APPLICATION FORM
FULL MEDICAL UNDERWRITING

MyHEALTH INDIVIDUAL MEDICAL PLANS

www.april-international.com

Please print only if necessary

YOUR APPLICATION, STEP BY STEP.

THIS IS YOUR APPLICATION FORM. COMPLETE IT, SIGN IT, SEND IT.

WANT TO SAVE TIME?
THE SUBMIT BUTTON AT THE END OF THIS FORM ALLOWS YOU TO SEND A SOFT COPY TO US IMMEDIATELY.
WE WILL ARRANGE FOR THE SIGNING OF THE FORM AT A LATER STAGE

AN UNDERWRITING OFFER WILL BE PROVIDED IN 2 WORKING DAYS OR LESS.

IF YOUR APPLICATION HAS BEEN ACCEPTED, IN 5 WORKING DAYS, YOU WILL RECEIVE:

- By Email: Your policy documents to the email address provided in your application.
- By Post: Your personalised member card

IF YOU WOULD LIKE TO HAVE YOUR POLICY DOCUMENTS IN A PRINTED FORMAT AND POSTED TO YOU, PLEASE MAKE YOUR REQUEST ON PAGE 1 OF THE APPLICATION FORM.

YOUR DETAILS

april international

IMPORTANT NOTICE:

The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardise coverage or invalidate a claim.

APPLICANT'S DETAILS

Family Name: ______________________

First Name(s): ______________________

Date of Birth: DD / MM / YYYY **Gender:** ◯ Male ◯ Female **Height (cm):** **Weight (kg):**

Occupation: (specify nature of duties) ______________________

Smoker: ◯ Yes ◯ No **Marital Status:** ______________________

Nationality: ______________________ **ID/Passport No.:** ______________________

Address: ______________________

Tel.: ______________________ **Mobile:** ______________________

Email: ______________________

Important: this email will be used for sending your policy documents and claims-related communication which may include sensitive medical information. Your membership card(s) will be posted to you and all policy documents sent by email. If you would prefer to have them printed and sent to you, please check this box ☐

FAMILY MEMBERS TO BE INSURED

	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Family Name				
First Name(s)				
Date of Birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Gender	◯ Female ◯ Male	◯ Female ◯ Male	◯ Female ◯ Male	◯ Female ◯ Male
Marital Status				
Relationship to Applicant				
Nationality				
Smoker	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
ID/Passport No.				
Occupation (specify nature of duties)				
Height and Weight	cm kg	cm kg	cm kg	cm kg

Please use separate sheet if necessary. Please advise us if any Family Members to be insured do not live at the Applicant's Residential Address.

CHOOSE YOUR COVER

Step 1: Select your Core Cover

The following core modules form the base of your policy. Each member has the flexibility to select the cover they want.

If family members will have the same cover as the Applicant, please tick here ☐ and complete cover options for the Applicant only.

CORE MODULES	APPLICANT	FAMILY MEMBER			
		1	2	3	4
Hospital and Surgery	☐ Essential Double Occupancy ☐ Extensive Double Occupancy ☐ Extensive Single Occupancy ☐ Elite Double Occupancy ☐ Elite Single Occupancy	☐ Essential Double Occupancy ☐ Extensive Double Occupancy ☐ Extensive Single Occupancy ☐ Elite Double Occupancy ☐ Elite Single Occupancy	☐ Essential Double Occupancy ☐ Extensive Double Occupancy ☐ Extensive Single Occupancy ☐ Elite Double Occupancy ☐ Elite Single Occupancy	☐ Essential Double Occupancy ☐ Extensive Double Occupancy ☐ Extensive Single Occupancy ☐ Elite Double Occupancy ☐ Elite Single Occupancy	☐ Essential Double Occupancy ☐ Extensive Double Occupancy ☐ Extensive Single Occupancy ☐ Elite Double Occupancy ☐ Elite Single Occupancy
Annual Deductible	☐ Nil ☐ USD 1,500 ☐ USD 5,000 ☐ USD 10,000	☐ Nil ☐ USD 1,500 ☐ USD 5,000 ☐ USD 10,000	☐ Nil ☐ USD 1,500 ☐ USD 5,000 ☐ USD 10,000	☐ Nil ☐ USD 1,500 ☐ USD 5,000 ☐ USD 10,000	☐ Nil ☐ USD 1,500 ☐ USD 5,000 ☐ USD 10,000
	• Your selected deductible applies to the Hospital and Surgery module only.				
Area of Cover	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide
	• The area of cover chosen will apply to all modules selected. • Services rendered outside of the area of cover are covered up to US$50,000 per period of insurance, only if they are directly caused by sudden illness or injury occurring during the first 30 travel days of any trip in the USA. • Please refer to clause 4 of the Policy Terms and Conditions.				

