



# AAA MediCare – Comprehensive Health Declaration

This Health Declaration must be completed by each person to be insured. (Use photocopy if more than one person to be insured.)

| Name of person to be insured | Height (ft/m)* | Weight (lbs/kgs)* | Weight change in past 12 months +/- (lbs/kgs)* |
|------------------------------|----------------|-------------------|--|
|                              |                |                   |  |

\*delete where appropriate.

1. Do you have any deformity, lameness, amputation or any congenital or acquired physical defect?  yes  no

2. Have you ever been diagnosed and / or treated for :

a. disorders of the eyes, nose, throat?  yes  no

b. neurological disorders, dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental, nervous disorders, shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, chronic respiratory disorder, jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, haemorrhoids, recurrent indigestion or other disorders of the stomach, intestines, liver, gall bladder, sugar, albumin, blood or pus in urine, venereal disease, stone or other disorders of kidney, bladder, prostate, or reproductive organs?  yes  no

c. chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorders of the heart or blood vessels?  yes  no

d. diabetes, thyroid or other endocrine disorders?  yes  no

e. neuritis, sciatica, rheumatism, arthritis, gout or disorders of the muscles or bones, including the spine, and back joints?  yes  no

f. disorders of skin, lymph glands or any kinds of cysts?  yes  no

g. tumour or cancer?  yes  no

h. allergies, anaemia or disorders of the blood?  yes  no

3. Are you actually receiving treatment for any or all of the above-mentioned disorders or accidents including prescriptions?  yes  no

4. Other than the above, have you within the past 5 years?

a. had any mental or physical disorder not listed above?  yes  no

b. had a check-up, consultation, illness, injury or surgery?  yes  no

c. been a patient in a hospital, clinic, sanatorium or other medical facility?  yes  no

d. had an electrocardiogram, X-ray or other diagnostic test?  yes  no

e. been advised to have a diagnostic test, hospitalization or surgery which was not completed?  yes  no

5. Have you ever had a policy or application for life, accident, or medical insurance refused, postponed, declined, withdrawn, or had any special terms (including extra premium or exclusions) imposed?  yes  no

6. Females only

a. Are you now pregnant as far as you know?  yes  no

b. Do you have any gynaecological disorder?  yes  no

7. Have you had or been advised to have any counselling or investigations in connection with A.I.D.S., Hepatitis B or Hepatitis C?  yes  no

8. What is your average intake of alcohol? \_\_\_\_\_ ml per week  yes  no

9. Family Background: Have your parents, brothers or sisters ever had diabetes, high blood pressure, heart or kidney disease, cancer or mental illness?  yes  no

If the answer to any of the above questions is yes, please give full details : (use a separate sheet if necessary)

| Question No. | Diagnosis of illness and full details of treatment received and dates of treatment | Name and address of the medical attendant (s) who attended the patients |
|--------------|--|---|
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|              |  |   |

Name and Address of the Family-attending physician : \_\_\_\_\_  
 \_\_\_\_\_ Tel. \_\_\_\_\_ Fax \_\_\_\_\_ Ref. No. \_\_\_\_\_

# AAA MediCare – Application Form

**PLEASE SIGN AND RETURN THIS FORM IN ORIGINAL, WITH THE FULL PREMIUM MADE PAYABLE TO “AAA MEDICARE LIMITED” ON BEHALF OF FALCON INSURANCE (HONG KONG) LIMITED BEFORE COVER CAN BE GRANTED.**

**1) Declaration**

I hereby apply to be enrolled in the Plan together with the person(s) to be insured listed above. I hereby declare to the best of my knowledge and belief that the foregoing statements, including any statement attached, are true, correct and complete. It is agreed that this declaration and information given in this Application shall form the basis of the contract(s) between the Insured Person(s) and the Insurer.

The Plan Rules attached to this Application have been read and understood by me and I accept them to be part of the contract of insurance issued as a result of this Application.

The Area 2 option is not available to citizens or permanent residents (whatever nationality) of the United States of America or Canada. Purchase of this insurance by those people will render the policy null and void.

**2) Personal Information Collection Statement**

The information you provide to **Falcon Insurance Company (Hong Kong) Ltd.** is collected to enable the company to carry on insurance business and may be used for the purpose of (i) any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or service; (ii) any claim or investigation or analysis of such claim; and (iii) exercising any right of subrogation. The information may be transferred to (i) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claim or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; (ii) any association, federation or similar organization of insurance companies (“Federation”) that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation; and (iii) any members of the “Federation” by the “Federation” for any of the above or related purposes.

Moreover, **Falcon Insurance Company (Hong Kong) Ltd.** is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance industry. You have the right to obtain access to and to request correction of any personal information concerning yourself held by **Falcon Insurance Company (Hong Kong) Ltd.** Requests for such access can be made to our Data Protection Officer (6/F DCH Commercial Centre, No. 25 Westlands Road, Quarry Bay, Hong Kong. Tel: 2232 2888 Fax: 2232 2799).

**3) Consent**

In accordance with the provisions of the Personal Data (Privacy) Ordinance of Hong Kong, I/and on behalf of all persons to be insured\* consent, by signing below, that the personal information of me/all persons to be insured\* provided by me/us\* and held by **Falcon Insurance Company (Hong Kong) Ltd.** (whether contained herein or otherwise obtained) may be held, used, disclosed, released and transferred by **Falcon Insurance Company (Hong Kong) Ltd.** to the parties and for the purposes mentioned in the “Personal Information Collection Statement”.

**4) Authorization**

a) I hereby authorize/and on behalf of all persons to be insured hereby authorize\* (i) any doctor, hospital, clinic, or insurance company, government office or any organization or persons who has any records/knowledge/information of me/all persons to be insured\* (whether medical or otherwise) to disclose, release or transfer to **Falcon Insurance Company (Hong Kong) Ltd.** or its representative such record, knowledge or information pertinent to this Application and any claim arising therefrom; (ii) **Falcon Insurance Company (Hong Kong) Ltd.** or any of its appointed medical/para-medical examiners or laboratories to perform necessary examination, medical assessment and tests to evaluate the health status of me/all persons to be insured \*in relation to (i) above.

b) This authorization shall bind the successors and assignees of me/all persons to be insured\* and remains valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original.

\*delete where appropriate.

\_\_\_\_\_  
Signature of Applicant  
(on behalf of all persons to be insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Broker / Agent (with company chop)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Signatory

\_\_\_\_\_  
Broker / Agent  
Code

**For office use only**

Is this a conversion case from RELEE CARE :  yes  no

If yes, please state the RELEE CARE PLAN \_\_\_\_\_ and the conversion premium discount \_\_\_\_\_ %

INSURER:  
Falcon Insurance Company (Hong Kong) Limited  
6/F, DCH Commercial Centre,  
No. 25 Westlands Road,  
Quarry Bay,  
Hong Kong

ADMINISTRATOR:  
AAA MediCare Limited  
Room 1007, Eastern Harbour Centre,  
28 Hoi Chak Street,  
Quarry Bay,  
Hong Kong