



Policy Number 保單編號：

Policy Service Application Form II

保單服務申請書 II

Important note:

- This form is to be completed by the Owner/Trustee/Collateral Assignee in BLOCK LETTERS and signed with the signature same as recorded in the policy file.
- If your application is submitted through your Financial Consultant, please state his/her consultant code, name and contact number.
- Please submit a copy of the identification document of the Owner, unless submitted before, together with this form.**
- For any changes on your identification information, please complete and submit the "Policy Service Application Form I" or "Supplement to Application - For Corporate Owner" to apply for the information change. We shall treat the relevant customer information unchanged from our latest record unless we receive your notice on the change of the information.
- We reserve the right to ask for additional identification documents where necessary.
- Please tick in the box to indicate the change(s) you want to apply.
- Please do not sign on blank form.
- The original of this form and supporting documents submitted will not be returned.

重要事項：

- 此申請書應由持有人/信託人/抵押轉讓受讓人以正楷填寫及簽名，簽名式樣須與保單上的記錄相符。
- 如此申請書經理財顧問遞交，請註明理財顧問編號、姓名及聯絡號碼。
- 如在此之前未有遞交身份證明文件，請隨此申請書一併遞交持有人的身份證明文件副本。**
- 如閣下的身分識別資料有所更改，請填寫並提交「保單服務申請書 I」或「投保/保單服務申請資料補充 – 持有人為公司團體專用」以辦理有關資料更改手續。倘若本公司未有收到閣下之申請，有關的資料將視作與本公司最近之記錄維持不變。
- 本公司有權因應需要要求持有人遞交其他文件。
- 請於方格內以「✓」來表示所申請的更改項目。
- 請勿在空白申請書上簽署。
- 所遞交之正本申請書及所需文件將不獲退還。

“The Company”
“本公司”或“貴公司”：

AXA China Region Insurance
Company (Bermuda) Limited
(Incorporated in Bermuda with
limited liability)
安盛保險(百慕達)有限公司
(於百慕達註冊成立的有限公司) /
AXA China Region Insurance
Company Limited
安盛金融有限公司 /
AXA Wealth Management (HK)
Limited
安盛財富管理(香港)有限公司

Personal Details of Insured/Owner/Trustee/Collateral Assignee

被保人/持有人/信託人/抵押轉讓受讓人個人資料

	Insured 被保人	Owner (Leave blank if Owner is the Insured) 持有人 (如持有人為被保人則無須填寫)
Name 姓名		
Name of Trustee/Collateral Assignee (if any) 信託人/抵押轉讓受讓人姓名 (如有)	Not Applicable 不適用	
Name of Employer 僱主名稱		
Office Address 辦事處地址	<div>Room/Flat 室/單位 Floor 層數 Block 座</div> <div>Name of Building/Estate 大廈或屋邨名稱</div> <div>Street No. & Name 街道名稱及號碼</div> <div>City/District 城市/地區</div> <div>Postal Code 郵寄代號 Country 國家</div>	<div>Room/Flat 室/單位 Floor 層數 Block 座</div> <div>Name of Building/Estate 大廈或屋邨名稱</div> <div>Street No. & Name 街道名稱及號碼</div> <div>City/District 城市/地區</div> <div>Postal Code 郵寄代號 Country 國家</div>
Office Contact Number 辦公室聯絡號碼		
Employer's Business Nature 僱主業務性質		
Occupation 職業	<div>Title 職位 Main Duties 主要職務</div>	<div>Title 職位 Main Duties 主要職務</div>
Current Monthly Income (HK\$) 現時每月收入 (港幣)		
Education 教育程度	<input type="checkbox"/> Primary or below 小學或以下 <input type="checkbox"/> Secondary/Advanced Level 中學/預科 <input type="checkbox"/> Tertiary or above 大專或以上	<input type="checkbox"/> Primary or below 小學或以下 <input type="checkbox"/> Secondary/Advanced Level 中學/預科 <input type="checkbox"/> Tertiary or above 大專或以上
Have you resided outside the country/city of the provided Residential Address for more than 6 months during the last 12 months? 您曾否於過去十二個月內在所提供之住宅地址的國家/城市以外居留超過六個月？	<input type="checkbox"/> Yes (Please provide the country and city): 有 (請註明國家及城市): <input type="checkbox"/> No 否	<input type="checkbox"/> Yes (Please provide the country and city): 有 (請註明國家及城市): <input type="checkbox"/> No 否

1. Coverage Changes 保障更改

Note 注意：

- Please complete Sections 7a - 7c. For Pink Medical Insurance Plan, please complete and submit "Health Declarations Form (Applicable to Designated Plan/ Campaign)" instead.
請填寫第 7a 至 7c 部份。如申請紅粉醫療保障，請填寫及遞交「健康聲明表格（適用於指定產品/推廣計劃）」。
- To comply with the requirements set out by the Insurance Authority, please complete and submit a "Client Needs Analysis" (if applicable) together with this form to apply for coverage changes.
為符合保險業監管局訂明之要求，請隨此申請書一併填妥及遞交「客戶需求分析」（如適用），以申請更改保障。
- Please contact your Financial Consultant or call our Customer Service Hotline at (852) 2802 2812 to enquire if a "Client Needs Analysis" is required for your application and obtain the form.
請聯絡您的理財顧問或致電本公司的客戶服務熱線 (852) 2802 2812，查詢您的申請是否需要遞交「客戶需求分析」並索取該表格。
- If the "Client Needs Analysis" is required but not duly completed, it will be resulted in the Company's inability to accept or process your application.
如您的申請需要遞交「客戶需求分析」，但該表格未有恰當地填妥，本公司將不能接受或處理您的申請。

