Application Form

Full Medical Underwriting

MyHEALTH Individual Medical Plans

Download our Easy Claim mobile app for quicker claims reimbursement!

Available on the App Store

GET IT ON Google play

april-international.com

Please print only if necessary

Liberty Insurance™

april International

INSURANCE MADE EASY

YOUR APPLICATION, STEP BY STEP.

This is your application form. Complete it, sign it, send it.

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.

Medical Insurance Needs Assessment Form

Please complete this form before insurance application

Please provide your information in this form to enable us to recommend medical insurance products that suit your objectives and needs. You are reminded that completion of this form does not mean APRIL Hong Kong Limited ("APRIL") has accepted an insurance application from you.

Please complete this document in Block Capitals in English.

A. Insurance Objectives

○	**Obtaining basic and affordable protection to cover future healthcare and medical costs.**
○	**Getting a high level of benefits to protect against the increasing cost of medical and healthcare services.**

B. Needs Assessment

1.	**What is the overall annual medical protection you are looking for?**	○ **USD1,500,000** ○ **USD2,500,000** ○ **USD4,500,000**	
2.	**Plan feature preferences**		
	a. Preferred hospital room type?	○ **Single occupancy** ○ **Double occupancy**	
	b. Options for reduced premium		
	› **Specified Inpatient Providers (Inpatient only)**	○ **Optional**	○ **No**
	› **Deductibles (Inpatient only)**	○ **Optional**	○ **No**
	› **Co-payment or cap outpatient**	○ **Optional**	○ **No**
	c. Optional benefits		
	› **Outpatient**	○ **Optional**	○ **No**
	› **Maternity**	○ **Optional**	○ **No**
	› **Dental/Optical**	○ **Optional**	○ **No**
	d. USA coverage?	○ **Optional**	○ **No**
3.	**Is the proposed insured member currently covered by an existing medical insurance policy?**	○ **Yes**	○ **No**

Medical Insurance Needs Assessment Form

C. Product Recommendation

Based on the information you provided, the product recommended by APRIL or your intermediary is

MyHEALTH Hong Kong

STEP 1 — CORE COVER

If dependants will have the same cover as the Applicant, please tick here ○ and complete cover options for the Applicant only.

MODULES	APPLICANT	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Hospital & Surgery	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room
	Double Occupancy Room option is only available to Hong Kong residents				
	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only
Annual Deductible	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000
Area of Cover	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide

STEP 2 — OPTIONAL COVER

If dependants will have the same cover as the Applicant, please tick here ○ 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 ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap
	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance
	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance
Dental and/or Optical Optical included with Elite plan only	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
Maternity	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000

Medical Insurance Needs Assessment Form

D. Customer choice

Product selected	MyHEALTH Hong Kong

STEP 1 — CORE COVER

If dependants will have the same cover as the Applicant, please tick here ○ and complete cover options for the Applicant only.

MODULES	APPLICANT	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Hospital & Surgery	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room
	Double Occupancy Room option is only available to Hong Kong residents				
	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only
Annual Deductible	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000
Area of Cover	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide

STEP 2 — OPTIONAL COVER

If dependants will have the same cover as the Applicant, please tick here ○ 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 ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap
	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance
	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance
Dental and/or Optical Optical included with Elite plan only	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
Maternity	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000

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	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Gender	Male ○ Female ○	Male ○ Female ○	Male ○ Female ○	Male ○ Female ○
Marital Status				
Relationship to Applicant				
Nationality				
Smoker	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
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 ○ and complete cover options for the Applicant only.

MODULES	APPLICANT	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Hospital & Surgery	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room	○ Double Occupancy Room ○ Single Occupancy Room
	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only
	• 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	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 1,500 ○ USD 3,000 ○ USD 5,000 ○ USD 10,000
	• Your selected deductible applies to the Hospital and Surgery module only.				
Area of Cover	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide
	• 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 ○ 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 ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap	Essential with ○ 20% coinsurance ○ USD 7,000 cap
	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance
	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance
Dental and/or Optical Optical included with Elite plan only	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
Maternity	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000	○ USD 5,000 ○ USD 10,000 ○ USD 15,000
	• **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		
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.	Yes ○	No ○
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).	Yes ○	No ○
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.	Yes ○	No ○

MEDICAL DETAILS AND HISTORY	Please indicate if you or any person to be insured have or have ever had 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 ○ No ○
2	Respiratory system: Asthma, bronchitis, allergies, rhinitis or sinusitis, tuberculosis, or other disorder of the respiratory system	Yes ○ No ○
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 ○ No ○
4	Gastrointestinal system: Indigestion, gastric reflux, gastric ulcer, hemorrhoids, hernia, or other disorder of the gastrointestinal system	Yes ○ No ○
5	Musculoskeletal: Bone fracture, joint injury, arthritis, back, neck or muscle pain, or other disorder of the spine	Yes ○ No ○
6	Tropical illness: Malaria, dengue fever	Yes ○ No ○
7	HIV/AIDS, sexually transmitted disease	Yes ○ No ○
8	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes ○ No ○
9	Liver, gallbladder and pancreas: Hepatitis, fatty liver, gallstone, or other disorder of the liver, gallbladder or pancreas	Yes ○ No ○
10	Endocrine, nutritional and metabolic diseases: Diabetes, Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid or endocrine glands	Yes ○ No ○
11	Brain and nervous system: Stroke, aneurysm, seizures, chronic headache, migraine, or other disorder of the brain or nervous system	Yes ○ No ○
12	Anxiety, depression, stress, addiction, or other mental, behavioral, developmental disorder	Yes ○ No ○
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 ○ No ○
14	Skin: Eczema, dermatitis, psoriasis, wart, or other disorder of skin	Yes ○ No ○
15	Eyes and ears: Cataract, glaucoma, otitis, hearing loss, or other disorder of eyes or ears	Yes ○ No ○
16	Congenital, hereditary conditions, birth defects, deformities, or conditions affecting mobility	Yes ○ No ○
17	Any other disorder/ injury	Yes ○ No ○

