Innovation for Wellbeing
SOMPO HONG KONG

William Russell

Personal health plans

Application form for individuals & families (full medical underwriting)

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email or post. You can find our contact details at the end of this form.

Broker/intermediary details

If you were introduced to us through a broker, please state their name and company.

.....

Your personal details

First name: ..... Surname: ..... Title: .....

Address: .....

.....

Mobile number: ..... Home number: .....

Email: ..... Occupation: .....

Nationality: ..... Date of birth: ..... ◯ Male ◯ Female

HKID number: ..... How long have you lived in Hong Kong? ..... years

Dependants to be insured on your health plan

Please enter details for all dependants to be covered. You may include your partner provided they are under age 70, and your children provided they are aged less than 18 years old, or less than 25 years old if in continuous, full-time education. Children aged 18 and over, and not in full-time education, must complete their own application form.

	Partner	Child 1	Child 2	Child 3
First name				
Surname				
HKID number*				
Date of birth				
Gender				
Relationship to you				
Nationality				
Country where they will be living				
Occupation/full-time education				

**Please provide copies of HKID cards for all persons included in this application when returning this form.*

Start date of your health plan

When would you like your health plan to start? ◯ On acceptance of your application ◯ Specific date: .....

Please note that your application is only valid for 28 days from the date we receive it. Cover cannot be backdated.

Previous/current insurance plans

1 Has anyone named on this form ever applied for a plan or been insured with William Russell? ◯ Yes ◯ No

If **YES**, please state the policy number: ..... Date of expiry of plan: .....

2 Has anyone named on this form ever had an application for insurance declined or accepted with special terms, or had an insurance plan cancelled by any insurance provider? ◯ Yes ◯ No

If **YES**, please provide details: .....

.....

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Previous/current insurance plans (continued)

3 Does anyone named on this form currently have any other health insurance? ◯ Yes ◯ No

If **YES**, please state the name of insurer: .....

Policy number: ..... Date of expiry of plan: .....

Choose your health plan

Please choose your health plan and excess combination from the table below, along with the optional benefits you require. The excess options and optional benefits available with each plan are shown in the column for the plan you select.

If you have one, please state the quote illustration reference for the quote you wish to accept: .....

Bronze	Silver	Gold
Excess options		
◯ Nil	◯ Nil	◯ Nil
Per claim options		
◯ HK$6,000/US$800	◯ HK$400/US$50	◯ HK$400/US$50
◯ HK$12,500/US$1,600	◯ HK$800/US$100	◯ HK$800/US$100
	◯ HK$6,000/US$800	◯ HK$6,000/US$800
	◯ HK$12,500/US$1,600	◯ HK$12,500/US$1,600
Per annum options		
◯ HK$2,000/US$250	◯ HK$2,000/US$250	◯ HK$2,000/US$250
◯ HHK$4,000/US$500	◯ HHK$4,000/US$500	◯ HHK$4,000/US$500
◯ HK$8,000/US$1,000	◯ HK$8,000/US$1,000	◯ HK$8,000/US$1,000
◯ HK$20,000/US$2,500	◯ HK$20,000/US$2,500	◯ HK$20,000/US$2,500
◯ HK$40,000/US$5,000	◯ HK$40,000/US$5,000	◯ HK$40,000/US$5,000
◯ HK$80,000/US$10,000	◯ HK$80,000/US$10,000	◯ HK$80,000/US$10,000

Bronze	Silver	Gold
Optional benefits		
◯ Medevac Plus	◯ Medevac Plus	◯ Medevac Plus
◯ Semi-private room discount†	◯ Enhanced well-being benefit	◯ Enhanced well-being benefit
◯ Ward discount‡	◯ Dental Basic	◯ Dental Plus
	◯ Dental Plus	◯ Direct billing*
	◯ Direct billing*	◯ Semi-private room discount†
	◯ Semi-private room discount†	◯ Ward discount‡
	◯ Ward discount‡	