☐ Change of plan 更改計劃

Change from 由 _____ to 改為 _____

☐ Increase Sum Insured/Protection Amount/Notional Amount of Basic Plan (in policy currency) 提高基本計劃保額/保障金額/名義金額（保單貨幣）

Increase to 提高為 \$ _____

☐ Change of Supplementary Benefit (Please state the details below) 更改附加契約（請於下列填寫有關的更改）

Supplement Name 附加契約名稱	Addition 新增	Increase/Upgrade 加大/提高	Sum Insured/Protection Amount after addition/increase (in policy currency) 新增/提高後之保額/保障金額（保單貨幣）
_____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
_____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
_____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____

2. Policy Reinstatement 保單復效

Note 注意：

Please complete Sections 7a-7c. For Investment-Linked Assurance Scheme (ILAS) products without sum insured, please complete Section 8 only.
請填寫第 7a 至 7c 部份。如復效不設投保額之投資連繫式壽險產品，只須完成第 8 部份。

☐ In accordance with policy provision 根據保單條款

☐ By forwarding (Redating) the Policy Date (Applicable to designated product only) 移前（更改）保單生效日期（僅適用於指定產品）

3. Removal/Reduction of Occupational Rating 剔除/減低職業額外風險

Note 注意：

Current occupation details must be provided on "Personal Details of Insured/Owner/Trustee/Collateral Assignee".
必須於「被保人/持有人/信託人/抵押轉讓受讓人個人資料」提供新工作資料。

☐ New Job started on 轉職/就職開始於 _____ (YYYY年/MM月/DD日)

4. Term Policy Conversion 定期保險轉換

Note 注意：

- Please also complete "Insurance Application Form".
請同時填寫「保險投保書」。
- Please note that any cancellation right in respect of a policy and right to refund of premium as a result of such cancellation is not applicable to any non-investment-linked policy issued from term conversion. When a new policy is issued, the sum insured converted will be reduced from the sum insured of the relevant term basic policy/term supplement accordingly. If the remaining sum insured of the term basic policy/term supplement is below the prevailing minimum issue limit of the basic plan/supplement as may be determined by the Company from time to time or if the whole amount of the sum insured of the term basic policy/term supplement is converted, the relevant term basic policy/term supplement shall be terminated and cease to be in effect upon the issue of the new policy and any premium paid in respect of the term basic policy/term supplement shall not be refunded.
請注意有關保單上的任何取消投保權益及因該取消投保而可獲發還保費的權益不適用於任何由定期保險轉換所續發的非投資連繫式保單。當新保單續發後，已轉換的保額將從有關的定期保險/定期附加保險的保額中減除。如剩餘的定期保險/定期附加保險保額低於當時有關基本計劃/附加契約按本公司可能不時釐定的保額下限，或如定期保險/定期附加保險的保額已經全數轉換，則有關的定期保險保單/定期附加保險契約將於新保單續發時終止及不再有效，而任何有關的定期保險保單/定期附加保險已繳之保費亦將不獲發還。

☐ Term Basic Conversion 定期保險轉換

☐ Term Supplement Conversion 定期附加保險轉換

Sum Insured to be converted (In policy currency) 轉換的保額（保單貨幣）：_____

Handling of remaining balance of Sum Insured after Conversion (If applicable) 轉換後剩餘保額處理方法（如適用）

☐ Cancel 取消

☐ Keep in Policy 保留於保單

☐ Other Requests 其他要求 _____

New Policy No. (to be completed by Company) 新保單編號（由公司填寫）：_____

5. Increase of Regular Investment Amount (Applicable to “AXA Wealth Management (HK) Limited” Only)
增加定期投資金額 (只適用於安盛財富管理 (香港) 有限公司)

- Note 注意：**
- 1. To comply with the requirements set out by the Insurance Authority, please complete and submit a “Client Needs Analysis” together with this form to apply for increase of Regular Investment Amount.
為符合保險業監管局訂明之要求，請隨此申請書一併填妥及遞交「客戶需求分析」，以申請增加定期投資金額。
 - 2. Please contact your Financial Consultant or call our Customer Service Hotline at (852) 2802 2812 to enquire if a “Client Needs Analysis” is required for your application and obtain the form.
請聯絡您的理財顧問或致電本公司的客戶服務熱線 (852) 2802 2812，查詢您的申請是否需要遞交「客戶需求分析」並索取該表格。
 - 3. If the “Client Needs Analysis” is required but not duly completed, it will be resulted in the Compañ’s inability to accept or process your application.
如您的申請需要遞交「客戶需求分析」，但該表格未有恰當地填妥，本公司將不能接受或處理您的申請。
 - 4. Please complete and submit “Important Facts Statement and Applicañ’s Declaration” together with this form.
請隨此申請書一併填妥及遞交「重要資料聲明及申請人聲明書」。
 - 5. If the Total Regular Annualized Premium is in excess of the Medical Requirements, please complete the Health Declaration in this section.
若每年定期總供款金額高於驗身要求，請填寫本部份的健康聲明。
 - 6. If “Waiver of Premium Benefit” / “Premium Protector Benefit” was attached, please complete Sections 7a-7c.
若「豁免保費保障」/「保費保障計劃」已附加於保單上，請填寫第 7a 至 7c 部份。

