

Cigna Medical Plan

Application Form (Individual / Family)

信諾醫療計劃申請書 (個人 / 家庭) (GI)



16/F, 348 Kwun Tong Road,
Kwun Tong, Kowloon, Hong Kong
Tel: 2560 1990 Fax: 2886 3722
www.cigna.com.hk

PRIVATE & CONFIDENTIAL 私人及機密

Part I 第一部份 – To be completed in English (Block Letter). Any changes should be signed by the relevant party. 請用英文正楷填寫。若更改任何資料，請在刪改處旁簽名。

In case the space provided is insufficient, please indicate the section and question number, and provide the details in a separate Additional Declaration. 如所提供之空位不敷應用，請於附加聲明表格上列明題號及詳情。

A - Particulars of Applicant 甲部 - 申請人資料

Title 稱謂 <input type="checkbox"/> Mr 先生 <input type="checkbox"/> Mrs 太太 <input type="checkbox"/> Ms 女士 <input type="checkbox"/> Miss 小姐	Family Name (Same as Identity Document) 姓 (與身份證明文件相同) English 英文 Chinese 中文	Given Name (Same as Identity Document) 名 (與身份證明文件相同)	Sex 性別 <input type="checkbox"/> M 男 <input type="checkbox"/> F 女	HKID / Passport No. (Please submit copy) 香港居民身份證 / 護照號碼 (請遞交副本) <input type="checkbox"/> HK Permanent Identity Card No. 香港永久性居民身份證號碼 <input type="checkbox"/> HK Non-Permanent Identity Card No. 香港非永久性居民身份證號碼 <input type="checkbox"/> Passport No. 護照號碼 Date of Birth 出生日期 (DD日 - MM月 - YYYY年)
Residential Address 住宅地址	Flat / Room 室 Floor 層 Building / Block 大廈 / 座 Street / Estate 街道 / 屋村 District 地區 <input type="checkbox"/> HK 香港 <input type="checkbox"/> KLN 九龍 <input type="checkbox"/> NT 新界 <input type="checkbox"/> Others 其他 _____ Country 國家	Correspondence Address 通訊地址 (if different from Residential Address 如與住宅地址不同) District 地區 <input type="checkbox"/> HK 香港 <input type="checkbox"/> KLN 九龍 <input type="checkbox"/> NT 新界 <input type="checkbox"/> Others 其他 _____ Country 國家	Flat / Room 室 Floor 層 Building / Block 大廈 / 座 Street / Estate 街道 / 屋村 District 地區 <input type="checkbox"/> HK 香港 <input type="checkbox"/> KLN 九龍 <input type="checkbox"/> NT 新界 <input type="checkbox"/> Others 其他 _____ Country 國家	Place of Birth 出生地 Nationality 國籍 (Please submit nationality proof if not holding HK Permanent Identity Card 若非持有香港永久性居民身份證，請遞交國籍證明)
Contact Number 聯絡電話 (At least provide 1 contact no. 最少提供一個聯絡電話)				
Residential 住宅	Office 辦公室	Mobile 流動電話		
Email Address 電郵地址 Please provide a valid and regularly used email address. This email address will be utilized for activating our online customer service portal MyCigna and receiving electronic communications. 請提供有效及常用的電郵地址。此電郵地址將用作啟動我們的網上客戶服務平台 MyCigna 及接收電子通訊。				
Electronic Policy and Electronic Correspondence 電子保單及電子通訊文件 The policy and correspondence are sent electronically by default. Upon policy issuance, we will send you a welcome email. Please follow the instructions provided in the email to download and activate our online customer service portal MyCigna to view your policy and all correspondence that we send to you. 保單及通訊文件預設以電子方式發送。當保單簽發後，我們會向您發出迎新電子郵件。請根據電子郵件的指示下載及啟動我們的網上客戶服務平台 MyCigna，以查閱您的保單及我們向您發出的所有通訊文件。 If you would like to additionally receive hard copy of policy and correspondence, please tick the box below. 若您希望額外收取紙本的保單及通訊文件，請在以下方格打剔。 <input type="checkbox"/> Request for additional hard copy of policy and correspondence 要求額外的紙本保單及通訊文件				

B - Particulars of Proposed Insured Person 乙部 - 準受保人資料

Code of Proposed Insured Person 準受保人編號	Application Number 投保編號	Please tick the below box if the Applicant is equal to the Proposed Insured Person 1 若申請人是準受保人 1，請在以下方格打剔	Family Name (Same as Identity Document) 姓 (與身份證明文件相同)	Given Name (Same as Identity Document) 名 (與身份證明文件相同)	Sex 性別
1		<input type="checkbox"/>	Applicant 申請人		
Details as above 資料同上					

Cigna Medical Plan (GI - Ind/Family)E-form version 6 -202405(B)

Code of Proposed Insured Person 準受保人編號	Application Number 投保編號	Family Name (Same as Identity Document) 姓 (與身份證明文件相同)	Given Name (Same as Identity Document) 名 (與身份證明文件相同)	Sex 性別
2		English 英文		<input type="checkbox"/> M男 <input type="checkbox"/> F女
		Chinese 中文		
HKID / Passport / Birth Cert. No. (Please submit copy) 香港居民身份證 / 護照 / 出世紙號碼 (請遞交副本) <input type="checkbox"/> HK Permanent Identity Card No. 香港永久性居民身份證號碼 <input type="checkbox"/> Passport No. 護照號碼 <input type="checkbox"/> HK Non-Permanent Identity Card No. 香港非永久性居民身份證號碼 <input type="checkbox"/> Birth Cert. No. 出世紙號碼		Date of Birth 出生日期 (DD日 - MM月 - YYYY年)		Live with the Applicant 與申請人同住 (If the answer is "NO", please also provide the residential address of Proposed Insured Person in an Additional Declaration) (若答案為「否」, 請於附加聲明表格上提供準受保人之住宅地址) <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
Place of Birth 出生地		Nationality 國籍 (Please submit nationality proof if not holding HK Permanent Identity Card 若非持有香港永久性居民身份證, 請遞交國籍證明)		
Relationship with the Applicant 與申請人的關係		<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Parent 父母 (aged 55 or more 五十五歲或以上) <input type="checkbox"/> Child 子女 (unmarried and below age 18 未婚及十八歲以下) <input type="checkbox"/> Grandparent 祖父母或外祖父母 (aged 55 or more 五十五歲或以上) <input type="checkbox"/> Sibling 兄弟姊妹 (unmarried and below age 18 未婚及十八歲以下) <input type="checkbox"/> Other 其他# _____		

Code of Proposed Insured Person 準受保人編號	Application Number 投保編號	Family Name (Same as Identity Document) 姓 (與身份證明文件相同)	Given Name (Same as Identity Document) 名 (與身份證明文件相同)	Sex 性別
3		English 英文		<input type="checkbox"/> M男 <input type="checkbox"/> F女
		Chinese 中文		
HKID / Passport / Birth Cert. No. (Please submit copy) 香港居民身份證 / 護照 / 出世紙號碼 (請遞交副本) <input type="checkbox"/> HK Permanent Identity Card No. 香港永久性居民身份證號碼 <input type="checkbox"/> Passport No. 護照號碼 <input type="checkbox"/> HK Non-Permanent Identity Card No. 香港非永久性居民身份證號碼 <input type="checkbox"/> Birth Cert. No. 出世紙號碼		Date of Birth 出生日期 (DD日 - MM月 - YYYY年)		Live with the Applicant 與申請人同住 (If the answer is "NO", please also provide the residential address of Proposed Insured Person in an Additional Declaration) (若答案為「否」, 請於附加聲明表格上提供準受保人之住宅地址) <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
Place of Birth 出生地		Nationality 國籍 (Please submit nationality proof if not holding HK Permanent Identity Card 若非持有香港永久性居民身份證, 請遞交國籍證明)		
Relationship with the Applicant 與申請人的關係		<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Parent 父母 (aged 55 or more 五十五歲或以上) <input type="checkbox"/> Child 子女 (unmarried and below age 18 未婚及十八歲以下) <input type="checkbox"/> Grandparent 祖父母或外祖父母 (aged 55 or more 五十五歲或以上) <input type="checkbox"/> Sibling 兄弟姊妹 (unmarried and below age 18 未婚及十八歲以下) <input type="checkbox"/> Other 其他# _____		

