



ZURICH®

蘇黎世

# HealthSure Voluntary Health Insurance Plan enrollment form

## 「智選守護」自願醫療保障計劃投保表格

For internal use only  
只供內部填寫

Broker name  
經紀人姓名：\_\_\_\_\_

Broker no.  
經紀人編號：\_\_\_\_\_

Enquiry no. 查詢電話：+852 2903 9391 Fax 傳真：+852 2968 0639

Please tick the appropriate box and \* delete where is inappropriate. 請✓適用方格及於\*號刪去不適用者。

Please use blue or black ink and write clearly in **CAPITAL** letters. Please complete the form in English. **All fields are mandatory.**

請用藍色或黑色原子筆，用英文大楷清晰填寫資料。所有項目必須填報。

**VHIS Certification Number 自願醫保認可產品編號：S00024-01-000-01**

### 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

D	D	M	M	Y	Y	Y	Y
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HKID card no./Passport no. 香港身份證號碼/護照號碼\*

Mobile phone number 流動電話號碼

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\*

Email 電郵地址

Marital status 婚姻狀況

Nationality 國籍

Usual place of residence  
慣常居住地

Hong Kong  
香港

Other, please specify:  
其他，請註明：\_\_\_\_\_

Industry 行業

Occupation and Position 職業及職位

## 2. Insured person's information<sup>1</sup> 受保人資料<sup>1</sup>

	Insured person 1 受保人 1	Insured person 2 受保人 2	Insured person 3 受保人 3	Insured person 4 受保人 4
Last name 姓				
First name 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
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	D M Y 日 月 年	D M Y 日 月 年	D M Y 日 月 年	D M Y 日 月 年
Relationship with applicant 與投保人關係	<input type="checkbox"/> Self (Details as above) 本人 (資料與以上相同) <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Child 子女 <input type="checkbox"/> Parents/parents-in-law 父母 / 配偶父母 <input type="checkbox"/> Siblings/Siblings of spouse 兄弟姊妹 / 配偶的兄弟 姊妹 <input type="checkbox"/> Grandparents/ Grandparents-in-law 祖父母 / 配偶的祖父母	<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Child 子女 <input type="checkbox"/> Parents/parents-in-law 父母 / 配偶父母 <input type="checkbox"/> Siblings/Siblings of spouse 兄弟姊妹 / 配偶的兄弟 姊妹 <input type="checkbox"/> Grandparents/ Grandparents-in-law 祖父母 / 配偶的祖父母	<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Child 子女 <input type="checkbox"/> Parents/parents-in-law 父母 / 配偶父母 <input type="checkbox"/> Siblings/Siblings of spouse 兄弟姊妹 / 配偶的兄弟 姊妹 <input type="checkbox"/> Grandparents/ Grandparents-in-law 祖父母 / 配偶的祖父母	<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Child 子女 <input type="checkbox"/> Parents/parents-in-law 父母 / 配偶父母 <input type="checkbox"/> Siblings/Siblings of spouse 兄弟姊妹 / 配偶的兄弟 姊妹 <input type="checkbox"/> Grandparents/ Grandparents-in-law 祖父母 / 配偶的祖父母
Usual place of residence 慣常居住地				
Occupation & Position 職業及職位				
Industry 行業				

<sup>1</sup> Separate policy will be issued for each insured person. 每位受保人會獨立發出一份保單。

## 3. Premium payment 保費支付

	Insured person 1 受保人 1	Insured person 2 受保人 2	Insured person 3 受保人 3	Insured person 4 受保人 4
Payment frequency 繳付保費形式	Annual 年繳 / Monthly 月繳 *	Annual 年繳 / Monthly 月繳 *	Annual 年繳 / Monthly 月繳 *	Annual 年繳 / 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 保費征費)				

#### 4. 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

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 Have you gained or lost weight of 5kg or more in the last five years? 過去五年內，您在有否增加或減少了五公斤或以上的體重？

#### Your living habits 您的生活習慣

3 Do you smoke? If "Yes", please state details. 您是否有吸煙的習慣？如「是」，請提供詳情。    
Type of tobacco: \_\_\_\_\_ pieces per day, for \_\_\_\_\_ years. 煙草類別: \_\_\_\_\_ 支/每日，達 \_\_\_\_\_ 年。