Plan Name 計劃名稱	Premium Term (Years) 供款年期 (年)	First Premium Due Date 首次供款日期	Existing Periodic Premium (US\$) 現有之每期供款金額 (美元)	Revised Periodic Premium (US\$) 修訂後之每期供款金額 (美元)

Health Declaration 健康聲明	Insured 被保人	
	Yes 是	No 否
Had the insured ever been hospitalized for observation, operation or medical treatment, or been advised to undergo treatment or investigation for cardiovascular or circulatory disease, stroke, any kind of tumour or cancer, disorder of the liver, kidneys or nervous system in the past 5 years? If yes, please provide details including dates, diagnosis, duration, treatment, result, names and addresses of all attending physicians. 在過去五年內，被保人曾否因任何腫瘤或癌症、心臟血管及循環系統、中風、肝、腎或神經系統的疾病而接受或被建議接受住院觀察、外科手術或治療？若有，請提供詳情，包括日期、診斷結果、持續時間、治療方法、治療結果、主診醫生姓名及地址。	<input type="checkbox"/>	<input type="checkbox"/>

6. Other Service Request
其他更改

7a. Personal Statement: Other Insurance Information
個人聲明：其他保險資料

Insurance in force and amount (including currently applied for) on Insured. Please complete the table below if applicable.
被保人所有現行生效 (包括在申請中) 之保險保障。如適用，請於下列表格內註明。

Insurance Company Name 承保公司名稱	Sum Insured/Protection Amount/Notional Amount/Benefit (HK\$) 保額 / 保障金額 / 名義金額 / 保障 (港幣)					Date of Issuance (YYYY/MM) 簽發日期 (年/月)
	Life Insurance 人壽保險	Disability Income 傷病入息保障	Critical Illness Insurance 嚴重疾病保險	Personal Accident 個人意外	Hospital Cash/Income 住院現金 / 入息	

Attention: Please read the below statement carefully before completing the sections 7b and 7c.
注意：在完成第 7b 及第 7c 部份前，請細閱以下聲明。

Statement for Collection of Information
資料收集聲明

(i). This questionnaire collects health-related information solely for the purpose of underwriting which is a process for 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。

7b. Personal Statement: Health-Related Information (Part I)
(For Individual Indemnity Hospital Insurance Plans (either Voluntary Health Insurance Scheme (VHIS) or non-VHIS compliant plans), please complete the Information in 7c - Personal Statement: Health-Related Information (Part II). For all other products including Cancer Therapy series and Cancer And Stroke Therapy series please complete)
個人聲明：健康相關資料 (第一部份)
(個人償款住院保險產品 (包括自願醫保計劃 (VHIS) 及非自願醫保計劃之相關產品) 請完成 7c - 個人聲明：健康相關資料 (第二部份)。其他產品包括癌症治療系列、癌症及中風治療系列請完成此部份)

The “you” and “your” under this section shall refer to Insured in this application. If Applicant’s Waiver of Premium is applied, Owner is also required to complete this section.
此部份所提及的「您」及「您的」，乃指有關此投保申請的被保人。如同時申請申請人之豁免保費，持有人亦必須完成此部份。
If your answer to any of the questions 1, 2, or 4, 5 below is “Yes”, please complete the Supplementary Health Information form.
若 1、2 或 4、5 題中任何一題之答案為「是」，請於「健康資料補充」表格中註明詳情。

	Insured 被保人		Owner 持有人	
	Yes 是	No 否	Yes 是	No 否
1. Have you ever been declined, postponed, or accepted with an increased premium or an exclusion applied in any Life, Critical Illness, Medical or Disability insurance application, reinstatement or renewal due to health/medical reasons? 您是否曾因健康 / 醫療理由於投保或要求復效或續保人壽、嚴重疾病、醫療或傷病保險時被拒絕、延期、增加保費或附加不保事項？	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever taken habit forming drugs or narcotics, or been treated or counselled for a drug or alcohol problem? 您是否曾服用成癮性藥物或麻醉劑，或因藥物或飲酒問題而接受治療或輔導？	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you participate or intend to participate in any hazardous activities such as diving, mountaineering, skydiving, parachuting, hang gliding, motor sports or aviation (excluding flying as a passenger on a regular scheduled airline)? If Yes, please complete the appropriate questionnaire/Personal Statement. 您是否有參與或打算參與任何危險性活動？例如：潛水、爬山、花式跳傘、跳傘、懸掛滑翔飛行、賽車或飛行 (以乘客身份乘搭商業性之民航客機除外)。如有，請填妥有關問卷 / 個人聲明。	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Information 健康資料

Applicant(s) are not required to disclose information regarding the medical conditions or treatments below – 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.