Code of Proposed Insured Person 準受保人編號	Application Number 投保編號	Family Name (Same as Identity Document) 姓 (與身份證明文件相同)	Given Name (Same as Identity Document) 名 (與身份證明文件相同)	Sex 性別
4		English 英文		<input type="checkbox"/> M男 <input type="checkbox"/> F女
		Chinese 中文		
HKID / Passport / Birth Cert. No. (Please submit copy) 香港居民身份證 / 護照 / 出世紙號碼 (請遞交副本) <input type="checkbox"/> HK Permanent Identity Card No. 香港永久性居民身份證號碼 <input type="checkbox"/> Passport No. 護照號碼 <input type="checkbox"/> HK Non-Permanent Identity Card No. 香港非永久性居民身份證號碼 <input type="checkbox"/> Birth Cert. No. 出世紙號碼		Date of Birth 出生日期 (DD日 - MM月 - YYYY年)		Live with the Applicant 與申請人同住 (If the answer is "NO", please also provide the residential address of Proposed Insured Person in an Additional Declaration) (若答案為「否」, 請於附加聲明表格上提供準受保人之住宅地址) <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
Place of Birth 出生地		Nationality 國籍 (Please submit nationality proof if not holding HK Permanent Identity Card 若非持有香港永久性居民身份證, 請遞交國籍證明)		
Relationship with the Applicant 與申請人的關係		<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Parent 父母 (aged 55 or more 五十五歲或以上) <input type="checkbox"/> Child 子女 (unmarried and below age 18 未婚及十八歲以下) <input type="checkbox"/> Grandparent 祖父母或外祖父母 (aged 55 or more 五十五歲或以上) <input type="checkbox"/> Sibling 兄弟姊妹 (unmarried and below age 18 未婚及十八歲以下) <input type="checkbox"/> Other 其他# _____		

This includes 包括:

- Child or sibling who is unmarried and aged 18 or more but under the age of 25 and receiving full time education at a university, college, school or other similar educational establishment.
子女或兄弟姊妹未婚及年滿18歲, 但未滿25歲, 並在大學、學院、學校或其他相類似的教育機構接受全日制教育。
- Child or sibling who is unmarried and aged 18 or more but incapacitated for work by reason of physical or mental disability.
子女或兄弟姊妹未婚及年滿18歲, 但因身體上或精神上無行為能力而不能工作。
- Parent or grandparent under the age of 55 but eligible to claim an allowance under the Government's Disability Allowance Scheme.
父母或祖父母或外祖父母未年滿55歲, 但有資格根據政府傷殘津貼計劃申索津貼。

Parent / grandparent / sibling shall include the parent / grandparent / sibling of the Applicant or the Applicant's spouse.
父母或祖父母或外祖父母或兄弟姊妹包括申請人或申請人配偶的父母或祖父母或外祖父母或兄弟姊妹。

Child shall include the child of the Applicant or the Applicant's spouse or the Applicant's former spouse.
子女包括申請人或申請人配偶或申請人前配偶的子女。

C - Beneficiary 丙部 - 受益人 Beneficiary(ies) to whom proceeds payable on the Insured Person's death. 受益人身故時獲付保險金之受益人。

Code of Proposed Insured Person 準受保人編號	Name of Beneficiary in English 受益人英文姓名	Name of Beneficiary in Chinese 受益人中文姓名
1	a	
	b	
	c	
	d	
Relationship with the Proposed Insured Person 與準受保人的關係	ID / Passport / Birth Cert. No.* 身份證 / 護照 / 出世紙號碼 *	Percentage Share 分配百分比 (whole number and add up to 100% 整數及加起來總數為100%)
a		%
b		%
c		%
d		%

Code of Proposed Insured Person 準受保人編號	Name of Beneficiary in English 受益人英文姓名	Name of Beneficiary in Chinese 受益人中文姓名
2	a	
	b	
	c	
	d	
Relationship with the Proposed Insured Person 與準受保人的關係	ID / Passport / Birth Cert. No.* 身份證 / 護照 / 出世紙號碼 *	Percentage Share 分配百分比 (whole number and add up to 100% 整數及加起來總數為100%)
a		%
b		%
c		%
d		%

Code of Proposed Insured Person 準受保人編號	Name of Beneficiary in English 受益人英文姓名	Name of Beneficiary in Chinese 受益人中文姓名
3	a	
	b	
	c	
	d	
Relationship with the Proposed Insured Person 與準受保人的關係	ID / Passport / Birth Cert. No.* 身份證 / 護照 / 出世紙號碼 *	Percentage Share 分配百分比 (whole number and add up to 100% 整數及加起來總數為100%)
a		%
b		%
c		%
d		%

Code of Proposed Insured Person 準受保人編號	Name of Beneficiary in English 受益人英文姓名	Name of Beneficiary in Chinese 受益人中文姓名
4	a	
	b	
	c	
	d	
Relationship with the Proposed Insured Person 與準受保人的關係	ID / Passport / Birth Cert. No.* 身份證 / 護照 / 出世紙號碼 *	Percentage Share 分配百分比 (whole number and add up to 100% 整數及加起來總數為100%)
a		%
b		%
c		%
d		%

- Note 註:
- For the basic plan with accidental death benefit, please designate Beneficiary(ies) and complete the above Section C. 若基本計劃有意外身故保障，請指定受益人及填寫以上丙部。
 - If more than one Beneficiary is designated, please give details of apportionment. Otherwise, Beneficiaries are to be paid in equal shares. 如受益人超過一位而保險金並非平均分配者，請列出分配之詳情，否則，保險金將作平均分配。
 - If there is no designation of Beneficiary, the accidental death benefit would be paid according to the policy provision. 若沒有指定的受益人，意外身故保障將會根據保單條款而支付。

Part II : Plan Details 第二部份：計劃詳情

1. Plan 計劃：(If the Proposed Insured Person selects more than 1 plan, please submit separate application form. 若準受保人選擇超過一個計劃，請提交另一份申請書。)

Cigna VHIS Series 信諾自願醫保系列

Plan Level 計劃級別	Accommodation Room Type 病房類別	Deductible (HKD) 自付費 (HKD)	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Cigna VHIS Series - Standard Plan 信諾自願醫保系列 - 標準計劃	NA 不適用	NA 不適用	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigna VHIS Series - Flexi Plan (SMM) 信諾自願醫保系列 - 靈活計劃 (附加保障)	NA 不適用	NA 不適用	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigna VHIS Series - Flexi Plan (Superior) 信諾自願醫保系列 - 靈活計劃 (優越)	Semi-Private Room 半私家病房	0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		15,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		25,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		50,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Standard Ward 普通病房	75,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		15,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		25,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cigna HealthFirst Elite 360 Medical Plan 信諾尊尚360醫療保

Accommodation Room Type 病房類別	Area of Cover 受保地區	Deductible (HKD) 墊底費 (HKD)	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Standard Private Room 標準私家房	Worldwide 環球	15,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		25,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		50,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		75,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Worldwide excluding the US 環球不包括美國	15,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		25,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		50,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		75,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Asia 亞洲	15,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		25,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		50,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		75,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Semi-Private Room 半私家房	Asia 亞洲	15,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		25,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		50,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		75,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Optional Insurance Benefits 自選保障	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Outpatient Benefits 門診保障	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Benefits 牙科保障	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy Benefits 藥物保障	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cigna Medical Plan (GI - Ind/Family)/E-form version 6-202405(B)

Cigna HealthFirst Choice Medical Plan 信諾自選醫療保

Plan Level 計劃級別	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Private Room 私家房	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Semi-Private Room 半私家房	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ward 普通房	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Optional Insurance Benefits 自選保障	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Supplementary Major Medical Benefit 附加醫療保障	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Benefits 門診保障	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Benefits 牙科保障	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cigna Plus Medical Plan 信諾升級醫療保

Plan Level 計劃級別	Deductible (HKD) 墊底費 (HKD)	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Plan 1 計劃一： Private Room 私家房	30,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	40,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	50,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	60,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	80,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	100,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	150,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan 2 計劃二： Semi-Private Room 半私家房	200,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	30,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	40,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	50,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	60,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	80,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	100,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan 3 計劃三： Ward 普通病房	150,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	30,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	40,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	50,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	60,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	80,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Cigna HealthFirst Elite-GEH Medical Plan 信諾尊尚醫療保 (團體醫療轉換計劃)

(Plan details referred to the Policy Conversion Request Form 計劃詳情請參考保單轉換申請書)

