CHUBB®

Agent's/Intermediary's Name
Agent's/Intermediary's contact phone no.
Agent's/Intermediary's code
Agency –

Addition of Riders (for Agent only)

Please tick ☑ appropriate box(es) for request ☐ New Request ☐ Reply

Policy Number:	Full Name of Insured:	Full Name of Policyowner:

This form is applicable to addition of riders for Insured only. If you would like to apply addition of riders for Other Insured (e.g. apply Child's Protection Benefit "CPBB"), please fill in Request For Change in Policy Form & Statement of Insurability accordingly. The current company record will be used for underwriting (if necessary). Should there be any change(s) on personal/financial information, please submit Request For Change in Policy Form accordingly.

For PRC customers applying Super Care Early Stage Illness Benefit/Living Well Benefit rider series/VCare Cancer Protector/Hospital and Surgical Benefit/Select Medical Top Up Plan/Hospital Cash, please fill in Application Supplement For Critical Illness/Cancer/Hospital/Personal Accident Plan (NB350).

In compliance with the legal and regulatory requirements with respect to the prevention of money laundering and terrorist financing, the Company requires to collect your identity information. If the identity document(s) of the policyowner has (have) not been provided before or has (have) been updated, please submit the copy(ies) of the latest and valid identity document(s) for our record.

1. **The New Sum Assured must be in Policy Currency.**
   Effective month _____/_____ (mm / yyyy)

Critical Illness

Living Well Benefit

☐ CIBL-BASIC ☐ CIBR-BASIC
☐ CIBL-BASIC-PRC ☐ CIBR-BASIC-PRC
☐ CIBL-TERM ☐ CIBR-TERM
New Sum Assured _____

Living Well Plus Benefit

☐ CIBPL ☐ CIBPR
☐ CIBPL-PRC ☐ CIBPR-PRC
New Sum Assured _____

Living Well Supreme Plus Benefit

☐ CIBSL ☐ CIBSR
☐ CIBSL-PRC ☐ CIBSR-PRC
New Sum Assured _____

VCare Cancer Protector

☐ RCBR ☐ RCBRC ☐ Plan 1 ☐ Plan 2

Super Care Early Stage Illness Benefit (Basic Option)

☐ ESP18 ☐ ECP18 ☐ ESPR
☐ ESP22 ☐ ECP22 ☐ ECPR
☐ ESPL ☐ ECPL
New Sum Assured _____

Super Care Early Stage Illness Benefit (Enhanced Option)

☐ ESS18 ☐ ECS18 ☐ ESSR
☐ ESS22 ☐ ECS22 ☐ ECSR
☐ ESSL ☐ ECSL
New Sum Assured _____

Super Care Multiple Protection Benefit

☐ MCI ☐ MCC
New Sum Assured _____

Medical

Hospital Cash Benefit (HC)

New Daily Benefit _____

Select Top-Up Medical Plan (TUR)

☐ Class I (Private) ☐ Class II (Semi-private) ☐ Class III-1 (Ward) ☐ Class III-2 (Ward)

Hospital & Surgical Benefit

☐ HS09 ☐ HSC9
☐ Class I (Private) ☐ Class II (Semi-private) ☐ Class III (Ward)
☐ Class I Plus (Private) ☐ Class II Plus (Semi-private) ☐ Class III Plus (Ward)

Personal Protection / Accident

Juvenile Accident Protector

☐ JAP New Sum Assured _____

Optional Benefit
☐ JAPMB* New Sum Assured _____

* JAPMB cannot be applied alone without JAP.

The One Accident Protector (FNA form (NB205) is required)

☐ PAR10 ☐ PAR20 New Sum Assured _____

Personal Accident Benefit

☐ PAADD New Sum Assured _____

Optional Benefit
☐ PAMB* New Sum Assured _____
☐ PAWAI* New Sum Assured _____

* PAWAI and PAMB cannot be applied alone without PAADD.

Others

Waiver of Premium Benefit ☐ WPB

Multi-Select Term

☐ MS1R ☐ MS15R
☐ MS5R ☐ MS20R
☐ MS10R ☐ MS25R
New Sum Assured _____

Lady's Partner Plan - Female Cover

☐ LDFML New Sum Assured _____

Optional Benefit
☐ LDPGY* New Sum Assured _____
☐ LDFCP* New Sum Assured _____

* LDPGY and LDFCP cannot be applied alone without LDFML.