Step 2: Select your Optional Modules

The following modules are optional. Each member has the flexibility to select the cover they want.

If family members will have the same cover as the Applicant, please tick here ☐ and complete cover options for the Applicant only.

CORE MODULES	APPLICANT	FAMILY MEMBER			
		1	2	3	4
Outpatient	☐ Essential with 20% coinsurance ☐ Extensive with nil coinsurance ☐ Extensive with 20% coinsurance ☐ Elite with nil coinsurance ☐ Elite with 20% coinsurance	☐ Essential with 20% coinsurance ☐ Extensive with nil coinsurance ☐ Extensive with 20% coinsurance ☐ Elite with nil coinsurance ☐ Elite with 20% coinsurance	☐ Essential with 20% coinsurance ☐ Extensive with nil coinsurance ☐ Extensive with 20% coinsurance ☐ Elite with nil coinsurance ☐ Elite with 20% coinsurance	☐ Essential with 20% coinsurance ☐ Extensive with nil coinsurance ☐ Extensive with 20% coinsurance ☐ Elite with nil coinsurance ☐ Elite with 20% coinsurance	☐ Essential with 20% coinsurance ☐ Extensive with nil coinsurance ☐ Extensive with 20% coinsurance ☐ Elite with nil coinsurance ☐ Elite with 20% coinsurance
Dental and/or Optical Optical included with Elite plan only	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite
Maternity	☐ USD 5,000 ☐ USD 10,000 ☐ USD 15,000	☐ USD 5,000 ☐ USD 10,000 ☐ USD 15,000	☐ USD 5,000 ☐ USD 10,000 ☐ USD 15,000	☐ USD 5,000 ☐ USD 10,000 ☐ USD 15,000	☐ USD 5,000 ☐ USD 10,000 ☐ USD 15,000
	• **Important:** Available to women between 19 to 45 years of age who have selected at minimum an Extensive or Elite Hospital and Surgery on a NIL deductible basis, plus an optional Outpatient module.				

UNDERWRITING QUESTIONNAIRE

INSURANCE DETAILS

Have you or any person to be insured ever applied for, been covered under, or held a policy administered by APRIL International? If Yes, please give details.	◯ Yes ◯ No
Do you or any person to be insured currently have health insurance with another company? If Yes, please give details and indicate if it will be continued (and if not, as of what date).	◯ Yes ◯ No
Have you or any person to be insured ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused or cancelled, or had any special terms imposed? If Yes, please give details.	◯ Yes ◯ No

MEDICAL DETAILS AND HISTORY

Please indicate if you or any person to be insured have or have ever had any of the **signs, symptoms, illnesses or disorders** below by ticking the appropriate box.