申請人無需披露以下健康狀況或治療 – 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。

Insured 被保人			Owner 持有人																																	
Yes 是	No 否		Yes 是	No 否																																
<div>4. Do you currently have or have you ever been diagnosed with any of the following diseases or medical conditions? 您目前是否有或曾被確診患有下列疾病或健康狀況？</div> <div><div>a. Cancer or carcinoma in situ (CIS), tumour, melanoma, cyst, nodule, polyp, lump or growth of any kind 癌症或原位癌、腫瘤、黑色素瘤、囊腫、結節、瘰癧或任何其他贅生物</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>b. Heart disease including chest pain, angina, heart rhythm disorder or structural heart abnormalities 心臟疾病包括胸痛、心絞痛、心律失常或心臟結構異常</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>c. Stroke including transient ischemic attack (TIA) or cerebral aneurysm/subarachnoid haemorrhage 中風包括短暫性腦缺血(俗稱「小中風」)或腦動脈瘤/蜘蛛網膜下腔出血</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>d. Hypertension/high blood pressure 高血壓</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>e. Thyroid disorders including hypothyroidism or hyperthyroidism 甲狀腺疾病，包括甲狀腺功能減退或甲狀腺功能亢進(甲亢)</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>f. Diabetes mellitus, impaired glucose tolerance or diseases of the kidney, genitourinary system (including bladder or prostate) or the reproductive organs 糖尿病、葡萄糖耐量異常、腎病、泌尿生殖系統(包括膀胱或前列腺)或生殖器官之疾病</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>g. Prolapsed intervertebral disc, degenerative spine conditions, arthritis or other joint disorders 椎間盤突出、脊椎退化性疾病、關節炎或其他關節疾病</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>h. 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</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>i. 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)</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>j. Physical defects, impairments, deformities, and/or conditions affecting mobility, sight, speech and/or hearing 身體缺陷、不健全、畸形，及/或影響活動能力、視力、說話能力及/或聽力的狀況</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>k. Mental health conditions (such as depression, anxiety disorders, 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)</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>l. Hypercholesterolemia or hyperlipidaemia (elevated cholesterol) 高膽固醇症或高血脂症</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>m. Human immunodeficiency virus (“HIV”) infection, liver disorders (example Hepatitis B or Hepatitis C (including tested positive), fatty liver or cirrhosis of liver) 人體免疫力缺乏病毒(愛滋病毒)感染、肝臟疾病(例如乙型肝炎或丙型肝炎(包括測試呈陽性反應)、脂肪肝或肝硬化)</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>n. Multiple sclerosis or neurological disorders (example Alzheimer’s disease, Epilepsy) 多發性硬化症或神經系統疾病(例如亞茲海默氏症、腦癇症)</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>o. Respiratory diseases, blood or vascular disorders, auto-immune diseases (example Myasthenia gravis), sleep disorders (example Obstructive sleep apnoea) 呼吸系統疾病、血液或血管之疾病、自身免疫性疾病(例如重症肌無力症)、睡眠障礙(例如阻塞性睡眠窒息症)</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div><div>p. Gallbladder or any gastrointestinal diseases (including gastric/duodenal ulcer, ulcerative colitis) 膽囊疾病、或任何腸胃疾病(包括胃/十二指腸潰瘍、潰瘍性結腸炎)</div><div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div></div>																																				
<div>5. Only for juvenile applicant (under age 18): Have you ever been diagnosed with or had signs or symptoms of physical or mental development problems? 只適用於少年申請人(18歲以下人士)：您是否曾被確診身體或精神發展問題，或有病徵或症狀出現？</div>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																														
<div>6. Has your biological mother, father, or any sister or brother been diagnosed prior to age 60 with any of the following? 您的親生父母、兄弟姊妹是否於六十歲前被診斷患有以下疾病？</div> <div><div><div><div>Cancer, heart disease, stroke, diabetes, Huntington’s disease, polycystic kidney disease, multiple sclerosis, Alzheimer’s disease or any other inherited conditions. If Yes, please complete the table below with exact nature of the illness e.g. breast cancer, colon cancer or heart attack etc. 癌症、心臟疾病、中風、糖尿病、亨丁頓舞蹈症、多囊性腎病、多發性硬化症、亞茲海默氏症或其他任何遺傳疾病。如有，請於下列表格內說明疾病性質，例如乳癌、大腸癌或心臟病發作等。</div><table><thead><tr><th colspan="3">Insured 被保人</th><th colspan="3">Owner 持有人</th></tr><tr><th>Relative 親屬</th><th>Diagnosis/Condition 診斷/狀況</th><th>Onset Age 病發年齡</th><th>Relative 親屬</th><th>Diagnosis/Condition 診斷/狀況</th><th>Onset Age 病發年齡</th></tr></thead><tbody><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></tbody></table></div><div><input type="checkbox"/> I am adopted 本人為領養的</div><div><input type="checkbox"/> I am adopted 本人為領養的</div></div></div>			Insured 被保人			Owner 持有人			Relative 親屬	Diagnosis/Condition 診斷/狀況	Onset Age 病發年齡	Relative 親屬	Diagnosis/Condition 診斷/狀況	Onset Age 病發年齡																			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insured 被保人			Owner 持有人																																	
Relative 親屬	Diagnosis/Condition 診斷/狀況	Onset Age 病發年齡	Relative 親屬	Diagnosis/Condition 診斷/狀況	Onset Age 病發年齡																															

