



Blue Cross 藍十字

An AIA Company 友邦保險成員公司



收集個人資料聲明
Personal Information Collection Statement



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個人健康記錄 Personal Health Record Form

每位申請加入醫療保險單內的受保人必須用英文正楷填寫此表格（父母可替子女填寫）。若未填妥交回，藍十字（亞太）保險有限公司（「藍十字」）概不處理索償。請在該受保人的保障生效日期起30天內交回藍十字。

To be filled in **BLOCK letters** by each person included in the policy (parents may fill in this form on behalf of children). No claims will be processed by Blue Cross (Asia-Pacific) Insurance Limited ("Blue Cross") unless the form is duly completed and return. Please return to Blue Cross within 30 days from the effective date of the coverage of such insured.

(I) 個人資料 Personal Information

保單持有人／僱主名稱 Name of Policyholder/Employer		保單號碼 Policy No.		
受保人姓名（以銀行戶口姓名為準） Name of Insured (as shown on bank account)	出生日期（日/月/年） Date of Birth (dd/mm/yy)	性別 Sex	香港身份證／護照號碼 HKID Card/Passport No.	婚姻狀況 Marital Status
職業／工作性質 Occupation/Job Nature	電郵地址 ¹ Email Address ¹			
僱員姓名（倘受保人是僱員家屬） Name of Employee (If Insured is a Dependant of Employee)	受保人與保單持有人／僱員之關係 ² Relationship of Insured with Policyholder/Employee ²			

1. 只接受40位或以下字母。Maximum of 40 characters is acceptable. 2. 關係 Relationship Code: E - 僱員 Employee S - 配偶 Spouse C - 子女 Child

(II) 健康狀況 Health Details

1. 在過去5年內，您是否曾感染下列疾病或接受有關治療？若「是」，請於下列適當空格內劃上「✓」號。
During the last 5 years, have you suffered from or been treated for any of the following disorders/diseases?
If "Yes", please tick the appropriate items below.

<input type="checkbox"/> 腎石或腎病 Stone or kidney diseases	<input type="checkbox"/> 靜脈曲張 Varicose Veins	<input type="checkbox"/> 風濕熱 Rheumatic Fever	只適用於女性 For Female Only : <input type="checkbox"/> 婦科疾病 Gynecological conditions <input type="checkbox"/> 與妊娠有關之疾病或其併發症 Diseases/complications or conditions associated with pregnancy 任何以上未提及之其他疾病，請附上詳細資料。 Please attach complete details for any other disorders/diseases not listed here.
<input type="checkbox"/> 各類型潰瘍症 Ulcer of any kind	<input type="checkbox"/> 疝氣 Hernia	<input type="checkbox"/> 腦癱症 Epilepsy	
<input type="checkbox"/> 各類型癌症或腫瘤 Cancer or tumours of any kind	<input type="checkbox"/> 鼻中隔或鼻甲骨偏側 Deviated nasal septum (or turbinates)	<input type="checkbox"/> 後天免疫力缺乏病毒感染 Infection by Human Immunodeficiency Virus (HIV)	
<input type="checkbox"/> 氣喘病或呼吸疾病 Asthma or respiratory diseases	<input type="checkbox"/> 姆趾外翻 Hallux Valgus	<input type="checkbox"/> 痛風 Gout	
<input type="checkbox"/> 精神病 Mental disorder or psychiatric problems/diseases	<input type="checkbox"/> 糖尿病 Diabetes	<input type="checkbox"/> 肛瘻 Anal Fistulae	
<input type="checkbox"/> 性病 Venereal diseases	<input type="checkbox"/> 高血壓 Hypertension	<input type="checkbox"/> 酗酒或藥癮 Alcoholism or drug addiction	
<input type="checkbox"/> 關節炎 Arthritis	<input type="checkbox"/> 心臟血管或循環系統疾病 Cardio Vascular or circulatory diseases	<input type="checkbox"/> 乙型肝炎 Hepatitis B	
<input type="checkbox"/> 瘧疾 Malaria	<input type="checkbox"/> 甲狀腺病 Thyroid Diseases	<input type="checkbox"/> 其他 Others	
<input type="checkbox"/> 痔瘡 Hemorrhoids	<input type="checkbox"/> 脊椎或肌肉及骨骼病 Spinal or muscular skeletal conditions/diseases		

2. 在過去5年內，您是否曾在醫院或療養院內接受手術、診察或治療？
Have you ever been in a hospital or sanitorium for surgery, observation or treatment within the last 5 years? 是 Yes 否 No

3. 您是否現正接受診察、治療或服用藥物？ Are you currently under observation or taking any treatment or medication? 是 Yes 否 No

4. 您是否曾在投保醫療、住院、意外或人壽保險時被拒絕，或有關保單曾被取消、增加保費或附加限制？如答案為「是」者，請說明原因。
Have you ever had any medical, hospitalisation, accident or life insurance application rejected or policy cancelled, rated or restricted? 是 Yes 否 No
If "Yes", please provide the reason(s).

若上述1至4項問題的答案為「是」者，請詳述於以下空格內。（若空位不足，請另頁詳加說明）

If you answered "Yes" to any of the above questions 1 to 4, please give details in the following table. (If the space provided is insufficient, please use a separate sheet.)

問題 Question	過往之健康狀況／發生日期 Medical History/Date of Occurrence	病症名稱 Diagnosis	所接受之護理及治療 Care & Treatment Received	現在的情況 Present Conditions	最近一次求診日期 Date of Last Consultation
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(III) 聲明及授權 Declaration and Authorisation

本人謹記聲明並同意：

- 上述所有問題的答案包括所有資料及細節均是準確無誤，真實及為事實之全部，並且是盡本人所知及所信而作答的。本人並沒有隱瞞任何重要資料。
- 本人／我們確認本人／我們已閱讀、明白及同意藍十字（亞太）保險有限公司的收集個人資料聲明（「該聲明」）。該聲明的符合相關守則及法規之最新版本可於表格上的二維碼下載及可供索取。

I HEREBY DECLARE AND AGREE THAT:

- The answers to all the above questions including all information and particulars given herein are accurate, true and complete and are given to the best of my knowledge and belief. I have not withheld any material information.
- I/We confirm that I/we have read, understood and agreed to the Personal Information Collection Statement of Blue Cross (Asia-Pacific) Insurance Limited (the "PICS"). The updated version of the PICS which complies with the relevant rules and regulations is available for download using the QR code on this form and upon request.

日期（日/月/年） Date (dd/mm/yy)	受保人簽署 Signature of Insured
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*本個人健康記錄的中文版本如有差異，以英文版本為準。Should there be any discrepancy between the English and the Chinese versions of this Personal Health Record Form, the English version shall apply and prevail.