redefining / standards

AXA General Insurance Hong Kong Limited
21/F, Manhattan Place, 23 Wang Tai Road
Kowloon Bay, Kowloon, Hong Kong
(852) 2523 3061
(852) 2810 0706
axahk@axa-insurance.com.hk
www.axa-insurance.com.hk

Application Form

InternationalExclusive

Please complete this form using Block Capitals and by ticking the relevant boxes. It is important that you provide the following information so that we can properly assess your application. If, therefore, you do not answer the questions we shall take that failure to answer to mean that you have nothing to disclose. **This application must be completed by you or your parent/legal guardian in your/their own handwriting. If you need to make a correction, please initial the change.**

1. Personal details of the applicant (please keep us informed of any change of your address)

Name of applicant - surname:		
Given name:		Sex:
HKID card no/passport no:	Date of birth: dd / mm / yyyy	Nationality:
Marital status: ☐ Single ☐ Married		
Principal country of residence* and address:		
Home country address if different from principal country of residence:		
Correspondence address if different from principal country of residence:		
Telephone no: country code area code phone no.	Fax no:	Mobile no:
Email:	Name of company/employer:	
Occupation/job position:	Job nature:	

* The country where you live or intend to live for most of the year being 185 days or more and which will be shown as your address and place of residence in our records.

2. Your choice of plan (The plan selected would be the same for each person covered by this application)

		Mode of premium payment
Plan	☐ **International**Exclusive ☐ **International**Exclusive Plus	☐ **Cheque -** Crossed and made payable to **AXA General Insurance Hong Kong Ltd** Bank ______ Cheque no ______
Currency of plan cover and premium payment	☐ HKD ☐ USD	☐ **Credit Card** Please complete the credit card authorization section
Zone#	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	
Area of cover	☐ Asia ☐ Worldwide excluding USA ☐ Worldwide	

Plan to commence on ______________ (dd/mm/yyyy) for one year. No liability will be accepted until this application has been accepted by AXA and the premium is received. The cover will be subject to no change in information as declared by you in this application form and at the time of commencement of the plan. Please declare to us any change in information as soon as it is known to you. Failure to do so may result in claims or benefits being refused or cover withdrawn.

Please refer to the premium table for your applicable zone.

3. Bank account details (for claim payment purposes only)

Account holder name ______________________________

Bank name ______________________ Account no ______________________

4. Medical practitioner(s) most frequently used in the last 5 years

Medical practitioner(s) name:	
Address:	
Telephone no:	Fax no:
Email:	

Please continue on the back of this form if required.

5. Persons to be covered

Is the applicant one of the persons to be covered? ☐ Yes ☐ No

Additional family members to be covered^				
1	Surname:	Given name:		Nationality:
	Relationship to the applicant:	Sex:	Date of birth: dd / mm / yyyy	Passport no/HKID card no:
	Principal country of residence*:			
	Occupation/job position:		Job nature:	
2	Surname:	Given name:		Nationality:
	Relationship to the applicant:	Sex:	Date of birth: dd / mm / yyyy	Passport no/HKID card no:
	Principal country of residence*:			
	Occupation/job position:		Job nature:	
3	Surname:	Given name:		Nationality:
	Relationship to the applicant:	Sex:	Date of birth: dd / mm / yyyy	Passport no/HKID card no:
	Principal country of residence*:			
	Occupation/job position:		Job nature:	
4	Surname:	Given name:		Nationality:
	Relationship to the applicant:	Sex:	Date of birth: dd / mm / yyyy	Passport no/HKID card no:
	Principal country of residence*:			
	Occupation/job position:		Job nature:	

* The country where you live or intend to live for most of the year being 185 days or more and which will be shown as your address and place of residence in our records.
^ Additional family members to be covered under the same application must be living with you. If you want to cover family members not living with you, please use a separate application form.

6. Existing or any previous health insurance

Question	Yes	No
Does any of the person to be insured have a current health cover or previously had a health cover with any insurer, including AXA?	☐ Yes	☐ No
Has any person to be insured ever been rejected, postponed, accepted at special terms for life or health application by an insurance company, or its renewal been refused?	☐ Yes	☐ No

If answer to any of the above question is "Yes", please provide details below (including name of the insurance company, scheme/plan name, period of insurance and membership number, if available).