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7c. Personal Statement: Health-Related Information (Part II)
(Please complete for ALL Individual Indemnity Hospital Insurance Plans (either Voluntary Health Insurance Scheme (VHIS) or non-VHIS compliant plans) PLUS all other insurance products where applicable)
個人聲明：健康相關資料 (第二部份)
(所有個人償款住院保險產品 (包括自願醫保計劃 (VHIS) 及非自願醫保計劃之相關產品) 及其他適用之保險產品請完成此部份)

The “you” and “your” under this section shall refer to Insured in this application. If Applicant’s Waiver of Premium is applied, Owner is also required to complete this section.
此部份所提及的「您」及「您的」，乃指有關此投保申請的被保人。如同時申請申請人之豁免保費，持有人亦必須完成此部份。
If your answer to any of the questions 3-8 below is “Yes”, please complete the Supplementary Health Information form.
若3至8題中任何一題之答案為「是」，請於「健康資料補充」表格中註明詳情。

General Information 基本資料

1.	Insured 被保人	Owner 持有人
a. Height 身高	_____ cm 厘米 Or 或 _____ ft 呎 _____ in 吋	_____ cm 厘米 Or 或 _____ ft 呎 _____ in 吋
b. Weight 體重	_____ kg 公斤 Or 或 _____ lbs 磅	_____ kg 公斤 Or 或 _____ lbs 磅

	Insured 被保人	Owner 持有人
	Yes 是	No 否
2. 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)。 If “Yes”, please provide types of tobacco product, frequency and quantity of consumption. 如有，請註明煙草產品種類、頻密度及吸食份量。	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
a. Cigarettes 香煙	<input type="checkbox"/> _____ pcs/day 支/每天	<input type="checkbox"/> _____ pcs/day 支/每天
b. Others (Please specify) 其他 (請註明)：	<input type="checkbox"/> _____ pcs/day 支/每天	<input type="checkbox"/> _____ pcs/day 支/每天

Health Information 健康資料

Applicant(s) are not required to disclose information regarding the medical conditions or treatments below – 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.
申請人無需披露以下健康狀況或治療 – 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。

	Insured 被保人	Owner 持有人
	Yes 是	No 否
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"/>
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 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"/>
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"/>
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"/>
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？	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
a. Normal test result is advised 檢驗結果正常	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
b. Abnormal test result is advised 檢驗結果異常	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
c. 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"/>
d. 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"/>
e. 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"/>

	Insured 被保人		Owner 持有人	
	Yes 是	No 否	Yes 是	No 否
8. Do you have any 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? 您是否有任何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"/>
9. [For children aged 2 or below only] Was the insured child born before 37th week of pregnancy and/or born with body weight less than 2.5 kg (5.51 lbs)? [只適用於兩歲或以下之受保兒童] 受保兒童是否於懷孕第 37 週前出生，及/或出生時體重少於 2.5 公斤 (5.51 磅)？ If the answer is “Yes”, please provide body weight at birth: 如答案屬「是」，請提供出生時之體重：	<input type="checkbox"/>	<input type="checkbox"/>		
a. more than 2.50 kg/5.51 lbs 多於 2.50 公斤/5.51 磅	<input type="checkbox"/>			
b. 1.51 - 2.50 kg/3.32 - 5.51 lbs 1.51 - 2.50 公斤/3.32 - 5.51 磅	<input type="checkbox"/>			
c. 1.00 - 1.50 kg/2.20 - 3.31 lbs 1.00 - 1.50 公斤/2.20 - 3.31 磅	<input type="checkbox"/>			
d. less than 1.00 kg/2.20 lbs 少於 1.00 公斤/2.20 磅	<input type="checkbox"/>			

8. Simplified Health Declaration (Applicable to ILAS Products without Sum Insured)
簡易健康聲明 (適用於不設投保額之投資連繫式壽險產品)

						Insured 被保人	
						Yes 是	No 否
Since the date of policy lapse, have you been hospitalised for observation, operation or medical treatment for more than 7 consecutive days, or been advised to undergo treatment or investigation for cardiovascular or circulatory disease, stroke, any kind of growth, lump, tumour or cancer, disorder of the liver, kidneys or nervous system OR are you awaiting the results of any investigations/tests or considering treatment, investigation or consultation for symptoms that you are currently experiencing? 自保單失效日起，您是否曾因心臟血管及循環系統疾病、中風、任何其他贅生物、腫塊、腫瘤或癌症、肝、腎或神經系統的疾病而住院超過連續七日而進行住院觀察、手術或醫療治療，或是否曾因上述情況被建議接受醫療治療或檢查；或是否就現有症狀正等候醫療檢查/測試結果，或正考慮接受治療、檢查或諮詢？						<input type="checkbox"/>	<input type="checkbox"/>
If the answer is “Yes”, please provide the below details. 若答案為「是」，請註明以下之詳情。							
Diagnosis/Condition Details 診斷 / 狀況詳情	Onset Date 病發日期	Last Symptom Date 最後病徵日期	Degree of Recovery 痊癒程度	Investigation/Treatment 檢驗 / 治療		Doctor/Clinic/Hospital Name 醫生 / 診所 / 醫院名稱	
				Date 日期	Details 詳情		

