NOW HEALTH INTERNATIONAL

WorldCare continuous transfer form: Individuals and families

供公司使用 — 保险中介详情及印章 For company use – intermediary details and stamp

保险中介公司： Intermediary company:	传真号码： Fax number:
	电邮地址： Email address:
联络姓名： Contact name:	官方印章： Official stamp:
电话号码： Telephone number:	

如果您申请我们的其中一款计划，而其提供的保障与您现有的保单相似，我们或可为您提供连续转保，这代表我们不会要求您提供完整的健康历史详情，且您的保障将得以延续。对于任何全新的保障，等候期仍然适用。任何原保单受保但我们计划未有涵盖的保障，在转保后将不符合受保资格。适用于您现有保单的任何附加条款将继续适用于您的新计划。

请以正楷英文填写本表格。您应附上以下文件的副本；您现有的保险凭证，详细列明所有批单和现有保单的生效日期。

未有告知所有的重要事实，可能会导致本公司解除保险合同及/或日后的理赔申请不被受理。重要事实指可能会影响本公司是否同意承保或提高保险费率的事实。如投保人不确定某事实是否属重要，投保人应披露该事实。

我们建议您妥善保存与此申请相关的所有向我们提供之资料记录。

如在您的投保单填妥后及在本公司的书面接受日期、支付保费日期或您的投保单申请生效日期/参保日期(以最迟者为准)前，发生任何会影响您在本投保申请所提供的资料(如您的健康状况或连带被保险人的健康状况发生变化)，您须书面告知我们该等变化。

假如您有获授权的保险经纪，您明白及同意于保单有效期内(包括续保期)我们会支付佣金给您的获授权保险经纪。您也明白我们必须取得您的同意，才可以处理有关投保申请。

保险人有权拒绝或接受被保险人的投保申请，或在订立特殊条款的前提下接受被保险人的投保单。

您可透过您的保险中介或直接寄送已填妥的投保单连同政府签发的身份证明文件复印件至时康国际(亚太)有限公司，香港北角电气道183号友邦广场33楼3301A室，您亦可将其扫描及电邮至AsiaPacSales@now-health.com。

If **You** are applying for one of **Our Plans** with **Benefits** similar to those of **Your** current policy, **We** may be able to offer **You** a continuous transfer. For any new **Benefits** the waiting period will apply. Any **Benefits** covered under **Your** previous policy but not covered under **Our Plan** will not be **Eligible** for cover following the transfer. Any endorsements that applied to **Your** existing policy will continue to apply to **Your** new **Plan**.

Please complete this form in BLOCK CAPITALS. **You** should attach a copy of **Your** existing certificate of insurance, detailing any endorsements and the **Start Date** of the existing policy.

A deliberate or reckless misrepresentation by **You** may lead to **Us** voiding **Your Plan** with loss of premium. Where **You** make a careless misrepresentation **We** may void **Your Plan** or decline or reduce related claim payments. A misrepresentation is an untrue statement of fact relied on by one party, in this case **Us**, in establishing the terms of a contract (**Your Plan**). **You** should ensure that **You** complete **Your** application carefully, accurately and fairly. If **You** are unsure on any matter **You** should contact **Us**.

We advise **You** to keep a record of all information **You** supply to **Us** in connection with this application.

If, after completing **Your** application form and before the latest of either **Our** written acceptance, payment of premium or **Your Start Date** anything occurs which affects the information **You** provided in this form, such as a change in **Your** state of health or the state of health of any of **Your Dependants** or employees, **You** must tell **Us** in writing about the change.

If **You** have used an authorised insurance broker **You** understand, acknowledge and agree that by buying this **Plan**, **We** will pay the authorised insurance broker commission during the life of the **Plan** including renewals. **You** also understand that this agreement is necessary for **Us** to proceed with **You**r application.

We reserve the right to decline or accept **Your** application or to accept **Your** application form with special terms.

Please send **Your** completed application form along with a copy of **Your** government issued identity document to **Us** via **Your** intermediary, or direct to Now Health International (Asia Pacific) Limited, Unit 3301A, 33/F, AIA Tower, 183 Electric Road, North Point, Hong Kong. **You** can also scan and email it to AsiaPacSales@now-health.com.

第一部分：购买过的医疗保险
Section 1: Previous Medical Insurance

保险单编号： Policy no.:	保障终止时间(日/月/年)： Date cover expires/expired (dd/mm/yyyy): / /
保险人(公司)的名称： Name of insurer:	
投保人打算继续维持现有保险吗？ Do you intend to continue with the existing insurance?	是 Yes ☐ 否 No ☐

第二部分：个人与家庭
Section 2: Individuals and families

2.1 投保人姓名
Name of Policyholder

名： First name(s):	姓： Family name:
我们应如何称呼您？ What does the applicant like to be called?	