4 Do you drink alcohol? If "Yes", please state details. 您是否會飲用酒精飲品？如「是」，請提供詳情。    
Weekly consumption \_\_\_\_\_ ml Type of drink: \_\_\_\_\_ 每週數量: \_\_\_\_\_ 毫升 飲品種類: \_\_\_\_\_

#### Your medical conditions 您的醫療狀況

5 Have you ever suffered from, had any signs, symptoms or received treatment including doctor consultation for any of the following conditions? If "Yes", please provide details in the box below. 您是否曾患上、有任何跡象或症狀，或就以下問題/疾病情況求診或接受治療？如「是」，請於下面表格中提供詳情。

- |                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| (i) The head and/or brain related symptoms or diseases, for example cerebrovascular disease, psychological or mental disorder, psychiatric condition, behavioral problems, personality disorder, nervous system, brain function disorder (e.g. dizziness, epilepsy, paralysis, anxiety, stroke, Alzheimer's disease or hereditary dementia), etc.<br>頭及/或腦部相關症狀或疾病，如腦血管疾病、心理或精神紊亂、精神疾病、行為問題、人格障礙、神經系統疾病、腦功能障礙(如頭暈、癲癇、癱瘓、焦慮、中風、阿爾茨海默氏症或遺傳性癡呆)等 | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Impairment of the eyes, ears, nose, nasal septum, turbinate, sinus conditions or other related symptoms or diseases, for example cataracts, ear infections, tonsillitis, etc.<br>眼、耳、鼻、鼻中隔、鼻甲或鼻竇症狀或其他有關的症狀或疾病，如白內障、耳道感染、扁桃腺炎等                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) The endocrine system related symptoms or diseases, for example diabetes, thyroid disorder, etc.<br>內分泌系統相關的症狀或疾病，如糖尿病、甲狀腺問題等                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| (iv) Breast or genitourinary organs related symptoms or diseases, for example any disease of the kidneys, bladder, reproductive organs disorder, etc.<br>乳房或泌尿生殖器官相關的症狀或疾病，如任何腎、膀胱、生殖器官疾病等                                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| (v) Sexually transmitted diseases, HIV infection, AIDS, AIDS related complex Venereal disease, AIDS related conditions, any blood test for HIV virus or any other related diseases<br>性病、愛滋病毒感染、愛滋病、與愛滋病有關的複雜性病、與愛滋病有關的狀況、曾接受愛滋病病毒血液測試或其他相關疾病                                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| (vi) Pregnancy complications, for example gestational hypertension, gestational diabetes, ectopic pregnancy, pre-eclampsia and eclampsia, IVF, fertility treatment, etc.<br>妊娠併發症，如妊娠高血壓、妊娠糖尿、宮外孕、先兆子癇及子癇、體外人工受孕、生育治療等                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| (vii) The heart and/or blood related symptoms, disorder or diseases, for example cardiovascular and/or circulatory disorders, high blood pressure, palpitations, murmurs, diabetes, chest pain, any disorder of the heart or arteries, stroke, varicose veins, rheumatic fever, anemia, hemophilia, etc.<br>心臟及/或血液相關的症狀或疾病，如心血管及/或循環系統疾病、高血壓、心悸、雜音、糖尿病、胸痛、心臟或動脈疾病、中風、靜脈曲張、風濕熱、貧血、血友病等                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| (viii) Skin and/or Musculoskeletal conditions, related symptoms or diseases, for example muscular or bone disorder, spinal condition, arthritis, gout or fractures requiring surgical implants, muscle or ligament tears, carpal Tunnel syndrome, etc.<br>皮膚及/或肌肉骨骼症狀或疾病，如肌肉或骨骼異常、脊椎問題、關節炎、痛風、因骨折需要外科植入物、肌肉或韌帶撕裂、腕管綜合症等                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| (ix) Lung and/or respiratory symptoms, conditions or diseases, for example chest discomfort, chest pain, chest stuffiness, shortness of breath, asthma, tuberculosis, chronic bronchitis, sleep apnea, etc.<br>肺及/或呼吸症狀或疾病，如胸部不適、胸痛、胸悶、氣喘、哮喘、肺結核、慢性支氣管炎、睡眠窒息症等                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| (x) Gastro-intestinal and hepatobiliary system, its conditions, and any symptoms or diseases, for example the gastro-intestinal tract, stomach, bowel, liver, any kind of hepatitis or liver disease, gastric or duodenal ulcer or ulcer of any kind, haemorrhoid, hernia and gall bladder, etc.<br>胃腸及肝膽系統相關的症狀或疾病，如胃腸道、胃、腸、肝、任何類型的肝炎或肝病、胃或十二指腸潰瘍或任何類型的潰瘍、痔瘡、疝氣和膽囊等                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| (xi) Tumor, cyst, lump, abnormal growth, cancer, malignant tumor or other related symptoms or diseases<br>腫瘤、囊腫、腫塊、異常增生、癌症、惡性腫瘤或其他有關的症狀或疾病                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| (xii) Other symptoms, diseases or conditions<br>其他症狀、疾病或狀況                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |

