



# VChoice Voluntary Health Insurance Plan Application Form

## 智適簡自願醫療保險計劃申請表

自願醫保認可產品編號: S00012-01-000-03 (標準計劃) VHIS Plan Certification Number: S00012-01-00-03 (Standard Plan)

- One application form for one Insured Person only 每份申請表只限投保一名受保人
- Insured Person must be applicant himself or his spouse, children (aged below 18, aged 18 to 25 with full-time education or aged 18 or above disabled), siblings/siblings of spouse (aged below 18, aged 18 to 25 with full-time education or aged 18 or above disabled), parents and grandparents/ parents and grandparents of spouse (aged 55 or above or aged 55 or below disabled).  
 受保人必須是申請人自己或其配偶、子女(年齡小於18歲、18歲至25歲而接受全日制教育者或18歲或以上之殘疾人士),其兄弟姐妹/配偶的兄弟姐妹(年齡小於18歲、18歲至25歲而接受全日制教育者或18歲或以上之殘疾人士),其父母或祖父母/其配偶的父母或祖父母(年齡達55歲或以上或年齡小於55歲之殘疾人士)。
- This insurance plan allows more than one Policyholder. If there is more than one Policyholder, a "Representative Policy holder" must be jointly designated by all the other Policyholder(s), the Representative Policyholder shall be authorised to give instructions or notices, and receive notices or benefits on behalf of all the Policyholders. The Applicant here will be set as the Representative Policyholder unless otherwise is specified. The relationship between the other Policyholder(s) (non-Representative Policyholder(s)) and the insured person must be the relationship listed in the above point no. 2.  
 本保險計劃允許多於一名保單持有人;如保單持有多於一人,需要所有保單持有人共同委任一名保單持有人作為「保單持有人代表」,授權其對本公司發出指示或通知,並代表所有保單持有人接收通知或保障,除非另有所指,此申請表之申請人將設定為保單持有人代表,其他保單持有人(非保單持有人代表)與受保人之關係亦必須符合以上第2點所列要求。
- This insurance plan is an automatic renewal policy. The policy will be automatically renewed on the policy expiry date. The policyholder will be required to pay the relevant renewal premium. The Policyholder or Representative Policyholder (if applicable) will be notified on the renewal premium separately until the policyholder's prior written instruction for cancellation.  
 此保險計劃為自動續保之保單。保單於到期日將自動續保,保單持有人需繳付相關保費,而續保保費將另函通知保單持有人或保單持有人代表(如適用),直至保單持有人書面通知取消為止。
- To ensure your future benefits, you have to disclose this application ALL material facts, which shall form the basis of our contracts; otherwise the policy issued may be declared void at the discretion of Bolttech Insurance (Hong Kong) Company Limited ("bolttech Insurance"). If you are in doubt whether a particular piece of information is a 'material fact', please disclose it on the application form.  
 為保閣下的未來利益,閣下必須在此申請書上填報一切有關之事宜,因閣下與保特保險(香港)有限公司(「保特保險」)之合約將以這些事實為根據,否則保特保險有權將所續發之保單宣告無效。如閣下不清楚某一項事實是否重要,亦請在此申請書上對之披露。

Please tick as appropriated 請選擇並加「✓」號	For bolttech Insurance use only 保特保險專用	Effective date: 生效日期:
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**Personal Details of Applicant (Applicant's age must be 18 years or above) (If there is more than one Policyholder, the applicant will be set as the Representative Policyholder and please complete the other Policyholders information section)**  
**申請人資料(申請人年齡必須為18歲或以上)(如保單持有多於一人,申請人將設定為保單持有人代表,並請填寫其他保單持有人資料部份)**

Name in English (same as HKID Card) 英文姓名(與香港身份證相同)			
Family Name 姓	Given Name 名	Name in Chinese 中文姓名	
HKID Card No. 身份證號碼	Date of Birth (DD/MM/YYYY) 出生日期(日/月/年)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female 性別 男 女	
Occupation* (Applicable to Applicant who is also to be the Insured Person) 職業*(適用於同時為受保人的申請人)		Nationality (Optional) 國籍(非必要填寫)	
Address* 地址* (Please complete in ENGLISH 請以英文填寫)			
Flat/Room 單位/室	Floor 層數	Block 座	Building 大廈 / Mansion 閣 / House 樓 / Estate 屋苑
Street 街 / Road 道	District 地區		<input type="checkbox"/> HK Island 香港島 <input checked="" type="checkbox"/> Kowloon 九龍 <input type="checkbox"/> N.T. 新界
Contact No. 聯絡電話	Mobile No. 流動電話號碼	Email Address* 電郵地址^	