9. Change of Personal Information
更新個人資料

If the identity document and/or address of Owner has/have been changed since last submission, please put a 「✓」 to the related box(es) below.
若持有人的身份證件和 / 或地址自上次提交後有所更改，請在下列相關的空格內加上「✓」號。

☐ Change of Identity Document (Please also submit copy of the latest identification proof)
更改身份證件 (請同時提交最新身份證明文件副本)

☐ Change of Residential Address/Business Address/Registered Office Address in Place of Incorporation (Please also submit copy of address proof issued within 3 months from the date of submission and “Policy Service Application Form I”)
更改住宅地址 / 公司業務地址 / 於成立註冊地點之公司註冊辦事處地址 (請同時提交於申請遞交日期 3 個月內發出之地址證明副本及「保單服務申請書 I」)

10. Declarations and Agreement
聲明及協議

I HEREBY CONFIRM that I am not acting on behalf of any other person for this policy change/service application unless otherwise expressly indicated in this application form or any other documents provided to the Company for this application.

I HEREBY DECLARE that I understand that the Company may deduct any outstanding amount applicable from the payout and/or sum received by the Company under the Policy according to the applicable statutory and/or regulatory requirement(s), including levy collected by the Insurance Authority.

I ACKNOWLEDGE that the terms, “Insured”, “Owner”, “Policy Anniversary”, “Policy Date” and “Issue Date” mentioned in the forms, letters and any communication means shall bear the same meaning as “Insured Person”, “Policy Holder”, “Renewal Date”, “Policy Effective Date” and “Policy Issuance Date” stated in the terms and benefits of the relevant certified plan under the Voluntary Health Insurance Scheme (“VHIS”) respectively.

Policy Service Application Form II 保單服務申請書 II

I HEREBY DECLARE AND AGREE on behalf of myself and other persons referred to in this application and in the relevant policy contract(s) (hereinafter referred to as “Relevant Persons”, “We”, “Our” or “Us”) (for the avoidance of doubt, the expressions “Relevant Persons”, “We”, “Our” or “Us” include myself and such other persons) that

- (1) my policy shall be changed in accordance with the particulars set in this application;
- (2) the application(s) shall only take effect provided all of the following conditions are met: (i) any required payment for the application(s) is paid in full; (ii) the application(s) is/are approved by the Company at the Company's office (as defined in the policy contract of the above policy) during the lifetime of the person(s) insured by the above policy;
- (3) the application(s) shall be effective from the date of this request unless a later date is specifically indicated, but only if the change is provided by the policy or is allowed by the Company under the policy;
- (4) the Incontestability Provision and Suicide Exclusion Provision in the policy shall apply upon reinstatement, changes or addition of sum insured/protection amount/notional amount or supplements and the period of time specified in the said provisions shall run from the date of approval of this application by the Company;
- (5) the application(s) as indicated above is/are based on my own judgement and I have not relied on any advice provided by Financial Consultant;
- (6) in the case of an investment-linked plan, I fully understand that investment in investment-linked plan involves risks. Value of units in investment options may rise or fall. The benefits payable under such plan are, depending on the policy features, in whole or in part, linked to the performance of the investment options in my investment option allocation instruction;
- (7) all information, statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true;
- (8) all statements and answers to such questions, together with this application, shall form the basis for policy change/service and become a part of the policy;
- (9) the Company is not bound by any statement which I may have made to any person if not written or printed here;
- (10) I have to reimburse the fees as charged by medical service providers if I apply to obtain the results of any Medical Examination Report/Laboratory Tests.

I HEREBY AUTHORISE on behalf of the Relevant Persons

- (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of me/the Relevant Persons and/or who has attended or may hereafter attend to me/the Relevant Persons to disclose such information to the Company as the Company may request;
- (2) the Company or any of its appointed medical examiners, paramedical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/the Relevant Persons in relation to this application and any claim arising therefrom.
- (3) the Company to give either the Insurance Authority or other parties, as required for relevant records or information.

This authorisation shall bind the successors and assignees of the Relevant Persons and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.

If We fail to provide any information requested in this application, it may result in the Company's inability to accept or process this application.

I HEREBY DECLARE AND AGREE that I have the full authority from and consent of the Relevant Persons to make the above declarations, agreements and authorisations.

