## Allianz 🕕

## HEALTHCARE PLANS FOR YOU AND YOUR FAMILY PLANS FOR HONG KONG

# **Application Form**

Please note that you can apply online for one of our International Healthcare Plans at www.allianzcare.com

#### Before you start, please consider that:

- You must complete the Application Form in full and tell us all relevant information.
- If you choose to complete a printed version of this form, **PLEASE COMPLETE IT IN BLOCK CAPITALS**.
- If you already have one of our healthcare plans and you are applying for a cover upgrade or for a new plan, please tell us about any medical conditions you have claimed for since joining us.
- The policyholder must sign Section 7.
- All adult applicants must sign Sections 8 and 11. In line with our legal obligations for processing data, we won't be able to process your application without these signatures. A parent or guardian should complete these sections for any applicants under the age of 18.
- All adult applicants wishing to appoint a broker as the main point of contact for this policy must sign Section 9.

#### Just for clarity...

You will see that we often refer to the following phrases in this form. This is what we mean: Home country: A country for which you (or your dependants, if applicable) hold a current passport or which is your principal country of residence. Principal country of residence: The country where you and your dependants (if applicable) live for more than six months of the year.

#### Please select your policy terms by ticking the relevant box below:

Moratorium Terms*	
Full Medical Underwriting Terms**	

#### \* Moratorium Terms

refer to a waiting period of 24 months from either the start date or the date shown in the special terms section of the Insurance Certificate that must have passed before claims for any pre-existing medical conditions may become eligible under the plan. This includes the underwriting term CPME/CTT previously MORI. Once the insured members have completed a continuous 24-month period after their start date, their pre-existing medical condition may be covered, provided that they have not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

#### \*\* Full Medical Underwriting Terms

refer to the assessment of insurance risk based on information that you give us when applying for cover. Our underwriting team uses this information to decide the terms of our offer.

#### If you are applying for a policy with moratorium, the below doesn't apply to you so you can skip to section 1.

#### What will happen next:

- 1. Once you have sent us your application, our Medical Underwriting Team will review the details.
- 2. If you have told us about any medical conditions, we may ask you for more information. We will then assess the information and get back to you with our decision as quickly as possible.
- 3. If any person applying for cover is undergoing dental treatment, please ensure that you complete a dental questionnaire as well. This can be requested by calling our Helpline.

## 1 Applicant's details (The applicant will be the policyholder)

Your contact details will also be used to communicate with you on important things regarding your policy. You must tell us if your contact details change over time, so we can ensure that correspondence reaches you.

We will consider applicants for cover up to the day before their 76th birthday if applying for a policy with full medical underwriting, or up to the day before their 65th birthday if applying for a policy with moratorium.

Mr. Mrs. Ms. Miss	Other															
First name																
Surname																
Date of birth D D /	M M / Y	YYY														
Gender at birth:	Male 🗆	Female 🗖														
Home country																
Nationality																
Principal country of residence	e															
Full address in principal cou	ntry of residenc	e (mandatory)														
Primary phone number	COUNTRY CODE		ARE	A COD	E											
Secondary phone number	COUNTRY CODE		ARE	A COD	E											
Email address (mandatory, plea	ase print)															
																٦
Occupation (mandatory – if you	are a student, plea	ise state it)							-					 		_
																٦
														 		_

#### Details of any current domestic or international health insurance:

Name of insurer																							
Policy number																							
Start date	DD	] / [	М	М	/ Y	Y	Y	Y															

## 2 Your dependants' details

You can add dependants to your policy. Dependant are your spouse/partner and any children financially dependent on you up to the day before their 18th birthday, or up to the day before their 26th birthday if they are in full-time education. If they are aged 18 to 25 and in full-time education, please attach either a letter from the college/university confirming their student status or a copy of their student ID. We will consider adult dependants for cover up to the day before their 76th birthday for policies with full medical underwriting, or up to the day before their 65th birthday for policies with moratorium.

If there is insufficient space for all dependants, please use another Application Form and ensure that all relevant Declaration(s) and Consent(s) are signed and dated.