**Details of Insured Person 受保人資料**

Please tick one and provide average stay in Hong Kong per year 請選擇一項並提供每年平均居港時間	<input type="checkbox"/> Myself (Details as above) 本人(資料與以上相同)	Please provide average stay of Insured Person in Hong Kong per year: 受保人每年平均居港時間: months _____ 月 If the average stay is less than nine months, please provide the place of residence outside Hong Kong: 如受保人之每年平均居港時間少於9個月,請提供海外居住地*名稱: _____
	<input type="checkbox"/> Others (Please provide Relationship with the Applicant): 其他(請提供與申請人關係)	
Name in English (same as HKID Card) 英文姓名(與香港身份證相同)		
Family Name 姓	Given Name 名	Name in Chinese 中文姓名
HKID Card No. 身份證號碼	Date of Birth (DD/MM/YYYY) 出生日期(日/月/年)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female 性別 男 女
Occupation* 職業*		Nationality (Optional) 國籍(非必要填寫)



### Choice of Cover 投保項目

<input checked="" type="checkbox"/> <b>VChoice Voluntary Health Insurance Plan</b> <b>智適簡自願醫療保險計劃</b>	<input type="checkbox"/> Annual Premium 每年保費	<b>HKD 港幣</b>  (Excluding Insurance Levy)(不包括保費徵費)
	<input type="checkbox"/> Monthly Premium 每月保費	
Levy collected by the Insurance Authority will be imposed on relevant policy at the applicable rate. The payment to be received for such levy will be remitted to the Insurance Authority under the prescribed arrangement. For further information please advise bolttechinsurance.hk/en/insurance-levy/ or contact: (852) 3123 3344. 保險業監管局將會按規定的徵費率向相關的保單徵收保費徵費，當中的徵費會按規定轉付予保險業監管局。詳情請瀏覽bolttechinsurance.hk/lc/insurance-levy/或聯絡(852) 3123 3344。		

#### Footnotes 注釋:

- # In the event of any changes in the insured person's place of residence or occupation, the policyholder must notify bolttech Insurance at the time of renewal. It's important to note that such changes will require re-underwriting, which may result in a modification of premiums or certain terms and benefits or even termination of the policy. 若受保人的職業或居住地有所變更，保單持有人需於續保時通知保特保險。請注意有關變更更需重新核保及其結果有可能導致保費或相關條款出現轉變，或終止保障。
- \* P.O. Box, hotel address and overseas address are not acceptable. 信箱、酒店地址和海外地址均不可接受。
- ^ Please provide email address to enjoy bolttech Insurance eServices app and to receive the policy, medical claim statement and renewal notice. 請提供電郵地址以享用保特保險eService應用程式及透過電子郵件收取保單、醫療索償理賠表及續保通知。