本人謹此確認本人並沒有代表任何其他人士提出此保單更改/服務申請；如在此申請書或就此申請提交的任何其他文件上另有註明則除外。

本人謹此聲明本人明白貴公司或會從保單的給付金額及/或貴公司為保單所收金額中，根據適用法定及/或規管要求扣除任何逾期金額，包括保險業監管局收取的徵費。

本人確認於表格、信件及任何通訊方式上所述的「被保人」、「持有人」、「保單週年日」、「保單日期」和「發出日期」一詞與自願醫保計劃（“VHIS”）下相關認可產品的條款及保障內所列的「被保人」、「保單持有人」、「續保日」、「保單生效日」和「保單簽發日」各自具有其相同意義。

本人謹此代表本人及其他在此申請書上及有關的保單合約內提及之人士（下稱「相關人士」或「我們」）（為免存疑，「相關人士」或「我們」指包括本人及此申請書提及之其他人士）聲明及同意

- (1) 本人之保單依照本申請書之選擇作出更改；
- (2) 申請需符合下列條件後方可生效：(i) 繳清所有申請所需之款項；(ii) 申請是於上述保單被保人在生之情況下經貴公司在公司辦事處（根據上述保單合約內之定義）批核；
- (3) 更改之要求由申請日期生效，除非特別指定一較遲日期，但該更改必須是保單內列為可更改事項或經貴公司許可；
- (4) 保單內之不得異議條款及自殺豁免條款將應用於所有復效、更改或增加保額/保障金額/名義金額或附加保險之申請，但條款內指定之時限將由公司批核日期起計；
- (5) 上述之申請是基於本人之個人判斷，並沒有依賴任何理財顧問所提供的意見；
- (6) 如投資連繫式壽險計劃，本人完全明白投資在投資連繫式壽險計劃涉及風險，投資選擇單位價值可升亦可跌，投資連繫式壽險計劃的全部或部分可支付利益將視乎保單的特點與本人之投資選擇分配指示中所揀選之投資選擇的表現連繫；
- (7) 上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所言，均為事實之全部並確實無訛；
- (8) 上述問題的所有答案（如適用）及此申請書，將成為更改保單的根據，並作為保單一部份；
- (9) 本人對任何人所作出的任何聲明，如沒有在此申請書上填寫或印出，貴公司不須受其約束；
- (10) 如本人申請獲取有關體格檢驗/化驗所測試報告的結論，本人必須向本公司補償由醫生/化驗所收取的費用。

本人謹此代表相關人士授權

- (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、或其他組織、機構或人士，凡知道或持有任何有關本人/相關人士之記錄，及/或曾診驗或可能將會診驗本人/相關人士者，均可應貴公司要求將該等資料提供給貴公司；
- (2) 貴公司或任何其指定之驗身醫生、醫療人員或化驗所，可就此申請或任何與此有關之賠償申請替本人/相關人士進行所需之醫療評估及測試，作為審核本人/相關人士之健康狀況；
- (3) 貴公司於有需要時，向保險業監管局或其他機構提供相關紀錄或資料。

此授權對相關人士之繼承人及受讓人具有約束力；即使相關人士死亡或無行為能力時，此授權仍具效力。此授權書的影印本與正本均有同等效力。

如我們不能提供任何此申請所需的資料，貴公司或不能接受或處理此申請。

本人謹此聲明及同意已獲相關人士授權及同意本人作出以上聲明、協議及授權。

11. Personal Information Collection Statement 收集個人資料的聲明

Please visit our website (www.axa.com.hk > Customer Service > Downloads > Life Insurance > Personal Information Collection Statement) and read carefully the details of the Personal Information Collection Statement (“PICS”) which can also be made available upon request.

For our policy on using your personal data for marketing purposes, please see the section below “**Use and provision of personal data in direct marketing**”.

Use and provision of personal data in direct marketing: The Company intends to:

- (1) use your name, contact details, products and services portfolio information, transaction pattern and behaviour, financial background and demographic data held by the Company from time to time for direct marketing;
- (2) conduct direct marketing (including but not limited to providing reward, loyalty or privileges programmes) in relation to the following classes of products and services that the Company, our affiliates, our co-branding partners and our business partners may offer: (a) insurance, banking, provident fund or scheme, financial services, securities and related products and services; (b) products and services on health, wellness and medical, food and beverage, sporting activities and membership, entertainment, spa and similar relaxation activities, travel and transportation, household, apparel, education, social networking, media and high-end consumer products; (3) the above products and services may be provided by the Company and/or: (a) any of our affiliates; (b) third party financial institutions; (c) the business partners or co-branding partners of the Company and/or affiliates providing the products and services set out in (2) above; (d) third party reward, loyalty or privileges programme providers supporting the Company or any of the above listed entities; (4) in addition to marketing the above products and services, the Company also intends to provide the data described in (1) above to all or any of the persons described in (3) above for use by them in marketing those products and services, and the Company requires your written consent (which includes an indication of no objection) for that purpose.

Before using your personal data for the purposes and providing to the transferees set out above, the Company must obtain your written consent, and only after having obtained such written consent, may use and provide your personal data for any promotional or marketing purpose.

You may in future withdraw your consent to the use and provision of your personal data for direct marketing.

