

APPLICATION FORM
FULL MEDICAL UNDERWRITING

MyHEALTH INDIVIDUAL MEDICAL PLANS

Download our Easy Claim mobile app
for quicker claims reimbursement!



 april-international.com

Please print only if necessary



Liberty
Insurance™



Insurance made easy.

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 for us to start the process. We will arrange for the signing of the form at a later stage.



An underwriting offer will be provided in 3 working days or less.



ONCE OUR OFFER HAS BEEN ACCEPTED, IN 5 WORKING DAYS, YOU WILL RECEIVE:

- ✓ Your full member's pack (by email)
This includes relevant documentation such as claim forms, instructions, terms and conditions, and benefit schedules.
- ✓ You will be able to download your member card containing emergency contact numbers for requesting assistance services or before admission to hospital on our Easy Claim app.

Should you wish to have your member's pack printed and posted to you, please tick here

1. YOUR DETAILS

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. : _____

Residential Address : _____

Postal Code : _____ Country : _____

Usual Country of Residence : _____
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 | <u>DD / MM / YYYY</u> | <u>DD / MM / YYYY</u> | <u>DD / MM / YYYY</u> | <u>DD / MM / YYYY</u> |
| Gender | Male <input type="radio"/> Female <input type="radio"/> | Male <input type="radio"/> Female <input type="radio"/> | Male <input type="radio"/> Female <input type="radio"/> | Male <input type="radio"/> Female <input type="radio"/> |
| Marital Status | | | | |
| Relationship to Applicant | | | | |
| Nationality | | | | |
| Smoker | Yes <input type="radio"/> No <input type="radio"/> | Yes <input type="radio"/> No <input type="radio"/> | Yes <input type="radio"/> No <input type="radio"/> | Yes <input type="radio"/> No <input type="radio"/> |
| ID/Passport No. | | | | |
| Occupation (Specify nature of duties) | | | | |
| Height & 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.

2. YOUR COVER

| STEP 1 | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SELECT YOUR COVER The following modules form the base of your policy. Each member has the flexibility to select the cover they want. If dependants will have the same cover as the Applicant, please tick here <input type="radio"/> and complete cover options for the Applicant only. | | | | | |
| MODULES | APPLICANT | FAMILY MEMBER 1 | FAMILY MEMBER 2 | FAMILY MEMBER 3 | FAMILY MEMBER 4 |
| Hospital & Surgery | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite |
| | <input type="radio"/> Double Occupancy Room <input type="radio"/> Single Occupancy Room | <input type="radio"/> Double Occupancy Room <input type="radio"/> Single Occupancy Room | <input type="radio"/> Double Occupancy Room <input type="radio"/> Single Occupancy Room | <input type="radio"/> Double Occupancy Room <input type="radio"/> Single Occupancy Room | <input type="radio"/> Double Occupancy Room <input type="radio"/> Single Occupancy Room |
| | <input type="radio"/> Free choice of provider <input type="radio"/> Specified Providers only | <input type="radio"/> Free choice of provider <input type="radio"/> Specified Providers only | <input type="radio"/> Free choice of provider <input type="radio"/> Specified Providers only | <input type="radio"/> Free choice of provider <input type="radio"/> Specified Providers only | <input type="radio"/> Free choice of provider <input type="radio"/> Specified Providers only |
| <ul style="list-style-type: none"> The Specified Inpatient Providers list is available at http://healthbyapril.com/specified-hospitals Double Occupancy Room option is only available to Hong Kong resident | | | | | |
| Annual Deductible | <input type="radio"/> Nil <input type="radio"/> USD 1,500 <input type="radio"/> USD 3,000 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 | <input type="radio"/> Nil <input type="radio"/> USD 1,500 <input type="radio"/> USD 3,000 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 | <input type="radio"/> Nil <input type="radio"/> USD 1,500 <input type="radio"/> USD 3,000 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 | <input type="radio"/> Nil <input type="radio"/> USD 1,500 <input type="radio"/> USD 3,000 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 | <input type="radio"/> Nil <input type="radio"/> USD 1,500 <input type="radio"/> USD 3,000 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 |
| | <ul style="list-style-type: none"> Your selected deductible applies to the Hospital and Surgery module only. | | | | |
| Area of Cover | <input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide | <input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide | <input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide | <input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide | <input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide |
| | <ul style="list-style-type: none"> The area of cover chosen will apply to all modules selected. Services rendered outside of the area of cover are covered up to US\$100,000 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 ANY OPTIONAL MODULES THAT YOU WISH The following modules are optional. Each member has the flexibility to select the cover they want. If dependants will have the same cover as the Applicant, please tick here <input type="radio"/> and complete cover options for the Applicant only. | | | | | |
| MODULES | APPLICANT | FAMILY MEMBER 1 | FAMILY MEMBER 2 | FAMILY MEMBER 3 | FAMILY MEMBER 4 |
| Outpatient | Essential with <input type="radio"/> 20% coinsurance <input type="radio"/> USD 7,000 cap | Essential with <input type="radio"/> 20% coinsurance <input type="radio"/> USD 7,000 cap | Essential with <input type="radio"/> 20% coinsurance <input type="radio"/> USD 7,000 cap | Essential with <input type="radio"/> 20% coinsurance <input type="radio"/> USD 7,000 cap | Essential with <input type="radio"/> 20% coinsurance <input type="radio"/> USD 7,000 cap |
| | Extensive with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance | Extensive with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance | Extensive with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance | Extensive with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance | Extensive with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance |
| | Elite with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance | Elite with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance | Elite with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance | Elite with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance | Elite with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance |
| Dental and/or Optical <small>Optical included with Elite plan only</small> | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite | <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite |
| Maternity | <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 <input type="radio"/> USD 15,000 | <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 <input type="radio"/> USD 15,000 | <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 <input type="radio"/> USD 15,000 | <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 <input type="radio"/> USD 15,000 | <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000 <input type="radio"/> USD 15,000 |
| <ul style="list-style-type: none"> 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. | | | | | |

