

Application Form

PallasHEALTH Individual Medical Plans

Download our Easy Claim mobile app
for quicker claims reimbursement!

april-international.com



亞洲保險
ASIA INSURANCE



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. Plan feature preferences

- | | | |
|----------------------|--------------------------------|--------------------------|
| a. Deductibles | <input type="radio"/> Optional | <input type="radio"/> No |
| b. Optional benefits | | |
| > Outpatient | <input type="radio"/> Optional | <input type="radio"/> No |
| > Maternity | <input type="radio"/> Optional | <input type="radio"/> No |
| > Dental/Optical | <input type="radio"/> Optional | <input type="radio"/> No |
| c. USA coverage? | <input type="radio"/> Optional | <input type="radio"/> No |

- | | | |
|----------------------------------------------------------------------------------------------|---------------------------|--------------------------|
| 2. Is the proposed insured member currently covered by an existing medical insurance policy? | <input type="radio"/> Yes | <input type="radio"/> No |
|----------------------------------------------------------------------------------------------|---------------------------|--------------------------|

Medical Insurance Needs Assessment Form

C. Product Recommendation	
Based on the information you provided, the product recommended by APRIL or your intermediary is	PallasHEALTH Hong Kong
CHOOSE YOUR COVER	APPLICANT
Combination of Modules	<input checked="" type="checkbox"/> Module I – Core Module, Hospital and Surgery, including evacuation and repatriation <input type="checkbox"/> Module II – Outpatient Benefits <input type="checkbox"/> Module III – Maternity Benefits <input type="checkbox"/> Module IV – Dental & Optical Benefits
Annual Deductible The annual deductible does not apply to Maternity Benefit or Dental & Optical Benefits	<input type="checkbox"/> Nil <input type="checkbox"/> USD 500 <input type="checkbox"/> USD 1,500 <input type="checkbox"/> USD 5,000 <input type="checkbox"/> USD 10,000
Area of Cover	<input type="checkbox"/> Worldwide <input type="checkbox"/> Worldwide excluding <i>North America and the Caribbean</i>

Medical Insurance Needs Assessment Form

D. Customer Choice	
Product selected	PallasHEALTH Hong Kong
CHOOSE YOUR COVER	APPLICANT
Combination of Modules	<input checked="" type="checkbox"/> Module I – Core Module, Hospital and Surgery, including evacuation and repatriation <input type="checkbox"/> Module II – Outpatient Benefits <input type="checkbox"/> Module III – Maternity Benefits <input type="checkbox"/> Module IV – Dental & Optical Benefits
Annual Deductible The annual deductible does not apply to Maternity Benefit or Dental & Optical Benefits	<input type="checkbox"/> Nil <input type="checkbox"/> USD 500 <input type="checkbox"/> USD 1,500 <input type="checkbox"/> USD 5,000 <input type="checkbox"/> USD 10,000
Area of Cover	<input type="checkbox"/> Worldwide <input type="checkbox"/> Worldwide excluding <i>North America and the Caribbean</i>

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: Gender: Male Female Smoker: Yes No

Height (cm): _____ Weight (kg): _____

Occupation: _____
(Specify nature of duties)

Marital Status: _____ ID No. : _____

Nationality: _____ Passport No. : _____

Residential Address: _____

Postal Code: _____ Country: _____

Usual Country of Residence: _____
Please advise us if you wish to use a different mailing address.

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	<input type="text" value="DD/MM/YYYY"/>		<input type="text" value="DD/MM/YYYY"/>		<input type="text" value="DD/MM/YYYY"/>		<input type="text" value="DD/MM/YYYY"/>	
Gender	Male <input type="radio"/>	Female <input type="radio"/>	Male <input type="radio"/>	Female <input type="radio"/>	Male <input type="radio"/>	Female <input type="radio"/>	Male <input type="radio"/>	Female <input type="radio"/>
Marital Status								
Relationship to Applicant								
Nationality								
Smoker	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
ID No.								
Passport No.								
Occupation (Specify nature of duties)								
Height & Weight	<input type="text" value="cm"/>	<input type="text" value="kg"/>	<input type="text" value="cm"/>	<input type="text" value="kg"/>	<input type="text" value="cm"/>	<input type="text" value="kg"/>	<input type="text" value="cm"/>	<input type="text" value="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					
If dependants will have the same cover as the Applicant, please tick here <input type="radio"/> and complete cover options for the Applicant only.					
MODULES	APPLICANT	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Area of Cover	<input type="radio"/> Worldwide <input type="radio"/> Worldwide excluding North America and the Caribbean	<input type="radio"/> Worldwide <input type="radio"/> Worldwide excluding North America and the Caribbean	<input type="radio"/> Worldwide <input type="radio"/> Worldwide excluding North America and the Caribbean	<input type="radio"/> Worldwide <input type="radio"/> Worldwide excluding North America and the Caribbean	<input type="radio"/> Worldwide <input type="radio"/> Worldwide excluding North America and the Caribbean
STEP 2					
CHOOSE YOUR ANNUAL DEDUCTIBLE					
The annual deductible does not apply to Maternity Benefit or Dental & Optical Benefits					
If dependants will have the same cover as the Applicant, please tick here <input type="radio"/> and complete cover options for the Applicant only.					
MODULES	APPLICANT	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Annual Deductible	<input type="radio"/> Nil <input type="radio"/> USD 500 <input type="radio"/> USD 1,500 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000	<input type="radio"/> Nil <input type="radio"/> USD 500 <input type="radio"/> USD 1,500 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000	<input type="radio"/> Nil <input type="radio"/> USD 500 <input type="radio"/> USD 1,500 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000	<input type="radio"/> Nil <input type="radio"/> USD 500 <input type="radio"/> USD 1,500 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000	<input type="radio"/> Nil <input type="radio"/> USD 500 <input type="radio"/> USD 1,500 <input type="radio"/> USD 5,000 <input type="radio"/> USD 10,000
STEP 3					
SELECT ANY COMBINATION OF MODULES					
Module I – Core Module, Hospital and Surgery, including evacuation and repatriation Module II – Outpatient Benefits Module III – Maternity Benefits Module IV – Dental & Optical Benefits					
If dependants will have the same cover as the Applicant, please tick here <input type="radio"/> and complete cover options for the Applicant only.					
MODULES	APPLICANT	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Combination of Modules	<input type="radio"/> Module I + <input type="radio"/> Module II <input type="radio"/> Module III <input type="radio"/> Module IV	<input type="radio"/> Module I + <input type="radio"/> Module II <input type="radio"/> Module III <input type="radio"/> Module IV	<input type="radio"/> Module I + <input type="radio"/> Module II <input type="radio"/> Module III <input type="radio"/> Module IV	<input type="radio"/> Module I + <input type="radio"/> Module II <input type="radio"/> Module III <input type="radio"/> Module IV	<input type="radio"/> Module I + <input type="radio"/> Module II <input type="radio"/> Module III <input type="radio"/> Module IV

