APPLICATION FORM
MORATORIUM UNDERWRITING

MyHEALTH EMPLOYEE AND FAMILY

www.april-international.com

Please print only if necessary

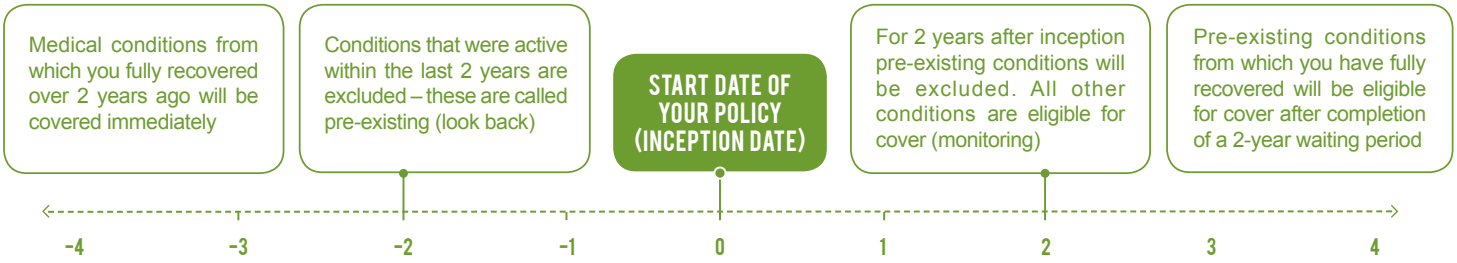
april international

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.

YOU ARE APPLYING FOR A POLICY UNDER MORATORIUM UNDERWRITING

WE ASK VERY FEW QUESTIONS WHEN YOU APPLY AND THE ELIGIBILITY OF EACH CLAIMS IS ASSESSED WHEN MADE, BASED ON THE FOLLOWING PRINCIPLES:



Any conditions which meet any of the following criteria will be subject to the moratorium terms, hence considered active in the explanation above:

- Was foreseeable
- Clearly showed itself
- You have had signs or symptoms or you were aware of the condition
- You have received treatment for or sought medical advice on the condition or a related condition (including checkups)
- To the best of your knowledge you were aware you had
- Requires monitoring according to generally accepted medical advice or opinion

Certain pre-existing conditions will never be covered under our moratorium policy, these include but are not limited to disabilities and chronic and incurable conditions such as diabetes, chronic hypertension (raised blood pressure), hyperlipidaemia (raised cholesterol levels), ischemic heart disease, cancer, thyroid disease, and auto-immune disorders.

Direct billing is not available for moratorium policies. The member will have to submit a claim in for reimbursement.

EMPLOYEE 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.:** _____

Residential Address: _____

_____ **Postal Code:** _____ **Country:** _____

If you wish to use a different mailing address please advise us

Tel.: _____ **Mobile:** _____

Email: _____

Important: this email will be used for sending your policy documents and claims-related communication which may include sensitive medical information.

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 Employee				
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 Employee's Residential Address.

II YOUR DETAILS

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 Employee, please tick here ☐ and complete cover options for the Employee only.

CORE MODULES	EMPLOYEE	FAMILY MEMBER			
		1	2	3	4
Hospital and Surgery	☐ Essential Semi-Private ☐ Extensive Semi-Private ☐ Extensive Private ☐ Elite Semi-Private ☐ Elite Private	☐ Essential Semi-Private ☐ Extensive Semi-Private ☐ Extensive Private ☐ Elite Semi-Private ☐ Elite Private	☐ Essential Semi-Private ☐ Extensive Semi-Private ☐ Extensive Private ☐ Elite Semi-Private ☐ Elite Private	☐ Essential Semi-Private ☐ Extensive Semi-Private ☐ Extensive Private ☐ Elite Semi-Private ☐ Elite Private	☐ Essential Semi-Private ☐ Extensive Semi-Private ☐ Extensive Private ☐ Elite Semi-Private ☐ Elite Private
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 Employee, please tick here ☐ and complete cover options for the Employee only.

CORE MODULES	EMPLOYEE	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.				

ADDITIONAL DETAILS

All the questions in this section must be answered. If incomplete, your application will not be accepted.

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
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
Are you or any person to be insured under medication? If Yes, please state the medicine name, dosage and the approximate cost.	◯ Yes ◯ No

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.

III QUESTIONNAIRE

ADDITIONAL SPACE FOR FURTHER REMARKS

You may use this space for any further comments. Please remember to enclose any supporting documents with your application.

INTERMEDIARY ACCESS

Would you like the insurance intermediary of the group plan 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 the insurance intermediary of this group plan?

◯ Yes ◯ No

Intermediary Name: _____ Intermediary Code: _____

Company Name: _____

Telephone: _____ Email: _____

NOTICE TO CUSTOMERS RELATING TO THE PERSONAL DATA ORDINANCE

IV

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.

h) 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.
   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).

V DECLARATION BY EMPLOYEE

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.*

NOTES

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

april international