<input type="checkbox"/> Employee Health Value+ Portable Plan 僱員健康增值保障計劃							
Plan Level 計劃級別	Accommodation Room Type 病房類別	Deductible (HKD) 墊底費 (HKD)	Reimbursement % 賠償百分比	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Plan 1 計劃一	Ward 普通病房	5,000	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan 2 計劃二	Semi-Private Room 半私家房	15,000	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan 3 計劃三	Standard Private Room 標準私家房	25,000	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan 4 計劃四	Ward 普通病房	200,000	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan 5 計劃五	Semi-Private Room 半私家房	300,000	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan 6 計劃六	Standard Private Room 標準私家房	500,000	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan 7 計劃七	Ward 普通病房	0	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan 8 計劃八	Semi-Private Room 半私家房	0	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan 9 計劃九	Standard Private Room 標準私家房	0	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Optional Insurance Benefits 自選保障	Plan Level 計劃級別	Reimbursement Percentage 賠償百分比	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Outpatient Benefits 門診保障	Plan 1 計劃一	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Plan 2 計劃二	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Plan 3 計劃三	80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Benefits 牙科保障	Plan 1 計劃一	NA 不適用	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Plan 2 計劃二	NA 不適用	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness Benefits 健康保障	Plan 1 計劃一	NA 不適用	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/> Other Medical Plan 其他醫療計劃				
(Please fill in the details 請填寫詳情資料)				
Basic Plan 基本計劃	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Name of Medical Plan 醫療計劃名稱				
Policy Currency 保單貨幣	<input type="checkbox"/> HKD 港元	<input type="checkbox"/> USD 美元	<input type="checkbox"/> HKD 港元	<input type="checkbox"/> USD 美元
<input type="checkbox"/> Plan Level 計劃級別 / <input type="checkbox"/> Sum Insured 保障額				
Overall Annual Limit 每年最高賠償額 (if applicable 如適用)				
Accommodation Room Type 病房類別 (if applicable 如適用)				
Annual Deductible Amount 每年墊底費金額 (if applicable 如適用)				
Area of Cover 受保地區 (if applicable 如適用)				
(Please fill in the details 請填寫詳情資料)				
Optional Insurance Benefits 自選保障	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Benefit 1 and plan level 保障一及計劃級別 (if applicable 如適用)				
Benefit 2 and plan level 保障二及計劃級別 (if applicable 如適用)				
Benefit 3 and plan level 保障三及計劃級別 (if applicable 如適用)				
Benefit 4 and plan level 保障四及計劃級別 (if applicable 如適用)				

2. Conversion 轉換 (Please submit the Policy Conversion Request Form 請遞交保單轉換申請書)

Yes 是 No 否

Code of Proposed Insured Person 準受保人編號 * 1 * 2 * 3 * 4 (Please tick請別選)

1 2 3 4

Employee Health Value+ Portable Plan 僱員健康增值保障計劃

Cigna HealthFirst Elite-GEH Plan 信諾尊尚醫療保(團體醫療轉換計劃)

Others 其他 _____

3. Payment Frequency 繳款形式 :

Code of Proposed Insured Person 準受保人編號	Payment Frequency 繳款形式 (Please choose either one 請選擇其中之一)	
	<input type="checkbox"/> Monthly 月繳* Monthly Premium 每月保費	<input type="checkbox"/> Annual 年繳 Annual Premium 每年保費
1		
2		
3		
4		

* Please complete the Direct Debit Authorization Form in page 18 of this application form. 請填妥本申請書第18頁的直接付款授權書。

4. Medical Protection Needs Assessment 醫療保障需要評估 :

(Please note: The following questions are to evaluate the suitability of the insurance product(s) under this application based on your needs and circumstances. Application can be suspended or rejected in case of suitability mismatch. 請注意：以下問題旨在評估此投保申請下的保險產品的適合性，以滿足閣下的需要及情況。如出現保險產品與閣下保障需要錯配的情況，投保申請可被暫緩或拒絕。)

<p>Question 1 問題</p> <p>Answer Options 答案選擇 :</p>	<p>What is/are your objective(s) for purchasing the medical insurance policy? (tick one or more) 請問您投保此醫療保單的目的是? (可選一項或多項)</p> <p><input type="checkbox"/> Option 1: For the expenses of hospitalization 選擇1: 為應付住院開支</p> <p><input type="checkbox"/> Option 2: For the financial need when suffer from Critical Illness 選擇2: 為應付患上危疾時的經濟需要</p> <p><input type="checkbox"/> Option 3: For the long term care and financial needs in case of permanent total disability 選擇3: 為永久完全傷殘時的長期醫療保健及經濟需要</p> <p><input type="checkbox"/> Option 4: For the expenses of outpatient visits and other medical needs (such as Dental, Vision benefit, etc) 選擇4: 為應付門診或其他醫療所需(例如牙醫、眼科等)</p>
<p>Question 2 問題</p> <p>Answer Options 答案選擇 :</p>	<p>Which type(s) of medical insurance you are looking for? (tick one or more) 請問您會考慮投保哪一類型的醫療保單呢? (可選一項或多項)</p> <p><input type="checkbox"/> Option 1: Indemnity (cover the eligible expenses by the policy) 選擇1: 彌償式賠償 (即按保單規定之合資格開支提供實報實銷式的賠償)</p> <p><input type="checkbox"/> Option 2: Non-indemnity (a payment based on a sum insured amount by the policy) 選擇2: 非彌償式賠償 (即按保單訂明的保額作出賠償)</p>

Part III : Underwriting Questions 第三部份 : 承保保險問題

A - Statement of Collection of Information 甲部 - 資料收集聲明

- (i) This questionnaire collects health-related information solely for the purpose of underwriting which is a process for Cigna Worldwide General Insurance Company Limited (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，而核保是信諾環球保險有限公司 (「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。

B - Health Questions 乙部 - 健康問題

Note for applicant(s): Questions of Part B do not require the applicant(s) to disclose information regarding the medical conditions or treatments below – 申請人須知：無需於乙部問題披露以下健康狀況或治療 –

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.

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)、痤瘡、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。

Proposed Insured Person 準受保人 1	Height 身高 (cm 厘米 / ft 呎):	Proposed Insured Person 準受保人 2	Height 身高 (cm 厘米 / ft 呎):
	Weight 體重(kg 千克 / lb 磅):		Weight 體重(kg 千克 / lb 磅):
Proposed Insured Person 準受保人 3	Height 身高 (cm 厘米 / ft 呎):	Proposed Insured Person 準受保人 4	Height 身高 (cm 厘米 / ft 呎):
	Weight 體重(kg 千克 / lb 磅):		Weight 體重(kg 千克 / lb 磅):

	Proposed Insured Person 準受保人 1		Proposed Insured Person 準受保人 2		Proposed Insured Person 準受保人 3		Proposed Insured Person 準受保人 4	
	Yes 是	No 否	Yes 是	No 否	Yes 是	No 否	Yes 是	No 否
1. 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b/ Brain tumor 腦部腫瘤	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c/ Heart disease 心臟疾病	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e/ Hypertension 高血壓	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g/ Kidney disease 腎病	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j/ Human immunodeficiency virus ("HIV") infection 人體免疫力缺乏病毒 (愛滋病病毒) 感染	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k/ 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l/ 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m/ 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n/ Hypercholesterolemia or Hyperlipidemia 高膽固醇症或高血脂症	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o/ 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p/ Multiple sclerosis 多發性硬化症	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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 / 息肉 / 結節 / 增生)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d/ Benign prostatic hypertrophy 良性前列腺肥大	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the last 5 years, have you ever had or been advised to have any regular or ongoing (such as monthly, every 2 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the last 5 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 (1) month? 在過去五年內，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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cigna Medical Plan (GI - Ind/Family)(E-form version 6-202405)(B)

	Proposed Insured Person 1 準受保人 1		Proposed Insured Person 2 準受保人 2		Proposed Insured Person 3 準受保人 3		Proposed Insured Person 4 準受保人 4	
	Yes 是	No 否	Yes 是	No 否	Yes 是	No 否	Yes 是	No 否
5. In the last 5 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last 5 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the last 5 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）？ 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/ Abnormal test result is advised 檢驗結果異常	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b/ You are still awaiting test / test result 您正等候檢驗或檢驗結果	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c/ 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d/ 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Apart from anything you have already disclosed in Questions 1 – 7, do you have any of the following conditions? 除了您在第1至7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 5 kg (11 lbs) over past 1 year 在過去一年內，體重無故地減少了5公斤（11磅）以上	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c/ In the last 1 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. 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六十歲或以前被確診下列疾病或健康狀況：								
a/ Cancer 癌症	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b/ Coronary heart disease 冠心病	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c/ Diabetes mellitus 糖尿病	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d/ Motor neuron disease 運動神經元疾病	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e/ Multiple sclerosis 多發性硬化症	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f/ Stroke 中風	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g/ Parkinson's disease 帕金森症	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h/ Hereditary diseases – 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. 遺傳病 – 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、多囊性腎病或亨頓舞蹈症。	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you smoke or have you smoked in the last 12 months? 您有沒有吸煙或在過去十二個月內曾否吸煙？ 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). 「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）。	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cigna Medical Plan (GI - Ind/Family)(E-form version 6 -202405)(B)

If the answer to the question 10 in Part III is 'Yes', please provide additional information as applicable -
若第三部分第10題之答案為「是」者，請在適用的問題提供更多資料 -

Code of Proposed Insured Person 準受保人編號 (1 / 2 / 3 / 4) (Please tick 請別選)		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Question No. 題號 10
Duration of smoking habit, and frequency and quantity of consumption 吸煙習慣的持續時間、頻密度及吸食份量	Smoking Period 吸煙年期: _____ years 年	If you no longer smoke now, 若您現時已沒有吸煙，	
	On average 平均, <input type="checkbox"/> less than 30 pieces of cigarettes per day 每天少於30支香煙 <input type="checkbox"/> 30 to 40 pieces of cigarettes per day 每天30至40支香煙 <input type="checkbox"/> more than 40 pieces of cigarettes per day 每天40支香煙以上	(a) when did you quit smoking? 請問您是何時戒煙的?	Date of ceased smoking: DD日/MM月/YYYY年
		(b) 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?	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Reason 原因: _____