	Dependant 1	Dependant 2	Dependant 3
Relationship to applicant	Spouse/Partner 🗆 Child 🗆	Spouse/Partner 🗆 Child 🗆	Spouse/Partner 🗆 Child 🗆
First name			
Surname			
Date of birth			
Gender at birth	Male 🗆 Female 🗆	Male 🗆 Female 🗆	Male 🗆 Female 🗆
Occupation (mandatory, please state if student)			
Email address (mandatory for dependants over 18)			
Home country			
Principal country of residence			
Nationality			
	and the second state and the solubly the second second		

Details of any current domestic or international health insurance

Name of current insurer (if applicable)		
Current policy number (if applicable)		

## 3 Start date of your cover

#### From what date do you require cover?

D / M M / Y Y Y

You will have confirmation that your application for cover has been accepted when we issue you the Insurance Certificate. Your cover will be valid from the start date shown on the Certificate.

## 4 Plan details

#### Select your area of cover:

The area of cover is subject to full terms and conditions as stated in the Benefit Guide.

Worldwide 🗆 Worldwide excluding USA 🗆

Next, please select the Core Plan and any optional plans that you require for your policy. Optional plans can only be purchased with a Core Plan; they can't be bought separately. You can find all details of the plans listed below in the Table of Benefits and Benefit Guide.

#### Select your Core Plan

	Hong Kong Care Pro	Hong Kong Care Plus	Hong Kong Care
Policyholder			
	If you select Hong Kong Care Pro or Hon the same Core Plan for all of your deper between Hong Kong Care Pro or Hong k dependants:	ndants (if any) or you can choose	☐ If you select Hong Kong Care, this Core Plan and any optional
Dependant 1			plans you select will apply to al persons included on your policy
Dependant 2			
Dependant 3			

#### Select your optional plans

#### **Out-patient Plans**

Policyholder	Hong Kong Active Pro 🗌 <b>OR</b> Hong Kong Active Plus 🗆 <b>OR</b> Hong Kong Active 🗆	
Dependant 1	Hong Kong Active Pro 🗆 <b>OR</b> Hong Kong Active Plus 🗆 <b>OR</b> Hong Kong Active 🗆	
Dependant 2	Hong Kong Active Pro 🗆 <b>OR</b> Hong Kong Active Plus 🗆 <b>OR</b> Hong Kong Active 🗆	Hong Kong Active 🛛
Dependant 3	Hong Kong Active Pro 🗆 OR Hong Kong Active Plus 🗆 OR Hong Kong Active 🗆	

#### **Maternity Plans**

An Out-patient Plan must be selected in conjunction with a Maternity Plan. Maternity Plans are available to couples and families i.e. a spouse/partner must also be insured on the policy.

Policyholder	Hong Kong Bloom Plus 🗆 🛛 OR Hong Kong Bloom 🗆	
Dependant 1	Hong Kong Bloom Plus 🗆 🛛 OR Hong Kong Bloom 🗆	Our Maternity Plans are not
Dependant 2	Hong Kong Bloom Plus 🗆 🛛 OR Hong Kong Bloom 🗖	available with the <b>Hong Kong</b> Care Core Plan.
Dependant 3	Hong Kong Bloom Plus 🗆 <b>OR</b> Hong Kong Bloom 🗆	

#### **Dental Plans**

If you select Hong Kong Smile Plus for anyone, all other applicants on your policy must select the Dental Plan available under their chosen Core Plan.

Policyholder	Hong Kong Smile Plus 🛛	Hong Kong Smile 🗆	
Dependant 1	Hong Kong Smile Plus 🛛	Hong Kong Smile 🛛	Hana Kana Smila 🗖
Dependant 2	Hong Kong Smile Plus 🛛	Hong Kong Smile 🛛	Hong Kong Smile 🛛
Dependant 3	Hong Kong Smile Plus 🛛	Hong Kong Smile 🛛	

#### **Repatriation Plan**

Policyholder	Hong Kong Repatriation Plan 🗆	
Dependant 1	Hong Kong Repatriation Plan 🗆	
Dependant 2	Hong Kong Repatriation Plan 🗆	Hong Kong Repatriation Plan 🛛
Dependant 3	Hong Kong Repatriation Plan 🗆	

If your plan is not listed in the sections above, please state your chosen Core Plan and any supplementary plans:

#### Select your Core Plan deductible

To reduce your Core Plan premium, simply select an optional deductible from the list below and read across to find the relevant premium discount. The level of discount will depend on whether you have selected a Maternity Plan. Please note that either a Core Plan deductible OR an Out-patient Plan co-payment can be chosen (details follow). Where a deductible is selected it is payable per person, per Insurance Year. Also, our premiums are expressed in whole numbers (i.e. without any cents or pence etc.), therefore, percentages may be slightly higher or lower than those stated below.

