Application Form

PallasHEALTH Individual Medical Plans

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.	**Plan feature preferences**		
	a. Deductibles	○ **Optional**	○ **No**
	b. Optional benefits		
	› **Outpatient**	○ **Optional**	○ **No**
	› **Maternity**	○ **Optional**	○ **No**
	› **Dental/Optical**	○ **Optional**	○ **No**
	c. USA coverage?	○ **Optional**	○ **No**
2.	**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	**PallasHEALTH Hong Kong**

CHOOSE YOUR COVER	APPLICANT
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
Annual Deductible The annual deductible does not apply to Maternity Benefit or Dental & Optical Benefits	☐ Nil ☐ USD 500 ☐ USD 1,500 ☐ USD 5,000 ☐ USD 10,000
Area of Cover	☐ Worldwide ☐ Worldwide excluding *North America and the Caribbean*

Medical Insurance Needs Assessment Form

D. Customer choice

Product selected	**PallasHEALTH Hong Kong**

CHOOSE YOUR COVER	APPLICANT
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
Annual Deductible The annual deductible does not apply to Maternity Benefit or Dental & Optical Benefits	☐ Nil ☐ USD 500 ☐ USD 1,500 ☐ USD 5,000 ☐ USD 10,000
Area of Cover	☐ Worldwide ☐ Worldwide excluding *North America and the Caribbean*

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 — CHOOSE YOUR AREA OF 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
Area of Cover	○ Worldwide ○ Worldwide excluding North America and the Caribbean	○ Worldwide ○ Worldwide excluding North America and the Caribbean	○ Worldwide ○ Worldwide excluding North America and the Caribbean	○ Worldwide ○ Worldwide excluding North America and the Caribbean	○ Worldwide ○ 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 ○ and complete cover options for the Applicant only.

MODULES	APPLICANT	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Annual Deductible	○ Nil ○ USD 500 ○ USD 1,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,500 ○ USD 5,000 ○ 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 ○ 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	**Module I +** ○ Module II ○ Module III ○ Module IV	**Module I +** ○ Module II ○ Module III ○ Module IV	**Module I +** ○ Module II ○ Module III ○ Module IV	**Module I +** ○ Module II ○ Module III ○ Module IV	**Module I +** ○ Module II ○ Module III ○ 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	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	Yes	No
8	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes	No
9	Liver: Diabetes, hepatitis, fatty liver, or other disorder of the liver	Yes	No
10	Thyroid: Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid	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 COVID-19 or Coronavirus infection	Yes	No
18	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

19 **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 ○

20 **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 ○

21 **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 ○

22 **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

Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account at healthbyapril.com/portal?			○ Yes ○ No
Do you authorise us to discuss and/or share claims and medical information with your 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			
Please select the payment method in which you wish to pay your premiums.			
	CREDIT CARD (Visa / Mastercard)	CHEQUE OR BANK DRAFT	BANK TRANSFER
Annual	○	○	○

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.	

4. PAYMENT METHODS

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 | Fax: +852 2526 0769 | Email: pallas@april.com

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 :	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 fax (+852 2526 0769) or email pallas@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. NOTICE TO CUSTOMERS RELATING TO THE PERSONAL DATA ORDINANCE

In relation to: (i) the personal data collected by APRIL Hong Kong Limited ("APRIL") in this application form, and (ii) any personal data about me/us which may be collected by APRIL in the future if a policy is issued (collectively "my/our personal data"), I/we agree and acknowledge that:

a. providing my/our personal data is necessary for APRIL to process this application and provide insurance coverage. If any such data is not provided, APRIL may not be able to process this application or provide insurance coverage.

b. my/our personal data will be transferred to Liberty International Insurance Limited ("Liberty International") and/or other members of the Liberty Mutual Group of Companies ("Liberty Mutual Group") for all the purposes stated in its privacy policy, available online here.

c. my/our personal data may be used by APRIL and Liberty Mutual Group for the following obligatory purposes:
   1. to decide whether to issue an insurance policy or to modify an existing policy;
   2. to manage and administer products and services you purchase;
   3. to provide customer service to you and respond to your enquiries;
   4. to compile statistics and to conduct research, insurance surveys and analysis for the purpose of product design and development;
   5. to provide claims service, including assessing, investigating, analysing and paying claims, and to exercise Liberty International's rights as defined in the policy wording including rights of subrogation;
   6. to carry on our business in areas such as finance and accounting, billing and collections, audits, IT system management, reporting, and obtaining reinsurance;
   7. enabling an actual or proposed assignee of Liberty International to evaluate the transaction intended to be the subject of the assignment;
   8. conducting identity and/or credit checks and/or debt collection;
   9. conducting medical or health reference checks for relevant insurance products;
   10. meeting disclosure requirements of any local or foreign law, regulations, codes or guidelines binding on them or their affiliates; and
   11. complying with the legitimate requests or orders of any court of competent jurisdiction and any regulator or self-regulatory entity including but not limited to theInsurance Authority, Hong Kong Federation of Insurers, auditors, governmental bodies and governmental-related establishments binding APRIL or the LibertyMutual Group of Companies.