If the answer to the question 9 in Part III is 'Yes', please provide additional information as applicable -
若第三部分第9題之答案為「是」者，請在適用的問題提供更多資料 -

Code of Proposed Insured Person 準受保人編號 (1 / 2 / 3 / 4) (Please tick 請別選)		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Question No. 題號 9
Which family member? 哪個親屬?	<input type="checkbox"/> Father 父親 <input type="checkbox"/> Brother 兄弟 <input type="checkbox"/> Mother 母親 <input type="checkbox"/> Sister 姊妹	<input type="checkbox"/> Father 父親 <input type="checkbox"/> Brother 兄弟 <input type="checkbox"/> Mother 母親 <input type="checkbox"/> Sister 姊妹	<input type="checkbox"/> Father 父親 <input type="checkbox"/> Brother 兄弟 <input type="checkbox"/> Mother 母親 <input type="checkbox"/> Sister 姊妹
Which disease? 哪種疾病?			
Onset age of disease 病發年齡	<input type="checkbox"/> age at or below 40 (40歲或以下) <input type="checkbox"/> age 41-50 (41-50歲) <input type="checkbox"/> age 51-60 (51-60歲)	<input type="checkbox"/> age at or below 40 (40歲或以下) <input type="checkbox"/> age 41-50 (41-50歲) <input type="checkbox"/> age 51-60 (51-60歲)	<input type="checkbox"/> age at or below 40 (40歲或以下) <input type="checkbox"/> age 41-50 (41-50歲) <input type="checkbox"/> age 51-60 (51-60歲)

Code of Proposed Insured Person 準受保人編號 (1 / 2 / 3 / 4) (Please tick 請別選)		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Question No. 題號 9
Which family member? 哪個親屬?	<input type="checkbox"/> Father 父親 <input type="checkbox"/> Brother 兄弟 <input type="checkbox"/> Mother 母親 <input type="checkbox"/> Sister 姊妹	<input type="checkbox"/> Father 父親 <input type="checkbox"/> Brother 兄弟 <input type="checkbox"/> Mother 母親 <input type="checkbox"/> Sister 姊妹	<input type="checkbox"/> Father 父親 <input type="checkbox"/> Brother 兄弟 <input type="checkbox"/> Mother 母親 <input type="checkbox"/> Sister 姊妹
Which disease? 哪種疾病?			
Onset age of disease 病發年齡	<input type="checkbox"/> age at or below 40 (40歲或以下) <input type="checkbox"/> age 41-50 (41-50歲) <input type="checkbox"/> age 51-60 (51-60歲)	<input type="checkbox"/> age at or below 40 (40歲或以下) <input type="checkbox"/> age 41-50 (41-50歲) <input type="checkbox"/> age 51-60 (51-60歲)	<input type="checkbox"/> age at or below 40 (40歲或以下) <input type="checkbox"/> age 41-50 (41-50歲) <input type="checkbox"/> age 51-60 (51-60歲)

If the answer to any of the questions 1-8 in Part III is 'Yes', please provide additional information as applicable -
若第三部分第1至8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 -

Code of Proposed Insured Person (1 / 2 / 3 / 4) (Please tick) 準受保人編號 (1 / 2 / 3 / 4) (請別選)		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Question No. 題號	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4 <input type="checkbox"/> Q5 <input type="checkbox"/> Q6 <input type="checkbox"/> Q7 <input type="checkbox"/> Q8
(1) Disease / medical condition / sign and symptom 疾病 / 健康狀況 / 病徵及症狀				
(2) Date of first occurrence of sign and symptom 首次出現病徵及症狀的日期	DD日/MM月/YYYY年			
(3) (a) Treatment / investigations / tests / scans that have been performed 已進行的治療 / 檢查 / 測試 / 掃描 (b) Date of such treatment / investigation / tests / scan 有關治療 / 檢查 / 測試 / 掃描日期	DD日/MM月/YYYY年			
(4) 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)				
(5) Date of last follow-up medical consultation / treatment 最後覆診 / 治療日期	DD日/MM月/YYYY年			
(6) 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				
(7) Name of Hospital, where applicable 醫院名稱 (如適用)				

If the answer to any of the questions 1-8 in Part III is 'Yes', please provide additional information as applicable -
 若第三部分第1至8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 -

Code of Proposed Insured Person (1 / 2 / 3 / 4) (Please tick) 準受保人編號 (1 / 2 / 3 / 4) (請剔選)		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Question No. 題號	<input type="checkbox"/> Q1	<input type="checkbox"/> Q2	<input type="checkbox"/> Q3	<input type="checkbox"/> Q4	<input type="checkbox"/> Q5	<input type="checkbox"/> Q6	<input type="checkbox"/> Q7	<input type="checkbox"/> Q8
(1) Disease / medical condition / sign and symptom 疾病 / 健康狀況 / 病徵及症狀														
(2) Date of first occurrence of sign and symptom 首次出現病徵及症狀的日期														
(3) (a) Treatment / investigations / tests / scans that have been performed 已進行的治療 / 檢查 / 測試 / 掃描 (b) Date of such treatment / investigation / tests / scan 有關治療 / 檢查 / 測試 / 掃描日期														
(4) 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)														
(5) Date of last follow-up medical consultation / treatment 最後覆診 / 治療日期														
(6) 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														
(7) Name of Hospital, where applicable 醫院名稱 (如適用)														

Code of Proposed Insured Person (1 / 2 / 3 / 4) (Please tick) 準受保人編號 (1 / 2 / 3 / 4) (請剔選)		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Question No. 題號	<input type="checkbox"/> Q1	<input type="checkbox"/> Q2	<input type="checkbox"/> Q3	<input type="checkbox"/> Q4	<input type="checkbox"/> Q5	<input type="checkbox"/> Q6	<input type="checkbox"/> Q7	<input type="checkbox"/> Q8
(1) Disease / medical condition / sign and symptom 疾病 / 健康狀況 / 病徵及症狀														
(2) Date of first occurrence of sign and symptom 首次出現病徵及症狀的日期														
(3) (a) Treatment / investigations / tests / scans that have been performed 已進行的治療 / 檢查 / 測試 / 掃描 (b) Date of such treatment / investigation / tests / scan 有關治療 / 檢查 / 測試 / 掃描日期														
(4) 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)														
(5) Date of last follow-up medical consultation / treatment 最後覆診 / 治療日期														
(6) 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														
(7) Name of Hospital, where applicable 醫院名稱 (如適用)														

In case the space provided is insufficient, please indicate the section and question number, and provide the details in a separate Additional Declaration.
 如所提供之空位不敷應用，請於附加聲明表格上列明題號及詳情。

Part IV 第四部份**A - Personal Information Collection Statement of Cigna Hong Kong 甲部 - 信諾香港個人資料收集聲明**

Cigna Worldwide General Insurance Company Limited (“Cigna Hong Kong”, “our”, “we”, “us”)
信諾環球保險有限公司（「信諾香港」或「我們」）

The protection of privacy in relation to personal information is the concern of Cigna Hong Kong. We respect personal information and are committed to fully implementing and complying with the Data Protection Principles and the Personal Data (Privacy) Ordinance (“the Ordinance”).
信諾香港關注保障個人資料私隱。我們尊重個人資料，並且全力執行及遵守保障資料原則，以及《個人資料(私隱)條例》（“私隱條例”）。

1) Personal Information We Collect and/or Hold 我們收集及/或持有的個人資料的範圍

We collect your personal information from you for the purposes as set out in this Personal Information Collection Statement. We may collect personal information directly or indirectly from you in a range of ways, including but not limited to when you complete or submit an application, or claim, or request services or products, contact us in person, phone, mail, email or online, when you participate in our programs, when you access our website and services. The personal information that we collect and/or hold includes your personal identification information, contact information, policy details, transaction records, financial background, claims history, biometric data including but not limited to your voice pattern and facial images, location information based on your device and medical and health records.

我們為本個人資料收集聲明中列明之目的向閣下收集個人資料。我們可能會以各種方式直接或間接向閣下收集個人資料，包括但不限於當閣下填寫或提交申請或索償，要求提供服務或產品，當面、透過電話、郵件、電郵或在線聯繫我們時，當閣下參與我們的計劃時，當閣下使用我們的網站和服務時。我們收集及/或持有的個人資料，包括閣下之個人識別資料、聯絡資料、保單詳情、交易記錄、財務背景、索償歷史、生物識別數據（包括但不限於閣下的聲音模式及面部圖像）、根據閣下設備的位置信息和醫療及健康記錄。

We may also collect personal information of the insureds, your beneficiaries (or any other personnel designated or entitled to receive benefits under the corresponding policies), assignees, authorized representatives, dependents, company employees, and other individuals to which you have provided personal information of. Where you provide personal information of others to us, you confirm that you have authority to do so as their parent or guardian or have obtained that person’s consent to provide such personal information to us for Cigna Hong Kong’s use and transfer in accordance with this Personal Information Collection Statement.