2. **Change of Sum Assured/ Notional Amount/Rider**

Effective Month _____ / _____
mm yyyy

Basic Plan/Rider	New Addition ^	Deletion #	Increase ^	Reduce #	New Sum Assured/ Notional Amount/Class
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____

^ New addition or increase of sum assured/notional amount or upgrade of benefit requires to submit "Statement of Insurability" for the application. Please submit NB428 "Standardized Underwriting Questionnaire for Chubb VHIS" if applying VHIS product.

^ New addition or increase of sum assured for product(s) with cash value requires to submit proposal.

Rider deletion or reduction of sum assured/notional amount, **NO** back-dating is allowed. If the effective month is not specified, the request will be effective on the next premium due date or on the specified date as stated in product provisions of specific products.

Target Healthcare Needss

(Only applicable to application of critical illness and/or medical insurance product. Apart from the mentioned products, please submit Financial Needs Analysis form.)

If you are considering critical illness and/or medical insurance product(s) to meet your objective of preparation for healthcare needs, what type(s) of the following critical illness and/or medical insurance product(s) will you consider to purchase? (You may tick one or more)

☐ Product offering a lump sum payout if I were to be diagnosed with a critical or specific illness.

☐ Product Reimbursing relevant medical expenses if I need to be hospitalized or undergo a surgery.

☐ Product providing small regular payouts during the period of hospitalization to compensate relevant loss or other expenses.

I confirm that I have conducted an assessment on the insurance product(s) to be purchased by me in order to ensure that I am able to pay the required premiums.

Questions 3-20 are applicable for INSURED only

3. Employer's name: _____ 4. Present occupation (including any part-time job): _____

5. Exact duties: _____

6. What is your monthly earned remuneration in average for the past 12 months? (Gross earnings excluding investment income less business expenses but before tax)

   Insured's monthly salary (HK$): _____

7. Do you have any in-force or pending insurance with other insurer(s) (new application or reinstatement) ? If "Yes", please state amount/sum assured and currency.

	Insurer	Life	Critical Illness	Disability Income	Hospital Income	Weekly Accident Indemnity	Accident Insurance	Date of Issue (mm/yyyy)
☐ Yes ☐ No								

8. Have your policy(ies) ever been voided/non-renewed or you ever been refused for applying insurance or reinstatement of it, or been offered a policy different in plan, term, amount/sum assured or premium from that applied for with other insurer(s)? If "Yes", please give name of insurer, date of application, amount/sum assured and the reason. Yes ☐ No ☐

   Details: _____

9. Do you participate or intend to participate in any hazardous activities whether related to your work or recreation? If "Yes", please complete and submit the appropriate questionnaire(s). ☐ ☐

10. Do you intend to travel outside of Hong Kong (including business trips and study) except holidays? If "Yes", what is the purpose of the trip, for how long will you be away, what is the destination and how often will you go per year? ☐ ☐

    Details: _____

11. Please provide the following information of the physician of the Insured last visited.

a. Full name of the physician: _____

b. Address: _____

c. Phone no.: _____ d. Last consultation date (dd / mm / yy): _____ /_____ /_____