Optional Core Plan Deductibles	Discount if a Maternity Plan is not included in your policy	Discount if a Maternity Plan is included in your policy
No deductible	0% premium discount	0% premium discount
US\$ 610/ HKD 4,760 deductible	5% premium discount	2.5% premium discount
US\$ 1,015/ HKD 7,920 deductible	10% premium discount	5% premium discount
US\$ 2,025/ HKD 15,800 deductible	20% premium discount	10% premium discount
US\$ 4,050/ HKD 31,590 deductible	35% premium discount	17.5% premium discount
US\$ 8,100/ HKD 63,180 deductible	50% premium discount	25% premium discount
US\$ 13,500/ HKD 105,300 deductible	60% premium discount	30% premium discount

#### Select your Out-patient Plan co-payment

Please note that either an Out-patient Plan co-payment OR a Core Plan deductible can be chosen. Where a co-payment is selected it is payable per person, per Insurance Year. Also, our premiums are expressed in whole numbers (i.e. without any cent), therefore, percentages may be slightly higher or lower than those stated below.

Optional Out-patient Plan co-payments	Discount
No co-payment	0% premium discount
10% co-payment, max. US\$ 2,000/ HKD 15,500	12% premium discount
20% co-payment, max. US\$ 4,000/ HKD 31,000	24% premium discount
30% co-payment, max. US\$ 5,000/ HKD 38,750	35% premium discount

## 5 Pre-existing medical conditions

#### If you are applying for a policy with full medical underwriting:

Pre-existing conditions are medical conditions for which one or more symptoms have appeared at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment.

We would deem any such condition to be pre-existing if we could reasonably determine that you or your dependants have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you complete the Application Form and the later of the following:

- The date we issue your Insurance Certificate, or
- The start date of your policy.

Pre-existing conditions will be subject to full medical underwriting and if they are not disclosed, they will not be covered. Therefore, it is important that in the periods outlined above, you inform us if there is any change to your and your dependants' health status or to any material facts (facts likely to influence our assessment and acceptance of this application). In addition, you will need to provide further information, if requested.

If you already have one of our healthcare plans and are applying for a cover upgrade or for a new policy, please tell us about any medical conditions you have claimed for since joining us.

#### If you are applying for a policy with moratorium:

As you are applying for a policy with moratorium terms, we want to clarify the conditions and procedures that will apply to your moratorium cover. Please ensure that you read the definition below which summarises how the moratorium will work – the full terms and conditions are detailed in the Benefit Guide.

Moratorium (MORI) is a waiting period of 24 months from either your start date or the date shown in the special terms section of your Insurance Certificate that must have passed before claims for any pre-existing medical conditions may become eligible under the plan.

Your claim will not be paid if it's relating to a pre-existing medical condition, should one or more of the following have applied within the 24-month period before your start date (or the date shown in your Insurance Certificate):

- It could be reasonably foreseen that the medical condition would occur after your start date.
- The condition clearly showed itself.
- You had signs or symptoms of the condition.
- You asked for advice about the condition.
- · You received treatment for the condition.
- To the best of your knowledge, you were aware you had the condition.

Once you've completed a continuous 24-month period after your date of joining, we may cover your pre-existing medical condition provided you've not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

## 6 Your health

per week?

if none state NO

1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit,

Please answer the following questions based on your own and your dependants' full medical history. You must disclose all material facts (i.e. facts likely to influence our assessment and acceptance of this application). If you are in any doubt about whether a fact is material, then you should disclose it to us. Failure to disclose all material facts may invalidate the policy.

This health declaration is valid for two months from the date you complete and sign the form.