我們亦可能收集下列人士的個人資料：受保人、閣下的受益人（或被指定或有權獲得相應保單下利益的任何其他人士）、受讓人、獲授權代表、受養人、公司僱員及閣下已提供其個人資料的其他個人。當閣下向我們提供他人個人資料時，閣下確認閣下作為其父母或監護人有權向我們提供其個人資料，或者已獲得該人同意向我們提供其個人資料，供信諾香港按照本個人資料收集聲明使用和轉移。

We may also collect personal information about you from third parties in certain circumstances, such as from other insurance companies, agents, brokers and other intermediaries, credit reference/reporting agencies, employers, vendors, financial institutions, fraud prevention agencies or databases, government agencies, medical personnel, courts or public record.

在特定情況下，我們亦可能向第三者收集有關閣下的個人資料，如其他保險公司、代理、經紀及其他中介人、信用查詢/報告機構、僱主、供應商、金融機構、防欺詐機構或數據庫、政府機構、醫務人員、法院或公共記錄。

2) Importance of Information Collection 收集個人資料的重要性

From time to time, it is mandatory and necessary for you to supply Cigna Hong Kong with personal information. Where you are unable or fail to supply the mandatory information requested by Cigna Hong Kong, Cigna Hong Kong may not be able to issue policies, process claims, applications or your requests, or provide products or services to you.

閣下不時有義務且有必要向信諾香港提供有關的個人資料。倘若閣下無法或未能向信諾香港提供強制性要求的資料，信諾香港可能無法簽發保單，處理索償、申請或閣下的要求，或向閣下提供產品或服務。

3) Purposes of Information Collection and Usage 收集個人資料的目的及用途

Your personal information held by Cigna Hong Kong may be used for the following purposes:-

信諾香港所持有閣下的資料可能會被用於下列用途：

- i) processing and evaluating any applications or requests made by you for products or services;
處理及評估閣下就產品或服務提出的任何申請或要求；
- ii) administration of insurance or financial or investment related products or services, including but not limited to alterations, variations, assignments, cancellation or renewal of such products or services;
處理保險或財務或投資相關產品或服務之日常運作，包括但不限於其更改、變動、轉讓、取消或續期；
- iii) processing, investigation or analysis of any claim applications made by, against or otherwise involving you in respect of any products or services;
處理、調查或分析就產品或服務而由閣下或針對閣下提出的或者其他涉及閣下的任何索償申請；
- iv) conducting research, satisfaction surveys, data analytics and statistics, to further understand your needs and to improve and test our facilities and services and/or products for any other purposes in connection with our business and the business of any member of the Cigna group companies;
為與我們的業務及信諾集團公司任何成員的業務有關的任何其他目的，進行研究、滿意度調查、數據分析和統計，以進一步瞭解閣下的需求，並改進和測試我們的設施及服務及/或產品；
- v) carrying out matching procedures;
進行核對程序；
- vi) (with your consent — see section 7 below) direct marketing including but not limited to promoting, marketing or selling of Cigna Hong Kong or co-branded or other third party insurance or financial or investment related products or services by electronic or other means;
(得到閣下的同意下 — 請看以下第7條) 直接促銷，包括但不限於透過電子或其他模式作推廣、宣傳或銷售信諾香港或信諾香港聯合的其它公司或其他第三者的保險、財務或與投資相關之產品或服務；
- vii) making disclosure under and/or complying with any law, rules, regulations, codes of practice or guidelines binding on or applicable to Cigna Hong Kong or any of its group companies and respond to requests from public, governmental authorities, regulatory bodies and litigation;
遵守適用於信諾香港或其集團公司的法律、規則、規例、實務守則或指引，及就其要求作出披露，並就公共、政府機構、監管機構和訴訟方面的要求作出答覆；
- viii) evaluating the policy or related risk intended to be the subject of reinsurance by an actual or proposed re-insurer of Cigna Hong Kong;
使信諾香港的確實或建議再保人，評核意圖再保交易的有關保單或相關風險；

- ix) conducting medical or health reference checks;
用作於醫療或健康參考上之用；
- x) conducting surveys, research and compiling statistics for insurance, financial or investment related purposes;
用作於保險、財務或投資相關調查、研究及統計之用；
- xi) investigation and settlement of claims, disputes and detection and prevention of fraud (whether or not relating to the policy issued in respect of an application); and
調查及處理索償、爭議，偵測及防止欺詐（無論是否與根據申請簽發之保單有關）；及
- xii) other purposes directly relating to any of the above.
與上述任何目的直接有關的其他目的。

4) Transfer of Personal Information 個人資料的轉移

Your personal information held by Cigna Hong Kong will be kept confidential, but may be shared with the following individuals and/or entities, whether within or outside Hong Kong, for any of the purposes set out above:-

信諾香港所持有閣下的資料會被絕對保密，但信諾香港可能會就上述任何目的把有關資料給予下列人士及 / 或實體（無論在香港境內還是境外）：

- i) any agent, contractor or third party service provider who provides administrative, accounting, data hosting, analytics and processing, customer service, call center, financial, legal, telecommunications, technology, fund management, debt collection, payment, anti-money laundering and other regulatory screenings, marketing, research, mailing, printing, loss adjustment or other services to Cigna Hong Kong;
任何向信諾香港提供行政、會計、資料寄存、分析及處理、客戶服務、電話中心、財務、法務、電訊、資訊科技、基金管理、收債、繳費、反洗黑錢及其他法規的審查、促銷、研究、郵寄、印刷、理賠、或其他服務的代理、承辦商或第三者服務供應商；
- ii) any insurance intermediary acting on your behalf (in placing an insurance policy with Cigna Hong Kong, in handling insurance claims with Cigna Hong Kong or as notified by you to Cigna Hong Kong) (an “Insurance Intermediary”) and (with your consent – see section 7 below) for its own direct marketing and business purposes, and such provision of your personal information may be for gain;
任何代表閣下安排購買信諾香港提供的保單，或代表閣下處理對信諾香港的保險索償，或由閣下通知信諾香港作為代表閣下的保險中介人（“保險中介人”）；（在得到閣下的同意下 – 請看以下第7條）個人資料作其直接促銷或業務推廣的用途，並可能從而得益；
- iii) any agent, contractor or third party service provider engaged by an Insurance Intermediary (as notified by such Insurance Intermediary to Cigna Hong Kong from time to time) to provide any services to the Insurance Intermediary in relation to the purposes set out under sections 3(i) and 3(ii) above;
任何由保險中介人聘用的代理，承辦商或第三者服務供應商（由保險中介人不時通知信諾香港）以提供任何有關第3(i)及(ii)條所載用途之服務；
- iv) any insurance adjusters, agents, brokers or other intermediaries; employers; medical service providers; health care professionals; hospitals; organizations that consolidate claims and underwriting information for the insurance industry; fraud prevention organizations; other insurance companies (whether directly or through fraud prevention organization or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information;
任何保險理賠員、代理、經紀或其他中介人；僱主；醫療服務提供者；專業醫護人員；醫院；為保險業整合索償及承保資料的組織；防欺詐組織；其他保險公司（無論是直接或透過防欺詐組織或本段中提及的其他人）；警方及保險業用作分析和基於現有資料核對所提供資料的數據庫或登記處（及其運營人）；
- v) any branch, subsidiary, holding company, associated company or affiliates of Cigna Hong Kong;
信諾香港的分行、附屬公司、控股公司、關聯公司或聯繫公司；
- vi) Chubb Life Insurance Hong Kong Limited, or any branch, subsidiary, holding company, associated company or affiliates of Chubb Life Insurance Hong Kong Limited, and their respective successors and assignees;
安達人壽保險香港有限公司，或其分行、附屬公司、控股公司、關聯公司或聯繫公司，以及其各別繼承人及受讓人；
- vii) any financial institution or credit / charge card issuer related to your premium payment account;
與閣下用作繳交保費戶口有關的金融機構或信用卡 / 記賬卡發卡人；
- viii) any actual or proposed re-insurer of Cigna Hong Kong;
信諾香港的確實或建議再保人；
- ix) any person or authority to whom Cigna Hong Kong is under an obligation to make disclosure under the requirement of any law, regulations, rules, codes of practice or guidelines binding on or applicable to Cigna Hong Kong or any of its group companies;
適用於及對信諾香港或任何其集團公司具法律、規則、規例、實務守則或指引約束力的規定下而信諾香港有責任對其作出披露的任何人或機構；
- x) any other person under a duty of confidentiality to Cigna Hong Kong which has undertaken to keep such information confidential;
其他對信諾香港資料有保密責任並承諾保密該等資料的人士；
- xi) any debt collection agencies; and
任何收賬代理；及
- xii) any organization or person who provides survey, research and statistics services.
任何調查、研究及統計機構/人員。

5) Transfer of Information Outside Hong Kong 轉移資料往香港以外地區

Cigna Hong Kong may from time to time transfer your personal information outside Hong Kong for different purposes set out above including but not limited to processing or storage.