1	Cancer, leukaemia, tumour or neoplasm (including benign growths), cysts including fibrocystic breast disorder, or any blood disorder	◯ Yes ◯ No
2	Asthma, chronic bronchitis, allergies, chronic rhinitis or sinusitis, tuberculosis, any disease or disorder of the lungs	◯ Yes ◯ No
3	Chest pain, raised blood pressure, heart condition, circulatory disorder	◯ Yes ◯ No
4	Indigestion, gastric reflux, gastric ulcer, haemorrhoids	◯ Yes ◯ No
5	Spinal condition, bone fracture, joint injury, back, neck or muscle pain	◯ Yes ◯ No
6	Malaria, dengue fever, other tropical illness	◯ Yes ◯ No
7	HIV/AIDS	◯ Yes ◯ No
8	Kidney Stones, kidney disorder, disorder of the urinary bladder or tract	◯ Yes ◯ No
9	Diabetes, liver disorder, hepatitis	◯ Yes ◯ No
10	Disorder of the brain or nervous system, stroke, aneurysm	◯ Yes ◯ No
11	Mental health problem, anxiety, addiction	◯ Yes ◯ No
12	Gynaecological disorders including pregnancy, irregular periods or bleeding, menstrual pain, complicated pregnancy, HPV infection, or an abnormal smear test result	◯ Yes ◯ No
13	Eczema, dermatitis, disorder of eyes, ears	◯ Yes ◯ No
14	Congenital conditions	◯ Yes ◯ No
15	Any other disorder/injury	◯ Yes ◯ No

If you answered "Yes" in the Medical Details and History section, please provide more information in the table below. You may be required to complete additional questionnaires or provide medical reports, depending on the severity and nature of the condition declared.

Person to be insured	Question no.	Date of first consultation	Details of Medical condition, including nature of treatment, results, date of last consultation,and whether you have fully recovered	Name & Address of doctor, Hospital or health professional consulted	Do you require any follow up treatment or consultation, if so when?
		DD/MM/YYYY			◯ Yes ◯ No DD/MM/YYYY
		DD/MM/YYYY			◯ Yes ◯ No DD/MM/YYYY
		DD/MM/YYYY			◯ Yes ◯ No DD/MM/YYYY

Please provide more details on a separate sheet if required.

16	Except as disclosed elsewhere in this form, have you or any person to be insured ever been admitted to hospital as an inpatient, or (within the last five years) undergone any procedures, scans, or diagnostic tests whether as an inpatient or outpatient? If Yes, please give details.	◯ Yes ◯ No
17	Are you or any person to be insured under medication? If Yes, please state the medicine name, dosage and the approximate cost.	◯ Yes ◯ No
18	Please enter the following details about the usual/family doctor for each person to be insured. If you do not have a usual/family doctor, please provide the names, addresses and contact information of medical providers you and your family members to be insured have seen in the last 3 years. Use a separate sheet if necessary. If you have never seen a doctor in the past 3 years, please indicate that below. Name: ____________ Address: ____________ ____________ Telephone: ____________ Fax: ____________ Email: ____________	

Please provide more details on a separate sheet if required.

UNDERWRITING QUESTIONNAIRE

ADDITIONAL SPACE FOR FURTHER REMARKS

You may use this space for any further comments about any medical conditions you have or have suffered from. Please remember to enclose any supporting documents with your application.

COMMENCEMENT DATE

◯ **On Acceptance**

◯ **Another Date:** DD/MM/YYYY

(We cannot backdate cover to a date earlier than the date you accept our final offer.)

INTERMEDIARY ACCESS

Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account at april.hk/portal?

◯ Yes ◯ No

Do you authorise us to discuss and/or share claims and medical information with your insurance intermediary?

◯ Yes ◯ No

Intermediary Name: ____________ Intermediary Code: ____________

Company Name: ____________

Telephone: ____________ Email: ____________

PREMIUM PAYMENT FREQUENCY

Please select the frequency in which you wish to pay your premiums.

	CREDIT CARD (Visa/Mastercard)	CHEQUE OR BANK DRAFT	BANK TRANSFER
Annual (No Surcharge)	◯	◯	◯
Semi-Annually (4% Surcharge)	◯	Not available	Not available
Quarterly (5% Surcharge)	◯	Not available	Not available

Important Notice for Semi-Annual & Quarterly Payments: This is an annual policy. You are responsible for the entire annual premium even if you choose to pay by instalments. The premium payment frequency cannot be changed during the policy year, only at renewal provided you notify us in writing. The credit card you authorise below must be valid for at least 15 months and will be used to automatically collect instalment premiums when due.