d. unless I/we have indicated otherwise by ticking the "Marketing Communications Opt-out" box below, my/our contact details (name, address, phone number and e-mail address) may be used:
   1. by APRIL, to contact me/us about other insurance products provided by APRIL and its affiliates; and
   2. by Liberty Mutual Group to provide marketing materials and conduct direct marketing activities (including but not limited to promoting, marketing or selling of the Company, Liberty Mutual Group or co-branded insurance or financial or investment related products or services by electronic or other means) in relation to insurance and/or financial products and services of the Company, the Liberty Mutual Group and/or other financial services providers.

e. APRIL may transfer my/our personal data to the following classes of persons (whether based in Hong Kong or overseas) for the purposes identified in (c) above:
   1. any affiliate of APRIL (HK);
   2. any Liberty Mutual Group of Companies;
   3. any other company carrying on insurance or reinsurance related business, or an intermediary;
   4. third parties providing services related to the administration of my/our policy (including reinsurers, accountants and data processors);
   5. any agent, contractor or third party service provider who provides administrative, telecommunications, computer, payment, banking or other services to the Company in connection with the operation of its business;
   6. financial institutions for the purpose of processing this application and obtaining policy payments or making claim settlements;
   7. in the event of a claim, loss adjustors, assessors, third party administrators, emergency assistance companies, legal services providers, investigators,retailers, medical providers and medical professionals, and travel carriers;
   8. any person to whom APRIL, Liberty International and/or Liberty Mutual Group is under an obligation to make disclosure under the requirements of any lawbinding on the Company or any of its associated companies for the purposes of any regulations, codes or guidelines issued by governmental, regulatory or otherauthorities with which the Company or any of its associated companies are expected to comply, or subject to any order of a court of competent jurisdiction;
   9. any actual or proposed assignee or transferee of the Liberty Mutual Group's rights in respect of the policy owners;
   10. providers of risk intelligence for the purpose of customer due diligence or anti-money laundering screening;
   11. credit reference agencies, and in the event of default, any debt collection agencies or companies carrying on claim or investigation services;
   12. other banking/financial institutions, commercial or charitable organizations with whom APRIL, Liberty International and/or Liberty Mutual Group maintain business referral or other arrangements for marketing communication, or third party marketing service providers and insurance intermediaries, unless you haveindicated that you wish to opt-out of receiving marketing communications; and
   13. other parties referred to in APRIL's Privacy Policy for the purposes stated therein.

f. I/we may gain access to or request correction of my/our personal data held by APRIL, or opt out of my/our personal data being used for direct marketing a any time, by writing to the Data Privacy Officer of APRIL Hong Kong Limited at 9th Floor, Chinachem Hollywood Centre, 1-13 Hollywood Road, Central, Hong Kong or privacy@april.com.

g. I/we may gain access to or request correction of my/our personal data held by Liberty International , or opt out of my/our personal data being used for direct marketing at any time, by writing to the Personal Data Privacy Officer of Liberty International Insurance Limited, 13/F Berkshire House, 25 Westlands Road, Quarry Bay, Hong Kong. APRIL and Liberty International reserve the right to charge a reasonable fee for access to data. if I am providing information about another person, such as a family member or employee, I confirm that they have consented to me providing that information to APRIL. If appropriate, I have provided them with this personal information collection statement or the APRIL Privacy Policy.

h. the full version of APRIL's Privacy Policy is available to me upon request from the Data Privacy Officer (see (e) above) or can be found at https://asia.april-international.com/en/privacy-policy. APRIL may make changes to the privacy policy by posting them at http://asia.april-international.com.

☐	Please tick this box if you do not wish to receive any marketing communications from APRIL (see d(1) above)
☐	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 (see d(2) above).

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 confirm that I have read and understood the sales documents of the relevant insurance product.**
2. **I understand the information contained in this form was used to analyse my medical insurance needs and provided as reference only for my choice of insurance plan and premium amount. I understand that the analysis and recommendation made in this form were based upon the information provided and APRIL Hong Kong Limited does not accept any liability for its accuracy.**
3. **I acknowledge that I 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 confirm that the relevant insurance product features are suitable for my current medical protection needs and the premiums are affordable.**
4. **I confirm that APRIL and/or my intermediary has reminded me that if the product selected is different from the product recommended in this form, this may indicate that my selection does not match with my needs. I can confirm that I have considered this and decided to continue to apply for the selected insurance plan.**
5. **I agree and understand that the information contained in this form will be handled in accordance with the Personal Information Collection Statement of APRIL attached to the insurance application form. I understand that I am required to inform APRIL Hong Kong Limited promptly if there is any substantial change of information provided in this form before the policy is issued.**

Applicant signature	Applicant's name	Intermediary's signature
		Intermediary's Name
	Date	**License number**
	DD/MM/YY	

SIGNATURE

Name : _____

Title : _____

DECLARATION BY APPLICANT

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, all persons to be insured are currently in good health. 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. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

Date : _____

Important : The application form must be sent to us **within 30 days** from this date for your application to be valid.

Underwritten by:

Liberty International Insurance Limited (Hong Kong)
13th Floor, Berkshire House
25 Westlands Road
Quarry Bay
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 I Fax: (+852) 2526 0769
Email: pallas@april.com

MH HK 2022/03

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