** Direct billing is free of charge, but is only available if you are resident in certain Asian countries and you have selected a **nil** or **HK$400/US$50 or HK$800/US$100 per claim excess**. You will also need to submit an application form for direct billing. Please note, we have the right to remove direct billing from your policy at any time within the policy year at our discretion.*

*† Semi-private room discount is only available to residents of Hong Kong with **Zone 1** as your area of cover. This option is not available if you have also selected the ward discount.*

*‡ Ward discount is only available to residents of Hong Kong with **Zone 1** as your area of cover. This option is not available if you have also selected the semi-private room discount.*

Please note, if you have not selected either a semi-private room discount or a ward discount, in-patient and day-patient treatment received in a private room will be subject to a 20% co-pay at the following hospitals: Matilda International Hospital, Hong Kong Sanatorium & Hospital, and Hong Kong Adventist Hospital.

Choose your health plan (continued)

The standard area of cover for the personal health plans is Zone 1: worldwide, excluding the USA. If you require cover in the USA, please select **one** of the USA cover options.

Area of cover & USA cover options

◯ **Zone 1** Worldwide, excluding the USA.

The following two options provide limited cover in the USA.

◯ **USA-45** We will cover you in the USA for temporary trips of up to 45 days' duration from the date on which you enter the country. Any trip of longer than 45 days will not be covered, but there is no limit to the number of temporary trips you can make to the USA during any one period of cover.

The overall maximum amount we will pay in respect of treatment you receive in the USA is HK$1,937,500/ US$250,000 per insured person, per period of cover. Within this amount, we will pay: -

- up to HK$775,000/ US$100,000 for elective treatment; and
- up to HK$1,937,500/ US$250,000 for accident & emergency treatment of a condition that you have not previously suffered from prior to commencing your temporary trip.

We do not cover emergency evacuation to, from or within the USA, even if you select the USA-45 option.

◯ **USA-90** We will cover you in the USA for temporary trips of up to 90 days' duration from the date on which you enter the country. Any trip of longer than 90 days will not be covered, but there is no limit to the number of temporary trips you can make to the USA during any one period of cover.

The overall maximum amount we will pay in respect of treatment you receive in the USA is HK$1,937,500/ US$250,000 per insured person, per period of cover. This overall maximum amount includes both elective treatment and accident & emergency treatment that you receive.

We do not cover emergency evacuation to, from or within the USA, even if you select the USA-90 option.

Paying for your health plan

Please select the currency in which you would like to pay your premium. The benefits for your health plan and your excess will be denominated in this currency.

◯ HK Dollars ◯ US dollars

Please select your payment method and the frequency with which you wish to pay your premium:

Credit card	◯ Annually	◯ Half-yearly[1]	◯ Quarterly[2]	◯ Monthly[2]
Bank transfer	◯ Annually			
Cheque[3]	◯ Annually			

[1] Half-yearly premiums are subject to a 3% surcharge.
[2] Quarterly or monthly premiums are subject to a 5% surcharge.
[3] Payable to William Russell Ltd., and must be drawn on a Hong Kong bank account.

Health declaration

Your health plan will be underwritten on a full medical underwriting basis. Please complete the following health declaration and provide us with full details of any medical conditions existing before the start date of your plan. Pre-existing medical conditions and related conditions will not be covered unless you have told us about them and we have agreed to cover them. This includes conditions arising between the time you submit this application form and the start date of your plan, so please contact us immediately if the information provided changes.

Please answer the following questions for each person named on this form fully, accurately, and to the best of your knowledge and belief. If you answer **YES** to any question, please supply full details in the spaces provided. If you require more space, please continue on a separate sheet of paper. If you do not answer the questions fully and accurately, your plan may be cancelled, claims may be rejected or special terms may be applied retroactively. If you are in any doubt as to whether you should tell us anything, please tell us anyway.