信諾香港可能不時就上述不同的目的（包括但不限於處理或儲存）將閣下的資料轉移往香港以外地區。

6) Data Access 資料查閱

I. Under and in accordance with the terms of the Ordinance, you have the right to:-

根據私隱條例中的條款，閣下有權：

- i) check whether Cigna Hong Kong holds data about you and seek access to such data; and
查詢信諾香港是否持有閣下的資料及查閱有關的資料；及
 - ii) require Cigna Hong Kong to correct any data relating to you which is inaccurate.
要求信諾香港改正有關閣下不準確的資料。
- II. Cigna Hong Kong may charge a reasonable fee for the processing of any data access request.
信諾香港有權就處理任何查閱資料的要求收取合理費用。
- III. Requests under section 6(l) should be addressed to the following: Cigna Hong Kong’s Data Protection Officer
16/F, 348 Kwun Tong Road, Kwun Tong, Hong Kong
任何關於上述條款6(l)的要求，應向右列人士提出：信諾香港資料私隱主任（香港觀塘觀塘道348號16樓）。

7) Direct Marketing 直接促銷

In accordance with the requirements of the Ordinance, Cigna Hong Kong intends to use and transfer your personal information for the purposes of conducting direct marketing and may not do so unless we have received your consent or written consent (in the case of transfer).

根據私隱條例的要求，信諾香港擬使用及轉移閣下的個人資料作直接促銷之用途，但除非我們得到閣下的同意或書面同意（在轉移的情況下），否則不得使用及轉移閣下的個人資料作此用途。

With your consent or written consent (in the case of transfer) (which includes an indication of no objection), Cigna Hong Kong may:

在得到閣下的同意或書面同意（在轉移的情況下）下（包括表示不反對），信諾香港可：

- I. use personal information, including your name, contact details, products and other services portfolio information, financial background and demographic data it holds about you for direct marketing purposes;
使用閣下提供予信諾香港的個人資料，包括閣下的姓名、聯絡資料、產品及服務組合資料、財務背景及人口統計資料作直接促銷之用途；
- II. conduct direct marketing in relating to the following classes of products and services that Cigna Hong Kong, our affiliates, our co-branding partners and our business partners may offer:
就信諾香港及信諾香港的聯繫公司、聯合品牌夥伴及商業合作夥伴可能提供之下列類別的產品及服務進行直接促銷；
 - i) insurance, financial or investment related products and services;
保險、財務或投資相關產品及服務；
 - ii) reward, loyalty, co-branding or privileges programs and related services and products on health, wellness and medical, sporting activities and membership, entertainment, travel and transportation, concierge, home care (including pet care), household, food and beverages, apparel, jewelry, telecommunication, education, social networking and media; and
獎賞、年資、聯合品牌及優惠計劃及其相關產品及服務：健康、保健及醫療、體育運動及會員服務、娛樂、旅遊及交通、禮賓、家庭護理（包括寵物護理）、家居、餐飲、服裝、珠寶、電訊、教育、社交網絡及媒體；及
 - iii) donations and contributions for charitable or non-profit making purposes;
作慈善或非牟利用途的捐獻；
- III. provide the personal information described in section 7(I) to any agent or contractor for the purpose of carrying out direct marketing of the above products and/or services on behalf of Cigna Hong Kong; and
將第7(I)條所述的個人資料提供予任何代理人或承辦商以代表信諾香港進行直接促銷上述產品及/或服務之用途；及
- IV. in addition to marketing the above products and services, share the personal information described in section 7(I), for gain, with any or all of the following persons for use in direct marketing, and Cigna Hong Kong requires your written consent (which includes an indication of no objection) for the purposes and will not do so without your written consent:
除促銷上述產品及服務外，將第7(I)條所述的個人資料提供予任何或所有下列人士作直接促銷之用，並從而得益；及信諾香港就此用途必須得到閣下的書面同意(包括表示不反對)，並在沒有閣下的書面同意下不會就此用途轉移閣下的個人資料：
 - i) any Insurance Intermediary acting on your behalf for its own direct marketing purposes in relation to insurance, financial or investment related products or services, and business purposes; and
任何代表閣下的保險中介人作其直接促銷保險、財務或投資相關產品或服務之用途，及業務推廣之用途；及
 - ii) any third party provider of any of the classes of products and/or services as described in section 7(II) for direct marketing purposes in relation to such classes of products and/or services.
任何提供第7(II)條所述的產品及/或服務類別之第三者供應商作直接促銷該等類別的產品及/或服務之用途。

If you do not consent to Cigna Hong Kong using and/or sharing your personal information for any of those purposes, you may exercise your opt-out right by notifying Cigna Hong Kong's Data Protection Officer at the above address, and we will not do so. You may also subsequently withdraw your consent by writing to Cigna Hong Kong's Data Protection Officer at the above address. If you exercise your right to opt out of the use/sharing of your personal information for any of the above purposes, it will mean that Cigna Hong Kong, your Insurance Intermediary and/or third party service providers will not be able to send you any direct marketing, targeted or special offers in the future.

如閣下不同意信諾香港就任何上述使用及/或轉移閣下的個人資料之用途，閣下可根據上述地址通知信諾香港資料私隱主任行使你的權利選擇拒絕直接促銷，我們便不會使用及/或轉移閣下個人資料作以上之用途。閣下亦可隨時根據上述地址致函給我們的信諾香港資料私隱主任撤回閣下的同意意願。如閣下行使你的權利選擇拒絕閣下的個人資料被用於或轉移作以上任何用途，這代表將來閣下不能從信諾香港、閣下的保險中介人及/或第三者服務供應商收到任何針對性或特別優惠的直接促銷。

Cigna Hong Kong will not use any personal data of minors for its own direct marketing purposes and/or share the personal data of minors with any third party for its direct marketing/business purposes.

信諾香港不會使用任何未成年人的個人資料作直接促銷之用及/或轉交至任何第三者作直接促銷/業務推廣的用途。

8) Retention of personal information 個人資料的保存

We retain your personal information for as long as necessary for the purposes set out in this Personal Information Collection Statement, or otherwise agreed between you and us, unless otherwise required or permitted under applicable law. Where we no longer require your personal information for the purposes under this Personal Information Collection Statement, or otherwise required under law, we will take appropriate steps to securely delete or destroy your personal information.

除非適用法律另有要求或允許，否則，我們按本個人資料收集聲明中規定目的所需的期限或閣下與我們另行約定的期限保存閣下的個人資料。倘若我們為本個人資料收集聲明列明之目的不再需要閣下的個人資料，或者法律另有要求，我們將採取適當措施，安全地刪除或銷毀閣下的個人資料。

This Personal Information Collection Statement shall from the date hereinafter appearing be deemed an integral part of all contracts, agreements and other binding arrangements which you have entered into or intend to enter into with Cigna Hong Kong. For any enquiries regarding this Personal Information Collection Statement, please contact our Customer Services Hotline at 2560 1990.

在此個人資料收集聲明發出的日期起，它將成為閣下與信諾香港或有意與信諾香港訂定之所有合約、協議、及其他約束性安排之一部份。如有任何有關此個人資料收集聲明的查詢，請致電2560 1990與我們的客戶服務部聯絡。

Release Date: November 2022

發出日期：二零二二年十一月

In case of discrepancies between the English and Chinese version, the English version shall apply and prevail.