3. UNDERWRITING QUESTIONNAIRE

| INSURANCE DETAILS | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| <p>Have you or any person to be insured ever applied for, been covered under, or held a policy administered by APRIL? If Yes, please give details.</p> | | |
| | | Yes <input type="radio"/> No <input type="radio"/> |
| <p>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).</p> | | |
| | | Yes <input type="radio"/> No <input type="radio"/> |
| <p>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.</p> | | |
| | | Yes <input type="radio"/> No <input type="radio"/> |
| MEDICAL DETAILS AND HISTORY | Please indicate if you or any person to be insured <u>have or have ever had</u> any of the signs, symptoms, illnesses or disorders below by ticking the appropriate box. | |
| 1 | Cancer, leukemia, tumor or neoplasm, cysts, fibrocystic breast disorder, polyp or growths of any kind | Yes <input type="radio"/> No <input type="radio"/> |
| 2 | Respiratory system: Asthma, bronchitis, allergies, rhinitis or sinusitis, tuberculosis, or other disorder of the respiratory system | Yes <input type="radio"/> No <input type="radio"/> |
| 3 | Circulatory system and blood disorder: Chest pain, raised blood pressure, raised cholesterol, heart condition, or other disorder of the circulatory system or blood | Yes <input type="radio"/> No <input type="radio"/> |
| 4 | Gastrointestinal system: Indigestion, gastric reflux, gastric ulcer, hemorrhoids, hernia, or other disorder of the gastrointestinal system | Yes <input type="radio"/> No <input type="radio"/> |
| 5 | Musculoskeletal: Bone fracture, joint injury, arthritis, back, neck or muscle pain, or other disorder of the spine | Yes <input type="radio"/> No <input type="radio"/> |
| 6 | Tropical illness: Malaria, dengue fever | Yes <input type="radio"/> No <input type="radio"/> |
| 7 | HIV/AIDS | Yes <input type="radio"/> No <input type="radio"/> |
| 8 | Urinary system: Kidney stones or other disorder of the urinary system or prostate | Yes <input type="radio"/> No <input type="radio"/> |
| 9 | Liver: Diabetes, hepatitis, fatty liver, or other disorder of the liver | Yes <input type="radio"/> No <input type="radio"/> |
| 10 | Thyroid: Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid | Yes <input type="radio"/> No <input type="radio"/> |
| 11 | Brain and nervous system: Stroke, aneurysm, seizures, chronic headache, migraine, or other disorder of the brain or nervous system | Yes <input type="radio"/> No <input type="radio"/> |
| 12 | Anxiety, depression, stress, addiction, or other mental, behavioral, developmental disorder | Yes <input type="radio"/> No <input type="radio"/> |
| 13 | Gynecological system: Pregnancy (including any complication), fibroid, endometriosis, irregular periods or bleeding, menstrual pain, HPV infection, or an abnormal smear test result, or other disorder of the gynecological system | Yes <input type="radio"/> No <input type="radio"/> |
| 14 | Skin: Eczema, dermatitis, psoriasis, wart, or other disorder of skin | Yes <input type="radio"/> No <input type="radio"/> |
| 15 | Eyes and ears: Cataract, glaucoma, otitis, hearing loss, or other disorder of eyes or ears | Yes <input type="radio"/> No <input type="radio"/> |
| 16 | Congenital, hereditary conditions, birth defects, deformities, or conditions affecting mobility | Yes <input type="radio"/> No <input type="radio"/> |
| 17 | Any other disorder/ injury | Yes <input type="radio"/> No <input type="radio"/> |

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

If you answered "Yes" to any of the above, please provide details in the table below. You may be required to provide a further medical questionnaire or medical reports, depending on the severity and nature of the condition declared.

