AIA International Limited

Personal Life & Medical Insurance Program

For Members of

Hong Kong Institute of Certified Public Accountants

Application Form

Personal Details of Insured Person

Member Accountant Information

Full Name (English):	Full Name (Chinese):
Contact no.:	HKICPA Membership No.:

Proposed Insured Information

☐ **Member Accountant** ☐ **Spouse*** ☐ **Child(ren)***

Full Name (English):	Full Name (Chinese):
Date of Birth:	Sex:
HKID no./Passport no.:	Nationality:
Below Information is required for Member Accountant Only	
E-mail Address:	Fax. No.:
Residential Address :	
Employer's Name and Tel No.:	
Occupation - Exact Duties and Nature of Business:	

A. Insured Person's Details of Cover

Life Insurance	☐ **Member Accountant** ☐ **Spouse**[1] ☐ **Child(ren)**[1]
Currency	☐ HKD ☐ USD
Basic Coverage – Life, AD&D and TPD benefits[2]	☐ New ☐ Revise to Total sum insured $_____
Rider on Basic Coverage – Disability Income Benefit [3], [4] Elimination Period Selection Option	☐ New ☐ Revise to Total sum insured $_____ ☐ 180 days ☐ 90 Days ☐ A ☐ B ☐ C
Optional Coverage – Critical Illness Benefit [5]	☐ New ☐ Revise to Total sum insured $_____
Medical Insurance	
Basic Coverage – Hospitalization & Surgical Benefit and Supplementary Major Medical Benefit	Plan _____
Optional Coverage [3] – Out-patient (AIA panel only)	☐ Yes ☐ No Plan _____

Note:
1. The amount of insurance for a dependent spouse or child(ren) shall not exceed that for the member accountant.
2. For Plans 7 to 17 benefit coverage of Term Life, AD&D and TPD shall not be available for child(ren)
3. Cannot select on standalone basis
4. Selection option should be same plan level with or at a lower level than Group Life Benefit plan (Basic Coverage)
5. For Plans 2 to 6 benefit coverage of CI shall not be available for child(ren)

B. Confidential Medical History

This section asks for health and medical details, past and present about you. Please tick Yes or No to every question for every person. If you tick **Yes** to a question, please give full details in Section C on the following page.

	Insured Person
1. Have you EVER had raised cholesterol, tuberculosis, diabetes, heart disease or mental disease?	☐Yes ☐No
2. Have you EVER used any habit forming drugs or narcotics or alcohol excessively or been treated for alcoholism or drug habits?	☐Yes ☐No
3. Have you any physical defects or health impairments?	☐Yes ☐No
4. Have you EVER had, or been told you had or been treated for (a) Asthma, tuberculosis, respiratory or any other lung disease	☐Yes ☐No

	Insured Person
(b) Rheumatic fever, high blood pressure, chest pain, disease of heart or blood disorders, blood or blood vessels	☐Yes ☐No
(c) Stomach ulcer, ulcer, bowel or digestive disorder, gall-bladder disease, hepatitis or any other liver diseases	☐Yes ☐No
(d) Renal stone, kidney diseases or any disorder of the genito-urinary system	☐Yes ☐No
(e) Epilepsy, diseases of the brain or nervous system, mental or psychiatric disorders	☐Yes ☐No
(f) Diabetes, venereal disease, cancer, cysts, tumor or lumps of any kind, any other disease, disorder or severe injury	☐Yes ☐No
(g) Nasal bleeding, coughing or vomiting blood, passing blood per rectum or in urine	☐Yes ☐No
(h) Stroke or recurrent fainting episodes	☐Yes ☐No
(i) Unexplained weight loss, night sweats, loss of appetite, recurrent fainting spells, or been advised to have further investigation, including biopsy, or a finding on medical examinations	☐Yes ☐No
5. In the past FIVE years, have you had any: (a) Diagnostic test such as X-rays, CAT scans, ECGs, blopsies, blood tests, etc (b) Illness, operation, medical advice, hospital treatment not mentioned above. If yes, please specify the date of medical checkup /examination, the detail of the tests, the results of the tests and provide reports if any.	☐Yes ☐No ☐Yes ☐No
6. Are you now a member of any military force or in the past five years have you engaged or contemplate to engage in any private flying or hazardous sports or race?	☐Yes ☐No
7. Have you ever had poliomyelitis, kidney disease, multiple sclerosis, hepatitis, cirrhosis, peptic ulcer, leukaemia, removal of cysts or growths, or been found to be a hepatitis B or hepatitis C carrier, paralysis or muscular dystrophy?	☐Yes ☐No
8. Have any of your natural parents, siblings, or children died or suffered from cancer, heart disease, diabetes, kidney disease, poliomyelitis, leukaemia, cirrhosis, hepatitis or been found to be a hepatitis B or hepatitis C carrier, paralysis or muscular dystrophy, multiple sclerosis or any hereditary disorder?	☐Yes ☐No
9. In the past 2 years, have you been absent from work due to illness or injury for a continuous period of more than 7 days?	☐Yes ☐No
10. Have you or your dependent been told to have or received, any medical advice, investigation, counseling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related condition, or in the last 6 months have you had any of the following symptoms for more than 1 week continuously: fatigue, weight loss, diarrhea, enlarged glands or unusual skin lesion?	☐Yes ☐No
11. Has any application for or reinstatement of life, or accident insurance ever been declined, postponed, rated or in any way modified? If yes, please give details of the date, insurer and type of policy.	
12. (a) Have you ever smoked? If yes, please specify for how many years, and number smoked per day?	☐Yes ☐No _____ years _____ / day