7. Confidential medical history (Declarations must be made in writing on this application. Verbal declarations WILL NOT be accepted)

Please Note: (i) NO LIABILITY WILL BE ACCEPTED FOR ANY MEDICAL CONDITION WHICH ORIGINATED BEFORE THE DATE OF ENROLMENT OR WHICH WAS FORESEEABLE AT THE TIME OF APPLICATION unless such medical condition has been declared to and accepted by AXA in writing. (ii) Failure to notify AXA of a medical condition may result in claims for benefit being refused or cover withdrawn. If you are in any doubt you should disclose the medical condition. Please ensure that you fully disclose any known or suspected conditions and symptoms experienced by anybody included in this application. This applies even if professional advice has not yet been sought. Typical examples are varicose veins, allergies, backache, foot disorders e.g. bunions, piles, gynaecological problems (including any irregularities of menstruation), complications of pregnancy, digestive irregularities, skin problems, trouble with heart, limbs, eyes, nerves, any ear, nose or throat problems or any pains, swellings, lumps or fever.

Part A You must declare your medical history even if you have been insured with us or anyone else before

Please consider the following six questions as they apply to each of the people named. Answer each question by clearly ticking one of the corresponding Yes/No boxes.	Applicant Name		1st Family member Name		2nd Family member Name		3rd Family member Name		4th Family member Name	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has any in-patient stay in a hospital or nursing home taken place within the last five years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Has any specialist/medical practitioner been consulted within the last five years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Have you experienced any symptoms but not consulted a medical practitioner in the last five years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Has any medical practitioner been consulted and/or provided prescriptions for any drugs or medication within the last two years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Does any chronic/long-term medical or dental condition exist or has there been any other known disability, abnormality or recurrent illness or injury during the last five years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Is there any known or foreseeable need to consult any doctor or other health professional?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If there is any major condition falling outside the five years period mentioned above that we should know about, in good faith you must declare it.

Part B* (Please use block capitals throughout)

1. Name of patient	2. Relevant section of Part A	3. Nature of illness/disability and treatment received	4. When did it start		5. How long did it last	6. Need for any further treatment or consultation	7. Present state of health in this respect
			Month	Year	Duration		

* Please continue on the back of this form if necessary. This part applies if you have indicated 'Yes' replies in Part A. Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply. Use column 3 to list them separately and give the further detailed information required by columns 4 to 6.

8. Your signature and declaration

Declaration: I declare that to the best of my knowledge and belief the statements on both sides of this application form are full, true and correct, that I shall read the AXA **International**Exclusive Membership Agreement when received and that I agree to be bound by it. In the event of any dispute, I agree to follow the AXA General Insurance Hong Kong Limited arbitration process in the first instance. I agree that the acceptance of my application shall be on the basis of these statements. I agree that AXA may contact my/our medical practitioner(s) for further details of my/our medical history and authorize such practitioner(s) to release any information AXA may require.

Signature ✗ ______________ Print name ✗ ______________ Date ✗ ______________

Please note: You are advised to keep a record of all information supplied in connection with this application, including any letters you send to us in connection with it. If you would like a copy of this application please let us know within three months. **After completing this application form and signing the Declaration, please return to AXA General Insurance Hong Kong Limited or broker office.**

Credit card authorization form

I hereby authorize AXA General Insurance Hong Kong Limited to charge my below Credit Card Account an appropriate amount in respect of premiums for my subscription.

Signature ✗ ______________________ Date ✗ ______________________

Credit card details

☐ VISA ☐ MasterCard ☐ Diners ☐ AMEX

Cardholder's name ______________________ Card no. ______ – ______ – ______ – ______

Expiry date (mm/yy) ______________________ Card Verification Value code (CVV)* ______

Amount to be debited ☐ HKD ☐ USD ______________

Cardholder's signature ✗ ______________________ Date ✗ ______________________

CVV * - Applicable to Visa and MasterCard only. The CVV is the last 3-digit no printed just above the signature panel in reverse italics on the back of your card.

If the above details are different for any additional persons, please list below.

Additional information

For AXA use only

Underwriting terms pertaining to this application

Underwriting terms accepted by applicant

☐ Yes ☐ No

Print name ______________________ Date ______________

Authorized signature ______________________

Underwriter's stamp	Membership number	Effective date

Broker/Agent name ______________________ Broker/Agent code ______________

HAP-PF-0110