Health declaration (continued)

Please complete the following table for yourself, your partner, and any dependants over age 18.

	You	Partner	Dependants over age 18
Height (cm)			
Weight (kg)			
If you smoke, how many cigarettes/cigars do you smoke daily?			
If you consume alcohol, how many of the following do you consume each week? • Pints of regular-strength beer/cider • Pints of strong beer or cider • 175ml glasses of wine • 250ml glasses of wine • 35ml measures of spirits			

Medical questions for EACH person named on this form

1 Has any person named on this form **ever** experienced any of the following conditions?

a) **Brain or nervous system conditions?** ◯ Yes ◯ No
For example: stroke/transient ischemic attack (TIA), epilepsy, migraines or repeated headaches, multiple sclerosis, meningitis, shingles, nerve pain.

b) **Cancer, tumours or growths?** ◯ Yes ◯ No
For example: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions.

c) **Heart or circulatory conditions?** ◯ Yes ◯ No
For example: high blood pressure, angina/chest pains, heart attacks or failure, abnormal heartbeat, varicose veins, raised cholesterol, stroke, deep vein thrombosis.

d) **Psychiatric or psychological conditions, drug & alcohol issues or sleep disorders?** ◯ Yes ◯ No
For example: depression, anxiety, stress, anorexia nervosa, autism, bipolar disorder, insomnia, narcolepsy, sleep apnoea, alcohol or drug dependency.

e) **Joint replacements?** ◯ Yes ◯ No

2 In the last **five** years, has any person named on this form seen a doctor, or experienced any symptoms, or been admitted to a hospital or medical facility for an operation or procedure, or undergone any tests or investigations, for any of the following conditions:

a) **Auto-immune disorders?** ◯ Yes ◯ No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Back, joint, muscular or skeletal problems?** ◯ Yes ◯ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, fractures, cartilage or ligament problems.

c) **Breathing or upper and lower respiratory conditions (including allergies)?** ◯ Yes ◯ No
For example: asthma, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, bronchitis, tuberculosis (TB), allergies to food substances and animals.

d) **Diabetes, thyroid or any other endocrine disorder?** ◯ Yes ◯ No
For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **Eyes, ear, nose and throat or oral/dental conditions?** ◯ Yes ◯ No
For example: glaucoma, cataracts, retinal detachment, macular degeneration, hearing difficulties, repeated ear infections, tonsillitis, sinusitis, dental problems, wisdom teeth problems, gingivitis.

f) **Gynaecological or breast conditions?** ◯ Yes ◯ No
For example: complications of pregnancy, heavy or irregular periods, fibroids, endometriosis, ovarian cysts, abnormal smear tests, miscarriage, pre- and post-natal complications, breast lumps/cysts.

g) **Skin conditions (including allergies)?** ◯ Yes ◯ No
For example: eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic reactions.

Health declaration (continued)

h) **Stomach, liver/gall bladder, or digestive system conditions?** ◯ Yes ◯ No
For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn abdominal pain, anaemia, hepatitis, cirrhosis, gallstones, hernias, haemorrhoids/piles.

i) **Urinary, kidney or prostate conditions?** ◯ Yes ◯ No
For example: kidney infections, kidney stones, incontinence, prolapse, prostate problems, recurrent bladder or urine infections.

j) **Any alcohol and/or drug dependency problems?** ◯ Yes ◯ No

k) **Any physical defect, infirmity or congenital condition?** ◯ Yes ◯ No

l) **Any other medical condition not mentioned above?** ◯ Yes ◯ No

3 Has any person named on this form experienced any signs or symptoms of any medical condition in the last six months, whether or not a doctor has been consulted? ◯ Yes ◯ No

4 Is any person named on this form currently taking any medication, prescribed or otherwise? ◯ Yes ◯ No

5 Is any person named on this form currently undergoing any treatment or periodic reviews for a medical condition, physical impairment, disability or recurrent illness not already mentioned? ◯ Yes ◯ No

6 Is anyone named on this form currently pregnant? ◯ Yes ◯ No

If you have answered YES to any of the above questions, please give full details

Question no: ..... Name of person affected: .....