e. Consultation reason, diagnosis and recovery date: _____

		Yes	No
12.	a. Height: _____m_____cm / _____ft_____inch b. Weight: _____kg / _____lb		
	c. Have you experienced weight loss of more than 5kgs (11lbs.) during the past 12 months? If "Yes", please state exact weight loss amount and the reason.	☐	☐
13.	This question is applicable **for female only**. (Applicable to age 12 or above)		
	a. In the past 10 years, have you ever had or been told to have or been treated for, or intending to be treated for disorder of pelvic organs, breast, menses or pregnancy? Are you now pregnant? If "Yes", please state the expected delivery date.	☐	☐
	b. Have you ever had, or been told to have, or are you intending to have mammogram, ultrasound of breast or pelvis, pap smear, cone biopsy or colposcopy?	☐	☐
	c. Have you ever had complications of pregnancy during gestation in the past 10 years (e.g. ectopic pregnancy, miscarriage, disseminated intravascular coagulation, diabetes or hypertension, etc.)?	☐	☐
14.	This question is applicable **for juvenile only**. (Applicable to age on or below 15)		
	a. Was the child's birth premature or postmature?	☐	☐
	b. Any special care needed after birth?	☐	☐
	c. Has the child had any physical defects or shown any sign of slow physical or mental development?	☐	☐
15.	Have any of your parents or siblings died or suffered from blood disease, liver disease (including hepatitis B carrier), heart or polycystic kidney disease, stroke, diabetes, hypertension, cancer, AIDS or known hereditary disease? If "Yes", please provide the relationship with Insured, name of disease together with the onset age. (i) Relationship: _____ (ii) Disease(s): _____ (iii) Onset age:_____	☐	☐
16.	a. Do you drink alcohol on regular basis? If "Yes", please provide the type and unit of alcohol consumed per week? Type: _____ Unit of consumption per week: _____	☐	☐
	b. Do you take or have you ever taken any narcotics or habit forming drugs or been treated or consulted for alcohol? If "Yes", please provide details.	☐	☐
	c. Do you use or have you ever used any tobacco products in the past 12 months? If "Yes", please complete (1) average daily consumption; and (2) number of years. If ceased in consuming any tobacco products, please also provide the termination cause and date. Average daily consumption: _____ Number of years: _____ Termination cause and date: _____	☐	☐
17.	Have you ever had or been told to have or been treated for or intending to be treated for any of the following diseases or conditions:		
	a. Disease or disorder of circulatory system, including cardiovascular system and lymphatic system, e.g. chest discomfort, palpitation, raised blood pressure, rheumatic fever, heart attack, shortness of breath or dyslipidemia?	☐	☐
	b. Disease or disorder of respiratory or endocrine system, e.g. asthma, persistent hoarseness or cough, diabetes, thyroid disease or disorder?	☐	☐
	c. Disease or disorder of digestive system such as jaundice, ulcer, colitis, disorder of stomach, liver disease or disorder (including hepatitis : please specify the exact type), bowels, gall bladder disease or disorder?	☐	☐
	d. Disease or disorder of genitourinary system or reproductive organs, e.g. abnormal urine or bladder, prostate, breasts, uterus, uterus cervix or kidney disease or disorder?	☐	☐
	e. Disease or disorder of eye or other sensory organs, dizziness, convulsions, epilepsy, neuritis, paralysis, stroke, mental or other nervous system disease or disorders?	☐	☐
	f. Deformity, lameness or amputation, arthritis, gout or spinal cord, systemic lupus erythematosus, other musculoskeletal or autoimmune disease or disorders?	☐	☐
	g. Cancer, tumour, cyst, any disease or disorders of skin, lymph node or blood?	☐	☐
	h. Sexually transmitted disease or HIV infection?	☐	☐
18.	In the past 5 years, do you plan to attend, or are you currently attending or have been advised to, attended any hospital, clinic or doctor for any investigating (other than routine health check) or diagnostic test (e.g. cholesterol, AIDS, hepatitis including hepatitis B, anaemia etc)?	☐	☐
19.	Other than covered above, have you ever had, or are you currently awaiting, or have been advised to, or do you intend to be counselled, tested, medically advised or treated in connection with any other illness, disease, signs and symptoms or disorder for more than 7 days, or undertaking operation, medical advice or hospitalization for more than 3 days?	☐	☐

20. Supplement

If the answer for Questions 12-19 is/are "Yes", please give details in Question 20.

Question no.	Reason - nature and severity of conditions (Include frequency, diagnosis, treatment, medication, surgery and results)	Onset (mm/yyyy)	Recovery (mm/yyyy)	Names and addresses of physicians, hospitals or medical facilities

