Application for "Asia Unique" Comprehensive Employee Medical Plan
「臻善」中小企僱員醫療保險計劃申請表

亞洲保險 ASIA INSURANCE

Please complete in Block Letters 請以正楷填寫

(I) Policy Holder Details 保單持有人詳情

Name of Company 公司名稱		
Business Nature 業務性質	☐ with Business Registration 包括商業登記	Contact Person 聯絡人
Tel. 電話	Fax 傳真	Email Address 電郵
Address 地址		
Policy Effective Date 保單生效日期 (DD/MM/YYYY 日/月/年)		Total no. of Employees 僱員總人數

(II) Affiliated Companies 附屬公司

Name 公司名稱
Address 地址
Name 公司名稱
Address 地址

(III) Participating Classification 參加者類別

For EXISITING Permanent Full-Time Employee 現任全職僱員

☐ On Policy Effective Date
保單生效日參加

☐ Immediate cover after _____ month(s) of employment
受僱 _____ 個月後參加

For FUTURE Permanent Full-Time Employee 將來全職僱員

☐ On Employment Date
受僱日參加

☐ Immediate cover after _____ month(s) of employment
受僱 _____ 個月後參加

	Class Type and Class description 僱員類別	Basic Cover 基本保障	Optional Cover 自選保障				Medical Card* 醫療卡*	Dependent Coverage 家屬保障
		Hospitalization Benefit 住院保障 (Plan 1 to Plan 5)	Supplementary Major Medical Benefit 額外醫療保障	Out-Patient Benefit 門診保障 (Plan 1 to Plan 5)	Dental Benefit 牙科保障 (Plan 1 to Plan 5)	Cancer Benefit^ 癌症保障^		
e.g. 例	Class 1 - Director	Plan 1	☑ Y 是 ☐ N 否	Plan 2 - 80%	Plan 2	☑ Y 是 ☐ N 否	☑ Y 是 ☐ N 否	☑ Y 是 ☐ N 否
1			☐ Y 是 ☐ N 否			☐ Y 是 ☐ N 否	☐ Y 是 ☐ N 否	☐ Y 是 ☐ N 否
2			☐ Y 是 ☐ N 否			☐ Y 是 ☐ N 否	☐ Y 是 ☐ N 否	☐ Y 是 ☐ N 否
3			☐ Y 是 ☐ N 否			☐ Y 是 ☐ N 否	☐ Y 是 ☐ N 否	☐ Y 是 ☐ N 否
4			☐ Y 是 ☐ N 否			☐ Y 是 ☐ N 否	☐ Y 是 ☐ N 否	☐ Y 是 ☐ N 否

^ If "Y", please fill in and sign the "Asia Unique" Applicant's Health Statement as stipulated in the Appendix II
如答「是」，請填寫並簽署附錄 II 的「臻善」健康申報表。

* If "Y", please sign and submit the Asia Medical Card Service Agreement together with the application form
如答「是」，請簽署亞洲醫療卡服務協議書，並與申請表一併提交。

Plan Rules 計劃守則

1. This insurance plan is only applicable to company registered in Hong Kong with minimum 3 covered employees.
   此保險計劃僅適用於香港註冊的公司，最少參與人數為 3 名僱員。
2. Optional Supplementary Major Medical Benefits must be purchased together with the same level of Hospitalization Benefits (e.g. HS Plan1 + SMM Plan 1), while there is no limitation on the combination of Optional Outpatient, Dental and Cancer Benefits.
   如申請自選額外醫療保障，須與同等計劃級別的住院保障一併投保，而自選門診，牙科及癌症保障則可自由配搭。
3. No standalone purchase of Optional Supplementary Major Medical, Outpatient, Dental or Cancer Benefits.
   不能只獨立購買自選額外醫療門診保障，牙科及癌症保障。
4. All eligible employees must be on a full-time basis and actively-at-work, and must participate in the plan.
   所有合資格僱員須為全職人員並正常在職工作，且必須參加此計劃。
5. If dependent coverage is provided, all eligible dependents must be enrolled.
   如有家屬保障，所有合資格家屬均必須參加此計劃。
6. Full time employee and spouse from the age of 16 to the age of 69 (Maximum entry age is 64), and their unmarried children from 14 days to age 18, or up to age 23 if in full-time education with proof are eligible to enroll.
   16 — 69 歲的全職僱員及其配偶(首次投保年齡上限為 64 歲)，及其出生後 14 天至 18 歲的未婚子女、及 23 歲及正在接受全日制教育的子女均合乎資格參加。或未滿 23 歲及正在接受全日制教育的子女均合乎資格參加。