此聲明備有中英文版本，如內容有異，以英文版本為準。

B - Declaration and Authorization 乙部 - 聲明及授權

- (1) It is declared and agreed that the answers in this application are complete and true to the best of my (our) knowledge and belief.
謹此聲明及同意以上各欄之填報，據本人（吾等）所知，均完全屬實無訛。
- (2) I (We) agree that except as otherwise provided in the Conditional Receipt, insurance under any policy issued on this application will become effective only when the policy is delivered and the first premium is paid, such delivery and payment being made while there has, since date of this application, been no deterioration in the Insured Person's insurability under the Company's rules.
本人（吾等）同意除非「附條件臨時保障收據」內之條文另有規定，否則，按本申請而發出的任何保單所提供的保險，須於首期保費繳清及保單送達保單持有人後才開始生效；而自本申請提出之後，至繳付保費及送達保單之時，按貴公司規則評定，受保人的受保資格不得下降。
- (3) I (We) agree that acceptance of any policy issued on this application will constitute an agreement to its terms and conditions and notification of any changes specified by the Company in this policy.
本人（吾等）同意接受本申請而發出的任何保單即等於接納保單內的條款，同時追認貴公司在保單上所作的任何更改。
- (4) I (We) understand that the information requested in this application is required in order for the Company to process this application for insurance, and failure to disclose any material facts or information which may influence or which the Company would regard as likely to influence the assessment and acceptance of this application, may render voidable by the Company the insurance coverage that may be issued pursuant to this application. In the event of doubt as to whether a fact or information is material, it should be disclosed in this application.
本人（吾等）明白本人（吾等）必須就本申請內要求的資料提供予貴公司作處理本投保申請之用。如未有披露任何重要事實或資料，而該等重要事實或資料足以影響貴公司評估及接受本申請，貴公司有權將所簽發的保單宣告無效。假如未能確定事實或資料重要性，則須於本申請披露該等事實或資料。
- (5) I declare that I am responsible for the medical expenses incurred as a result of any sickness / disease / injury suffered by the Proposed Insured Person(s).
本人聲明本人須負責因準受保人蒙受任何不適/疾病/受傷而產生的醫療開支。
- (6) I (We) agree that during the Insured Person's life-time and subject to the policy's Beneficiary provision, the Policy Holder can change the Beneficiary designation without the consent of any Beneficiary.
本人（吾等）同意在保單內關於受益人之條款約束下，在受保人有生之年，保單持有人可更改受益人而毋須任何受益人同意。
- (7) I (We) declare that the above questions have been explained to me (us) and that they are fully understood and truthfully answered.
本人（吾等）聲明，以上各欄問題已向本人（吾等）清楚解釋，本人（吾等）徹底明白該等問題，並誠實作答。
- (8) I (We) understand and agree that additional information / document in relation to the identification and verification of identity of the Applicant and the Insured Person may be requested by the Company, as deemed necessary.
本人（吾等）明白及同意，貴公司有權於有必要情況下就識別和驗證申請人及受保人之身分，向本人（吾等）索取額外資料/文件。
- (9) I (We) hereby authorize, and (in case the Applicant is not the Proposed Insured Person(s)) confirm that the Proposed Insured Person(s) has authorized, any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my (our) or the Proposed Insured Person(s)'s health to give to the Company and its reinsurers any such information for the purpose of assessment of this insurance proposal or subsequent assessment of any insurance claim under the policy that may be issued pursuant to this application. A photographic copy of this authorization shall be as valid as the original.
本人（吾等）授權，而且（倘申請人並非準受保人）確認準受保人已授權，凡存有關於本人（吾等）或準受保人健康狀況任何記錄或得悉此方面資料的任何持牌醫師、醫生、醫院、診所或其他醫療或與醫療相關的設施、保險公司或其他組織、機構或個人，可向貴公司及其再保險公司提供有關資料，以評估本保險申請或日後評估根據本申請書簽發的本保單下提出任何的保險索償。此授權書的複印本與正本同樣有效。
- (10) I (We) agree that the Company may use and / or disclose my (our) personal information in accordance with the Company's Personal Information Collection Statement ("Statement") and acknowledge that I (we) have read and understood the Statement. I (We) understand that I (we) have the right to opt out of the use of my (our) personal information in accordance with the options set out below. I (We) understand that opting out will mean that the Company or insurance intermediary or third party provider of the specified classes of products and services will not be able to send me (us) any direct marketing, targeted or special offers in the future.
本人（吾等）同意貴公司可根據其個人資料收集聲明（「聲明」），使用及 / 或披露本人（吾等）之個人資料。本人（吾等）確認已閱讀及明白此聲明。本人（吾等）明白本人（吾等）有權根據以下選擇拒絕本人（吾等）個人資料被用於下列用途。然而，本人（吾等）也明白選擇拒絕本人（吾等）個人資料被用於下列用途會導致將來本人（吾等）不能從貴公司或保險中介人或指定產品及服務類別之第三者供應商處收到任何針對性或特別優惠的直接促銷。
- Applicant 申請人：
- I do not want the Company to use my personal data for the Company's direct marketing purposes. 本人不願貴公司使用本人個人資料作直接促銷之用。
- I do not want the Company to share my personal data with insurance intermediaries for their marketing purposes and / or business purposes. 本人不願貴公司將本人個人資料給予保險中介人作直接促銷及 / 或業務推廣之用。
- I do not want the Company to share my personal data with third party product/ service providers for direct marketing purposes. 本人不願貴公司將本人個人資料給予第三者產品 / 服務供應商作直銷之用。
- Parent / guardian of the Proposed Insured Person (if the Proposed Insured Person is under 18) 準受保人的家長 / 監護人（如準受保人是十八歲以下）：
I declare that I am the parent/guardian of the Proposed Insured Person and I reasonably believe that the Company's use and disclosure of the Proposed Insured Person's personal data for the purposes stated in the Statement are in the best interests of the minor.
本人謹此聲明本人是未成年準受保人的家長 / 監護人及本人合理地相信貴公司使用及 / 或披露未成年準受保人的個人資料是以未成年準受保人的最佳利益為依歸。

(11) The Applicant understands, acknowledges and agrees that, as a result of the Applicant purchasing and taking up the policy to be issued by the Company, the Company will pay the relevant insurance intermediary 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 the Company that he or she is authorised to do so. The Applicant further understands that the above agreement is necessary for the Company to proceed with the applicant.

申請人明白、確知及同意，貴公司會就申請人購買及接受保險公司簽發的保單，於保單有效期內（包括續保期），向負責安排有關保單的保險中介人支付佣金。假如申請人為法人團體，代表申請人簽署的獲授權人員須向貴公司確認他/她已獲法人團體授權簽署。申請人亦明白貴公司必須取得申請人以上的同意，才可以處理有關申請。

(12) "Cancellation Rights and Refund of Premium(s) within Cooling-off Period": I understand that I have the right to cancel the policy and obtain a refund of any premium(s) and levy paid by giving a written notice to Cigna Worldwide General Insurance Company Limited. I understand that to exercise this right, the notice of cancellation must be signed by me and received directly by Cigna Worldwide General Insurance Company Limited at 16/F, 348 Kwun Tong Road, Kwun Tong, Kowloon, Hong Kong within the Cooling-off Period. I understand that the Cooling-off Period is the period of thirty (30) calendar days immediately following either the day of delivery of the policy or the Cooling-off Notice to me or my nominated representative (whichever is the earlier). I understand that the Cooling-off Notice is a notice that will be sent to me or my nominated representative by Cigna Worldwide General Insurance Company Limited to notify me of the Cooling-off Period around the time the policy is delivered.

冷靜期內取消保單的權利及退還保費：本人明白本人有權以書面通知要求信諾環球保險有限公司取消保單並獲退還所有已繳保費及保費徵費。本人明白為行使這項權利，該取消保單的通知必須由本人簽署並由信諾環球保險有限公司在香港九龍觀塘觀塘道348號16樓於冷靜期內直接收到。本人明白冷靜期為緊接保單或冷靜期通知書交付予本人或本人的指定代表之日起計的三十(30)個曆日的期間（以較早者為準）。本人明白冷靜期通知書是由信諾環球保險有限公司在交付保單時致予本人或本人的指定代表的一份通知書，以就冷靜期一事通知本人。

Signed in Hong Kong 香港 On _____
 簽署於 Place 地方 Day 日 Month 月 Year 年 Signature of Applicant 申請人簽署

Signed in Hong Kong 香港 On _____
 簽署於 Place 地方 Day 日 Month 月 Year 年 Signature of Proposed Insured Person 2 (if Age 18 or above)
 準受保人 2 簽署 (若 18 歲或以上)

Signed in Hong Kong 香港 On _____
 簽署於 Place 地方 Day 日 Month 月 Year 年 Signature of Proposed Insured Person 3 (if Age 18 or above)
 準受保人 3 簽署 (若 18 歲或以上)

Signed in Hong Kong 香港 On _____
 簽署於 Place 地方 Day 日 Month 月 Year 年 Signature of Proposed Insured Person 4 (if Age 18 or above)
 準受保人 4 簽署 (若 18 歲或以上)

 Name of Insurance Intermediary 持牌保險中介人姓名 Code of Insurance Intermediary 持牌保險中介人編號

 Registration no. 註冊號碼 Insurance Intermediary's contact no. 持牌保險中介人聯絡電話

Signed in Hong Kong 香港 On _____
 簽署於 Place 地方 Day 日 Month 月 Year 年 Signature of Insurance Intermediary 持牌保險中介人簽署 Company Name and Company Chop 公司名稱及公司蓋章

PLEASE DO NOT SIGN ON BLANK FORM 請勿在空白表格上簽署

Cigna Medical Plan (GI - Ind/Family)(E-form version 6-202405)(B)

Special Request 特別指示 :

- Request for hard copy of medical card 要求實體醫療卡
- Date Back 提前生效 _____
(DD日/MM月/YYYY年)
 Date Back Reason 提前生效原因: _____
- Discount 折扣

	Proposed Insured Person 1 準受保人 1	Proposed Insured Person 2 準受保人 2	Proposed Insured Person 3 準受保人 3	Proposed Insured Person 4 準受保人 4
Child Discount 子女折扣	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse Discount 配偶折扣	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promotional Discount 推廣折扣	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Discount 其他折扣				
Application No. for Reference (if applicable) 相關之投保編號(如適用) <small>(If you cannot provide the application no., please provide the full name of participants. 如未能提供投保編號, 請提供參加者的全名。)</small>				