### Health Declaration of Insured Person 受保人健康聲明

1. Insured Person's Height and Weight 受保人的身高及體重	身高 Height 米m:      釐米cm:      尺ft:      寸inc 體重 Weight: 公斤Kg:      磅lb:																																	
2. Has the Insured Person ever had or been told to have any of the following: 受保人有否曾患有或獲悉患有下列疾病:	<table border="1"> <tr> <td></td> <td>Yes 有</td> <td>No 否</td> </tr> <tr> <td>i. Diseases of the Heart 心臟病</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>ii. Cancer or tumor 癌症或腫瘤</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>iii. Diabetes or high blood sugar 糖尿病或高血糖</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>iv. Hepatitis B or C 乙型肝炎或丙型肝炎</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>v. Kidney Failure 腎功能衰竭</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>vi. Stroke 中風</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Yes 有	No 否	i. Diseases of the Heart 心臟病	<input type="checkbox"/>	<input type="checkbox"/>	ii. Cancer or tumor 癌症或腫瘤	<input type="checkbox"/>	<input type="checkbox"/>	iii. Diabetes or high blood sugar 糖尿病或高血糖	<input type="checkbox"/>	<input type="checkbox"/>	iv. Hepatitis B or C 乙型肝炎或丙型肝炎	<input type="checkbox"/>	<input type="checkbox"/>	v. Kidney Failure 腎功能衰竭	<input type="checkbox"/>	<input type="checkbox"/>	vi. Stroke 中風	<input type="checkbox"/>	<input type="checkbox"/>												
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3. In the last 5 years, has the Insured Person received medical advice or been treated for any of the following: 在過去的5年裡，受保人有否曾就下列疾病接受過醫療建議或治療:	<table border="1"> <tr> <td></td> <td>Yes 有</td> <td>No 否</td> </tr> <tr> <td>i. Carcinoma in situ, abnormal growth, cysts or polyps 原位癌、異常生長、囊腫或息肉</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>ii. Asthma, tuberculosis, pneumonia or chronic obstructive lung disease 哮喘、肺結核、肺炎或慢性阻塞性肺病</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>iii. Stomach ulcer, pancreatitis or gastritis 胃潰瘍、胰腺炎或胃炎</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>iv. High blood pressure or high cholesterol 高血壓或高膽固醇</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>v. Abnormal liver function 肝功能異常</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>vi. Nephritis or abnormal kidney function, renal stones, gall bladder disorders, prostate enlargement or elevated PSA levels, polycystic ovarian syndrome or endometriosis 腎炎或腎功能異常、腎結石、膽囊疾病、前列腺肥大或PSA值高於正常水平、多囊卵巢綜合症或子宮內膜異位</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>vii. Any injury or disorder of the eyes (excluding vision corrected by prescription lens), ears, bones, muscle, joints or spine or physical disability 任何眼鏡的手上或病症(不包括通過處方鏡片矯正視力)、耳朵、骨骼、肌肉、關節或脊柱或身體殘疾</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>viii. HIV infection or positive HIV test result 愛滋病感染或愛滋病檢測陽性結果</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>ix. Depression, mental disease or neurological disorder or intellectual disability 抑鬱症、精神病或神經系統的疾病或智力障礙</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>x. Any disorders of the breast, thyroid or large intestine 任何乳房、甲狀腺或大腸的疾病</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Yes 有	No 否	i. Carcinoma in situ, abnormal growth, cysts or polyps 原位癌、異常生長、囊腫或息肉	<input type="checkbox"/>	<input type="checkbox"/>	ii. Asthma, tuberculosis, pneumonia or chronic obstructive lung disease 哮喘、肺結核、肺炎或慢性阻塞性肺病	<input type="checkbox"/>	<input type="checkbox"/>	iii. Stomach ulcer, pancreatitis or gastritis 胃潰瘍、胰腺炎或胃炎	<input type="checkbox"/>	<input type="checkbox"/>	iv. High blood pressure or high cholesterol 高血壓或高膽固醇	<input type="checkbox"/>	<input type="checkbox"/>	v. Abnormal liver function 肝功能異常	<input type="checkbox"/>	<input type="checkbox"/>	vi. Nephritis or abnormal kidney function, renal stones, gall bladder disorders, prostate enlargement or elevated PSA levels, polycystic ovarian syndrome or endometriosis 腎炎或腎功能異常、腎結石、膽囊疾病、前列腺肥大或PSA值高於正常水平、多囊卵巢綜合症或子宮內膜異位	<input type="checkbox"/>	<input type="checkbox"/>	vii. Any injury or disorder of the eyes (excluding vision corrected by prescription lens), ears, bones, muscle, joints or spine or physical disability 任何眼鏡的手上或病症(不包括通過處方鏡片矯正視力)、耳朵、骨骼、肌肉、關節或脊柱或身體殘疾	<input type="checkbox"/>	<input type="checkbox"/>	viii. HIV infection or positive HIV test result 愛滋病感染或愛滋病檢測陽性結果	<input type="checkbox"/>	<input type="checkbox"/>	ix. Depression, mental disease or neurological disorder or intellectual disability 抑鬱症、精神病或神經系統的疾病或智力障礙	<input type="checkbox"/>	<input type="checkbox"/>	x. Any disorders of the breast, thyroid or large intestine 任何乳房、甲狀腺或大腸的疾病	<input type="checkbox"/>	<input type="checkbox"/>
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**Other Policyholders information section (Policyholder's age must be 18 years or above) (This part only applicable to more than one Policyholder)**  
**其他保單持有人資料部份(保單持有人年齡必須為18歲以上)(此部份只於保單持有人多於一人時使用)**