(IV) Additional Services 自選服務

(can select more than one option 可選多於一項)

☐ E- Claims Statements 電子索償報告單

- ☐ to Employee 給予僱員
- ☐ to HR 給予人事部
- ☐ to Intermediary 給予中介人

☐ Medical On-line Enquiry Services 網上醫療查詢服務

Noted: Medical On-line Enquiry Services for both the policyholder and employee are inclusive; Details of the login information and the user manual will be provided to you 3 working days after the issuance of the policy.
注意：保單持有人及僱員均可使用網上查詢服務；此服務的登錄信息及用戶手冊將由保單發出日 3 個工作天後發送給您。

(V) Claim Settlement Mode 索償處理方式

☐ Autopay to Employee 自動轉賬給予僱員

☐ Cheque to Employee 開發支票給予僱員 (For policy with hospitalization plan only 適用於只參與住院計劃之保單)

If select Autopay, please provide Bank Account information by completion of the attached member enrollment form.
如選擇自動轉賬，請於附上之僱員登記表提供銀行户口資料。

The Applicant understands this 申請人明白：

1. The applicant agrees to furnish Asia Insurance the information in related to the eligible persons or insurance plan thereof;
   申請人同意提交包括合資格人士和保險計劃的資料給亞洲保險。
2. If members are required to contribute for insurance (Contributory plan), all the eligible persons will be given an opportunity to contribute for the insurance; and the number of the participation shall not be less than 75% of the total number of the eligible persons of the company;
   若僱員須為本保險供款，則所有合資格人士均為本保險供款人。同時參加人數將不少於總合資格人士的 75%，否則本保單不會以僱員繳付形式推出。
3. According to the new regulation of Insurance Authority (IA), an additional levy will be applied on all the medical/life policies with effective from 1 Jan 2018.
   根據保險業監管局新規條，由 2018 年 1 月 1 日開始，所有醫療及人壽的保單持有人，將要繳付一筆徵費。
4. Any personal information collected by the Company may be used, stored or disclosed to any individual or organization to evaluate this application, to provide our services and products to you, including administering, maintaining, managing and operating such services and products, or to provide subsequent services. Requests for personal data access or correction may be addressed to Data Protection Officer of the Company.
   本公司所收集的任何個人資料，將用於、儲藏於任何個人及機構以用核實申請，提供服務及產品包括管理、維持、處理及運作有關服務及產品，及提供售後服務的用途。閣下可聯絡本公司的個人資料保護主任，要求更改任何交予本公司的個人資料。
5. It is our policy to comply with the requirement of the Personal Data (Privacy) Ordinance (Cap. 486) of the laws of the Hong Kong Special Administrative Region. The applicant read and agreed the Personal Information Collection Statement ("PICS") at Appendix I of this brochure.
   本公司會遵守「個人資料（私隱）條例」（香港法例第 486 章）。申請人已閱讀並同意附錄 I 中的個人資料收集聲明 (PICS)。

The Applicant declares this 申請人聲明及確認：

1. On acceptance of this application by Asia Insurance, the policy is to be issued to the policyholder named in accordance with the information shown on this application.
   亞洲保險一旦接受此申請，保險將根據保單持有人的名義並以本申請表內的資料發行。
2. The information relating to the eligible employees and/or their dependents (if applicable) provided in this Application is correct to the best of my/our knowledge.
   就本人/吾等所知，在此申請提供的僱員及/或其家屬（如適用）的資料均屬正確無誤。

Commission Disclosure Statement 佣金披露聲明

The applicant understands, acknowledges and agrees that, upon taking up this Policy, Asia Insurance will pay the authorized insurance broker commission(s) during the continuance of the Policy including renewals. The applicant further understands that this agreement is necessary for Asia Insurance to proceed with the application.
申請人明白、確知及同意，亞洲保險會就申請人接受其簽發的保單，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。申請人亦明白亞洲保險必須取得申請人以上的同意，才可以處理其保險申請。

