within the body 需要植入醫療儀器或義肢的疾病或健康狀況	<input type="checkbox"/>	<input type="checkbox"/>
(j) Congenital conditions (medical, physical or mental abnormalities that existed at the time of or before birth) 先天性疾病(指於出生時或之前已存在的醫學、生理或精神上的異常)	<input type="checkbox"/>	<input type="checkbox"/>
(k) Physical defects, impairments, deformities, and/or conditions affecting mobility, sight, speech or hearing 身體缺陷、不健全、畸形、及/或影響活動能力、視力、說話能力或聽力的狀況	<input type="checkbox"/>	<input type="checkbox"/>
(l) Mental health conditions (such as depression, anxiety, schizophrenia, eating disorders, or bipolar disorders) 精神健康狀況(例如抑鬱、焦慮、精神分裂、飲食失調或躁狂抑鬱症)	<input type="checkbox"/>	<input type="checkbox"/>
(m) Hypercholesterolemia or Hyperlipidemia 高膽固醇症或高血脂症	<input type="checkbox"/>	<input type="checkbox"/>
(n) Liver disorder (such as hepatitis B or hepatitis C (including tested positive), fatty liver or cirrhosis of liver) 肝臟疾病(例如乙型或丙型肝炎(包括測試呈陽性反應)、脂肪肝或肝硬化)	<input type="checkbox"/>	<input type="checkbox"/>
(o) Multiple sclerosis 多發性硬化症	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you currently have any of the following diseases or medical conditions? 您目前是否患有下列疾病或健康狀況?		
(a) Hernia 疝氣(俗稱「小腸氣」)	<input type="checkbox"/>	<input type="checkbox"/>
(b) Breast lesion (tumour / mass / lump / cyst / nodule / growth) 乳房病變(腫瘤/硬塊/腫塊/囊腫/結節/增生)	<input type="checkbox"/>	<input type="checkbox"/>
(c) Uterine or ovarian lesion (tumour / mass / lump / cyst / polyp / nodule / growth) 子宮或卵巢病變(腫瘤/硬塊/腫塊/囊腫/瘖肉/結節/增生)	<input type="checkbox"/>	<input type="checkbox"/>
(d) Benign prostatic hypertrophy 良性前列腺肥大	<input type="checkbox"/>	<input type="checkbox"/>
(e) Gall bladder stone or urinary stone (renal stone, ureteric stones or urinary bladder stone) 膽結石或泌尿道結石(腎結石、輸尿管結石或膀胱結石)	<input type="checkbox"/>	<input type="checkbox"/>
(f) Cataract, glaucoma or retinopathy 白內障、青光眼或視網膜病變	<input type="checkbox"/>	<input type="checkbox"/>
(g) Arthritis or other joint disorder 關節炎或其他關節疾病	<input type="checkbox"/>	<input type="checkbox"/>
7. In the last five years, have you ever had or been advised to have any regular or ongoing (such as monthly, every two 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? 在過去五年的時間內，您是否曾經或被建議定期或持續(例如每月、每兩個月、每半年、每年)為任何疾病或健康狀況接受專業醫護人員(例如專科醫生、物理治療師、精神科醫生)的跟進診治或醫療護理?	<input type="checkbox"/>	<input type="checkbox"/>
8. In the last five 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 one month? 在過去五年的時間內，您是否曾被醫生建議定期(例如按醫生指示每日/每週一次/有需要時)服用為期超過一個月的處方藥物?	<input type="checkbox"/>	<input type="checkbox"/>

