® **Sun Flower Insurance Brokers Limited**
Room 1105-08, Hing Yip Commercial Centre, 282 Des Voeux Road Central, Hong Kong
Tel: 2521 1881 Fax: 2521 1919 Email: vip@sunflowergroup.com.hk www.sunflowerVIP.com

Thank you for considering Sun Flower to be one of your selected intermediaries.

We are pleased to get in touch should you have any enquiry regarding the captioned insurance.

GENERALI
Assicurazioni Generali S.p.A.
忠 利 保 險 有 限 公 司

Personal Accident Insurance Proposal Form

(Please use Block Letters and tick the appropriate box)

Applicant Information (Applicant should be aged 18 to 65)

Name of Applicant (in English)	Name of Applicant (in Chinese)	Sex
Tel No. (Home / Office / Mobile)	Place/Country of Residence	Policy Effective Date (d d / m m / y y)
Correspondence Address (if Policyholder is a Company/Employer, please also state the Company/Employer's Name and Address)		
Name and Correspondence Address of Employer		

Insured Person's Personal Information

Name of Covered Family Members (English and Chinese)	Date of Birth (dd/mm/yy)	Sex (M/F)	HKID No.	Relationship with 1st Insured	Occupation / Position* (Exact job Duties)	Height (cm) / Weight (kg)	Left Handed
				1st Insured			☐
							☐
							☐
							☐

* Please state all occupations/exact job duties (including full-time/part-time)

Beneficiary will be the Own Estate of the Insured according to the Hong Kong jurisdiction.

Benefits Required		Sum Insured (HK$)	
		1st Insured	Spouse
Individual Plan		☐ Plan 1 ☐ Plan 2 ☐ Plan 3	
Tailor-made Plan			
Basic Benefits	A1) Accidental Death and Disablement		
Optional Benefits	A2) Accidental Medical Expenses		
	B) Temporary Total Disablement	per week	per week
	C) Double Indemnity		
	D) Broken Bones and Burns		

Past Experience and Insurance History

All questions must be answered fully.
If any of the answer is "Yes", please give further details in the space below, noting the question number(s), the name(s), address(es) of any doctor(s) consulted (if more space is required, please write on a separated sheet and sign your name on the original application form).

1. Do you or other covered members currently have or are you applying for any life, accident or medical insurance? If yes, please state the Insurer, benefit, sum insured, etc. ☐ Yes ☐ No
2. Have your or other covered members' applications of life, accident or medical insurance ever been declined or postponed, or your insurance ever been modified, rated-up, cancelled or refused invitation for renewal? If yes, please state the Insurer, benefit, sum insured, reason, condition, etc. ☐ Yes ☐ No
3. Do you or other covered members have any physical or mental impairment or condition? If yes, please state the suffered area or diagnosis, etc. ☐ Yes ☐ No
4. Have you or other covered members ever suffered from hypertension, heart disease, mental disorder, diabetes mellitus, cancer, tumour, ulcer, tuberculosis, asthma, epilepsy, stroke, emphysema, pleurisy, colitis, rheumatic fever, venereal disease; or any other disease of brain, central nervous system, gastro-intestinal tract, liver (or is Hepatitis B Carrier), pancreas, kidney, genito-urinary organs, back, spinal column, etc? If yes, please state suffered date, extent of recovery or any recurrence, etc. ☐ Yes ☐ No
5. Have you or other covered members received in the past 5 years, currently receiving or will you contemplate to receive any medical, surgical treatment or medication? If yes, please state the type of surgery and medicine, doctor's name and address. ☐ Yes ☐ No
6. Are you or other covered members frequent traveler? If yes, please state the traveling country(ies) and number of trips per year. ☐ Yes ☐ No
7. Are you self-employed? ☐ Yes ☐ No