(如投保人的全名为John Andrew Smith，您可能希望我们称您为 John 或 Smith先生或 Andy。保险人将在所有通讯中以这种方式称呼您。)
(If the applicant's full name is John Andrew Smith, the applicant might like to be called John or Mr Smith or Andy. The insurer will address all correspondence to the applicant in this way.)

2.2 投保人详情
Policyholder details

地址： Address:
电邮地址： Email address:
首选电话号码(包括国家代码)： Preferred telephone number *(including country code)*:
该号码为投保人的 手机电话 ☐ 家庭电话 ☐ 办公电话 ☐ Is this the applicant's Mobile Home Work *如您希望以短讯的方式获得通知, 请告知我们您的手机号码：* *If the applicant would like SMS notifications, please tell us the applicant's mobile number:*

性别：男性 Male ☐ 女性 Female ☐ Gender:	出生日期(日/月/年)： Date of birth (dd/mm/yyyy): / /
居住国家： Country of Residence:	国籍(护照签发国家)： Nationality (Country of passport issuance):
身高(厘米/英尺)： Height (cm/ft):	体重(公斤/磅)： Weight (kg/lbs):
职业： Occupation:	行业： Occupation industry:

您或本投保单的任何预定成员, 或其家庭成员或紧密联系人有否涉及政治风险？
(如是, 请提供进一步的细节)
Are **You** or any intended member of this policy, or any family member or close associate a politically exposed person?
(If yes please provide further details)

是 Yes ☐ 否 No ☐

2.3 配偶及连带被保险人详情
Spouse and Dependant details

配偶详情 **Spouse details**	
名： First name(s):	姓： Family name:
我们应如何称呼他/她？ What does he/she like to be called?	
性别：男性 Male ☐ 女性 Female ☐ Gender:	出生日期(日/月/年)： Date of birth (dd/mm/yyyy): / /
居住国家： Country of Residence:	国籍(护照签发国家)： Nationality (Country of passport issuance):
身高(厘米/英尺)： Height (cm/ft):	体重(公斤/磅)： Weight (kg/lbs):
职业： Occupation:	行业： Occupation industry:

连带被保险人详情 **Dependant Details**	**连带被保险人 1** **Dependant 1**	**连带被保险人 2** **Dependant 2**	**连带被保险人 3** **Dependant 3**	**连带被保险人 4** **Dependant 4**
名： First name(s):				
姓： Family name:				
我们应如何称呼他/她们？ What do they like to be called?				
性别： Gender:	男性 Male ☐ 女性 Female ☐	男性 Male ☐ 女性 Female ☐	男性 Male ☐ 女性 Female ☐	男性 Male ☐ 女性 Female ☐
出生日期(日/月/年)： Date of birth (dd/mm/yyyy):	/ /	/ /	/ /	/ /

居住国家： Country of Residence:				
国籍： Nationality:				
身高(厘米/英尺)： Height (cm/ft):				
体重(公斤/磅)： Weight (kg/lbs):				
与投保人的关系： Relationship to policyholder:				
职业(16岁以上者)： Occupation (ages 16+):				

2.4 健康声明 Health declaration

如投保人有超过五位连带被保险人，请使用另一张纸，并将其随附于本申请表格。
If the applicant has more than five dependants, please use a separate sheet of paper and attach it to this application.
投保人无需披露有关普通感冒、疫苗接种或花粉过敏的事宜。
The applicant does not need to disclose matters related to common colds, vaccinations or hayfever.

	投保人/主被保险人 Policyholder/ Direct Insured	连带被保险人（配偶） Dependant (Spouse)	连带被保险人1 Dependant 1	连带被保险人2 Dependant 2	连带被保险人3 Dependant 3	连带被保险人4 Dependant 4
2.4.1 过去五年，您是否曾经接受任何外科手术或在医院、诊所、疗养院、护理院或其他医疗机构看病或接受治疗，而因此停止工作超过一周，及/或接受超过10天的治疗？ Have You in the last five years ever undergone any Surgical Procedure, been a patient or been treated in a Hospital, clinic, sanatorium, nursing home or other medical institution where You were off work for more than one week, and/or received more than 10 days Treatment?	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐
2.4.2 您曾否因任何类型的疾病，身体缺陷、先天性或有体征或有症状或遗传性的疾病、残疾、反复发作的疾病、当前怀孕、终止妊娠、严重受伤或医疗状况而被确诊或因而住院或曾接受过治疗、测试或检查？ Have You ever been diagnosed with, hospitalised for, received Treatment, tests or investigations for any type of disease, physical impairment, congenital or had signs or symptoms of or hereditary disorder, disability, recurrent illness, currently pregnant, termination of pregnancy, major injury or Medical Condition?	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐
2.4.3 您目前是否正在接受任何类型的药物（除口服避孕药外）或接受或计划接受任何治疗或测试，或预先安排任何日间留院或住院治疗？ Are You currently taking any kind of medication (other than oral contraceptives), or is any Treatment or tests currently being performed or planned, or any day or In-Patient hospitalisation scheduled?	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐	是 Yes ☐ 否 No ☐