- Others 其他:

Application Checklist 申請書清單 (applicable to Insurance Intermediary 適用於保險中介人)

- 1. Initial Premium 首期保費 Payment method 繳款形式 _____
(Pay by the Applicant 由申請人支付) Credit card 信用卡 Cheque 支票 ; or 或
 Other 其他 _____
- 2. If the initial premium is paid by cheque, please make it payable to “Cigna Worldwide General Insurance Company Limited”.
 若以支票繳付首期保費, 請註明支票抬頭為「信諾環球保險有限公司」
- 3. True copies* of identification document of the Applicant and the Proposed Insured Person 申請人及準受保人的身份證明文件認證副本*
*Certified by suitable certifiers (e.g. authorized insurance brokers, appointed insurance agents or other professional third parties)
 須由適合的證明人 (例如獲授權保險經紀、獲委任保險代理人或其他專業第三者) 認證
- 4. Nationality proof for not holding HK Permanent Identity Card 若非持有香港永久性居民身份證, 請遞交國籍證明
- 5. Medical record of Proposed Insured Person past medical history (if any) 準受保人過去病歷之醫療記錄 (如有)
- 6. Policy Conversion Request Form (if applicable) 保單轉換申請書 (如適用)

Company Endorsement 公司背書 (Office use only 內部專用)

Appendix 附件 - Application Form Terminology Mapping Table 申請書用語對應表

Please refer to the table below for the summary of terminology in the application form, the terms in the same row are interchangeable.
 請參閱下表有關申請書用語的摘要, 同一行中的用語是可互換的。

Insured Person 受保人	Person Insured 受保人	Registered Medical Practitioner 醫生	Physician 醫生
Policy Holder 保單持有人	Policyholder 保單持有人	Deductible 自付費	Deductible 墊底費
Riders 附加契約	Optional Insurance Benefits 自選保障	Endorsement 背書	Endorsement 批注

Direct Debit Authorization Form 直接付款授權書

PRIVATE & CONFIDENTIAL 私人及機密

Please fill in the appropriate boxes and print in block letters. 請填寫適當方格及用正楷填寫

Direct Debit via Savings / Current Account 經儲蓄 / 來往賬戶直接付款 (Applicable to subsequent premium payment only 只適用於首期保費後之每期保費)

Name to be credited (The Beneficiary) 收款一方的名稱(受益人)

Cigna Worldwide General Insurance Company Limited 信諾環球保險有限公司

I/We hereby authorize my/our below named Bank to effect transfers from my/our account to the account of the above named beneficiary (hereinafter referred to as the "Beneficiary") in accordance with such instructions as my/our Bank may receive from the Beneficiary from time to time, including the settlement of policy premium, levy, or other relevant charges under the relevant policy(ies). This authorization shall remain valid until further notice. 本人/吾等現授權本人/吾等之下述銀行，根據上述受益人（以下簡稱“受益人”）不時給予本人/吾等銀行之指示，自本人/吾等之賬戶內轉賬予受益人之賬戶，以繳付保費、徵費或其他相關保單費用。本授權書將繼續生效直至另行通知。

I/We further agree and confirm 本人/吾等同意及確認：

- my/our Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me/us. 本人/吾等之銀行毋須證實該等轉賬通知是否已交予本人/吾等。
- my/our signature(s) on this authorization form is/are the same as that/those for the operation of my/our Savings/Current Account to be debited for the transfer. 本人/吾等證明本人/吾等在此授權書上之簽名式樣與本人/吾等之儲蓄/來往賬戶簽名式樣一致。
- to notify the Beneficiary of any change of bank account or cancellation of payment method. 如更改銀行賬戶或取消此付款方式時，將通知受益人。
- to jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our account which may arise as a result of any such transfer(s). I/We agree that should there be insufficient funds in my/our Bank account to meet any transfer hereby authorized, the Bank shall be entitled, at its discretion, not to effect such transfer in which event the Bank may make the usual service charge to be paid by me/us. 如因該等轉賬而令本人/吾等之賬戶出現透支(或令現時之透支增加)，本人/吾等願共同及個別承擔全部責任。本人/吾等並同意如本人/吾等之賬戶並無足夠款項支付該等轉賬時，本人/吾等之銀行有權不予轉賬，且銀行可收取慣常之服務費用。
- that any notice of cancellation or variation of this authorization which I/we may give to my/our Bank shall be given at least fifteen (15) working days prior to the date on which such cancellation/variation is to take effect. 本人/吾等取消或更改本授權書之任何通知，須於取消/更改生效日最少十五個工作天之前交予本人/吾等之銀行。

BANK NAME 銀行名稱： _____ BRANCH NAME 分行名稱： _____

BANK ACCOUNT 銀行賬戶： - -
Bank No. 銀行編號 Branch No. 分行編號 Account No. 賬戶編號

Please note 請注意：

- It takes 6-8 weeks to process this authorization, as such two (2) months' and all outstanding premium, levy, and other relevant charges under the relevant policy(ies) are requested to be sent along with this Authorization Form. 由於銀行處理此授權書需時約6至8個星期，故此請連同兩個月保費及所有所欠之保費、徵費及其他相關保單費用一併交回。
- At least fifteen (15) working days' written notice in advance is required for termination of this payment instruction. 如需取消此繳費指示，請於最少15個工作天前以書面提出。
- This facility is applicable to the Policyholder or Insured Person/Proposed Insured Person only. 此項目只適用於保單持有人或受保人/準受保人。

Direct Debit via Credit Card 經信用卡直接付款

- INITIAL PREMIUM PAYMENT 首期保費繳款 SUBSEQUENT PREMIUM PAYMENT 後續保費繳款 INITIAL PREMIUM PAYMENT & SUBSEQUENT PREMIUM PAYMENT 首期保費繳款及後續保費繳款

NAME OF CARD ISSUING BANK 發卡銀行名稱： _____

COUNTRY OF CARD ISSUING BANK 發卡銀行國家： _____

VISA / MASTERCARD CREDIT CARD ACCOUNT VISA / 萬事達信用卡賬戶號碼： - - -

CARD EXPIRY DATE (MONTH - YEAR) 信用卡有效日期(月 - 年)： -

Please note 請注意：

- The Issuer of the credit card identified above is authorized to pay the amount as requested by the Beneficiary upon proper presentation. The Cardholder promises to pay such total (including policy premium and levy under the relevant policy(ies), together with any other charges due thereon) subject to and in accordance with the agreement governing the use of such credit card. 本人授權發出上述信用卡之機構，在收到有關指示時，即支付受益人所要求之金額。本人承諾根據所持信用卡之合約繳付全部款項（包括相關保險的保費、徵費，及其他相關保單有關費用）。
- All outstanding premium, levy, and other relevant charges under the relevant policy(ies) are requested to be sent along with this Authorization Form. 請將此授權書連同所欠之保費、徵費及其他相關保單費用一併交回。
- This facility is applicable to the Policyholder or Insured Person/Proposed Insured Person only. 此申請只適用於保單持有人或受保人/準受保人。
- This payment method is for regular premium and selected products only. 此付款方法只適用於定期繳付之保費及指定之保險計劃。
- Non-monthly premium will be debited on the same month of the premium due date. In case of unsuccessful transaction, premium will be debited again (if applicable). 非每月供款之保費將於保費到期日之一月份過數。如未能成功過數，保費將會再扣除（如適用）。
- At least fifteen (15) working days' written notice in advance is required for termination of this payment instruction. 如需取消此付款指示，請於最少15個工作天前以書面提出。
- Prior approval is required for non-Hong Kong issued credit card. 如信用卡非由香港銀行發行，必須預先獲本公司審批。

General Information 一般資料

I.D NUMBER OF ACCOUNT HOLDER(S) 賬戶持有人身份證明文件號碼：	I.D TYPE 身份證明文件類別： <input type="checkbox"/> HKID 香港居民身份證 <input type="checkbox"/> PASSPORT 護照 <input type="checkbox"/> BUSINESS REGISTRATION 商業登記證 <input type="checkbox"/> CERTIFICATE OF INCORPORATION 公司註冊證明書 <input type="checkbox"/> Others 其他： _____
NAME OF ACCOUNT HOLDER(S) IN ENGLISH 賬戶持有人英文姓名： (AS RECORDED IN STATEMENT / PASSBOOK / CREDIT CARD) (在月結單 / 存摺 / 信用卡所記錄之名稱)	SIGNATURE OF ACCOUNT HOLDER(S) 賬戶持有人簽名： DATE 日期： SIGNATURE MUST BE CONSISTENT WITH YOUR BANK'S RECORD 簽名式樣必須與銀行檔案相同 (DD日/MM月/YYYY年)

Payment submitted: HKD 已付款銀碼：港元 _____ (By Cash/Cheque* 以現金/支票付款*)