CREDIT CARD AUTHORISATION (ANNUAL, SEMI-ANNUALLY AND QUARTERLY)

In which currency do you wish to pay your premiums? ☐ HKD ☐ USD

If paying in HKD, the conversion rate of USD1 to HKD7.8 will be used. If you do not specify the currency, we will automatically default to the currency stated on the debit note as the currency of payment.

Credit Card: ◯ VISA ◯ MasterCard (Note: no other type of credit cards are accepted)

Cardholder's Name: ______________________________

Card No.: ______________________________ **Expiry Date (mmyy):** ______________

Issuing Bank: ______________________________

I/we, the undersigned, authorise APRIL Hong Kong Limited to charge my credit card for premiums due, unless I advise otherwise in writing.

Signature: ______________________ **Date:** DD/MM/YYYY

Note: 1. The actual processed deduction by the credit card centre will be considered as valid payment.
2. All other charges related to credit card payment will be born by the cardholder

Automatic Credit Card Billing Authorisation for Future Renewals

To use this option, your credit card must be valid for at least 15 months.

I authorise APRIL Hong Kong Limited, to charge this credit card in respect of renewal premiums as and when these become due, unless I advise otherwise in writing prior to the premium due date or renewal date. APRIL Hong Kong Limited will inform us in advance of any premium adjustments to my policy. ☐ Yes ☐ No

Note for existing policyholders: If your prior authorisation to APRIL Hong Kong Limited to charge your credit card for renewals and the credit card details are still valid, you do not need to complete this form. We will rely on your credit card details on file.

Please send the completed credit card authorisation to:
APRIL Hong Kong Limited
9th Floor Chinachem Hollywood Centre,
1-13 Hollywood Road, Hong Kong, SAR.
Tel: +852 2526 0918 | Fax: +852 2526 0769 | Email: ops.hk@april.com

PAYMENT METHODS

CHEQUE OR BANK DRAFT (ANNUAL PAYMENT ONLY)

- Cheques should be drawn on a Hong Kong or United States clearing bank and made payable to “APRIL Hong Kong Limited”. If paying in HKD, please use the conversion rate of USD1 to HKD7.8.
- Please indicate the policyholder’s name, policy number and debit note number on the back of the cheque.
- Please send payment to:

APRIL Hong Kong Limited
9th Floor Chinachem Hollywood Centre,
1-13 Hollywood Road, Hong Kong, SAR.
Tel: +852 2526 0918 | Fax: +852 2526 0769 | Email: ops.hk@april.com

BANK TRANSFER (ANNUAL PAYMENT ONLY)

- Transfers can be made either in HKD or USD. Please refer to the banking details below for each account type. If paying in HKD, please use the conversion rate of USD1 to HKD7.8.
- Please send full payment (inclusive of all bank charges) to:

Hong Kong Dollar (HKD) Account

Beneficiary Bank

Account Holder:	APRIL Hong Kong Limited
Bank:	The Bank of East Asia Limited
Account Number:	015-521-40-400295-3
Swift Code:	BEASHKHH

US Dollar (USD) Account

Beneficiary Bank

Account Holder:	APRIL Hong Kong Limited
Bank:	The Bank of East Asia Limited
Account Number:	015-521-50-00132-1
Swift Code:	BEASHKHH

Intermediary Bank

ABA No.:	026009593
Recipient Bank:	Bank of America N.A., New York
IBAN:	USA CHIPS UID 009953
Account Number:	6550-4-90452
Swift Code:	B0FAUS3N

1. All bank charges will be borne by the remitter.
2. Please indicate your Policy Number and Debit Note number as a payment detail to your banker.
3. Please fax (+852 2526 0769) or email ops.hk@april.com the bank remittance advice or instruction slip with your Policy Number, name and debit note number to us for our accounting records and to issue an Official Receipt.

CLAIM REIMBURSEMENT

Please provide your banking details for claim reimbursement.