Section A: Declaration & Authorization

I/WE HEREBY DECLARE AND AGREE THAT: (1) All statements and answers to all questions in this statement and any questionnaire or declarations of insurability or health answered and made in this statement including but not limited to those made/completed in any related medical examinations, whether or not written by my/our own hands are to the best of my/our knowledge and belief full, complete and true. (2) All answers to such questions, together with this statement shall form the basis and become part of the Policy issued by Chubb Life Insurance Hong Kong Limited (the "**Company**"). (3) The Company is not bound by any statement which I/we may have made to any person, including but not limited to the Agent named herein if not written or printed here. (4) I/We shall disclose to the Company any change in the health or insurability of the Insured(s) subsequent to the signing of this statement but prior to any endorsement/confirmation letter being issued AND the failure to disclose any material facts and/or circumstances relating to any change in the health or insurability of the Insured(s) shall render the contract voidable. (5) (Where applicable) Any payment made in connection with application of this Policy does not guarantee immediate approval of the coverage applied. The insurance coverage applied for shall only take effect when due premiums are paid during the lifetime and continuous good health of the Insured(s). **I/We hereby irrevocably authorize** (i) any employer, doctor, hospital, clinic, insurance company, government office or any organizations of persons who have any records, knowledge or information of me/us (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to this application for insurance, reinstatement and any claim arising therefrom; (ii) the Company or any of its appointed medical/ para-medical examiners or laboratories to perform necessary medical assessment and tests to evaluate the health status of me/us in relation to this application for insurance, reinstatement and any claim arising therefrom. This authorization shall bind the successors and assignees of me/us and remains valid notwithstanding my/our death or incapacity. A photocopy of this authorization shall be as valid as the original.

Section B: Collection of Levy by the Insurance Authority

Pursuant to the Insurance (Levy) Regulation, with effect from 1 January 2018, the policy owner under a contract of insurance issued by an authorized insurer must, each time a premium is paid, also pay to the insurer a prescribed levy for the premium. The Insurance Authority may impose on the policy owner a pecuniary penalty if such policy owner fails to pay the prescribed levy.

Section C: Use of Personal Information Collection Statement

I/WE UNDERSTAND AND CONSENT THAT, by signing the application, any personal data collected or held by Chubb Life Insurance Hong Kong Company Limited (the "Company") is provided and may be used, processed, stored, disclosed, transferred by the Company to (a) any branch, subsidiary, holding company, associated company or affiliates of the Company ("Group Companies"); (b) any agents, insurance intermediaries, third party providers or administrators such as medical and healthcare providers, hospitals, in connection with the distribution of the Company's products and services, placement or handling of my/our insurance policy(ies) and any related claims and/or services; (c) any agents, contractors, advisors or third party service providers providing accounting, finance, legal, payment, data processing and storage, administration, telecommunications, mailing, printing, computer, technology, security, analytics, research, funds management, regulatory screenings, customer services, call centre services, and/or other services in connection with the Company's operations; (d) reinsurers, claims investigators, loss adjudicators, medical advisors, recovery agents, credit reference agencies, debt collection agencies, law enforcing bodies and police, insurance industry associations and federations and organizations that consolidate underwriting and claims information for the insurance industry, fraud prevention/detection agencies, and databases or registers (and their operators) used by the insurance industry to analyze and check information provided against existing information; and (e) government or judicial or competent regulatory bodies or any person to whom the Company is under legal and/or regulatory obligations to make disclosure, in each case whether within or outside of Hong

Kong to (i) evaluate or process this application and any future insurance application for the insurance policy; (ii) administer and process my/our insurance policy(ies), payment instructions and premium collection; (iii) perform medical, security and underwriting checks; (iv) assess insurance claims and process payments; (v) provide insurance products and related services; (vi) with my/our consent, to promote and directly market to me/us: (a) the insurance products and services of the Company; (b) mandatory provident fund-related products/services sponsored by the third party providers connected with the Company; (c) insurance, financial or investment related products/services, rewards, loyalty, co-branding and/or other privileges programs offered by the Company, the Company's affiliates, the Company's co-branding partners or the Company's business partners; (vii) perform data matching and communicate with me/us and/or another person in connection with my/our application or insurance policy(ies), which may include but is not limited to my/our dependents, the insured, the beneficiaries, my/our authorized representatives and any other individuals whom I/we have provided personal data of for such purposes; (viii) cooperate with law enforcement bodies for law enforcement purposes, to prevent any serious threat to public safety; for police investigation purposes; or to comply with laws, rules, regulations, codes of practice, guidelines, or requirements imposed by or agreed with government or regulatory bodies or for litigation; (ix) apply registration of activities organized and/or sponsored by the Company; (x) enable industry associations, federations, government or regulatory bodies to carry out their functions and requirements that may be assigned to them from time to time as are reasonably required and in the interests of the insurance industry; (xi) conduct research, surveys, data analytics and statistics, administration, communications, computer, security and other services (including medical services, mailing and IT services) in connection with the usual operations of the Company as a life insurance company; and (xii) for any other purpose directly relating to any of the above. Moreover, the Company is hereby authorized to obtain access to and/or to verify any of my/our data with the information collected by the insurance industry associations, the federations, the government and regulatory bodies and medical personnel or organizations. I/We am/are obliged to supply the information required from me/us under this application which is a condition precedent for this application. Failure to supply the required information may result in the Company being unable to process this application. I/We understand that I/We have the right to obtain access to and to request correction of any personal data held by the Company or be given reasons for any refusal of access or correction. I/We also understand that a reasonable fee may be charged by the Company for processing of any access. Any questions regarding personal data, access to or correction of personal data should be made in writing and forwarded to The Data Protection Officer, Chubb Life Insurance Hong Kong Limited at 35/F, Chubb Tower, Windsor House, 311 Gloucester Road, Causeway Bay, Hong Kong.