	Applicant	Dependant 1	Dependant 2	Dependant 3			
Height	cm	cm	cm	cm			
Weight	kg	kg	kg	kg			
	Please note: <b>only</b> if you are applying for a <b>policy with moratorium</b> , you don't need to comple rest of this section 6 and <b>you can now skip to section 7</b> .						
Have you used any form of tobacco in the past year? If yes, how much per day on average? 1 cigarette = 1 unit, 1 medium cigar = 2 units, 1 gram roll-your-	Yes 🗌 No 🗌	Yes 🗌 No 🗌	Yes 🗌 No 🗌	Yes 🗌 No 🗌			
own tobacco = 2 units, 1 pipe bowl tobacco = 2.5 units, 10mg e-cigarette nicotine = 1 unit, if none state NO	/day	/day	/day	/day			
Do you drink alcohol?	Yes 🗆 No 🗆	Yes 🗆 No 🗆	Yes 🗆 No 🗆	Yes 🗌 No 🗌			
If Yes, how many units of alcohol do you drink							

/week

/week

/week

## Has any person included in this application ever suffered from, been in hospital with, or had tests, investigations or treatment of any kind, for the following conditions?

/week

a)	Any heart or circulatory disease or disorder, such as, but not limited to, heart attack, coronary artery disease, vascular disease, irregular heartbeat, murmur, chest pain, clots, blood disorder, abnormal blood pressure, high cholesterol, etc.	Yes 🗌 No 🗌
b)	Any dermatological disease or disorder, such as, but not limited to, psoriasis, dermatitis, eczema, allergy, acne, etc.	Yes 🗌 No 🗌
c)	Any endocrine disease or disorder, such as, but not limited to, diabetes, pancreatitis, weight problems, gout or thyroid problems or other hormonal imbalances, etc.	Yes 🗌 No 🗌
d)	Any eye, ear, nose and throat disease or disorder, such as, but not limited to, cataract, glaucoma, detached retina, hearing loss, ear infections, sinus problems, tonsillitis, adenoiditis, myopia with levels greater than -6, etc.	Yes 🗌 No 🗌
e)	Any gastrointestinal disease or disorder, such as, but not limited to, stomach problems, hernia, haemorrhoids, gall stones, colon polyps, Crohn's disease, colitis, liver problems, etc.	Yes 🗌 No 🗌
f)	Any infectious or viral disease or disorder, such as, but not limited to, hepatitis A/B/C, herpes, HIV, SARS-CoV-2 / COVID-19, malaria, meningitis, blood infection, sexually transmitted disease, etc.	Yes 🗆 No 🗆
g)	Any muscular or skeletal disease or disorder, such as, but not limited to back, neck or joint pain, arthritis, fibromyalgia, joint replacement, any cartilage and/or ligament problem, carpal tunnel syndrome, etc.	Yes 🗌 No 🗖
h)	Any neurological disease or disorder, such as, but not limited to, stroke, multiple sclerosis, epilepsy, neurodegenerative disorder, paralysis, seizures, migraine, Alzheimer's or other form of dementia, etc.	Yes 🗌 No 🗖
i)	Any oncological disease or disorder, such as, but not limited to, any cancer, leukaemia, lymphoma, tumour, skin lesion, growth, lump, cyst, mole, polyp, naevus, etc.	Yes 🗌 No 🗌
j)	Any psychiatric or psychological disorder, such as, but not limited to, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, depression, anxiety, chronic fatigue syndrome, eating disorder, obsessive-compulsive disorders, phobic disorders, alcohol/drug problem, etc.	Yes 🗌 No 🗌
k)	Any respiratory or lung disease or disorder, such as, but not limited to, chronic obstructive pulmonary disorder, sarcoidosis, asthma, bronchitis, sinusitis, shortness of breath, allergy, etc.	Yes 🗌 No 🗌
l)	Any urological or reproductive organs disease or disorder, such as, but not limited to, kidney or urinary tract problem, menstrual impairment, fertility problem, fibroids, endometriosis, testicular or prostate problem, etc.	Yes 🗌 No 🗌
m)	Any congenital disease or disorder present at or before birth, such as but not limited to adrenal hyperplasia, cystic fibrosis, Down syndrome, haemophilia, heart defects, Huntington's disease, Klinefelter's syndrome, Marfan syndrome, malformations and spina bifida.	Yes 🗌 No 🗌
	Please do NOT disclose results of any genetic (DNA or RNA) tests as these are not required for the underwriting process.	
n)	Any other accident, injury, disease or disorder not already disclosed.	Yes 🗌 No 🗌
Ple	ease tell us whether you or your dependants:	
0)	Are currently taking any prescribed or over-the-counter drugs, medication, tablets or other treatment.	Yes 🗌 No 🗖
p)	Are expecting to have a medical review, have been referred for further tests/investigations, or are awaiting results or any treatment due to accident, injury, disease or disorder.	Yes 🗌 No 🗌
q)	Have undergone any tests or investigations within the last 10 years which resulted in referral for further medical advice or treatment, such as, but not limited to biopsy, colonoscopy, colposcopy, computed tomography (CT), mammogram, magnetic resonance imaging (MRI), Papanicolaou test (PAP) or prostate-specific antigen test (PSA), echocardiogram (Echo), ultrasound (US), etc.	Yes 🗌 No 🗖

Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting.

- r) Have experienced, within the past two years, any recurrent or ongoing symptoms or medical complaints NOT related to a condition already disclosed such as, but not limited to:
  - Fever (103°F/39.4°C or above) and/or continuous cough
  - Shortness of breath
  - Hoarseness
  - Severe/ongoing headache
  - Mole or skin marking that has bled, changed or become painful
  - Tingling
  - Blurred or double vision
  - Unexpected weight loss
  - Bleeding per rectum, change in bowel habit or urine frequency
  - Loss of sensation, seizures, loss of consciousness
  - Abnormal bleeding
  - Joint pain/stiffness

## s) Have been, within the past 30 days, recommended or decided to self-isolate?

#### Please complete the following question only if you are purchasing dental cover.

t) Is any person included in this application currently undergoing or have they been advised to undergo any dental treatment, dental surgery, dental prosthesis, orthodontics or periodontics? Yes No
 If yes, please complete our Dental Questionnaire. You'll find it here:
 www.allianzcare.com/en/international-individual-health-insurance/paper-applications/

#### Additional information for 'Yes' answers

If you answered Yes to any part of the questions from a) to t) above, please provide details in the table below. Please tell us if a full recovery has been made or if you or your dependants have any medical condition or disease related to or arising from the original diagnosis. Please enclose supporting up-to-date medical reports/test results if possible.

Question	Name of the person affected by the medical condition	Diagnosis – where applicable state the area of the body affected (e.g. left arm, right foot)	Exact date of onset of the condition	Frequency and severity of symptoms	Date of last symptoms	Investigations, blood tests or readings (please include the dates, results and any diagnosis)	Past and current treatment (please include name, dosage and frequency of usage of medication and provide dates of when treatment started, how often it was required and when it ended)	Current status (e.g. any complications, complete recovery, recurrent or ongoing)

Yes 🗌 No 🗌

Yes 🗆 No 🗆

Please provide the name, address and telephone number of the regular/family doctor for everyone included in this application. Please use a separate sheet if the space provided is not sufficient.

## 7 Declaration

Please read the following declarations carefully and only sign below if you understand and accept them.