1	Policyholder 保單持有人	Name in English (same as HKID Card) 英文姓名(與香港身份證相同)	Name in Chinese 中文姓名
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Relationship with the Insured Person 與受保人關係	HKID Card No. 身份證號碼	Date of Birth (DD/MM/YYYY) 出生日期(日/月/年)	Sex 性別 <input type="checkbox"/> Male <input type="checkbox"/> Female 男 女
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I hereby designated the Applicant to be the Representative Policyholder of this insurance policy and authorise him/her to apply for this policy application, to give instructions or notices, and receive notices or benefits from bolttech Insurance for the policy to be issued on behalf of me. I confirm that I have read, understood and accepted the Personal Information Collection Statement of bolttech Insurance.  
 本人謹此指定申請人為本保單的保單持有人代表,並授權他/她作出此保單申請,並就日後發出之保單作出指示或通知,並代表本人接收保特保險的通知或保單。本人確認已細閱、明白及接受保特保險之收集個人資料聲明。  
 Opt out from marketing communications or materials and bolttech Insurance to use of personal data for direct marketing purpose.  
 拒絕接收推廣訊息或資料及保特保險對本人的個人資料作直接促銷的用途。

Signature 簽署	Signed in Hong Kong on 於香港簽署之日期 (DD/MM/YYYY 日/月/年)
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2	Policyholder 保單持有人	Name in English (same as HKID Card) 英文姓名(與香港身份證相同)	Name in Chinese 中文姓名
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Relationship with the Insured Person 與受保人關係	HKID Card No. 身份證號碼	Date of Birth (DD/MM/YYYY) 出生日期(日/月/年)	Sex 性別 <input type="checkbox"/> Male <input type="checkbox"/> Female 男 女
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I hereby designated the Applicant to be the Representative Policyholder of this insurance policy and authorise him/her to apply for this policy application, to give instructions or notices, and receive notices or benefits from bolttech Insurance for the policy to be issued on behalf of me. I confirm that I have read, understood and accepted the Personal Information Collection Statement of bolttech Insurance.  
 本人謹此指定申請人為本保單的保單持有人代表,並授權他/她作出此保單申請,並就日後發出之保單作出指示或通知,並代表本人接收保特保險的通知或保單。本人確認已細閱、明白及接受保特保險之收集個人資料聲明。  
 Opt out from marketing communications or materials and bolttech Insurance to use of personal data for direct marketing purpose.  
 拒絕接收推廣訊息或資料及保特保險對本人的個人資料作直接促銷的用途。

Signature 簽署	Signed in Hong Kong on 於香港簽署之日期 (DD/MM/YYYY 日/月/年)
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3	Policyholder 保單持有人	Name in English (same as HKID Card) 英文姓名(與香港身份證相同)	Name in Chinese 中文姓名
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Relationship with the Insured Person 與受保人關係	HKID Card No. 身份證號碼	Date of Birth (DD/MM/YYYY) 出生日期(日/月/年)	Sex 性別 <input type="checkbox"/> Male <input type="checkbox"/> Female 男 女
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 本人謹此指定申請人為本保單的保單持有人代表,並授權他/她作出此保單申請,並就日後發出之保單作出指示或通知,並代表本人接收保特保險的通知或保單。本人確認已細閱、明白及接受保特保險之收集個人資料聲明。  
 Opt out from marketing communications or materials and bolttech Insurance to use of personal data for direct marketing purpose.  
 拒絕接收推廣訊息或資料及保特保險對本人的個人資料作直接促銷的用途。

Signature 簽署	Signed in Hong Kong on 於香港簽署之日期 (DD/MM/YYYY 日/月/年)
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4	Policyholder 保單持有人	Name in English (same as HKID Card) 英文姓名(與香港身份證相同)	Name in Chinese 中文姓名
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Relationship with the Insured Person 與受保人關係	HKID Card No. 身份證號碼	Date of Birth (DD/MM/YYYY) 出生日期(日/月/年)	Sex 性別 <input type="checkbox"/> Male <input type="checkbox"/> Female 男 女
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 本人謹此指定申請人為本保單的保單持有人代表,並授權他/她作出此保單申請,並就日後發出之保單作出指示或通知,並代表本人接收保特保險的通知或保單。本人確認已細閱、明白及接受保特保險之收集個人資料聲明。  
 Opt out from marketing communications or materials and bolttech Insurance to use of personal data for direct marketing purpose.  
 拒絕接收推廣訊息或資料及保特保險對本人的個人資料作直接促銷的用途。

Signature 簽署	Signed in Hong Kong on 於香港簽署之日期 (DD/MM/YYYY 日/月/年)
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## Cooling-off period 有關冷靜期

### Cancellation within cooling-off period

The Policyholder may exercise the right of cancellation with full refund of paid premium and levy without interests during the cooling-off period. The cancellation right is subject to the following conditions-

- (a) The request to cancel must be signed by the Policyholder or Representative Policyholder and received by bolttech Insurance within 21 days after
  - (i) the delivery of the Terms and Benefits and the Policy Schedule; or
  - (ii) the issue of a notice to the Policyholder or his representative stating that the Terms and Benefits and the Policy Schedule are available and when the cooling-off period would expire, whichever is the earlier, and
- (b) No refund can be made if a benefit payment has been made, is to be made or impending.