### 3. Health questionnaire (continued) 醫療問卷 (續)

	Yes 是	No 否
9. In the last five years, have you been admitted into a hospital? 在過去五年內·您是否曾入住醫院?	<input type="checkbox"/>	<input type="checkbox"/>
10. In the last five years, have you undergone a surgical procedure (including endoscopy or biopsy) without being admitted into a hospital? 在過去五年內·您是否曾在非住院情況下接受外科程序 (包括內窺鏡檢查或活組織化驗)?	<input type="checkbox"/>	<input type="checkbox"/>
11. In the last five 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)? 在過去五年內·您是否曾接受或曾被建議接受檢查 (例如驗血·驗尿·心電圖·X光·超聲波·電腦掃描·磁力共振·正電子掃描·愛滋病測試·乙型肝炎測試·丙型肝炎測試)?	<input type="checkbox"/>	<input type="checkbox"/>
If the answer is "Yes", do your investigation result(s) include the followings? 如果答案屬「是」·您的檢查結果是否包括下列情況?		
(a) Normal test result is advised 檢驗結果正常	<input type="checkbox"/>	<input type="checkbox"/>
(b) Abnormal test result is advised 檢驗結果異常	<input type="checkbox"/>	<input type="checkbox"/>
(c) You are still awaiting test or test result 您正等候檢驗或檢驗結果	<input type="checkbox"/>	<input type="checkbox"/>
(d) Test result is inconclusive or uncertain (retesting or follow up test is required) 檢驗結果為無定論或不確定 (需要重新或進一步檢驗)	<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) 就檢驗結果已尋求醫療意見或需要接受治療 (例如一些未必需要即時治療的情況如肝囊腫 / 腦囊腫 / 關節退化或鈣化 / 於成像檢測中發現肺部或乳房或甲狀腺出現鈣化)	<input type="checkbox"/>	<input type="checkbox"/>
12. Apart from anything you have already disclosed in Questions 5-11, do you have any of the following conditions? 除了您在第5至11項問題中已披露的資料外·您是否有下列情況?		
(a) Unintentional weight loss by more than five kg over past one year 在過去一年內·體重無故地減少了五公斤以上	<input type="checkbox"/>	<input type="checkbox"/>
(b) Abnormal bleeding (such as vaginal bleeding, rectal bleeding, nose bleeding or coughing up of blood) for at least one month 不正常出血 (例如陰道出血·便血·流鼻血或咳血) 至少一個月	<input type="checkbox"/>	<input type="checkbox"/>
(c) In the last one year, you had or have been required to have follow-up consultation with a healthcare professional (such as specialist doctor, physiotherapist, psychiatrist) for any medical condition or sign and symptom 在過去一年內·您有任何健康狀況或病徵及症狀曾經接受或需要接受專業醫護人員 (例如專科醫生·物理治療師·精神科醫生) 的跟進診治	<input type="checkbox"/>	<input type="checkbox"/>
(d) 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 其他健康狀況或病徵及症狀 (例如腫塊·頭痛·持續咳嗽·胸痛或上腹痛) 而正在或打算尋求醫療意見	<input type="checkbox"/>	<input type="checkbox"/>
13. At your best knowledge, have any of your parents or siblings by blood been diagnosed with any of the following diseases or medical conditions at or before age 60: 就您所知·您的親生父母或兄弟姊妹曾否於60歲或以前被確診下列疾病或健康狀況:		
(a) Cancer 癌症 Family member 親屬	<input type="checkbox"/>	<input type="checkbox"/>
Onset age of disease 病發年齡	<input type="checkbox"/> age at or below 30 30歲或以下	<input type="checkbox"/> age 31-40 31-40歲
	<input type="checkbox"/> age 41-50 41-50歲	<input type="checkbox"/> age 51-60 51-60歲
(b) Cancer 冠心病 Family member 親屬	<input type="checkbox"/>	<input type="checkbox"/>
Onset age of disease 病發年齡	<input type="checkbox"/> age at or below 30 30歲或以下	<input type="checkbox"/> age 31-40 31-40歲
	<input type="checkbox"/> age 41-50 41-50歲	<input type="checkbox"/> age 51-60 51-60歲
(c) Diabetes mellitus 糖尿病 Family member 親屬	<input type="checkbox"/>	<input type="checkbox"/>
Onset age of disease 病發年齡	<input type="checkbox"/> age at or below 30 30歲或以下	<input type="checkbox"/> age 31-40 31-40歲
	<input type="checkbox"/> age 41-50 41-50歲	<input type="checkbox"/> age 51-60 51-60歲
(d) Motor neuron disease 運動神經元疾病 Family member 親屬	<input type="checkbox"/>	<input type="checkbox"/>
Onset age of disease 病發年齡	<input type="checkbox"/> age at or below 30 30歲或以下	<input type="checkbox"/> age 31-40 31-40歲
	<input type="checkbox"/> age 41-50 41-50歲	<input type="checkbox"/> age 51-60 51-60歲
(e) Multiple sclerosis 多發性硬化症 Family member 親屬	<input type="checkbox"/>	<input type="checkbox"/>
Onset age of disease 病發年齡	<input type="checkbox"/> age at or below 30 30歲或以下	<input type="checkbox"/> age 31-40 31-40歲
	<input type="checkbox"/> age 41-50 41-50歲	<input type="checkbox"/> age 51-60 51-60歲