Bank Name: ______________________

Bank Address: ______________________

A/C Name: ______________________ A/C No.: ______________________

Currency: ◯ HKD ◯ USD ◯ EUR ◯ GBP

For all other currencies, please check with APRIL Hong Kong. For international transfers to a foreign bank, note that your bank may charge you fees for each transaction which will be your responsibility to bear.

The following information must be provided for bank accounts outside of Hong Kong:

Sort Code: ______________________

BIC (Swift) Code: ______________________

Corresponding Bank Details (if applicable): ______________________

NOTICE TO CUSTOMERS RELATING TO THE PERSONAL DATA ORDINANCE

In relation to: (i) the personal data collected by APRIL Hong Kong Limited ("APRIL") in this application form, and (ii) any personal data about me/us which may be collected by APRIL in the future if a policy is issued (collectively "my/our personal data"), I/we agree and acknowledge that:

a) providing my/our personal data is necessary for APRIL to process this application and provide insurance coverage. If any such data is not provided, APRIL may not be able to process this application or provide insurance coverage.

b) my/our personal data will be transferred to Liberty International Insurance Limited ("Liberty International") and/or other members of the Liberty Mutual Group of Companies ("Liberty Mutual Group") for all the purposes stated in its privacy policy, available at www.liuhongkong.com.hk/footer/privacy-policy.

c) my/our personal data may be used by APRIL and Liberty Mutual Group for the following obligatory purposes:
   1. to decide whether to issue an insurance policy or to modify an existing policy;
   2. to manage and administer products and services you purchase;
   3. to provide customer service to you and respond to your enquiries;
   4. to compile statistics and to conduct research, insurance surveys and analysis for the purpose of product design and development;
   5. to provide claims service, including assessing, investigating, analysing and paying claims, and to exercise Liberty International's rights as defined in the policy wording including rights of subrogation;
   6. to carry on our business in areas such as finance and accounting, billing and collections, audits, IT system management, reporting, and obtaining reinsurance;
   7. enabling an actual or proposed assignee of Liberty International to evaluate the transaction intended to be the subject of the assignment;
   8. conducting identity and/or credit checks and/or debt collection;
   9. conducting medical or health reference checks for relevant insurance products;
   10. meeting disclosure requirements of any local or foreign law, regulations, codes or guidelines binding on them or their affiliates; and
   11. complying with the legitimate requests or orders of any court of competent jurisdiction and any regulator or self-regulatory entity including but not limited to the Insurance Authority, Hong Kong Federation of Insurers, auditors, governmental bodies and governmental-related establishments binding APRIL or the Liberty Mutual Group of Companies.

d) unless I/we have indicated otherwise by ticking the "Marketing Communications Opt-out" box below, my/our contact details (name, address, phone number and e-mail address) may be used:
   1. by APRIL, to contact me/us about other insurance products provided by APRIL and its affiliates; and
   2. by Liberty Mutual Group to provide marketing materials and conduct direct marketing activities (including but not limited to promoting, marketing or selling of the Company, Liberty Mutual Group or co-branded insurance or financial or investment related products or services by electronic or other means) in relation to insurance and/or financial products and services of the Company, the Liberty Mutual Group and/or other financial services providers.