6 Have you ever suffered from or had sign of any conditions or symptoms or diseases that has not been mentioned above or have you received medical treatment requiring more than one day of hospitalization or require ongoing treatments, therapy or medication? If "Yes", please provide details in the box below. 您是否有曾患上或有任何跡象患上上述未提及的任何狀況、症狀或疾病，或者您是否曾住院超過一天或接受了需要的持續治療、治療或藥物治療？如「是」，請於下面表格中提供詳情。

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

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          | Yes<br>是                 | No<br>否                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 7 Have any of your parents, brothers or sisters been diagnosed any hereditary diseases, illness or medical condition? For example cancer, diabetes, heart disease, Alzheimer's disease, Parkinson's disease, familial hypertension, multiple sclerosis, kidney disease, hepatitis or any other hereditary diseases. If "Yes", please provide details in the box below.<br>您的父母、兄弟姐妹是否曾被診斷出患有任何遺傳性疾疾病、疾病或健康狀況？如癌症、糖尿病、心臟病、阿爾茨海默氏症、帕金森病、家族性高血壓、多發性硬化症、腎病、肝炎或任何其他遺傳性疾疾病。如「是」，請於下面的表格中提供詳情。 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 Have you ever taken any medication for a period longer than 30 days? If "Yes", please list the name of the medication and the dosages below.<br>您是否曾服用超過30天的藥物？如「是」，請於下面列出藥物名稱及劑量。                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 Are you currently experiencing any pain or symptoms with which you have not investigated or consulted a doctor for diagnosis? If "Yes", please state further detail below.<br>您目前是否有任何未經調查或經醫生診斷的疼痛或症狀？如果「是」，請於下面提供詳情。                                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 Do you undergo an annual check-up?<br>If "Yes", please specify whether it is a general check up for a specific condition and provide the name of your doctor and frequency<br>您是否有接受年度身體檢查？<br>如「是」，請在下面說明是否針對特定情況進行一般性檢查，並提供您的醫生姓名和次數。                                                                                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 (Applicable to insured person aged 18 below)<br>Were you born prematurely (before 37 weeks of gestation) or had any conditions or illness that resulted from birth complications, deformities and/or experienced any developmental delays? If "Yes", please provide details in the box below.<br>(適用於18歲以下的受保人)<br>您是否早產(在懷孕37週之前)或有任何因出生引起的併發症、畸形、及/或經歷任何發育遲緩而導致的任何情況或疾病？如「是」，請於下面表格中提供詳情。                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### Other information 其他資料