### 3. Health questionnaire (continued) 醫療問卷 (續)

Yes 是 No 否

13. At your best knowledge, have any of your parents or siblings by blood been diagnosed with any of the following diseases or medical conditions at or before age 60:

就您所知，您的親生父母或兄弟姊妹曾否於60歲或以前被確診下列疾病或健康狀況：

(f) Stroke 中風						<input type="checkbox"/>	<input type="checkbox"/>	
Family member 親屬								
Onset age of disease 病發年齡	<input type="checkbox"/> age at or below 30 30歲或以下	<input type="checkbox"/> age 31-40 31-40歲	<input type="checkbox"/> age 41-50 41-50歲	<input type="checkbox"/> age 51-60 51-60歲				
(g) Parkinson's disease 帕金森症						<input type="checkbox"/>	<input type="checkbox"/>	
Family member 親屬								
Onset age of disease 病發年齡	<input type="checkbox"/> age at or below 30 30歲或以下	<input type="checkbox"/> age 31-40 31-40歲	<input type="checkbox"/> age 41-50 41-50歲	<input type="checkbox"/> age 51-60 51-60歲				
(h) Hereditary diseases 遺傳病						<input type="checkbox"/>	<input type="checkbox"/>	
- including cystic fibrosis, familial adenomatous polyposis, Alzheimer's disease, familial cardiomyopathy, inherited blood disorders (hemophilia, thalassemia, sickle cell disease), muscular dystrophy, polycystic kidney disease or Huntington's disease								
- 包括囊性纖維化、家族性大腸腺息肉病、亞茲海默氏症、家族性心肌病、遺傳性血病 (血友病、地中海貧血、鐮刀型貧血)、肌肉萎縮症、多囊性腎病或亨丁頓舞蹈症								
Family member 親屬								
Onset age of disease 病發年齡	<input type="checkbox"/> age at or below 30 30歲或以下	<input type="checkbox"/> age 31-40 31-40歲	<input type="checkbox"/> age 41-50 41-50歲	<input type="checkbox"/> age 51-60 51-60歲				

#### For female only 只適用於女性

14. Are you currently pregnant? 您現時是否懷孕?  Yes  No

If "Yes", expected date of delivery Day日 Month月 Year年  
如「是」，預產日期為

#### For insured children aged six or below only 只適用於六歲或以下之受保兒童

15. Was the insured child born before 37<sup>th</sup> week of pregnancy and/or born with body weight less than 2.5 kg (5.5 lbs)? 受保兒童是否於懷孕第37週前出生，及/或出生時體重少於2.5公斤(5.5磅)?  Yes  No

If "Yes" 如「是」

(a) At which week of pregnancy was the insured child born? 受保兒童在孕期哪一週出生?  
 Week 25 or before 25週或以前  Week 26-30 26-30週  Week 31-35 31-35週  Week 36-37 36-37週

(b) Body weight at birth 出生時體重  
 1.0 kg or less 1公斤或以下  1.1 - 1.5kg 1.1 - 1.5公斤  1.6 - 2.0kg 1.6 - 2.0公斤  2.1 - 2.5kg 2.1 - 2.5公斤

#### Part C: Supplementary Health Information to Question 5 - 12

丙部：第5-12題的健康資料補充

If the answer to any of the questions 5-12 in Part B is "Yes", please provide additional information as applicable.

若乙部第5-12題任何一項問題之答案為「是」者，請在適用的問題提供更多資料。

Please provide information as detailed as possible (e.g. provide year and month if exact date could not be recalled) for the sake of fair assessment in underwriting.