### 冷靜期內取消保單

保單持有人可在冷靜期內行使權利取消保單及獲發還全數已付保費，但行使此項權利時，必須符合以下條件：

- (a) 取消要求必須由保單持有人或保單持有人代表簽署，並確保保單於以下日期後起計的21日內收到該要求，並以較先者為準：
  - (i) 保單條款及保障和保單資料頁交付至保單持有人；或
  - (ii) 向保單持有人或其代表發出通知書，列明保單條款及保障和保單資料頁已備妥及冷靜期何時屆滿；及
- (b) 若曾獲賠償或將獲賠償，則不獲發還保費及保險費

## Declaration and Authorisation 聲明及授權

1. I declare to the best of my knowledge and belief that all the statements and answers in the above are full, complete and true and form part of the application and the basis of the policy to be issued. I understand and agree that if any of the statements and answers given in the above are inaccurate or I have not disclosed any material facts, bolttech Insurance shall be entitled to cancel the policy or to reissue the policy with changee even after the policy has been issued, I/we further authorise any physician, hospital, insurance company or organisation to furnish part of or all medical history (including but not limited to information in respect of consultations, diagnostic test results, prescriptions or treatment) with respect to any illness or injury of the Insured Person to bolttech Insurance or its authorised representative. A photocopy of this authorisation shall be considered as effective and valid as the original.  
本人僅聲明書本人所知所信，以上的答案皆完全屬實及真確無訛，以此作為投保申請書的一部分，並為日後簽發保單之基礎。本人了解並同意如在本投保申請書上的陳述及以上之答案有不確之處或隱瞞任何重要事實，即使保單已獲簽發，保特保險仍保留終止保單或就此修訂而重新簽發另一保單的權利。本人及受保人授權任何醫生、醫院、保險公司或機構，可以將部分或全部有關受保人傷患之病歷（包括但不限於診症、診斷性檢驗結果、藥方或治療資料）給予保特保險或其所獲授權之代理人。此授權之副本與正本具同等效力。
2. I undertake that I will inform/have informed the Insured Person and other Policyholders (if applicable) about this Policy and the Personal Information Collection Statement ("PICS") of bolttech Insurance (whether contained herein or otherwise obtained) before transferring his/her personal data to bolttech Insurance. bolttech Insurance shall not accept any liability for the Insured Person and other Policyholders) not having been so informed. I further undertake that I will comply with the Personal Data (Privacy) Ordinance and confirm I have obtained the consent from the Insured Person for the transfer of his/her personal data to bolttech Insurance for the purpose of enrolling him/ her in this insurance plan.  
本人承諾於遞交所需之個人資料予保特保險前，須通知受保人及其他保單持有人（如適用）有關本保單及保特保險之收集個人資料聲明（不論是否就此申請表或由其他途徑取得），保特保險將不會就受保人及其他保單持有人未被通知的情況承擔任何責任。本人承諾會遵守個人資料（私隱）條例，並確認已獲得受保人及其他保單持有人的同意，將其個人資料移交保特保險以作申請本計劃之用。
3. I, as the applicant, understand that I declare and sign on behalf of the Insured Person in this Application (if applicable). I also understand that the coverage effective date shall be the date when this Application is accepted by bolttech Insurance.  
本人作為申請人，明白本人代表此申請表內之受保人作出聲明及簽署（如適用）。本人亦明白生效日期須為保特保險接受此申請之日期。
4. I, as the applicant, am willing to be the Representative Policyholder (if applicable) and understand that I also declare and sign on behalf of the other Policyholders in this Application. I will notify the other Policyholder(s) on the information I received on this Application and the policy to be issued.  
本人作為申請人，願意作為保單持有人代表（如適用），明白本人亦代表其他保單持有人作出聲明及簽署，並會將本申請及日後簽發保單的全部資料通知所有其他保單持有人。
5. I confirm having read and understood the product brochure and policy provisions. I acknowledged this medical insurance product's suitable for my and the Insured Person's insurance needs.  