Date(s) on which the injury or condition first occurred: .....

Date symptoms were last experienced: .....

Please state what diagnosis was made: .....

.....

.....

.....

.....

.....

What treatment was received: .....

.....

.....

.....

Is any future treatment required, including consultations with a doctor or periodic tests or reviews? ◯ Yes ◯ No

If **YES**, please give details: .....

.....

.....

.....

Health declaration (continued)

Question no: ..... Name of person affected: .....

Date(s) on which the injury or condition first occurred: .....

Date symptoms were last experienced: .....

Please state what diagnosis was made: .....

.....

.....

.....

.....

.....

What treatment was received: .....

.....

.....

.....

Is any future treatment required, including consultations with a doctor or periodic tests or reviews? ◯ Yes ◯ No

If **YES**, please give details: .....

.....

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.....

If you are attaching any supporting medical documents, please note that we can only accept them in English.

Your doctor's details

Please provide details of the doctor who is most familiar with the medical history of all those named on this form. If any of your dependants regularly see a different doctor, please provide this information on a separate piece of paper.

Name of doctor: ..... Title: .....

Address: .....

Telephone number: ..... Email: .....

How long have you been known to this doctor? .....

Marketing communication preferences

We'd like to stay in touch with you in ways we think you might find helpful. Every now and then, we share information about international healthcare and expat life, plus other useful content we think could be of interest to you. We also send occasional emails that promote our products and services.

We won't spam you or share your details with third parties, and you can unsubscribe at any time. You can read our privacy policy at william-russell.com.hk/privacy.

Please tick the box to opt into our marketing communications:

- ◯ Email
- ◯ Newsletter
- ◯ Telephone
- ◯ Text message/SMS

Personal Information Collection Statement

1 **Purpose:** Sompo Insurance (Hong Kong) Co., Ltd. and William Russell Ltd. (collectively the "Company") is committed to protecting the personal data of our customers. The Company is also committed to the implementation of the data protection principles set out in Schedule 1 of Personal Data (Privacy) Ordinance ("the PDPO") (Chapter 486 of the laws of Hong Kong). From time to time it is necessary for you to supply the Company with personal data of you, insured and beneficiary under the insurance policy which may be used, stored, processed, transferred, disclosed or shared by the Company for the following purposes:

a) processing and evaluating your application or request for and any alterations, variations, cancellation, renewals and reinstatements of any insurance products and/ or services offered by the Company;

Personal Information Collection Statement (continued)

b) administering your insurance policy and providing services in relation to your insurance policy;
c) any purposes in connection with any claims made by or against or otherwise involving you in respect of any products and/ or services provided by the Company, including processing and/ or investigating any claims and detect/ prevent fraud;
d) invoicing and collecting premiums and/ or outstanding amounts from you;
e) exercising any right of subrogation, if applicable;
f) conducting statistical analysis;
g) contacting you for any of the above purposes;
h) meeting the requirements to make disclosure (i) under any law binding on the Company; or (ii) under any applicable rules, regulations, codes or guidelines or to assist in law enforcement purposes, investigation by police or other government or regulatory authorities; or (iii) for complying with any requirements, policies or measures for using data and information within Sompo Holdings Group ("the Group") in accordance with any Group-wide programmes from time to time for compliance with sanctions or prevention or detection of money laundering, terrorist financing or other unlawful activities/ misconducts;
i) other purposes directly related to any of the above purposes.

For using the personal data provided by you for promotional/ marketing purposes, please refer to the section titled "**Use of Personal Data in Direct Marketing**".

The failure of providing the Personal Data by you may result in the Company being unable to provide products and services, assess your policy application, process claims under insurance policies issued by us, or process any other requests, enquiries, or complaints from you, or any of the purposes listed above.