請盡量提供齊全資料 (例如在未能回憶確實日期的情況下提供年份及月份) 以便作出公平核保決定。

Question no.: \_\_\_\_\_ Disease/medical condition/sign and symptom: \_\_\_\_\_  
 題號: \_\_\_\_\_ 疾病/健康狀況/病徵及症狀: \_\_\_\_\_

(a) Date of first occurrence of sign and symptom: \_\_\_\_\_  
 首次出現病徵及症狀的日期

(b) Treatment/investigations/tests/scans that have been performed and Date of such treatment/investigation/tests/scans  
 已進行的治療/檢查/測試/掃描及有關治療/檢查/測試/掃描日期

Details 詳情 \_\_\_\_\_

(c) Date of last follow-up medical consultation/treatment  
 最後覆診/治療日期

(d) Present condition  Fully recovered 完全康復  Follow-up action 仍然跟進中  Medication 服用跟進藥物  Others 其他: \_\_\_\_\_  
 現況

(e) Name of doctor \_\_\_\_\_  
 醫生姓名

(f) Name of Hospital, where applicable \_\_\_\_\_  
 醫院名稱 (如適用)

Next follow up date 下次覆診日期:

### 3. Health questionnaire (continued) 醫療問卷 (續)

Question no.: \_\_\_\_\_ Disease/medical condition/sign and symptom: \_\_\_\_\_

題號: \_\_\_\_\_ 疾病 / 健康狀況 / 病徵及症狀: \_\_\_\_\_

(a) Date of first occurrence of sign and symptom:

首次出現病徵及症狀的日期

Day日	Month月	Year年
<input type="text"/>	<input type="text"/>	<input type="text"/>

(b) Treatment/investigations/tests/scans that have been performed and Date of such treatment/investigation/tests/scans

已進行的治療 / 檢查 / 測試 / 掃描及有關治療 / 檢查 / 測試 / 掃描日期

Day日	Month月	Year年
<input type="text"/>	<input type="text"/>	<input type="text"/>

Details 詳情

(c) Date of last follow-up medical consultation/treatment

最後覆診 / 治療日期

Day日	Month月	Year年
<input type="text"/>	<input type="text"/>	<input type="text"/>

(d) Present condition  Fully recovered  Follow-up action  Medication  Others

現況

完全康復

仍然跟進中

服用跟進藥物

其他:

Next follow up date

下次覆診日期:

(e) Name of doctor

醫生姓名

Day日	Month月	Year年
<input type="text"/>	<input type="text"/>	<input type="text"/>

(f) Name of Hospital, where applicable

醫院名稱 (如適用)

Please photocopy this Section C if you have more questions that need to submit supplementary health information.

如您有更多問題需要提交健康資料補充, 請複印此丙部醫療問卷。

#### Statement for Collection of Information 資料收集聲明

- (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.  
此問卷收集與健康相關的資料僅作為核保之用途, 而核保是本公司評估申請人之健康風險及決定申請結果的程序。本公司採用的核保程序應為公平合理, 並會因應客戶要求解釋申請結果。
- (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.  
作為申請人, 閣下需要盡其所知所信, 按本問卷中要求向本公司提供完整及準確的資料。本公司根據閣下提供的資料, 可能會提出跟進問題或查詢而需要閣下進一步提供資料以作核保之用。
- (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.  
若閣下在提交本申請表後至閣下收到保單前的期間就本問卷中提供的資料有任何改變或更新, 閣下需要及早通知本公司。
- (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).  
即使已成功投保並獲簽發保單, 若閣下未按 (ii) 所述盡其所知所信向本公司提供完整及準確的資料, 或未按 (iii) 所述就資料的任何改變或更新而及早通知本公司, 閣下的保險保障可能會受到影響, 本公司亦可能因此終止、作廢或撤銷有關保單, 或拒絕賠償。



## 4. Payment method 付款方式

By credit card 以信用卡繳付

Annual payment 每年繳付

Monthly payment 每月繳付

Credit card type 信用卡類別

VISA

MasterCard

Cardholder's name

持卡人姓名

Credit card no.