Who we may share your personal information with

We may for the purposes stated in this PICS disclose or transfer your or the relevant persons' personal information, within or outside of Hong Kong, to:

(i) our authorized agents, insurance intermediaries, third party providers or administrators including healthcare providers, in connection with the placement or handling of your insurance policy and any related claims and/or services;

(ii) reinsurers, claims investigators, loss adjudicators, fraud investigators, medical advisers, debt recovery agents, credit reference agencies, law enforcement bodies, fraud prevention agencies;

(iii) any branch, subsidiary, holding company, associated company or affiliates of Chubb Life HK ("**Group Companies**");

(iv) our appointed third-party vendors, agents, contractors, advisers;

(v) insurance industry associations and federations, government or judicial or regulatory bodies, or any person to whom we have a legal or regulatory obligation to make disclosure.

Your data access rights

You have the right to obtain access to and to request correction of your personal information held by Chubb Life HK or be given reasons for any refusal of access or correction. We may charge you a reasonable fee to process your data access request.

For more details of the Company's policies on personal data and privacy protection, please read the Chubb Life HK's Privacy Policy available at https://www.chubb.com/hk-en/footer/chubb-life-privacy-policy.html. Any questions regarding personal data, access to or correction of personal data should be made in writing and submitted to: Data Protection Officer of Chubb Life Insurance Hong Kong Limited at 35/F, Chubb Tower, Windsor House, 311 Gloucester Road, Causeway Bay, Hong Kong.

In case of discrepancies between the English and Chinese version, the English version shall apply and prevail.

Use of Personal Information for Direct Marketing Purposes Statement

Chubb Life HK intends to use or transfer your and the relevant persons' name, contact information, and policy details ("**Relevant Data**") for direct marketing of insurance related product and services of our and our Group Companies, mandatory provident fund-related products/ services sponsored by the third-party scheme providers connected with us, and/or insurance, financial or investment related products/ services, rewards, loyalty, co-branding and/or other privileges programs related to health, wellness, medical, entertainment, media, offered by third party partners appointed by us. In doing so, we may transfer your Relevant Data to our Group Companies and/or our appointed partners, for the purposes of them providing you with promotional communications and materials in relation to their products and/or services. However, we cannot use your Relevant Data without your consent. Please sign at the end of this statement to indicate your consent to such use. Should you find such use of your Relevant Data not acceptable, please indicate your objection by selecting the opt-out box below.

- ☐ I do not want Chubb Life HK or the Group Companies to use my Relevant Data for direct marketing purposes.
- ☐ I do not want Chubb Life HK to share my Relevant Data with third party scheme providers for their marketing purposes.
- ☐ I do not want Chubb Life HK to share my Relevant Data with third party product/service providers for direct marketing purposes.

If you have consented to direct marketing but later decide that you no longer wish to receive direct marketing, you may exercise the right to opt-out at any time by writing to: The Data Protection Officer of Life Administration of Chubb Life Insurance Hong Kong Limited at 35/F, Chubb Tower, Windsor House, 311 Gloucester Road, Causeway Bay, Hong Kong.

NOTE：
Please do not sign on BLANK Form
Signature must be consistent with that in your policy record and please submit the form within 14 days

Signed at Hong Kong On _____

dd/mm/yyyy

Signature of Witness (Name :)

Signature of Insured
(Signature is required for the person whose age is 18 or above)

Signature of Policyowner

Chubb. Insured.℠