本人確認已閱讀及明白此醫療保險產品的產品小冊子及保單條款的內容，本人確認此醫療保險產品適合本人及受保人的需要。
6. I confirm that I understood that all benefits described in the insurance plan are applicable worldwide except for psychiatric treatment and all benefit described in this insurance plan are not subject to any restriction in the choice of healthcare services providers and ward class. I also confirm that I understood that there is the Coinsurance arrangement of Prescribed Diagnostic Imaging Tests under this insurance plan.  
本人確認及明白除精神科治療外，保險計劃內的所有保障均全球適用。保險計劃內的所有保障對醫療服務供應者選擇或病房級別選擇均不設限制。本人並確認明白此保險計劃的保障中，診斷成像檢測的共同保險安排。
7. I understand that this insurance plan is a Certified Plan under Voluntary Health Insurance Scheme and is eligible for claiming tax deduction under the Inland Revenue Ordinance (Cap.112). bolttech Insurance and its intermediaries do not provide tax advice and I shall consult my tax advisor for any tax advice. For further information, I shall visit the website of Inland Revenue Department ([www.ird.gov.hk](http://www.ird.gov.hk)) and the website of Voluntary Health Insurance Scheme ([www.vhis.gov.hk](http://www.vhis.gov.hk)).  
本人明白此保險計劃是於自願醫保計劃的認可產品，並可享根據稅務條例（第112章），就保費支出提供稅務扣減，保特保險及其中介並不提供稅務建議。本人會向本人的稅務顧問諮詢稅務建議。如需進一步資料，本人可瀏覽稅務局網頁（[www.ird.gov.hk](http://www.ird.gov.hk)）及自願醫保計劃網頁（[www.vhis.gov.hk](http://www.vhis.gov.hk)）。
8. I have the duty to immediately inform bolttech Insurance and correct the above information I provided if they have become incomplete, untrue and inaccurate subsequent to before any policy is issued.  
本人明白於保單生效前，若因任何原因改變，導致上述本人所提供之資料不再完整、不再正確或不再準確，本人有責任立即通知保特保險並對該資料作出更正。
9. Any payment made in connection with this Application does not guarantee immediate approval of the coverage applied for. The insurance coverage applied for shall only take effect when the relevant policy has been issued and the initial premium paid (including any additional initial premium payable due to revisions of the policy terms and conditions).  
就有關本申請所作出付款，並不代表能保證立刻批准所申請的承保範圍。承保範圍只在發出保單及交妥首期保費時方會生效（包括因更改受保條件而需繳付的額外首期保費）。
10. I have read, understood and accepted the Personal Information Collection Statement of bolttech Insurance.  
本人已細閱、明白及接受保特保險之收集個人資料聲明。  
bolttech Insurance intends to send you marketing communications or materials and use Your Personal Data in accordance with paragraphs 8 & 9 of PICS. If you do not agree to receive such marketing communications or bolttech Insurance's intended use of Your Personal Data, please tick below to exercise your right to opt-out.  
保特保險有意向閣下發送推廣訊息或資料及根據收集個人資料聲明第8及第9段使用閣下的個人資料。如閣下不同意接收有關的推廣訊息或不同意保特保險就該目的使用閣下的個人資料，請在以下有關方格內加上（✓）號，藉以行使閣下不同意此項安排的權利。  
 拒絕接收推廣訊息或資料及保特保險使用本人的個人資料作直接促銷的用途。  
Opt-out from marketing communications or materials and bolttech Insurance to use of my personal data for direct marketing purpose.





Applicable to Insurance Broker only:

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

只適用於保險經紀：

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

**Cancellation Rights and Refund of Premium(s)**

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 Bolttech Insurance (Hong Kong) Company Limited at 9/F, FWD Financial Centre, 308 Des Voeux Road Central, 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.