信用卡號碼

Credit card expiry date

信用卡有效期至

Month月 Year年

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The cardholder hereby authorizes Zurich Insurance Company Ltd to charge automatically the premium due from his/her credit card stated above including subsequent premium payment for renewal of this policy and accepts full responsibility for any overdraft on his/her credit card which arises as a result of such transfer. For the continuation of coverage, the cardholder understands that he/she should arrange sufficient credit balance in his/her credit card by the premium due date for the automatic debit of premium.

持卡人茲授權蘇黎世保險有限公司從他 / 她上述之信用卡以直接轉帳自動支付應繳保費金額包括往後續保的各期保費及同意因該等轉帳而令他 / 她信用卡出現透支，持卡人願承擔全部責任。為了持續的保障，持卡人明白他 / 她須於保費到期日前安排足夠的信貸餘額於他 / 她的信用卡上作保費自動轉帳之用。

If credit cardholder is not the applicant, please explain the relationship between the credit cardholder and the applicant:

若信用卡持有人並非投保人，請列明信用卡持有人與投保人的關係：

Signature of credit cardholder

信用卡持卡人簽署

Day日 Month月 Year年

Date

日期

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## 5. Declaration 聲明

1. I/We hereby apply for HealthSure Voluntary Health Insurance Plan/HealthFlexi Voluntary Health Insurance Plan/HealthFlexi Plus Voluntary Health Insurance Plan ("Plan"). I/We declare that to the best of my/our knowledge and belief the information on this enrollment form is true and complete in every respect and all information disclosed have been verified by me/us as true and correct. Where applicable, I/we declare that I/we have full and complete authority from the insured person(s) to sign this enrollment form and disclose any personal information being requested to assess this application. I/We understand and agree that this enrollment form and declaration will form the basis of the contract between me/us and Zurich Insurance Company Ltd (the "Company").

本人 / 我們現投保申請「智選守護」自願醫療保障計劃 / 「智選無憂」自願醫療保障計劃 / 「智選無憂+」自願醫療保障計劃（「計劃」）。本人 / 我們特此聲明此投保表格的資料乃根據本人 / 我們所知及所信為確實及完全而填報，屬實無訛，所有已披露的信息已經由本人 / 我們核實正確無誤。在適用的情況下，本人 / 我們聲明本人 / 我們已獲受保人授予全權簽署此投保表格並披露所要求的任何個人資料，以作評估申請之用。本人 / 我們明白本人 / 我們與蘇黎世保險有限公司（「貴公司」）的保險合約將照此投保表格及聲明而訂立。

2. I/We authorize the Company to obtain medical information from the insured person's medical practitioner(s) and I/we agree to supply additional information relevant to the policy of this Plan at my/our own expense.  
本人 / 我們授權 貴公司有權向受保人之醫生索取有關病歷資料，本人 / 我們亦同意提供任何進一步與此計劃有關之資料並自付所需費用。
3. I/We understand that I/we shall refer to the policy of this Plan for details of the insurance coverage, exclusion clauses and terms and conditions.  
本人 / 我們明白所有保障範圍、不承保事項、條款及細則概以此計劃保單為準。
4. I/We understand that I/we must complete and provide all information requested in this enrollment form, failing which the Company cannot process my/our application for this Plan.  
本人 / 我們明白本人 / 我們必須完成及提供此投保表格要求之所有資料，否則 貴公司將不會受理本人 / 我們資料不全之保單申請。
5. I/We agree that this policy will be automatically renewed according to the Terms and Conditions and Supplement (if applicable) of this policy.  
本人 / 我們同意，本保單將會按條款及細則及補充文件（如適用）自動續保。
6. I/We understand and acknowledge that the Company has the right to request the policyholder to transfer the ownership of the policy to the insured person who has reached the age of 18.  
本人 / 我們明白並確認 貴公司有權要求保單持有人將保單的所有權轉讓給年滿18歲之受保人。
7. I/We acknowledge that the premium paid under this Plan shall not be automatically entitled to tax deduction even if this application is approved by the Company. I/We understand that I/We am/are required to fulfill the conditions and assessment criteria imposed by the Inland Revenue Department and any applicable laws (which may amend from time to time), which include but not limited to allowable relationship for dependent, age/disability/full-time education requirement, date and amount of qualifying premium paid, in order to enjoy any tax deduction.