- I declare that all information supplied above is true and complete, including those answers that are not in my own handwriting. I also declare that I have
  not suppressed, misrepresented or misstated any material fact. I understand that this application will be the basis of the contract between Allianz Global
  Corporate & Specialty SE, Hong Kong Branch and myself, and that any false, incorrect or misleading statement or non-disclosure of material information
  may make this insurance null and void.
- If applying for a policy with full medical underwriting, I undertake to inform Allianz Global Corporate & Specialty SE, Hong Kong Branch immediately in writing of any changes in my or my dependants' state of health occurring between completing the Application Form and the start date of the policy.
- I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information in the context of this application for insurance. I consent to allow Allianz Global Corporate & Specialty SE, Hong Kong Branch, if it considers it appropriate, to check statements concerning my health condition and to check with other healthcare insurers all statements concerning previous or existing contracts I may have applied for.
- Subject to legal restrictions, Allianz Global Corporate & Specialty SE, Hong Kong Branch (or its medical advisers, appointed representatives or third-party
  experts in case of disputes) may request medical information about me from medical professionals. In these circumstances I authorise all such practitioners,
  physicians, dentists, members of medical professions, and employees of hospitals, health authorities and medical facilities to provide relevant medical
  information as requested. I also make this statement for my dependants under the age of 18 and for dependants who cannot assess the meaning of this
  statement.
- I confirm that:
  - I have read and understood the full definitions, benefits, exclusions and conditions of this policy, including the details relating to pre-existing conditions
    (and the moratorium conditions if applying for a policy with moratorium).
  - I accept the terms and conditions as summarised and further explained in my Benefit Guide.
  - Based on the information provided within these documents and the plan selections that I have made, I believe the product I selected is most suited to my specific insurance needs.
- I understand that:
  - This Application Form is valid for two months from the date of completing and signing it.
  - I can withdraw my application in writing by letter or email within 30 days from the date I receive the full terms and conditions of my policy. Provided that I have not submitted a claim, I am then entitled to a full refund of the premium.
- I accept that:
  - It is my responsibility to check the accuracy of the information contained within the Insurance Certificate, once issued. If the content is not in accordance with the Application Form but I enter no protest within 30 days following the issue date of the Insurance Certificate, I will be considered to have accepted the offer of cover.
  - Cover will be subject to the standard terms and conditions that apply at the start or renewal date of the policy and are set out in the Benefit Guide.
  - The cover provided by Allianz Global Corporate & Specialty SE, Hong Kong Branch may not be suitable if my dependants and I are or become resident in countries where local compulsory health insurance restrictions are in place (e.g. Switzerland).
  - It is my responsibility to check if I am subject to any local compulsory health insurance requirements in my country of residence and I can confirm that my healthcare cover is legally appropriate.

#### As the applicant, I sign and date this form for and on behalf of everyone included in this application.

Applicant's signature	
Applicant's printed name	
Date	

#### 8 Policyholder appointment

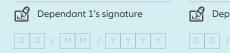
#### This section must be completed by all dependants wishing to appoint the policyholder as the main point of contact.

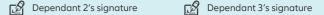
To help us administer the policy, you can nominate the policyholder as the main contact for the insurance. To do this, simply sign below.

l authorise

INSERT NAME OF POLICYHOLDER

to act on my behalf in the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I ask Allianz Global Corporate & Specialty SE, Hong Kong Branch in writing to revoke it.





## 9 Broker appointment (if applicable)

auth	orise
addi	101150

INSERT NAME OF BROKER

For office use only — Agent details and stamp

to act on my behalf in relation to the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I ask Allianz Global Corporate & Specialty SE, Hong Kong Branch in writing to revoke it.

Applicant's signature	Dependant 1's signature	Dependant 2's signature	Dependant 3's signature
DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY

#### 10 Your personal data

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. To read our Data Protection Notice, visit: https://www.agcs.allianz.com/footer/privacy-notice.html

Alternatively, you can contact us on + 353 1 630 1301 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by email at: AP.EU1DataPrivacyOfficer@allianz.com

#### 11 Data consent

We need your consent to collect and process your health and other personal data . If you do not give explicit consent, we may not be able to provide you with your policy or process any claims you may be entitled to make. If you agree, we will process your data for the following reasons and activities.

A parent or guardian should complete the consent for any member under the age of 18.