	Insured Person
(b) Did you previously smoke more than you do now? If so, how many did you smoke per day, when did you cut down, or stop and on whose advice? _____ / day Stop / cut down since year _____ Advise by _____	☐Yes ☐No
(c) In the past 1 year, did you drink alcohol regularly? If so, what type of alcohol, how much and how often did you drink? Have you ever been in the habit of drinking more than you do now, or told to cut down the amount you drink? If yes, please provide details.	☐Yes ☐No Type:_____ _____ml _____/week
13. For Female applicants only: (a). Are you now pregnant? If yes, please state expected delivery date (MM/DD/YY).	☐Yes ☐No Expected Delivery date _____
(b). Have you ever suffered from any complication during the previous pregnancy or delivery?	☐Yes ☐No
(c). Have you suffered from any disorder of the breast or reproductive organs including abnormal smear test (s) and irregular menses?	☐Yes ☐No
(d). Have you ever been pregnant? If yes, age at 1st pregnancy	☐Yes ☐No Age _____
(e). Have you ever been advised to have a repeat pap smear, repeat breast exam, mammography, or breast biopsy?	☐Yes ☐No
(f). Do you have a family history of breast cancer? (including grandmother, mother, aunts, sisters)	☐Yes ☐No
14. (a) Height _____(cm) and Weight _____(kg)	
(b) Has your weight been decreased by more than 3 kg in the last 12 months? If yes, please giver reason (if known) and the amount of weight lost. Reduced Amount _____ (kg) Reason _____	
15. Name and address of your attending physician(s) (List ALL).	

C. <u>For any question(s) in Section B to which your answer is "yes", please elaborate in this section (Please add additional page for details if necessary)</u>

The relevant question number from Section B	
Please specify as accurately as possible the name of the illness or medical problem.	
When did the symptoms start and when was treatment completed?	
What treatment did you receive and when (please include dates, names and details of medications)?	
What was the outcome of the treatment (eg, ongoing, completed recovery, recurrent or likely to recur)?	
Others	

D. Beneficiary(ies) - For Life Insurance Only

Insured Person's Name: _____

The following person(s) will be the beneficiary(ies) of Life Insurance for the above named Insured Person:				
Name in English	Name in Chinese	HK/Macau I.D. Card No./ Passport No.	Share (%)*	Relationship to the Insured Person

*If more than one beneficiary is designated, all policy proceeds will be paid to each beneficiary in equal share unless herein specified.

For child (ren) below 18 years of age will need parent/guardian to sign this Declaration on his/her behalf.

E. Declaration and Authorization

I declare and agree on behalf of myself and any person or persons, firm or corporation, who may have or claim any interest in any insurance on this health declaration that: -

(a) No statement, information or agreement made or given by or to the person soliciting or making this application form or by or to any other persons, shall be binding on AIA International Limited (herein called "AIA"), unless reduced to writing, and then only if presented to and approved by an officer specified in the relevant policy.

(b) All the foregoing statements and answers in this application form together with those in any required medical examination, questionnaire or amendments, are full, complete and true, and I understand that AIA, believing them to be such, will rely and act on them, otherwise any policy issued hereunder may be void.

(c) Any insurance herein applied for shall not take effect unless and until the relevant policy or policies is/are issued and delivered to me pursuant to my application form as completed and the first premium under the policy or policies requested is actually paid in full during my lifetime and good health, provided, however, that if any payment of premium is made in cash at the time of signing this application form and a conditional receipt issued. Therefore, the terms of the receipt shall apply hereto and are agreed to.

(d) All my declarations herein made, and my statements or answers in this application form and any required questionnaire or amendments together with the relevant policy shall constitute the entire contract between the parties thereto in so far as it may be relevant to the policy or policies I have requested.

(e) In the event of differences arising in respect of this application form, it is hereby noted and agreed that the English version which is the basis of all policies issued pursuant to this application form is considered absolute and binding.

(f) If I request AIA to provide copy of results of my medical examination initiated by AIA, AIA shall reserve the right to charge a corresponding service fee applicable at that time.

Furthermore, I hereby irrevocably authorize:

(i) Any organization, institution, or individual that has any record or knowledge of my employment, sick leave records, accident or loss details (of any sorts), health and medical history or any treatment or advice that has been or may hereafter be consulted to disclose to AIA such information. This authorization shall bind my successors and assignees and remain valid notwithstanding my death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

(ii) AIA or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests, to underwrite and evaluate my health status in relation to this application form and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immune deficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.

F. Personal Data Collection and Use

I confirm that I have read and understood the AIA Personal Information Collection Statement ("AIA PIC"). On behalf of myself, and my covered dependents (if applicable), I declare and agree that any personal data and other information relating to me or my covered dependents (if any) or my/our policy(ies) or investments contained in this application form or collected, obtained, compiled or held by AIA by any means from time to time may be collected and utilized in accordance with the AIA PIC. I acknowledge and consent to the transfer of my personal data (and that of my covered dependents, if any) outside of Hong Kong for the purposes and to the types of transferee as set out in the AIA PIC. The updated version of AIA PIC is available for download from its website: www.aia.com.hk, and is made available upon request.

_____ _____ on _____

Signature of Proposed Insured | Signature of Member Accountant | Date Signed

A child below 18 years of age will need parent/guardian to sign this Declaration on his/her behalf.