附加资料
Additional information

如您在第2.4.1题至2.4.3题中的任何一条问题的回答为「是」，请在以下方框内提供详情 。
请提供最详尽细节，包括诊断日期及性质、症状出现频率及严重程度、最近发作日期以及任何过往、目前或已知的日后治疗的详情 。

If **You** answered 'Yes' to any of questions 2.4.1 to 2.4.3, please provide details in the box below.
Please provide as much detail as possible, including the date and nature of diagnosis, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future Treatment.

会员姓名 **Member name**				
诊断 （如果没有提供，请描述症状的确切性质） **Diagnosis** (If none made please describe the exact nature of symptoms suffered)				
就诊日期 **Date of consultation**				
接受治疗 **Treatment/Medication received**				
最近治疗日期/症状 **Date of last treatment/ symptoms**				
任何潜在的原因 **Any underlying cause**				
身体上的具体位置，包括左侧或右侧 **Specific location on body including left or right**				
结果 （例如：正在进行治疗，完全康复，可能会复发）或需要随访子宫颈抹片检查的频率（每年一次或每6个月一次） **Outcome** (e.g. on-going complete recovery, likely to recur) or for pap smear, frequency (annually, 6-monthly)				

2.5 医生的联络资料 Doctor's contact details

请提供您现时平常就诊的医生或对您的病历最熟悉的医生的详情 。
Please give details of the applicant's current usual doctor or the one who is most familiar with his/her medical history.

医生详情
Medical practitioner's details

姓名： Name:	电话号码： Telephone number:
地址： Address:	
最近就诊的日期及原因： Date of last attendance and reason:	

2.6 赔偿方法 Claim reimbursement method

银行汇款而言 For bank transfer

账户持有人姓名： Account/payee name:	付款货币： Payment currency:
银行名称(含支行)： Bank name (and branch name):	
银行账户号码： Bank code:	银行支行账户号码： Branch code:
银行支行地址/国家： Branch address & country:	
银行账户货币： Bank account currency:	国际银行号码： IBAN no:
账户号码： Account no:	路由代码： Routing code:
本地银行代码： Local banking code:	SWIFT代码： Swift code:
任何其他相关信息： Any other relevant information:	

第三部分：生效日期
Section 3: Start Date

在保险人收到本投保单及正确保费, 且投保人接受保险人的全部条款及条件后, 保险方可生效 。投保人可要求在本投保单填妥后的60日内保单开始生效。
Cover cannot start until the applicant has accepted all of the insurer's terms and conditions following the insurer's receipt of this application form and the insurer has received the correct premium. The applicant can apply for cover to start at a future date within 60 days of completion of this application.

保险计划计划将从(日/月/年)开始生效： The date the policy will start from (dd/mm/yyyy):	/ /

第四部分：我们的环境政策 — 您的文件递送设置
Section 4: Our environmental policy – Your document delivery settings

- 您可以通过您的网上会员平台查看和下载保险计划文件，包括您的保险凭证
- **You** can use **Your** secure online portfolio to view and download Plan documents, including **Your Certificate of Insurance**
- 您可以通过您的网上会员平台下载您的虚拟会员卡
- **You** can use **Your** secure online portfolio to download **Your** virtual membership card
- 将您的会员卡加入您的智能手机钱包
- Add **Your** membership card to **Your** smartphone wallet

第五部分：付款人与保费的支付方式
Section 5: Payor and Frequency of premium payment

请注意，如投保人现根据指示性报价作出付款，在本公司审核本投保单后，应付金额可能会发生变动 。
投保人须在保险期开始前，同意并支付修改后的保费 。请选择投保人支付保费的频率 。请注意季度保费需支付3%的附加费,月度保费需支付5%的附加费 。
Please note that if the payment the applicant is to make now is based on an indicative quote, the amount due may change once the insurer has reviewed this application. The applicant will need to both agree and pay the revised premium before cover can start. Please select the frequency the applicant would like to pay premiums in. Please note that quarterly premiums have a 3% surcharge and monthly premium have a 5% surcharge.