#### I (the applicant), and the dependants named below agree with the following:

Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3

- Permission to collect, store and use my health data: Allianz Global Corporate & Specialty SE, Hong Kong Branch may collect, store and use my health data to administer the policy, for example to provide me with a quote for insurance cover, underwrite the risks to be insured or process any claims. Allianz Global Corporate & Specialty SE, Hong Kong Branch may store my health data in accordance with the Consumer Code of the law applying to this insurance policy or with any other applicable law requiring the retention of the data.
- Permission to obtain my data from third parties. To provide me with insurance cover, underwrite the risks to be insured or process any claims, Allianz Global Corporate & Specialty SE, Hong Kong Branch may obtain my health and other data from physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, my plan sponsor, professional associations and public authorities. I agree to release all individuals at these institutions and Allianz Global Corporate & Specialty SE, Hong Kong Branch from their respective confidentiality obligations relating to my health data or other data that they have to share and use for the purposes stated above.
- Sharing my data outside of Allianz Global Corporate & Specialty SE, Hong Kong Branch. Allianz Global Corporate & Specialty SE, Hong Kong Branch may share my health and other data with the experts or institutions set out below. They will only use the data to the same extent and for the same purposes as Allianz Global Corporate & Specialty SE, Hong Kong Branch. I understand that Allianz Global Corporate & Specialty SE, Hong Kong Branch has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and Allianz Global Corporate & Specialty SE, Hong Kong Branch has put in place arrangements with their respective confidentiality obligations relating to my health data and other data that they have to share and use for the purposes set out below:
  - With independent medical experts to enable them to assess insurance risks and any benefits to be paid to me or to the third party providing treatment or service to me under my insurance policy.
  - With service providers outside of the Allianz Group of companies that perform certain services on behalf of Allianz Global Corporate & Specialty SE, Hong Kong Branch, such as risk assessments and claims handling, where:
    - these services involve the collection and use of my health and other data, and
    - Allianz Global Corporate & Specialty SE, Hong Kong Branch would not be able to administer my policy or pay any claims due to me without such data.
  - With co-insurers to distribute the coverage of the insurance risk jointly with other companies to which Allianz Global Corporate & Specialty SE, Hong Kong Branch issues the policy, and to handle claims jointly.
  - With other insurers/reinsurers that may be covering the same insurance risk at the same time (multiple insurance) to:
    - distribute the payment of any compensation that may be owed to me, or
    - collaborate in the detection or prevention of fraud and financial crime.

If I change my mind about my preferences above, including withdrawing my consent to any of these items, I can let Allianz Global Corporate & Specialty SE, Hong Kong Branch know by emailing AP.EU1DataPrivacyOfficer@allianz.com

🖉 Applicant's signature 🖉 Dependant 1's signature 📝 Dependant 2's signature 📝 Dependant 3's signature

## 12 Marketing preferences

I (the applicant) and my dependants agree that Allianz Global Corporate & Specialty SE, Hong Kong Branch may collect, use and disclose my personal data to provide me with marketing information. I understand that my personal data will only be used for the following reasons and activities, which I have expressly agreed to by ticking the boxes below.

	Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3
Information that Allianz Gla promotions and new produ		ong Kong Branch sends about thei	r products and services, including	updates on their latest
Information sent directly by them for that purpose.	other Allianz Group companies c	n their products and services. I un	derstand that you will disclose my	relevant contact information to
	the business partners of Allianz C evant contact information to ther		long Kong Branch on their produc	ts and services. I understand
Such communications shou	ld be sent to me by the following	methods:		
Email				
In-app notifications				
Phone				
Post				

## 12 Payment details

Please don't make any payments until you receive your policy number.

#### **Payment currency**

Please tick to indicate your preferred payment currency:

Payment frequency a	and method
---------------------	------------

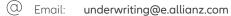
Payments are subject to the following administration surcharges: 0% for annual payment, 3% for half-yearly payments, 4% for quarterly payments and 5% for monthly payments.

US Dollars	
HK dollars	

Please tick to indicate your preferred payment frequency and method:

	Annual	Half-yearly	Quarterly	Monthly
Card				
Bank transfer				Not available

## Please return your fully completed form by:



Post:

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Allianz Care 15 Joyce Way Park West Business Campus Nangor Road Dublin 12, Ireland

If you have any questions regarding this Application Form or the application process, please contact our Helpline on: **+852 3077 5486** 

The insurer is Allianz Global Corporate & Specialty SE (incorporated in the Federal Republic of Germany with limited liabilities), Hong Kong Branch, address Suites 403-11, 4/F, 12 Tai Koo Wan Road, Tai Koo Shing Island East Hong Kong, Hong Kong, Company Registration No. F18771.

This policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. Part of the Allianz Group, AWP Health & Life SA is registered in France: No. 401 154 679 RCS Bobigny. Irish Branch is registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. AWP Health & Life SA provides administration services and technical support for the policy. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.