e) APRIL may transfer my/our personal data to the following classes of persons (whether based in Hong Kong or overseas) for the purposes identified in (c) above:
   1. any affiliate of APRIL (HK);
   2. any Liberty Mutual Group of Companies;
   3. any other company carrying on insurance or reinsurance related business, or an intermediary;
   4. third parties providing services related to the administration of my/our policy (including reinsurers, accountants and data processors);
   5. any agent, contractor or third party service provider who provides administrative, telecommunications, computer, payment, banking or other services to the Company in connection with the operation of its business;
   6. financial institutions for the purpose of processing this application and obtaining policy payments or making claim settlements;
   7. in the event of a claim, loss adjustors, assessors, third party administrators, emergency assistance companies, legal services providers, investigators, retailers, medical providers and medical professionals, and travel carriers;
   8. any person to whom APRIL, Liberty International and/or Liberty Mutual Group is under an obligation to make disclosure under the requirements of any law binding on the Company or any of its associated companies for the purposes of any regulations, codes or guidelines issued by governmental, regulatory or other authorities with which the Company or any of its associated companies are expected to comply, or subject to any order of a court of competent jurisdiction;
   9. any actual or proposed assignee or transferee of the Liberty Mutual Group's rights in respect of the policy owners;
   10. providers of risk intelligence for the purpose of customer due diligence or anti-money laundering screening;
   11. credit reference agencies, and in the event of default, any debt collection agencies or companies carrying on claim or investigation services;
   12. other banking/financial institutions, commercial or charitable organizations with whom APRIL, Liberty International and/or Liberty Mutual Group maintain business referral or other arrangements for marketing communication, or third party marketing service providers and insurance intermediaries, unless you have indicated that you wish to opt-out of receiving marketing communications; and
   13. other parties referred to in APRIL's Privacy Policy for the purposes stated therein.

f) I/we may gain access to or request correction of my/our personal data held by APRIL, or opt out of my/our personal data being used for direct marketing at any time, by writing to the Data Privacy Officer of APRIL hong Kong Limited at 9th Floor, Chinachem Hollywood Centre, 1-13 Hollywood Road, Central, Hong Kong or privacy@april.com.
   I/we may gain access to or request correction of my/our personal data held by Liberty International , or opt out of my/our personal data being used for direct marketing at any time, by writing to the Personal Data Privacy Officer of Liberty International Insurance Limited, 13/F DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong.

g) APRIL and Liberty International reserve the right to charge a reasonable fee for access to data.
   if I am providing information about another person, such as a family member or employee, I confirm that they have consented to me providing that information to APRIL. If appropriate, I have provided them with this personal information collection statement or the APRIL Privacy Policy.

h) the full version of APRIL's Privacy Policy is available to me upon request from the Data Privacy Officer (see (e) above) or can be found at http://en.april-international.com/general-terms-of-use/hong-kong-privacy-statement. APRIL may make changes to the privacy policy by posting them at http://en.april-international.com.

☐ Please tick this box if you do not wish to receive any marketing communications from APRIL (see d(1) above)

☐ Please tick this box if you do not wish to receive any marketing communications from Liberty Mutual Group or companies with whom it maintains marketing arrangements (see d(2) above).

DECLARATION BY APPLICANT

I declare that the statements contained in this application form are correctly recorded, and that they are full, complete and true. I further declare that I have not withheld any material fact and that except as declared herein, all persons to be insured are currently in good health. I will notify APRIL Hong Kong Limited immediately if after signing this application and before a policy is issued if I become aware of material facts not disclosed in this form, or if the health of any person to be insured changes such that any answer on this form is not full complete, and true. If a policy is issued to me, this proposal and the statements made herein shall form the basis of the policy between me/us and Liberty International Insurance Limited. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

Name & Title	Signature	Date (DD/MM/YYYY)

Important: *The application form must be sent to us within 14 days from this date for your application to be valid.*

Underwritten by:

Liberty International Insurance Limited (Hong Kong)
13/F, Berkshire House
25 Westlands Road,
Quarry Bay
Hong Kong

Arranged and administered by:

APRIL Hong Kong Limited
9th Floor, Chinachem Hollywood
1-13 Hollywood Road, Central
Hong Kong
Tel: (+852) 2526 0918 | Fax: (+852) 2526 0769
Email: ops.hk@april.com

SUBMIT YOUR APPLICATION

SUBMIT ELECTRONICALLY

SUBMIT

Click SUBMIT if want your default email program to send this document to us.

Alternatively, save this file and send it to ops.hk@april.com

OR

PRINT, SIGN, EMAIL

PRINT

Send the scanned copy to ops.hk@april.com

Mail to APRIL
9th Floor, Chinachem Hollywood Centre
1-13 Hollywood Road, Central
Hong Kong