2 **Transfer:** The Company may disclose your personal data to the following transferees in Hong Kong or overseas, including transferring into and out of the European Economic Area, for the above purposes:

a) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist the Company to carry out the above purposes (including medical service providers, hospitals, emergency assistance service providers, mailing houses, IT service providers and data processors);
b) in the event of a claims, loss adjusters, claims investigators and medical advisors;
c) in the event of default, debt collectors and recovery agents;
d) insurance reference bureaus or credit reference bureaus;
e) reinsurers and reinsurance brokers;
f) financial services intermediaries that are authorized by the Company for the distribution of products and services provided by the Company including your insurance agents, intermediaries or brokers, if applicable;
g) legal and professional advisors of the Company;
h) The Group and any associated companies of the Company;
i) the policyholder, when none of the insured person(s) of that policy is the policyholder, for the purpose of policy application, administration, renewal and / or claims administration (if applicable);
j) relevant industry association and federation that exists or is formed from time to time;
k) the fraud prevention database or registers (and the operators) and any participating parties of the database including other insurance companies and service providers handling claims for them;
l) governments and authorities within or outside HKSAR as required or permitted by law. The Company may also use and disclose your personal data otherwise with your consent;
m) any third party in connection with a transfer or potential transfer of all or part of the business of the Company that some of the transferees may be located within or outside of HKSAR.

3 **Access:** You have the right to ascertain what type of personal data the Company holds, whether the Company holds your personal data and, if so, the right to request access to and to request correction of any personal data concerning you held by the Company. Such request can be made to the Data Protection Officer, Sompo Insurance (Hong Kong) Co., Ltd, 19/F, Lincoln House, Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong. The Company reserves the right to charge a reasonable fee for processing a request to access your personal data access request.

Use of Personal Data in Direct Marketing

Apart from the aforementioned purpose, the Company may also use your name, contact details, demographic information, policy details, products and services portfolio information, transaction pattern and behavior, and financial background held by the Company to contact you with direct marketing communications regarding financial and insurance products by mail, email, telephone, facsimile or SMS. The Company may also provide your name, contact details, demographic information, policy details, products and services portfolio information, transaction pattern and behavior, and financial background held by the Company to the following transferees: (I) third party financial institutions, insurers, banks, credit card companies, securities and investment services providers; (II) third party reward, loyalty, privileges programme providers or merchants; and (III) charitable or non-profit making organizations for gain

Personal Information Collection Statement (continued)

who may send you direct marketing communications regarding (1) insurance, banking, credit card, financial, provident fund scheme and related products and services; (2) reward, loyalty or privileges programmes and related products and services; and (3) donations and contributions for charitable and / or non-profit making purposes by mail, email, telephone, facsimile or SMS.

Before using your personal data for contacting you with direct marketing communications, the Company must obtain your written consent, and only after having obtained written such consent, the Company may use your personal data for any direct marketing purpose.

You may in future withdraw your consent to the use of your personal data for direct marketing purposes by the Company or the transferees and thereafter the Company shall, without charge to you, cease to use such data for direct marketing purposes. If you wish to withdraw your consent, please inform the Company by writing to the Data Protection Officer, Sompo Insurance (Hong Kong) Co., Ltd, 19/F, Lincoln House, Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong.

Amendment to the Personal Information Collection Statement

The Company reserves the right at anytime, with or without notice, amends this PICS which will be found in our website or in writing to notify you how the Company will collect, use and transfers your personal data. Should there be any amendment to this PICS in the future, such amendment will become effective with immediate effect.

I acknowledge and confirm that I have read and understood the PICS. I confirm that I have been advised to read carefully the PICS, and I have read it carefully about its effect and impact in respect of my personal data collected or held by the Company. I hereby give my acknowledgement and agree to the use and transfer of my personal data by the Company in accordance with the PICS, including the use and provision of my personal data for the purpose of direct marketing.