	年缴 Annually	半年缴 Semi-annually	季缴 Quarterly	月缴 Monthly
信用卡 Credit card	☐	☐	☐	☐
银行转账 Bank transfer	☐	N/A	N/A	N/A

开具发票的相关注意事项，请参见 — "付款人及发票抬头要求"。
The matters related to fapiao issuance, please refer to — "The Payor and the Issuance of Fapiao Request".

信用卡： 我们接受 **Visa**、**MasterCard**（万事达卡）及 **American Express**（美国运通卡）。我们将会联络您以收取所需款项。您的发卡机构可能会就处理此项付款收取额外的汇率兑换费或交易手续费。

银行转帐： 请务必在转帐详情中注明您的家族或公司名称，并将款项汇入以下银行帐户。

Credit card: Visa, MasterCard and American Express can be accepted. **We** will contact **You** to take the required payment. **Your** card issuer may charge an additional conversion or transaction fee to process this payment.

Bank transfer: Please make sure **You** tell **Us Your** family or company name in the transfer details and send it to the bank account below.

	美元户口 USD account
银行名称 Bank	**花旗银行** Citibank N.A.
银行帐户名称 Bank account name	**时康国际 (亚太) 有限公司** Now Health International (Asia Pacific) Ltd
银行地址 Address	**香港中环花园道3号冠君大厦** Champion Tower, Three Garden Road, Central, Hong Kong
银行户口号码 Account no.	00639162577093
国际代码 Swift code	CITIHKHX

第六部分：保险计划选项
Section 6: Plan options

有关保险计划选择的详细资料，请参阅全球保保障一览表。您的保费支付的币种将由系统根据您的居住国家/地区自动选择，且计划免赔额亦以该货币计值。请指明您的保险计划选择、免赔额及任何其他选项。

For detailed information about the **Plan** choices available, please refer to WorldCare **Benefit Schedule**. The currency **You** pay **Your** premium in is chosen for **You** by **Your Country of Residence** and the **Plan Deductible** will also be denominated in this currency. Please indicate **Your Plan** choice, **Deductible,** and any additional options.

(i) 计划选项 Choice of Plan

保障 Benefit	尊安 Essential	尊乐 Advance	尊爱 Excel	尊享 Apex
年度最高计划限额 Maximum annual limit	美元 USD 3m	美元 USD 3.5m	美元 USD 4m	不适用 N/A
住院及日间留院护理 **In-Patient** and **Day-Patient** care	▶	▶	▶	不适用 N/A
器官移植 **Organ Transplant**	▶	▶	▶	不适用 N/A
癌症治疗 **Cancer Treatment**	▶	▶	▶	不适用 N/A
怀孕和分娩期间出现的医疗状况 Acute **Medical Conditions** during **Pregnancy** and childbirth	▶	▶	▶	不适用 N/A
转运和送返 **Evacuation** and **Repatriation**	▶	▶	▶	不适用 N/A
日间留院和门诊手术 **Day-Patient** or **Out-Patient** surgery	▶	▶	▶	不适用 N/A
门诊医生费用 **Out-Patient Medical Practitioner** fees	▶	▶	▶	不适用 N/A
康复治疗 **Rehabilitation**	▶	▶	▶	不适用 N/A
先天性疾病 Congenital cover	▶	▶	▶	不适用 N/A
慢性疾病 **Chronic Condition** cover	▶	▶	▶	不适用 N/A
例行及复杂牙科治疗 Routine and complex dental **Treatment**	▶	▶	▶	不适用 N/A
例行生育保障 Routine maternity cover	▶	▶	▶	不适用 N/A
请选择 Please choose	☐	☐	☐	不适用 N/A

▶ *全额赔偿 Full refund* ▶ *不予承保 Not covered* ▶ *有限承保 Subject to limits*

(ii) 计划免赔额 Plan Deductible

如果您选择了全球保尊乐, 尊爱或尊享计划下的其中一项的自选免赔额选项, 您需要就门诊费用的自付比例或门诊每次就诊免赔额的其中一项作出相关选择 。如果您选择了全球保尊安计划下的自选免赔额 150美元, 250美元, 500美元, 1,000美元, 2,500美元或 5,000美元及门诊医生费用保障选项或门诊医生费用保障 — 选项 2, 您需要就门诊费用的自付比例的其中一项作出相关选择 。

If **You** choose an Optional **Deductible**, on WorldCare Advance, WorldCare Excel or WorldCare Apex, **You** must also select an **Out-Patient Co-Insurance** Option or an **Out-Patient Per Visit Excess** Option. On WorldCare Essential if **You** choose an optional **Deductible** USD 150, USD 250, USD 500, USD 1,000, USD 2,500 or USD 5,000 and an **Out-Patient** Charges Option or **Out-Patient** Charges – Option 2, **You** must also select an **Out-Patient Co-Insurance** Option.