| | | | |
|--------------------------------------------------------------------------------------|----------------|----------------|----------------|
| Person to be insured | | | |
| Question No. | | | |
| Disease/ Medical Condition/ Sign & Symptom | | | |
| Date of first occurrence of sign & symptom | DD / MM / YYYY | DD / MM / YYYY | DD / MM / YYYY |
| Frequency of sign & symptom | | | |
| Treatment Details (including name, date, duration of medication, surgery etc.) | | | |
| Date of last follow-up medical consultation/ treatment | DD / MM / YYYY | DD / MM / YYYY | DD / MM / YYYY |
| Any on-going, regular, planned or preventive treatment required? | | | |
| Any on-going sign or symptom? | | | |

MEDICAL DETAILS AND HISTORY - CONTINUED

| | | | | |
|----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| 18 | <p>Except as disclosed elsewhere in this form, have you or any person to be insured ever been admitted to hospital as an inpatient, or undergone any procedures including endoscopy, biopsy whether as an inpatient or outpatient? If Yes, please give details.</p> | | | |
| | | | Yes <input type="radio"/> No <input type="radio"/> | |
| 19 | <p>In the last five years, have you or any person to be insured been notified of any abnormal test results or awaiting results for any scans or tests performed (e.g. blood or urine test, ECG, endoscopy, X-ray, ultrasound, CT scan, MRI, PET scan etc.)? Please also answer "yes" if there are any inconclusive or uncertain results (retesting or follow up test required) and abnormal findings that may not require treatment at present (e.g. cyst, joint degeneration, calcification, etc.)</p> | | | |
| | | | Yes <input type="radio"/> No <input type="radio"/> | |
| 20 | <p>In the last five years, have you or any person to be insured currently taking or been prescribed any medications for a continuous period of more than one month? If Yes, please state the medicine name, dosage and the approximate cost.</p> | | | |
| | | | Yes <input type="radio"/> No <input type="radio"/> | |
| 21 | <p>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.</p> | | | |
| | Name | | | |
| | Address | | | |
| | Telephone | | Fax | |
| | Email | | | |

Please provide more details on a separate sheet if required.

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

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 healthbyapril.com/portal? | | Yes <input type="radio"/> | No <input type="radio"/> |
| Do you authorise us to discuss and/or share claims and medical information with your insurance intermediary? | | Yes <input type="radio"/> | No <input type="radio"/> |
| Intermediary Name | | Intermediary Code | |
| Company Name | | Telephone | |
| Email | | | |

CLAIM REIMBURSEMENT

Please provide your banking details for claim reimbursement.

| | | | |
|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Bank Name | | | |
| Bank Address | | | |
| A/C Name | | A/C No. | |
| Currency | <input type="radio"/> HKD <input type="radio"/> USD <input type="radio"/> EUR <input type="radio"/> 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) | | | |

4. PAYMENT METHODS

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) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Semi-Annually (4% Surcharge) | <input type="radio"/> | Not Available | Not Available |
| Quarterly (5% Surcharge) | <input type="radio"/> | 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)

If you choose to pay your premiums by credit card, you will receive a payment link by email sent to the address you provided on this form.

In which currency do you wish to pay your premiums?

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.

HKD USD

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

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

SIGNATURE

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

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.

Date :

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

4. 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 Hongkong and Shanghai Banking Corporation Limited
Bank code : 004
Account Number : 741-208490-001
Swift Code : HSBCCHKHHKH
Bank address : 1 Queen’s Road Central, Hong Kong

US Dollar (USD) Account

Beneficiary Bank

Account Holder : APRIL Hong Kong Limited
Bank : The Hongkong and Shanghai Banking Corporation Limited
Bank code : 004
Account Number : 741-208490-201
Swift Code : HSBCCHKHHKH
Bank address : 1 Queen’s Road Central, Hong Kong

Intermediary Bank

ABA No. : 0108
Recipient Bank : HSBC Bank USA NA, New York
IBAN : USA CHIPS UID 075995
Fedwire Number : 021001088
Account Number : 000-04441-5
Swift Code : MRMDUS33

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.

5. 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 online [here](#).
- 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 adjusters, 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.
- g. 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 Berkshire House, 25 Westlands Road, Quarry Bay, Hong Kong. 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 <https://hk.april-international.com/en/hong-kong-privacy-policy>. APRIL may make changes to the privacy policy by posting them at <http://hk.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).

SIGNATURE

Name : _____

Title : _____

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.

Date : _____

Important : The application form must be sent to us **within 30 days** from this date for your application to be valid.

Underwritten by:

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

Arranged by:

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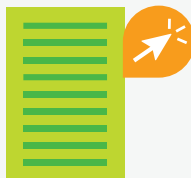


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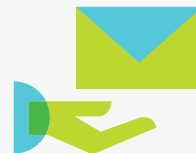
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