Delcaration & Authorization

I/We hereby declare that the information given above is true and complete to the best of my/our knowledge and believe that all material information affecting the assessment of this application have been disclosed.
I/We hereby authorized any licensed physician, hospital, clinic or other medical or medically related facility, insurance company, institution or persons, that has any records or knowledge of myself/ourselves, to give to the Company any such information. To facilitate rapid submission of such information, I/We authorize all said sources to give such records or knowledge to any agency employed by the Company to collect and transmit such information. A photographic copy of this authorization shall be valid as the original.
False Information – Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance, containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.
This insurance application will not be in force until it has been underwritten by the Company and the premium has been paid.
The information I/We provide to Generali is collected to enable Generali to carry on insurance business and may be used for the purpose of: (i) any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or service; (ii) any claim or investigation or analysis of such claim; and (iii) exercising any right of subrogation; and may be transferred to: (a) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; (b) any association, federation or similar organisation of insurance companies ("Federation") that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation; and/or (c) any member(s) of the "Federation" by the "Federation" for any of the above or related purposes. Moreover, Generali is hereby authorized to obtain access to and/or to verify any of my/our data with the information collected by the Federation from the insurance industry.
I/We have the right to obtain access to and to request correction of any personal information concerning myself/ourselves held by Generali. Requests for such access can be made to Generali's Personal Data Protection Officer. (Hong Kong Branch : 5/F, Generali Tower, 8 Queen's Road East, Hong Kong.)

Applicant Signature	Date	Producer Signature	For Office Use Only

The applicant understands, acknowledges and agrees that, as a result of the applicant purchasing and taking up the policy to be issued by Assicurazioni Generali S.p.A. Assicurazioni Generali S.p.A. will pay the authorized insurance broker commission during the continuance of the policy including renewals, for arranging the said policy. Where the applicant is a body corporate, the authorized person who signs on behalf of the applicant further confirms to Assicurazioni Generali S.p.A. that he or she is authorized to do so.

The applicant further understands that the above agreement is necessary for Assicurazioni Generali S.p.A. to proceed with the application.

GENERALI
Assicurazioni Generali S.p.A.
忠 利 保 險 有 限 公 司

人身意外保險計劃投保書

(請以英文正楷填寫及於適當方格內剔上答案)

申請人資料 (申請人必須為18 至 65歲)

投保人英文姓名	投保人中文姓名	性別
聯絡電話 (家居 / 辦公室 / 手機)	原居地	保單生效日期 (日 / 月 / 年)
通訊地址 (如申請人為公司，請註明公司名稱及地址)		
受僱公司名稱及地址		

受保人資料

受保家庭成員姓名 (英文及中文)	出生日期 (日/月/年)	性別 (男/女)	身份証號碼	與第一受保人關係	職業 / 職位 (實際職務)*	身高 (厘米) / 體重 (公斤)	右手為強手 (是/否)
				第一受保人			☐
							☐
							☐
							☐

* 請列明所有職業及實際職務 (包括正職及兼職)

受益人乃根據香港法例之合法承繼人。

保障項目		投保額 (港幣)	
		第一受保人	夫婦
個人計劃		☐ 計劃一 ☐ 計劃二 ☐ 計劃三	
自訂計劃			
基本保障	A1) 意外死亡及永久完全或部份傷殘		
附加保障	A2) 意外醫療費用		
	B) 暫時完全傷殘	每週	每週
	C) 雙倍賠償		
	D) 骨折及燒傷保障		

其他保險及健康狀況資料

請將各問題填妥。
倘各項問題中，若答案是「 是 」者，請在以下空間提供詳細資料，註明有關問題號碼，並提供有關之醫生姓名及地址 (如需要更多空間填寫，可另加紙張，並須附有簽署)。