	尊安 Essential	尊乐 Advance	尊爱 Excel	尊享 Apex
标准免赔额 Standard **Deductible**	零 Nil	零 Nil	零 Nil	零 Nil
自选免赔额 Optional **Deductible**				
美元 USD 150	☐	☐	☐	不适用 N/A
美元 USD 250	☐	☐	☐	不适用 N/A
美元 USD 500	☐	☐	☐	不适用 N/A
美元 USD 1,000	☐	☐	☐	不适用 N/A
美元 USD 2,500	☐	☐	☐	不适用 N/A
美元 USD 5,000	☐	☐	☐	不适用 N/A
美元 USD 10,000	☐	☐	☐	不适用 N/A
美元 USD 15,000	☐	☐	☐	不适用 N/A
门诊每次就诊免赔额选项 **Out-Patient Per Visit Excess** Option				
美元 USD 25	不适用 N/A	☐	☐	不适用 N/A
美元 USD 15	不适用 N/A	☐	☐	不适用 N/A

附加选项 Additional options	尊安 Essential	尊乐 Advance	尊爱 Excel	尊享 Apex
美国境内的选择性治疗^ USA elective **Treatment^**	☐	☐	☐	不适用 N/A
门诊医生费用 **Out-Patient** Charges	☐	不适用 N/A	不适用 N/A	不适用 N/A
门诊医生费用 – 选项2 **Out-Patient** Charges – Option 2	☐	不适用 N/A	不适用 N/A	不适用 N/A
门诊医生费用 – 选项3 **Out-Patient** Charges – Option 3	☐∞	不适用 N/A	不适用 N/A	不适用 N/A
10% 门诊费用的自付比例 10% **Co-Insurance** on **Out-Patient Treatment**	☐*	☐	☐	不适用 N/A
20% 门诊费用的自付比例 20% **Co-Insurance** on **Out-Patient Treatment**	☐*	☐	☐	不适用 N/A
香港优选医疗网络(仅适用于香港居民) Hong Kong Preferred Provider Network (Hong Kong residents only)	☐	☐	☐	不适用 N/A
香港病房限制(仅适用于香港居民) **Hospital** room restriction in Hong Kong (Hong Kong residents only)	☐	☐	☐	不适用 N/A
香港和中国大陆的病房限制(仅适用于中国大陆居民) **Hospital** room restriction in Hong Kong and China (PRC residents only)	☐	☐	☐	不适用 N/A
香港昂贵医院限制(仅适用于香港居民) High Cost Provider Restriction Option (Hong Kong residents only)	☐	☐	☐	不适用 N/A
转运和送返的增强保障选项 Extended **Evacuation** and **Repatriation** Option	☐	☐	☐	不适用 N/A
体检、眼科、疫苗 ø Wellness, optical **Benefits** and **Vaccinations** ø	☐	☐	☐	不适用 N/A
体检、眼科、疫苗 – 选项2 Wellness, optical **Benefits** and **Vaccinations** – Option 2	不适用 N/A	☐	☐	不适用 N/A
体检、疫苗 – 选项3 ø Wellness and **Vaccinations** – Option 3 ø	☐	☐	☐	不适用 N/A
牙科保障 Dental Care	☐#	☐	已承保 Already covered	不适用 N/A
移除生育保障 Removal of Maternity	不适用 N/A	不适用 N/A	不适用 N/A	不适用 N/A

* 请注意，如果您选择了尊安计划下的门诊费用保障或门诊费用保障选项2，您可选择门诊费用的自付比例 。
* Please note that on WorldCare Essential a **Co-Insurance Out-Patient Treatment** Option can only be taken if **You** select an **Out-Patient** Charges Option or **Out-Patient** Charges Option 2.

∞ 尊安计划下的门诊费用保障 – 选项3，不提供门诊自付比例或门诊每次就诊免赔额选项保障 。尊安计划下的门诊费用保障 – 选项3，紧急门诊保障需扣除门诊每次就诊免赔额25美元 。
∞ No **Out-Patient Co-Insurance** Option and **Out-Patient Per Visit Excess** Option is allowed for WorldCare Essential with **Out-Patient** Charges – Option 3 as **Out-Patient** Charges – Option 3 on WorldCare Essential is subject to default USD 25 **Out-Patient Per Visit Excess**.