本人 / 我們明白即使此申請已獲 貴公司接納，本計劃下已繳付的保費並不會自動享有稅務扣減。本人 / 我們明白本人 / 我們須符合稅務局及任何適用的法律（可不時修改）所規定的條件及評估標準方可享有稅務扣減，包括但不限於認可的受供養人、年齡 / 殘疾 / 全日制學生資格，以及支付合資格保費的金額及日期。



## 5. Declaration (continued) 聲明 (續)

8. I/We hereby authorize any company within the Zurich Insurance Group which is in possession of my/our personal information to release part or all of the information to the Company or its agents.

本人 / 我們特此授權蘇黎世保險集團中任何持有本人 / 我們個人資料的公司提供部分或全部資料予 貴公司或其代理人。

This insurance application will not be in force until the application(s) has been accepted by the Company and the premium has been paid.

此保險申請須待 貴公司覆核、接納投保書及收訖保費後才能生效。

## 6. Notice to customers relating to the Personal Data (Privacy) Ordinance (“Ordinance”) 有關個人資料 (私隱) 條例 (「私隱條例」) 的客戶通知

The personal information of customers (including policyholders, insured persons, beneficiaries, premium payors, trustees, policy assignees and claimants) collected or held by **Zurich Insurance Company Ltd (“Company”)** from time to time, which also includes data collected or generated in the ordinary course of the Company’s business and the continuation of relationship with the customer (such as claim information and medical history received from third parties), may be used by the Company and/or a company within its group (“**Zurich Insurance Group**”) for the purposes **necessary** in providing services to the customers (otherwise the Company is unable to provide services to customers who fail to provide the required information). 由蘇黎世保險有限公司 (「本公司」) 不時收集或持有的客戶 (包括保單持有人、受保人、受益人、保費付款人、信託人、保單受讓人及索償人) 個人資料，其中亦包括在公司日常業務過程中以及就持續與客戶的關係而收集或產生的資料 (例如從第三方收到的索償資料和病歷)，均可供本公司及 / 或其所屬集團 (「蘇黎世保險集團」) 內的公司使用作為向客戶提供服務而必須的用途 (否則本公司將無法為未能提供所需資料的客戶提供服務)。

Please read carefully the details of the Company’s privacy policy which is made available on our website at [www.zurich.com.hk/pics](http://www.zurich.com.hk/pics) or by scanning the QR code. You may also contact our Customer Care Center at 2968 2288 or insurance intermediaries for enquires. 本公司之私隱政策詳載於 [www.zurich.com.hk/pics](http://www.zurich.com.hk/pics) 或可透過掃描QR碼細閱。您亦可致電2968 2288與我們的客戶服務中心聯絡又或向保險中介人查詢。



### Consent for marketing purposes - Voluntary:

就市場推廣用途之同意 – 自願性：

Certain personal information of policyholders and insured persons collected or held by the Company (which also includes data collected or generated in the ordinary course of the Company’s business and the continuation of relationship with the customer), in particular, names, contact information, age, gender, identity document reference, marital status, financial background, demographic data, transaction pattern and behavior, policy information, claim information, and medical history may be used by the Company, **only upon having such policyholders’ or insured persons’ consent or indication of no objection**, for providing marketing materials and conducting direct marketing activities in relation to insurance and/or financial products and services of the Zurich Insurance Group and/or other financial services providers, and/or other related services of business partners, with whom the Company maintains business referral or other arrangements (such as reward, loyalty, co-branding or privileges programs and related services and products, services and products offered by the Company’s business or co-branding partners, donations or contributions for charitable and/or non-profit making purposes). For the avoidance of doubt, the latest instruction (for example, consent or indication of no objection, or request for opt-out) received from a customer shall override any previous instruction given to the Company in this regard in relation to all personal information of the customer collected or held by the Company from time to time.