1. 閣下或其他受保家庭成員有否已投保或現正申請投保人壽、意外身故、傷殘、或醫療保險？如有，請註明保險公司、保障項目、投保額等。 ☐ 是 ☐ 否
2. 閣下或其他受保家庭成員有否已投保意外、疾病、傷殘、醫療或人壽保險被拒保、延擱或撤銷或曾持有該種保險或證書，而於事後曾被修正、增加保費、取消、或被拒絕續保？如有，請註明保險公司、保障項目、投保額、原因、現狀等。 ☐ 是 ☐ 否
3. 閣下或其他受保家庭成員之身體或四肢有無任何殘缺？如有，請註明殘缺部位或病徵等。 ☐ 是 ☐ 否
4. 閣下或其他受保家庭成員曾否患有或正在治療以下疾病：心臟病、高血壓、糖尿、癌症、腫瘤、潰瘍、肺結核、哮喘、癲癇、氣腫、肋膜炎、結腸炎、風濕性高熱病、梅毒、或任何腦部、中樞神經系統、腸胃、肝臟、胰、或生殖泌尿器等疾病？ ☐ 是 ☐ 否
5. 閣下或其他受保家庭成員於過去五年是否曾經或打算將來接受任何醫藥治療、外科手術或服食任何藥物？如有，請註明手術及藥物名稱、主診醫生姓名及地址。 ☐ 是 ☐ 否
6. 閣下是否須經常離港？如是，請列明往何國家及每年外遊次數。 ☐ 是 ☐ 否
7. 閣下是否自僱人士？ ☐ 是 ☐ 否

聲明及授權

本人/吾等謹此聲明此投保書之資料，均就本人/吾等所知，全部正確無訛，一切影響評核風險之資料，亦已申報。
本人/吾等授權任何註冊醫生、醫院、診所或任何有關之醫療設施、保險公司或任何組織熟悉本人/吾等健康情況之人士，將本人/吾等過往之病狀或病歷詳細資料提供予貴公司或貴公司之代表，此授權書之影印本亦屬有效。
虛假資料 – 任何人知情地及蓄意欺騙保險公司或第三者，提供虛假及隱瞞任何有關資料以投保保險及騙取保險，均屬違法。
此保險申請須待保險公司覆核，接納投保書及繳訖保費後才能生效。
本人/吾等提供的資料，為忠利保險提供保險業務所需，並可能使用於下列目的：(i) 任何與保險或財務有關的產品或服務、或該等產品或服務的任何更改、變更、取消或續期；(ii) 任何索償、或該等索償的調查或分析；(iii) 行使任何代位權；及可能移轉予：(a) 任何有關的公司、或任何其他從事與保險或再保險業務有關的公司、或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；(b) 現存或不時成立的任何保險公司協會或聯會或類同組織 (「 聯會 」)，以達到任何上述或有關目的、或以便「 聯會 」執行其監管職能、或其他基於保險業或任何「 聯會 」會員的利益而不時在合理要求下賦予「 聯會 」的職能；及/或 (c) 透過「 聯會 」移轉予任 何「 聯會 」的會員，以達到任何上述或有關目的。此外，在此授權忠利保險由「 聯會 」從保險業內收集的資料中查閱及/或核對本人/吾等任何資料。
本人/吾等有權查閱及要求更正由忠利保險持有有關本人/吾等的個人資料，如有需要，可向忠利保險個人資料保護主任提出。(香港分行：香港皇后大道東8號忠利集團大廈5樓。)

申請人簽署	日期

Sun Flower Insurance Brokers Limited
Room 1105-08, Hing Yip Commercial Centre, 282 Des Voeux Road Central, Hong Kong
Tel: 2521 1881 Fax: 2521 1919 Email: vip@sunflowergroup.com.hk www.sunflowerVIP.com

Thank you for considering Sun Flower to be one of your selected intermediaries.

We are pleased to get in touch should you have any enquiry regarding the captioned insurance.

申請人明白、確知及同意，忠利保險有限公司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[illegible]，向忠利保險有限公司確認他／她已獲該法人團體授權。

申請人亦明白忠利保險有限公司必須取得申請人的同意，才可以處理其保險申請。