^ 如果您选择了自选免赔额，则无法享受美国境内的选择性治疗。
^ US elective **Treatment** is not available if **You** selected an optional Regional Cover.

如果您选择了尊安计划下的门诊费用保障或门诊费用保障选项2，您可选择牙科保障 。
Dental Care can only be taken on WorldCare Essential if **You** select an **Out-Patient** Charges or **Out-Patient** Charges – Option 2.

ø 已选择尊安计划门诊医生费用保障选项1或选项2 。
ø WorldCare Essential when **Out-Patient** Charges -Option 1 or 2 has been selected.

第七部分：重要备注
Section 7: Important notes

在上述详情维持不变的条件下，报价将在30天内有效，且报价按照全球保医疗保险计划的条款、条件及责任免除事项发出 。

所报保费是根据每人于报价日期的年龄计算 。如在您于时康的全球保医疗保险计划的实际生效日期前，任何人士的年龄出现增长，保费可能会因此而改变 。在我们收到本投保申请及正确保费，且您接受我们的全部条款及条件后，保险方可生效 。

所报保费是根据您的身体质量指数在正常限度内厘定。

资料隐私政策

在审核您以及与连带被保险人的投保申请往来的过程中，我们将收集您与连带被保险人相关的信息（包括健康情况、银行账户和职业）。该信息将被用于确认您的核保及保障范围、管理已签发的保险计划以及处理理赔案 。您的信息可能因为上述目的而被转交至核保人、医生、医疗援助公司及理赔管理人，包括那些位于香港境外的公司 。任何协助管理您的保险计划的第三方，包括那些位于香港境外的公司，亦需承担相同的保密责任 。除上述者外，您的个人资料将不会在没得到您的同意向其他组织披露 。

您有权查阅及修改我们持有与您有关的资料 。如您意欲行使上述任何一种权利，请与我们联系 。我们收集有关您的若干资料可能构成敏感数据，亦即指有关种族或民族及身体或精神健康的资料 。资料保护法例订明有关敏感资料的特定条件，包括在某些情况下，在我们处理数据前须获取您的明确同意 。

透过签署本投保单，您同意根据本通知所述处理及转移数据（包括敏感数据在内）。在未获得此同意前，我们将无法审核您的投保 。

时康国际集团公司可能会通过信函、短信或电子邮件与您联系，告知您可能感兴趣的产品及服务或相关产品和服务的详细信息 。如您希望我们如此行事，请勾选本方框☐。您随时可以选择拒收我们的市场营销信息 。我们集团公司的名单和联络资料以及资料隐私政策可上网www.now-health.com查询 。

通过在线或其他接受程序选择参与本计划，即表示您声明同意此处所述的数据处理惯例 。您还同意时康国际集团公司收集、处理和使用个人数据（定义见适用的数据保护法），以及将个人数据转移给此处提及的第三方，以提供本计划条款所规定的服务 。这些第三方可能位于根据适用数据保护法不属于数据传输指定管辖区的国家/地区 。

任何未满十八 (18)周岁的会员应由其父母或监护人填写同意书 。如果您接受上述条款，请签名、注明日期并勾选下方的「我同意」方框，以确认您已获得本申请表所有受保人的事先明确同意，并代表他们提交此申请 。

☐ 我同意　　☐ 我不同意

时康国际集团公司可能会与您联系，告知您可能感兴趣的其他产品和服务的详细信息 。我们可能会通过邮寄、电话或电子邮件（如适用）与您联系 。

☐ 我同意　　☐ 我不同意

Quotations are valid for 30 days subject to the above details remaining the same and are issued in accordance with Now Health International **Plan** terms, conditions and exclusions.

The premiums quoted have been calculated based on each person's age at the date of the quotation. Premiums may be subject to change if the age of any person increases prior to the actual **Start Date** of **Your** Now Health International **Plan**. Cover cannot start until **You** have accepted all of **Our** terms and conditions following **Our** receipt of this application form and **We** have received the correct premium.

The premiums quoted have been based on Your Body Mass Index being within normal limits.

Data Privacy

We and **Your Underwriters** collect personal information about **You** and **Your Dependants** (including health, bank account and occupation) in the course of considering **Your** application and, if a **Plan** is issued to **You**, conducting **Our** relationship with **You**. This information will be processed for the purposes of underwriting **Your** insurance coverage, managing any **Plan** issued and administering claims. **Your** information may be passed to Now Health group companies administering **Your Plan, Underwriters,** Insurers, **Your** Intermediary, Reinsurers, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside theHKSAR. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outsidethe HKSAR. **Your** personal details will not be disclosed to other organisations without **Your** consent.