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 **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.

Yes ○ No ○

19 **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.)

Yes ○ No ○

20 **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.

Yes ○ No ○

21 **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.

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

By choosing to give any access to your intermediary, you declare that you have obtained consent from all the members.

I/We would like our insurance intermediary to have access to my/our policy details and claims transactions through their online account at **https://members.april-international.com**.			○ Yes ○ No
I/We authorise APRIL to discuss and/or share claims and medical information with my/our insurance intermediary.			○ Yes ○ No
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	○ HKD ○ USD ○ EUR ○ 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)	○	○	○
Semi-Annually (4% Surcharge)	○	Not Available	Not Available
Quarterly (5% Surcharge)	○	Not Available	Not Available

Important Notice for Semi-Annual & Quarterly Payments: This policy is issued on an annual basis. By opting to pay in instalments, you acknowledge liability for the full annual premium. The payment frequency cannot be changed during the policy year, only at renewal provided you notify us in writing. The credit card you authorize below must remain valid for the entire duration of the policy and be active at the time instalment premiums are due, as it will be used to automatically collect these payments. If your credit card is lost or stolen, please notify us immediately to update your payment method and avoid disruption to your policy.

CREDIT CARD PAYMENT (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?	○ HKD ○ USD
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.	

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 | 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 :	HSBCHKHHHKH
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 :	HSBCHKHHHKH
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 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. ACKNOWLEDGEMENT & PERSONAL DATA (PRIVACY) ORDINANCE (Cap. 486)

PERSONAL DATA PROTECTION STATEMENT

I give consent to Liberty International Insurance Limited and third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished via any means in the past, present & in the future, for one or more of the purposes described in **Liberty Insurance Personal Information Collection Statement**, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing policies, communications, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. If there is any personal data relating not to myself but to other individuals that I have furnished via any means in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty International Insurance Limited and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

☐ Please tick this box if you do not wish to receive any marketing communications from APRIL.

☐ 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.

MEDICAL INSURANCE NEEDS ASSESSMENT FORM

If the product selected is different from the product recommended in Section C, it may mean your selection does not meet your objectives or needs indicated in this form. If you decide to continue to apply for the product selected, please indicate your reason(s) below:

○ I prefer the level of coverage in the product selected	○ Others (please specify)
○ The premiums of the product selected are more affordable	

CUSTOMER DECLARATIONS

1. I/We hereby confirm this declaration is correct and consent to disclose personal data to APRIL and the insurer.
2. I/We have read and agree to the **Levy** & Commission Disclosure Statement.
3. I/We acknowledge that I/we have made my own independent decision in applying for the product selected with the premium information and key product features informed by APRIL or my intermediary. I/we confirm that the relevant insurance product features are suitable for my/our current medical protection needs and the premiums are affordable.
4. I/We (and my dependents where applicable) have read, understand, and consent to **Liberty Insurance Personal Information Collection Statement** and **APRIL Hong Kong Limited Privacy Notice**, and if my dependents are minors, I am providing such consent as parent or legal guardian of such minors.
5. I/We (and my dependents where applicable) have read, understand, and agree to the **Brochure**, **Policy Terms and Conditions**, **Benefits Schedule**, and these **Statements & Authorizations**.

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. 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. In the event that the provided information is not true or complete, I understand and further agree that the premium could be changed; the insurance contract could be declared void; or the insurance company is entitled to deny its responsibility for any material misrepresentation of non-disclosure. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

APPLICANT SIGNATURE	
	Name : _____
	Title : _____
	Date : _____
	Important : The application form must be sent to us **within 30 days** from this date for your application to be valid.

INTERMEDIARY SIGNATURE	
	Name : _____ License Number : _____

Underwritten by:

Liberty International Insurance Limited (Hong Kong)
Suites 2601-04 & 2613-16, 26/F
1111 King's Road, Taikoo Shing
Hong Kong

Arranged and administered by:

APRIL Hong Kong Limited
9th Floor, Chinachem Hollywood Centre
1-13 Hollywood Road, Central
Hong Kong
Tel: (+852) 2526 0918
Email: ops.hk@april.com

MH HK 2024/12

Liberty Insurance™

April International

SUBMIT YOUR APPLICATION

SUBMIT ELECTRONICALLY

SUBMIT

Save this file and
send it to
asia.app@april.com

OR

PRINT, SIGN, EMAIL

PRINT

Send the scanned copy to
asia.app@april.com

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