Important: If you do not agree to the use and provision of your personal data for direct marketing as set out in the section “**Use and provision of personal data in direct marketing**”, please indicate your request by ticking the box below. Once your opt-out instruction is recorded, we will not use your personal data for direct marketing.

I/WE ACKNOWLEDGE AND CONFIRM that I/We have read and understood the Personal Information Collection Statement (“PICS”). **I/We confirm** that I/We have been advised to read carefully the PICS, and I/We have read it carefully its effect and impact in respect of my/Our personal data collected or held by the Company (whether contained in this application or otherwise). Based on the foregoing, I/We hereby give my/Our acknowledgement and agree to the use and transfer of my/Our personal data by the Company in accordance with the PICS, including the use and provision of my/Our personal data for the purpose of direct marketing.

☐ I/We do not agree with the use and provision of my/Our personal data for direct marketing purposes as set out above in the **Personal Information Collection Statement** (see **“Use and provision of personal data in direct marketing”**) and do not wish to receive any promotional and direct marketing materials.

請登入本公司網頁 (www.axa.com.hk > 客戶服務 > 下載區 > 人壽保險 > 收集個人資料聲明) 下載或向本公司索取收集個人資料的聲明 (“該聲明”)，並細閱《該聲明》的詳細資料。如欲了解本公司為促銷目的使用閣下的個人資料的政策，請參閱下文 **“在直接促銷中使用及將其個人資料提供予其他人士”** 部份。

在直接促銷中使用及將其個人資料提供予其他人士：本公司有意：

(1) 使用本公司不時持有的閣下的姓名、聯絡資料、產品及服務的組合資料、交易模式及行為、財政背景及人口統計數據以進行直接促銷；(2) 就本公司，安盛關聯方，本公司合作品牌夥伴及商業合作夥伴可能提供關於下列類別的服務及產品而進行直接促銷 (包括但不限於提供獎賞、客戶或會員或優惠計劃)：(a) 保險、銀行、公積金或公積金計劃、金融服務、證券和相關產品及服務；(b) 健康、保健及醫療、餐飲、體育運動及會員服務、娛樂、健身浴或類似的休閒活動、旅遊及交通、家居、服裝、教育、社交網絡、媒體的產品及服務及高級消費類產品；(3) 以上服務及產品將會由本公司及/或以下機構提供：(a) 任何安盛關聯方；(b) 第三方金融機構；(c) 提供上文(2)所列之服務及產品之本公司及/或安盛關聯方的商業合作夥伴或合作品牌夥伴；(d) 向本公司或任何以上所列機構提供支援的第三方獎賞、客戶或會員或優惠計劃提供者；(4) 除由本公司促銷上述服務及產品外，本公司亦有意將上文(1)段部份所述的資料提供予上文(3)段部份所述的全部或任何人士，以供該等人士在促銷該等服務及產品中使用，而本公司為此目的須獲得客戶書面同意 (包括表示不反對)。

在使用閣下的個人資料作上文所述的目的或提供予上文所述的人士之前，本公司須獲得閣下的書面同意，及只在獲得閣下的書面同意後方可使用閣下的個人資料及提供予其他人士作任何推廣及促銷用途。

閣下日後可撤回閣下給予本公司有關使用閣下的個人資料及提供予其他人士作任何促銷用途的同意。

重要通知：如閣下不同意根據**“收集個人資料的聲明”**使用和轉移閣下的個人資料作直接促銷用途 (參閱**“在直接促銷中使用及將其個人資料提供予其他人士”**部份)，請在下列表格內加上剔號 (“✓”)。當閣下拒絕直接促銷的指示被紀錄後，本公司將不會使用閣下的個人資料作為直接促銷用途。

本人/我們確認本人/我們已閱讀並明白收集個人資料的聲明**《該聲明》**。本人/我們確認本人/我們已被通知本人/我們須詳細閱讀**《該聲明》**，而本人/我們已詳細閱讀**《該聲明》**對貴公司所收集或持有之本人/我們的個人資料的影響 (不論是否此表格所載或從其他途徑所取得)。根據以上所述，本人/我們特此確認並同意貴公司根據**《該聲明》**使用及轉移本人/我們的個人資料，包括在直接促銷中使用及將本人/我們個人資料提供予其他人士。

☐ 本人/我們不同意貴公司根據**“收集個人資料的聲明”**使用和轉移本人/我們的個人資料作直接促銷用途 (參閱**“在直接促銷中使用及將其個人資料提供予其他人士”**部份) 及並不願意接收任何貴公司的推廣及直接促銷的材料。

12. Signature 簽署

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

Signature of Insured (If aged 18 or above) 被保人簽署 (如十八歲或以上)	Signature of Owner / Trustee / Collateral Assignee / Irrevocable Beneficiary 持有人 / 信託人 / 抵押轉讓受讓人 / 不可更換受益人簽署
Signature of Witness/Financial Consultant 見證人 / 理財顧問簽署	Sign Date (YYYY/MM/DD) 簽署日期 (年 / 月 / 日)
Full Name of Witness/Financial Consultant 見證人 / 理財顧問之姓名	

Financial Consultant Details 理財顧問資料			
Name 姓名			
Code 編號	Contact Number 聯絡號碼		

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