Agent/Broker's Name 代理人/經紀姓名

Applicant 申請人

Signature 簽署

Authorized Signature & Company Chop 獲授權人簽署及蓋印

Agent/Broker's Code 代理人/經紀編號

Name & Job Title of Authorized Person 獲授權人姓名及職銜

Date (DD/MM/YYYY) 日期（日/月/年）

Date (DD/MM/YYYY) 日期（日/月/年）

"Asia Unique" Employee's Health Statement
「臻善」僱員之健康申報書

亞洲保險
ASIA INSURANCE

7/F & 8/F, 118 Connaught Road West,
Sheung Wan, Hong Kong
Email: medical@afh.hk
www.asiainsurance.hk

Appendix II
附錄II

Health statement for the group size of 5 employees or less / with the purchase of Lump Sum Cancer Benefit, please fill in this health statement. The copy of the health statement is also accepted.
如集團規模在 5 人或以下/已購買一筆過癌症保障，須填寫此健康申報書。此健康申報書之副本亦適用。

Name of Company 公司名稱		Employee Name 僱員姓名	
Job Nature and Title 工作性質和職位		Staff No. 僱員編號	
Details of Proposed Insured 投保人之詳細資料			
Full Name in English 英文姓名		Full Name in Chinese 中文姓名	
Date of Birth 出生日期 (DD/MM/YYYY 日/月/年)	☐ Male 男性 ☐ Female 女性	☐ Single 未婚 ☐ Married 已婚	Date of Marriage 結婚日期 (DD/MM/YYYY 日/月/年)
Relationship with Employee 與僱員之關係		Height (CM) 身高(厘米)	Weight (KG) 體重(千克)

Health Condition and Insurance History of Proposed Insured 投保人之健康狀況及投保記錄

1	Have you been rated, declined, postponed, or added exclusion by any other insurance company? 閣下曾否在投保時被加費，拒絕，延期受保或在除外條件下被接受？		☐ Yes 是 ☐ No 否
2	What is your average daily consumption of alcoholic beverages? 平均每日飲酒數量?	Have you ever taken treatment for alcoholic habit? 曾否因慣性服用酒精而需要接受治療? ☐ Yes 是 ☐ No 否	If yes, when? 如有，何時?
3	What is your daily consumption of tobacco? 每日吸煙數量		
4	Have you ever taken any drugs other than those prescribed by a doctor? 是否曾經服用非醫生處方藥物? ☐ Yes 是 ☐ No 否		If yes, please provide the name and dosage: 如有，請提供藥物名稱及服用劑量：
Female Only 女性須填			
5	Are you currently pregnant? 你現在是否懷孕?		☐ Yes 是 ☐ No 否
6	Any menstrual disorder or symptoms of disease of breast, uterus, cervix or ovaries? 是否患有經期失調，或乳房，子宮，子宮頸或卵巢等疾病?		☐ Yes 是 ☐ No 否