**取消保單權益及發還保費**

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(扣除市場價值調整後計算，如適用)及保費徵費；但是本人必須親自在此書面通知上簽署，並確保保持保險(香港)有限公司於香港中環德輔道中308號富衛金融中心9樓將於以下時段內直接收到該書面通知：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。

X _____ Applicants Signature 申請人簽署	Signed in Hong Kong on 於香港簽署之日期  DD/MM/YYYY 日/月/年
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**Advisor/Broker's Information 代理人/經紀資料**

Advisor / Broker's Name 代理人/經紀 <b>SUN FLOWER</b>	Account Code 帳戶號碼 <b>SF1AHH</b>
Email Address 電郵地址 <b>medical@sunflowergroup.com.hk</b> <small>Please provide email address to receive policy and medical claim statement by email. 請提供電郵地址以收取保單及醫療索償理賠表。</small>	Contact No. 聯絡電話 <b>25211881</b> <small>(Required field) (必需填寫)</small>

**Credit Card Payment Authorisation Form 信用卡付款授權書**

Visa 卡     Master Card 萬事控卡

Cardholder's Name 持卡人姓名	
Credit Card Account No. 信用卡號碼	Credit Card Expiry Date (MM/YY) 信用卡到期日
<input type="checkbox"/> I hereby authorise Bolttech Insurance (Hong Kong) Company Limited 本人茲授權保持保險(香港)有限公司從本人上述之信用卡帳戶支取此保險所應繳之保費及保險徵費(包括續保保費)，直至另行通知。	
X _____ Cardholder's Signature 持卡人簽署	Date 日期



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

Please scan the following QR code for review of Bolttech Insurance (Hong Kong) Company Limited’s (the “Company”) PICS. You can also request a copy of the PICS by calling the Company’s Customer Service Hotline at 3123 3344.

請掃描以下二維碼查看保特保險(香港)有限公司(「本公司」)的收集個人資料聲明。您亦可致電本公司的客戶服務熱線 3123 3344 索取收集個人資料聲明副本。



English



中文

## Important Notes

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

## 重要事項

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



# Product Suitability Assessment Form

## 產品合適性評估表

Please provide the personal information in this Suitability Assessment Form in order for us to analyse your medical, financial, and coverage needs to make suitable medical coverage recommendations for you. By providing the information below, you understand and agree that the information provided in this form will be handled in accordance with the Personal Information Collection Statement ("PICS") of Bolttech Insurance (Hong Kong) Company Limited.

請根據此產品合適性評估表提供個人資料以助我們分析您在醫療、財務及保障上的需要，以便提供合適的醫療保障建議。客戶在填寫此分析表時，即表示您明白及同意有關資料將根據保特保險(香港)有限公司之個人資料收集聲明予以處理。

Applicant's name: 申請人姓名:	Proposed insured's name: 準受保人姓名:	Proposed Insured's Age: 準受保人年齡:	Proposed insured's Sex: 準受保人性別:	Proposed insured's relationship to applicant: 準受保人與申請人關係:

### Step 1: Customer's medical insurance needs and objectives: 第一步: 客戶醫療保險需求及目標:

- Are you able to pay medical insurance premium every year to enjoy the benefits and services as stated in the medical insurance policy for future illnesses or injuries?  
 您確定每年都能支付醫療保險保費，以享用醫療保險保單中所指定的保障項目和服務來保障未來可能出現之疾病或傷患嗎？  
 a) Yes 確定  
 b) No 不確定
- What is your annual budget for medical insurance protection?  
 您的每年醫療保障費用預算為？  
 HK\$ 港幣 \_\_\_\_\_
- Do you have any existing personal medical insurance(s)?  
 您有現有的個人醫療保險嗎？  
 a) Yes 有 \_\_\_\_\_  
 (If yes, please indicate no. of in-force policy)  
 如有，請寫出生效之保單數目：  
 i) Medical expense reimbursement insurance 醫療費用實報實銷保險 \_\_\_\_\_  
 ii) Daily cash for hospitalization insurance 每日住院現金保險 \_\_\_\_\_  
 iii) Critical illness insurance 危疾保險 \_\_\_\_\_  
 iv) Personal accident insurance 個人意外保險 \_\_\_\_\_  
 b) No 沒有
- Why do you want to purchase a new medical insurance?  
 您為什麼想購買一份新的醫療保險？  
 a) For insurance protection of the increasing medical treatment costs 為日益增加的醫療費用提供保險保障  
 b) For income protection during sickness 用於疾病期間的收入保障  
 c) My existing medical insurance cover is insufficient 我的現有醫療保險保障不足  
 d) To enjoy tax allowance of VHIS compliant product ("Voluntary Health Insurance Scheme") 我希望享受「自願醫保」所提供的免稅額  
 e) Others, please specify 其他，請註明： \_\_\_\_\_
- What are your preferred benefits and coverages for your newly applied medical insurance?  
 在您新投保的醫療保險中，您首要考慮的保障項目和保險範圍是什麼？  
 a) Basic hospitalization and surgical benefits 基本住院及手術保障之項目  
 b) Comprehensive medical insurance protection 全面的醫療保險保障  
 c) Income protection during sickness 疾病期間的收入保障  
 d) Annual deductible or co-insurance options to lower the annual premium 每年以自付費或共付保險形式投保之選項，以降低每年的保費