You have a right of access to, and correction of, information that **We** hold about **You**. Please contact **Us** if **You** would like to exercise either of these rights. Some of the information **We** collect about **You** may be classified as "sensitive" – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including, in some circumstances, the need to obtain **Your** explicit consent before **We** process the information.

By signing this Application Form **You** consent to the processing and transfer of information (including sensitive information) described in this notice. Without this consent **We** will not be able to consider **Your** application.

Now Health International group companies providing IPMI products may contact **You** by letter, SMS or email with details of other IPMI or related products and services, which may be of interest to **You**. If **You** do not wish this to happen please tick this box ☐ . **You** may opt out of future marketing by contacting **Us** at any time. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com.

By electing to participate in the Plan via online or other acceptance procedure, You are declaring that You agree with the data processing practices described herein. You also consent to the collection, processing and use of Personal Data (as defined under the applicable data protection law) by the Now Health group companies as well as the transfer of Personal Data to the third parties mentioned herein for the purpose of providing the services set out under the terms of this Plan. These third parties may be located in countries which may not be designated jurisdictions for data transfer as per applicable Data Protection Laws.

A parent or guardian should complete the consent for any member that is under the age of eighteen (18). If you accept the above, please sign, date and check the "I consent" box below which confirms that you have the prior and express consent of all persons to be covered pursuant to this application form, to submit this application on their behalf.

☐ I consent　　☐ I do not consent

Now Health International may contact **You** with details of other products and services which may be of interest to **You**. **You** may be contacted by post, telephone or email if appropriate.

☐ I consent　　☐ I do not consent

第八部分：声明及授权
Section 8: Declaration and authorisation

本人特此代表本投保单中列名的所有人士就上文指明的时康全球保医疗保险计划申请保险 。

本人已收取并阅读本计划的保障一览表、条款及条件、定义、保障和责任免除事项 。本人明白投保单、保险凭证、保障一览表、以及附有本医疗保险计划条款和条件的保险条款, 将构成我们双方之间的合同以及本计划协议的所有部分 。本人知道投保覆盖范围将根据协议提供 。

- 本人声明所填投保单内所提供各项及告知事项乃属真实, 确无欺瞒 。就本投保单的各名人士作出的披露乃属完整, 即便所提供的若干数据并非本人亲笔书写 。本人明白, 本人或本人的连带被保险人为欺诈或企图欺诈时康国际而向时康国际提供错误、不完整或有误导性的事实或数据属违法 。惩罚包括监禁、罚款、拒绝承保、取消赔偿及法定损害赔偿 。
- 本人明白本人须在书面接受日期、支付保费日期或保单生效日期/参保日期(以最迟者为准)前, 通知Now Health International (Asia Pacific) Limited 关于本投保单内所载事实的任何变动, 比如本投保单内列名的任何人士的健康状况的变化 。
- 就本投保申请而言, 本人授权曾经对本投保单内列名的任何人士 进行过治疗或作出过咨询的任何医生, 向时康国际提供其可能需要的、与本计划下索赔相关的任何治疗资料 。本人已与本人的伴侣及有足够能力的成年连带被保险人讨论本授权书的条款, 且本人已获取该等人士的同意以根据本授权书提供其医疗资料 。
- 本人声明, 本人已阅读并明白全球保医疗保险条款，包括产品信息和产品规定, 与有关我的权利和您的义务的详细资料，这包括以下章节:
  - 取消和终止权利
  - 投诉程序
  - 有关计划的法律及司法管辖区
  - 计划的语言及我们的服务
  - 赔偿安排
  - 全球保医疗保险计划是由Now Health International (Asia Pacific) Limited 代表AXA General Insurance Hong Kong Limited安排、签发及管理保单, 收取保费及支付索赔 。
- 本人明白, 如时康国际因任何原因无法收取本人的保费, 且本人未在时康国际提出使用其他支付方法的要求后的七天内, 向时康国际提供其它支付方法, 因而令本人的保险计划失效, 时康国际对此不承担责任亦因此无需支付理赔申请 。
- 本人同意如本人或本人的任何连带被保险人在指定医疗网络内接受治疗, 包括但不止于门诊直付, 预先审核住院等等, 而最后该治疗或医疗状况所涉及的费用, 根据保险计划的条款及条件被确定为不予偿付的, 本人同意负责向时康国际偿还其已垫付的所有上述费用 。
- 本人明白并确认, 如本人未偿还时康国 际基于诚信而垫付的不在保障范围之内的治疗费用, 则本人其它的有效理赔申请可被欠付时康国际的款项所抵消及/或本人的保险计划可能被终止直至欠付款项被全数结清 。
- 本人确认, 如时康国际确定一项理赔申请为欺诈, 本人的医疗保险计划可能被终止, 且该终止将立即生效 。
- 本人明白, 如果本人能够向其他保险保单索赔任何治疗费用或其他保障, 时康国际(亚太)有限公司仅负责理赔总额中相应比例的部分 。
- 本人已认真阅读并理解上述《重要备注》的内容, 严格履行明确告知义务 。
- 本人同意上述声明并明白保险乃根据时康国际保险计划的条款及条件提供 。