If you do not agree to the use and provision of your personal data for direct marketing as set out in the PICS, please tick the box(es) below and we will not use your personal data for the purpose of direct marketing.

◯ Please tick if you do not consent to receive direct marketing communications from us.

◯ Please tick if you do not consent to receive direct marketing communications from any transferees specified in the PICS.

Name of applicant: .....

Signature of applicant: ..... **Date:** .....

Declaration for your health plan

Please read this section carefully and sign on the following page.

- I understand that the above Personal Information Collection Statement will apply to the information I provide in this application form and any other information I provide in connection with my application for a health plan, including any supplementary questionnaires I may complete.
- I understand that this application is subject to written acceptance by William Russell Ltd.
- I declare that I have taken reasonable care to answer all questions for each person named on this form fully, accurately, and to the best of my knowledge and belief. I confirm that I have checked with each person that the information I have provided is a true representation of the facts.
- I understand that misrepresentation (whether in this application form, any supplementary form I may complete, or any other information I may provide), could result in claims being rejected or not fully paid, and/or my plan being cancelled.
- I understand that this plan does not cover medical conditions existing before the start date of the plan, unless I have provided full details to William Russell Ltd. and they have agreed to cover them. I also understand that my cover note/certificate of insurance will advise me of any medical conditions excluded from cover based on the information provided in this form.
- I understand that I must inform William Russell Ltd. in writing of any changes in the facts provided in this application, including any change in health of any persons named in this application occurring before the start date of my plan.
- I understand that, to process my claims, William Russell Ltd. may need to obtain details of my medical history and the medical histories of persons named on this form.
- I authorise William Russell Ltd. to send all insurance documents as PDF files to the email address I have provided on this form. If I have applied through a broker or intermediary, I understand that these documents may be sent via email to that broker or intermediary.
- I give my consent and consent on behalf of all persons named on this form for William Russell Ltd. to use our personal information, including sensitive personal information, in accordance with the privacy policy of William Russell Ltd. I confirm that I have read and understood the privacy policy, and that I have brought it to the attention of all persons named on this form.
- I understand that, upon receipt of my insurance documents, if I am not entirely satisfied, I can cancel my application from inception and receive a full refund of the premium paid, provided I notify William Russell Ltd. within 30 days of the plan start date, and provided no claim has been made.

Declaration for your health plan (continued)

Some important notes

Please make sure that this form and all supplementary documents are legible. Your completed application form is valid for 28 days from the date you signed the form. If cover has not commenced within 28 days, you may have to complete a new form. If the health of any person named on this forms changes after you submit this form but before your plan starts, you must let us know immediately.

You can find a credit card authorisation form below.

Name of applicant: .....

Signature of applicant: ..... **Date:** .....

Credit card authorisation

Only complete this section if you wish to pay your premium by credit card.

I would like to pay my plan premium to William Russell by the following credit card:

◯ VISA ◯ MasterCard ◯ American Express

Card number: ..... Start date: ..... Expiry date: .....

Name as it appears on the card: .....

Address to which the card is registered: .....

.....

.....

Authorisation

I/we hereby authorise that the card specified above may be debited with the appropriate annual/monthly premium(s) due, and all subsequent renewal premiums due as notified by William Russell Limited, until I give notice in writing that I wish to terminate my plan agreement.

I/we understand that the premiums may increase at each plan renewal date. I understand that premiums due under the plan must be received by William Russell Limited on or before their due date and, should any attempt by William Russell Limited to debit the above card be declined, I understand that my plan cover will cease from the day before the unpaid premium due date, and that William Russell Limited will not be liable for any lapse in cover.

Signature of applicant: .....

Signature of card holder (if not applicant): ..... **Date:** .....

William Russell Ltd.
Suite 1304, 13/F Office Plus
303 Hennessy Road
Wan Chai, Hong Kong

T +852 3702 6162
E hks@william-russell.com
william-russell.com.hk