由本公司收集或持有的保單持有人及受保人的某些個人資料 (其中亦包括在本公司日常業務過程中以及就持續與客戶的關係收集或產生的資料)，特別是姓名、聯絡資料、年齡、性別、身份證明文件資料、婚姻狀況、經濟背景、人口統計數據、交易模式和行為、保單資料、索償資料及醫療紀錄等，**於獲該保單持有人或受保人同意或作不反對指示後**，均可供本公司使用作為蘇黎世保險集團及 / 或與本公司維持業務引薦關係或其他安排之其他金融服務供應商的保險及 / 或金融產品及服務，及 / 或其他商業合作夥伴之相關服務，提供市場推廣資料及進行直接市場推廣活動。(例如獎賞、忠誠獎勵、合作品牌或優惠計劃以及相關服務和產品，由本公司商業合作夥伴或合作品牌夥伴提供的服務和產品，出於慈善及 / 或非牟利目的的捐贈或捐款)。為免生疑問，就本公司不時收集或持有的所有客戶個人資料，本公司將會以從客戶收到的最新指示 (例如同意或表示不反對的指示，或提出反對要求)。

The Company may provide (and may receive money or property in return for providing) certain personal information, in particular, name, contact information, age, gender and policy information of a policyholder and an insured person, **only upon having such policyholder’s and insured person’s written consent**, to be used by the following parties, within or outside of Hong Kong, for their own and/or the Company’s **marketing purposes** set out above:

- (1) companies within the Zurich Insurance Group;
- (2) other banking/financial institutions, commercial or charitable organizations with whom the Company maintains business referral or other arrangements;
- (3) third party reward, loyalty, co-branding or privileges program providers;
- (4) third party marketing service providers and insurance intermediaries.

**於獲保單持有人及受保人書面同意後**，本公司方可就以下人士本身及 / 或就本公司的市場推廣用途，向以下於香港境內或境外的人士提供其某些個人資料 (並可能收到金錢或其他財產作為回報)，特別是姓名、聯絡資料、年齡、性別、保單持有人及受保人的保單資料等，以供其使用：

- (1) 蘇黎世保險集團成員公司；
- (2) 與本公司維持業務引薦關係或其他安排的其他銀行 / 金融機構、商業或慈善組織；
- (3) 第三方獎賞、忠誠獎勵、合作品牌或優惠計劃提供者；
- (4) 第三方市場推廣相關服務供應商及保險中介人。

I/We understand that I/we can withdraw any consent provided for marketing purposes anytime by notice to the Company.

本人 / 我們明白可隨時通知 貴公司以撤回任何就市場推廣用途所給予之同意。

I/We do not agree to the use or transfer of my/our personal data for marketing purposes as set out above.

本人 / 我們不同意 貴公司使用或向第三方提供本人 / 我們的個人資料作上列市場推廣用途。

Policy effective date

Day日 Month月 Year年

保單生效日

Date  
日期

□	□	□	□	□	□	□	□
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The policy effective date is subject to the final approval by Zurich Insurance Company Ltd.

保單生效日最終由蘇黎世保險有限公司決定。

I/We confirm that all information provided by me/us in this enrollment form is true, correct and accurate. I/We further confirm my/our agreement to all sections in this enrollment form, including without limitation, the above declaration and the notice to customers relating to the Personal Data (Privacy) Ordinance.

本人 / 我們確認由本人 / 我們於此投保表格提供之所有資料均為事實正確無誤。本人 / 我們更確認同意本投保表格內之所有部分，包括但不限於上列之聲明及有關個人資料（私隱）條例的客戶通知。

#### Cancellation Rights and Refund of Premium(s) 取消保單權益及發還保費

I understand that I have the right to cancel and obtain a refund of any premium(s) paid (less any market value adjustments, if any) and any levy by giving written notice. Such notice must be signed by me and received directly by Zurich Insurance Company Ltd at 25-26/F, One Island East, 18 Westlands Road, Island East, Hong Kong within 21 days after the delivery of the policy or issuance of a notice to the Policy Holder or the Policy Holder's representative, whichever is the earlier.

本人明白本人有權以書面通知要求取消保單及取回所有已繳保費（扣除市場價值調整，如適用）及保費徵費；但是本人必須簽署該通知，並確保蘇黎世保險有限公司（地址：香港港島東華蘭路18號港島東中心25-26樓）於以下時段內直接收到該通知，保單交付本人或本人的代表後或《通知書》發予本人或本人的代表後，起計的21天，以較先者為準。

Signature of applicant

投保人簽署

Day日 Month月 Year年  
Date  
日期

□	□	□	□	□	□	□	□
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