I hereby apply for cover on behalf of all the persons named in this application form for a Now Health International **Plan** as specified above.

I have received and read the **Benefit Schedule**, Terms and Conditions, Definitions, **Benefits** and exclusions of this **Plan**. I understand that the Application Form, **Certificate of Insurance**, **Benefit Schedule** and the Members' Handbook incorporating the **Plan** terms and conditions make up the contract between **Us** and all form part of the **Plan** Agreement. I am aware that cover shall be provided in accordance with the Agreement.

- I declare that the information given in this application is true and that disclosure in respect of each person included in this application is complete, even if some of the information provided is not in my own handwriting. I understand it is unlawful for me or my **Dependants** to knowingly provide false, incomplete or misleading facts or information to Now Health International for the purpose of defrauding or attempting to defraud Now Health International. Penalties may include imprisonment, fines, denial of coverage, loss of premium, loss of **Benefits** and legal damages.
- I understand that I must notify Now Health International (Asia Pacific) Limited of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it, before the latest of either written acceptance, payment of premium or the **Start Date/Entry Date**.
- For the purpose of this application I authorise any doctor who has ever treated or advised any of the persons named in this application to provide Now Health International with any information they may require in connection with **Treatment** related to any claim under this **Plan**. I have discussed the terms of this authorisation with my partner and competent adult **Dependants**, and I have obtained their consent to the release of their healthcare information pursuant to this authorisation.
- I declare that I have read and understood the following from the members' handbook:
  - cancellation and termination rights
  - complaints procedures
  - law and jurisdiction of the **Plan**
  - language of the **Plan** and **Our** service
  - compensation arrangements
  - Now Health International (Asia Pacific) Limited is acting on behalf of AXA General Insurance Hong Kong Limited for the purposes of issuing and administering **Plans**, receiving premiums and paying claims.
- I understand that Now Health International cannot be liable and therefore will not pay claims if my **Plan** is lapsed should Now Health International be unable to collect my premium for whatever reason and I do not provide Now Health International with an alternate method of payment within seven days of Now Health International requests for alternative methods of payment.
- I agree that where medical **Treatment** is received within the provider network by me or any of my **Dependants** and, except where previously agreed by Now Health International, it is determined that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Plan**, I agree that I am liable to Now Health International for all claims settled for such medical **Treatment** in connection with any non-covered claim.
- I understand and confirm that where I have not repaid funds disbursed in good faith by Now Health International in respect of non-covered medical **Treatment**, valid claims may be offset against outstanding funds due to Now Health International and/or my **Plan** may be suspended until the outstanding amounts have been settled in full.
- I acknowledge that if it is determined by Now Health International that a claim was fraudulent my **Plan** may be voided with immediate effect.
- I understand that if I am able to claim any costs from another insurance policy for the cost of any treatment or benefits received, Now Health International (Asia Pacific) Limited will only be liable for a proportional share of the total costs.
- I have read the important notes.
- I agree to the declaration above and understand that cover is provided in accordance with the terms and conditions of the Now Health International **Plan**.

签署(被保险人/投保人)：
Signature (Insured/main applicant):

日期(日/月/年)：
Date (dd/mm/yyyy):

/ /

本文件以英文和中文拟定 。如有任何争议, 本文件的英文版本应优先于任何其他语言版本或翻译版本 。
This document has been drawn up in English and Chinese. In the event of any dispute, the English version of this document shall prevail over any other language version or translation.

Plans issued in Hong Kong are underwritten by AXA General Insurance Hong Kong Limited and arranged by Now Health International (Asia Pacific) Limited.

Registered address: Units 3301A, 33/F, AIA Tower, 183 Electric Road, North Point, Hong Kong.
Insurance Agent Registration Number: 10974559.