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          |                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 12 Do you currently or will you require any assistance with activities of daily living or self-care such as feeding, dressing, grooming, bathing or showering because of a medical condition or disability?<br>您目前或您可預見的將來之日常生活活動是否會因健康狀況或殘疾而需要任何協助，例如進食、更衣、梳洗、沐浴或淋浴？                                                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 Do you participate or are you planning to participate in any hazardous sport or activity (e.g. mountaineering or rock-climbing, parachuting, skydiving or hang gliding, private aviation, motor car or motor-cycle racing, diving of any kinds, etc.)?<br>您是否參加或計劃參加任何危險運動或活動(如登山或攀岩、跳傘、高空跳傘或懸掛式滑翔、駕駛私人飛機、汽車或摩托車比賽、任何類型的潛水等)？                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 14 Have you ever been refused or been subject to any special terms or additional premium for any insurance application, renewal, reinstatement or claim of life insurance, medical insurance, personal accident insurance, hospital income/hospital surgical insurance, critical illness insurance or any other insurance,? If "Yes", please state further details.<br>您是否曾於投保、續保、復效或索償任何人壽保險、醫療保險、個人意外保險、住院現金或手術現金保險、危疾保險或其他保險時被拒或需附加特別條款或增收保費始被接納？如「是」，請提供詳情。 | <input type="checkbox"/> | <input type="checkbox"/> |

If any answer(s) to questions 5 – 7, 11 is "Yes", please give full details below.  
若問題5 – 7, 11之答案為「是」，請提供以下詳情。

Nature of diagnosis 疾病性質	Full details of care, treatment or surgery received 所接受之護理、治療或手術之詳情	Outcome of treatment e.g. ongoing, complete recovery, recurrent or likely to recur 治療結果，如持續治療、完全康復、已復發或有機會復發	Name and address of the medical attendant(s) 主診醫生名稱及地址

If any answer(s) to questions 8 to 10, 12 to 14 is "Yes", please give full details below.  
若問題8至10、12至14之答案為「是」，請提供以下詳情。

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\*\* If you have answered "Yes" to any of the questions above, please provide all medical documents/information for the consideration of your application. e.g. blood tests and scans, medical records, hospital discharge documents relating to the conditions or treatment mentioned above.  
如果您對上述任何問題的回答「是」，請提供所有與以上狀況或治療相關文件/資料以供考慮您的申請，如血液測試和掃描、醫療記錄、出院文件。

## 5. Payment method 付款方法

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 number

信用卡號碼：

Credit card expiry date

信用卡有效期至

Month 月 Year 年

M	M	Y	Y	Y	Y
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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賬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賬而令他/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賬之用。

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

Date 日期

Day 日	Month 月	Year 年
D	D	Y
M	M	Y
Y	Y	Y

## 6. Declaration 聲明

1. I/We hereby apply for HealthSure 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 has 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 application 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(「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。

8. 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 authorized insurance broker commission during the continuance of the policy including for renewals, for arranging the said policy. I/We further understand that the above consent is necessary for the Company to proceed with the application.

本人/我們明白、確知及同意，貴公司會就本人/我們購買及接受其簽發的保單，於保單有效期內(包括續保期)向負責安排有關保單的獲授權保險經紀支付佣金。本人/我們亦明白 貴公司必須取得申請人同意，方可以處理其保險申請。

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。

## 7. 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 (include policyholders, insured persons, beneficiaries, premium payors, trustees, policy assignees and claimants) collected or held by **Zurich Insurance Company Ltd (“Company”)** may be used by the Company 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」)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，均可供本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-related purposes - Voluntary: 就市場推廣相關用途之同意 – 自願性：

Certain personal information of policyholders and insured persons collected or held by the Company, in particular, names, contact information, age, gender, identity document reference, marital status, 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 conduct 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.

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，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、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。

The Company may provide 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 the following parties, within or outside of Hong Kong, for the above **marketing-related purposes**:

- (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 marketing service providers and insurance intermediaries.

於獲保單持有人及受保人書面同意後，本公司方可就上述市場推廣相關用途，向以下於香港境內或境外的人士提供其某些個人資料，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：

- (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) 第三方市場推廣服務供應商及保險中介人。

I/We understand that I/we can withdraw any consent provided for marketing-related 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相關用途所給予之同意。

I/We wish to opt out of the above marketing-related purposes.  
本人/我們欲選擇退出上列之市場推廣相關用途。

Policy effective date      Date      Day 日      Month 月      Year 年  
保單生效日      日期     

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

Date      Day 日      Month 月      Year 年  
日期     



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