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 <input type="radio"/>	No <input type="radio"/>
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 <input type="radio"/>	No <input type="radio"/>
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 <input type="radio"/>	No <input type="radio"/>
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 <input type="radio"/> No <input type="radio"/>
2.	Respiratory system: Asthma, bronchitis, allergies, rhinitis or sinusitis, tuberculosis, or other disorder of the respiratory system	Yes <input type="radio"/> No <input type="radio"/>
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 <input type="radio"/> No <input type="radio"/>
4.	Gastrointestinal system: Indigestion, gastric reflux, gastric ulcer, hemorrhoids, hernia, or other disorder of the gastrointestinal system, liver, gallbladder and pancreas: Hepatitis, fatty liver, gallstone, or other disorder of the liver, gallbladder or pancreas	Yes <input type="radio"/> No <input type="radio"/>
5.	Musculoskeletal: Bone fracture, joint injury, arthritis, back, neck or muscle pain, or other disorder of the spine	Yes <input type="radio"/> No <input type="radio"/>
6.	Infectious and Viral Disease Disorder: Malaria, dengue fever, HIV/AIDS, sexually transmitted disease	Yes <input type="radio"/> No <input type="radio"/>
7.	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes <input type="radio"/> No <input type="radio"/>
8.	Endocrine, nutritional and metabolic diseases: Diabetes, Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid or endocrine glands	Yes <input type="radio"/> No <input type="radio"/>
9.	Brain and nervous system: Stroke, aneurysm, seizures, chronic headache, migraine, or other disorder of the brain or nervous system	Yes <input type="radio"/> No <input type="radio"/>
10.	Anxiety, depression, stress, addiction, or other mental, behavioral, developmental disorder	Yes <input type="radio"/> No <input type="radio"/>
11.	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 <input type="radio"/> No <input type="radio"/>
12.	Skin: Eczema, dermatitis, psoriasis, wart, or other disorder of skin	Yes <input type="radio"/> No <input type="radio"/>
13.	Eyes and ears: Cataract, glaucoma, otitis, hearing loss, or other disorder of eyes or ears	Yes <input type="radio"/> No <input type="radio"/>
14.	Congenital, hereditary conditions, birth defects, deformities, or conditions affecting mobility, or any other disorder/injury	Yes <input type="radio"/> No <input type="radio"/>

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

15.	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 <input type="radio"/> No <input type="radio"/>
16.	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 <input type="radio"/> No <input type="radio"/>
17.	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 <input type="radio"/> No <input type="radio"/>
18.	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	
Email		

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

We cannot backdate cover to a date earlier than the date you accept our final offer.

On Acceptance
 Another Date : DD / MM / YYYY

INTERMEDIARY ACCESS

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

I/ We **authorise** our insurance intermediary to have access to my/our policy details and claims transactions through their online **portal**. 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	<input type="radio"/> HKD <input type="radio"/> USD <input type="radio"/> EUR <input type="radio"/> 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

Please select the payment method by which you wish to pay your premiums

Annual

Bank Transfer

Credit Card (Visa / Mastercard)

Cheque or Bank Draft

BANK TRANSFER

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: 853-034767-001
Swift Code: HSBCHKHKKH
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: 853-034767-201
Swift Code: HSBCHKHKKH
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 to us for our accounting records and to issue an Official Receipt.

CREDIT CARD PAYMENT

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.

CHEQUE OR BANK DRAFT

- 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: hkpremium@april.com

5. Acknowledgement & Personal Data (Privacy) Ordinance (Cap. 486)

PERSONAL DATA PROTECTION STATEMENT

I give consent to Asia Insurance Company, 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 **Asia 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 Asia Insurance Company, Limited and its Appointees to collect, use and disclose their personal data for the above mentioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Asia Insurance Company, Limited 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 Asia Insurance Company, Limited 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 **Asia 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 Asia Insurance Company, 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 :

MH HK 2025/10

Underwritten by:
Asia Insurance Company, Limited
7/F & 8/F, 118 Connaught Road West,
Sheung Wan, Hong Kong
Tel: (+852) 3806 9933
Fax: (+852) 2810 0218

Arranged and administered by:
APRIL Hong Kong Limited
9/F Chinachem Hollywood Centre
1-13 Hollywood Road, Central
Hong Kong
Tel: (+852) 2526 0918
Email: contact.hk@april.com



亞洲保險
ASIA INSURANCE



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