Have you ever had/been treated for any disease of disturbance of: **閣下是否因下列疾病而接受治療:**			**Have you ever suffered from or had the followings:** **閣下曾否有下列疾患:**		
7	The brain, nerves or mental system 腦部, 神經線或精神系統	☐ Yes 是 ☐ No 否	13	Gout, rheumatism, tuberculosis, or syphilis 痛風、風濕病、結核病或梅毒	☐ Yes 是 ☐ No 否
8	The throat or lungs 咽喉或肺部	☐ Yes 是 ☐ No 否	14	Vertigo or dizzy spells 眩暈或片刻眩暈	☐ Yes 是 ☐ No 否
9	The heart or blood vessels 心臟或血管	☐ Yes 是 ☐ No 否	15	Raised or spat blood 吐血或血痰	☐ Yes 是 ☐ No 否
10	The stomach, liver, intestines, kindeys or bladder 胃、肝、腸、腎或膀胱	☐ Yes 是 ☐ No 否	16	Thyroid gland or lymph node enlargement 甲狀腺或淋巴結腫大	☐ Yes 是 ☐ No 否
11	The genito-urinary organs 生殖器與泌尿器	☐ Yes 是 ☐ No 否	17	Surgical operation 手術	☐ Yes 是 ☐ No 否
12	The skin, bones, glands, eyes or ears 皮膚、骨、腺、眼或耳	☐ Yes 是 ☐ No 否	18	Any other illness not mentioned above 上述未提及之病症	☐ Yes 是 ☐ No 否
19	Have you ever had or have you ever been advised to undergo investigations (such as ultrasound, cone biopsy, fine needle aspiration, etc.) or to repeat tests within 6 months? 閣下曾否或曾被建議接受檢查（如超聲波，錐形活檢，細針穿刺檢查等）， 或需在 6 個月內作重複測試?				☐ Yes 是 ☐ No 否
20	Have you ever been counselled or medically advised in connection with aids or had an aids blood test? 閣下曾否作受愛滋病測試或檢查？				☐ Yes 是 ☐ No 否
21	Has any of your parents or brother or sister ever had cancer diagnosed before age 55? 閣下之父母或兄弟姐妹是否曾在 55 歲之前被診斷為癌症?				☐ Yes 是 ☐ No 否
22	Have you ever experienced any weight loss of more than 5 kg within 6 months? 閣下曾否在 6 個月內體重下降超過 5 公斤？				☐ Yes 是 ☐ No 否
23	Have you ever been consulted with physician or treated for any chronic or critical illness during the past 5 year? 閣下過去五年內曾否接受醫生診斷或治療任何長期或嚴重疾病？				☐ Yes 是 ☐ No 否

I agree that the foregoing answers shall form part of my proposal to the Asia Insurance Co., Ltd., and that the foregoing answer shall also become part of any policy that may be issued on the strength thereof.
本人同意上述聲明為已呈交於亞洲保險有限公司之投保書及保單契約法律效力之一部份。
I authorize any physician, hospital, clinic or any organization of person that has any records of knowledge of my health, to give Asia Insurance Co., Ltd., any such information. A photocopy of this authorization shall be as vaild as the original.
本人授權任何醫生、醫院、診所或任何組織及任何人士，持有熟悉本人健康資料，均可以將該病歷詳細資料供給亞洲保險有限公司。
此授權書之影印本亦屬有效。

Signature of Employee 僱員簽署

Date (DD/MM/YYYY) 日期（日/月/年）

/ /

Signature of Proposed Insured 投保人簽署

Date (DD/MM/YYYY) 日期（日/月/年）

/ /

Supplementary Health Information
健康資料補充

Appendix III
附錄III

If the answer to any of the questions 6-23 in Appendix II is "Yes", please provide additional information as applicable –
若附錄 II 第 6 至 23 項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

Question No. _____ **題號 _____**		
Disease/medical condition/sign and symptom 疾病/健康狀況/病徵及症狀		
Date of first occurrence of sign and symptom 首次出現病徵及症狀的日期		
Treatment/investigations/tests /scans that have been performed 已進行的治療/檢查/測試/掃描		
Date of such treatment/investigation/ tests/scan 有關治療/檢查/測試/掃描日期		
Present condition (such as whether fully recovered, follow up action/medication/ next follow up date) 現況（例如是否已完全康復、有否跟進/服用跟進藥物/下次覆診日期）		
Date of last follow-up medical consultation/ treatment 最後覆診/治療日期		
Name of doctor who treated the disease/ sickness/medical condition/sign and symptom 治療有關疾病/不適/健康狀況/病徵及症狀的醫生姓名		
Name of Hospital, where applicable 醫院名稱（如適用）		

* 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。

I agree that the statements made in this form shall be the basis of the proposed contract between the Company and myself and that if anything contrary to the truth be stated or if any information which would be regarded as likely to influence the assessment and acceptance of this form be withheld or concealed, the Company will be entitled to make any policy issued void.
我同意此補充內之陳述，均成為亞洲保險有限公司與我成立合約的基礎。如提供之任何資料與事實不符，或被視為可能影響評核及接納投保之申請，貴公司有權令保單無效。

Signature of Proposed Insured 投保人簽署

Date (DD/MM/YYYY) 日期（日/月/年）

/ /