**Step 2: Insurance intermediary product recommendation after product suitability assessment**  
**第二步：產品合適性評估後，保險中介人之產品建議**

Insurance intermediary product recommendations: 保險中介人之產品建議：

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Step 3: Customer selected product after product suitability assessment**  
**第三步：產品合適性評估後客戶選擇之產品**

I / we confirm that I have gone through the above product suitability assessment and confirm the below medical insurance product is selected by my / our own decision.

本人/我們確認本人/我們已進行上述之產品合適性評估並確認以下之醫療保險產品選擇是本人/我們自己所決定的。

Plan name 計劃名稱: \_\_\_\_\_

Annual Deductible option (if applicable) 每年自付費選擇(如有): HK\$ \_\_\_\_\_

Optional benefit (if applicable) 自選保障(如有): \_\_\_\_\_

**客戶聲明 Customer Declaration:**

- 1) I / We have read and understood the product brochure, information sheet and policy provision of the medical insurance product I / we selected. 本人/我們已細閱及明瞭本人/我們所選擇之醫療保險產品的產品小冊子、資訊單張及保單條款之內容。
- 2) I / We confirm the medical insurance product I / we selected (in respect of any type of indemnity, non-indemnity, or combo product) is suitable for my / our insurance needs and my / our objectives for purchasing a medical insurance product (including but not limited to (i) income protection during hospital confinement; (ii) preparation for the hospitalization and medical treatment expenses due to illness or injury), and I / we can afford to pay the required premium. 本人/我們確認本人/我們所選擇之醫療保險產品(包括任何種類之賠償、非賠償、或組合產品)符合本人/我們的保險需要及購買醫療保險產品的目標(包括但不限於(i)住院期間的收入保障;(ii)為疾病或受傷之住院及其醫療費用作準備),及本人/我們有能力支付其所需的保費。
- 3) I / We confirm the medical insurance product I/we selected is my / our own decision with no forced pressure from any third parties. 本人/我們確認本人/我們所選擇之醫療保險產品是在沒有受第三者壓力下由本人/我們自行決定的。
- 4) I / We understand the information contained in this form was used to analyse my / our medical insurance needs and provided as reference only for my choice of medical insurance product and premium amount. I / We also understand and agree that the information contained in this form will be handled in accordance with the Personal information Collection Statement ("PICS") of Bolttech Insurance (Hong Kong) Company Limited. 本人/我們明白此表格內所提供之資料乃用作分析本人/我們的醫療保險需求,並為本人/我們在選擇保險計劃及保費金額時作參考。本人/我們亦明白此表格內之資料會根據保特保險(香港)有限公司的收集個人資料聲明予以處理。
- 5) We understand that the analysis and choices made in this form were based upon the information provided and it does not create any liability to Bolttech Insurance (Hong Kong) Company Limited. 本人/我們明白此表格之分析及選擇乃基於本人/我們所提供之資料而作出的,當中並不構成保特保險(香港)有限公司之任何責任。
- 6) I / We understand that I / We are required to inform Bolttech Insurance (Hong Kong) Company Limited if there are any substantial changes to the information provided in this form prior to the insurance policy being issued. 本人/我們明白,如本人/我們就此表格內的資料有任何重大更改,本人/我們需在保單生效前通知保特保險(香港)有限公司。

I / We, as the Applicant, confirm that I / we have read and understood all the contents in this form and provided all the correct information for the above on behalf of the proposed insured / existing insured listed in this application. 本人/我們作為申請人確認已細閱及明瞭此表格之內容,並代表此計劃之準受保人/現有受保人就以上問題提供正確無誤之資料。

Applicant's name  
申請人姓名

Applicant's Signature  
申請人簽署

Date (DD / MM / YYYY)  
日期(日/月/年)

Proposed insured's name  
(if different from the Applicant)  
準受保人姓名(如跟申請人不同)

Proposed insured's Signature  
準受保人簽署

Date (DD / MM / YYYY)  
日期(日/月/年)

**SUN FLOWER INSURANCE BROKERS LTD.**  
Name of Agent / Broker  
經紀姓名

SF1AHH  
Agent's / Broker's Code  
經紀編號

Agent's / Broker's signature  
經紀簽署