CHUBB®

Agent's/Intermediary's name _____

Agent's/Intermediary's contact phone no. _____

Agent's/Intermediary's code _____

Agency _____ – _____

Request For Addition of Riders Form (for Agent only)

Please tick ☑ appropriate box(es) for request ☐ New Request ☐ Reply

Policy Number:	Full Name of Insured:	Full Name of Policyowner:

This form is applicable to addition of riders for Insured only. If you would like to apply addition of riders for Other Insured (e.g. apply Child's Protection Benefit "CPBB"), please fill in Request For Change in Policy Form & Statement of Insurability accordingly. The current company record will be used for underwriting (if necessary). Should there be any change(s) on personal/financial information, please submit Request For Change in Policy Form accordingly.

For PRC customers applying Super Care Early Stage Illness Benefit/Living Well Benefit rider series/VCare Cancer Protector/Hospital and Surgical Benefit/Select Medical Top Up Plan/Hospital Cash, please fill in Application Supplement For Critical Illness/Cancer/Hospital/Personal Accident Plan (NB350).

In compliance with the legal and regulatory requirements with respect to the prevention of money laundering and terrorist financing, the Company requires to collect your identity information. If the identity document(s) of the policyowner has (have) not been provided before or has (have) been updated, please submit the copy(ies) of the latest and valid identity document(s) for our record.

1. **The New Sum Assured must be in Policy Currency.**

   Effective month _____ / _____ (mm / yyyy)

Critical Illness

Living Well Benefit

☐ CIBL-BASIC ☐ CIBR-BASIC
☐ CIBL-BASIC-PRC ☐ CIBR-BASIC-PRC
☐ CIBL-TERM ☐ CIBR-TERM

New Sum Assured _____

Living Well Plus Benefit

☐ CIBPL ☐ CIBPR
☐ CIBPL-PRC ☐ CIBPR-PRC

New Sum Assured _____

Living Well Supreme Plus Benefit

☐ CIBSL ☐ CIBSR
☐ CIBSL-PRC ☐ CIBSR-PRC

New Sum Assured _____

VCare Cancer Protector

☐ RCBR ☐ RCBRC ☐ Plan 1 ☐ Plan 2

Super Care Early Stage Illness Benefit (Basic Option)

☐ ECPR ☐ ESPR
☐ ECPL ☐ ESPL

New Sum Assured _____

Super Care Early Stage Illness Benefit (Enhanced Option)

☐ ECSR ☐ ESSR
☐ ECSL ☐ ESSL

New Sum Assured _____

Super Care Multiple Protection Benefit

☐ MCI ☐ MCC

New Sum Assured _____

Medical

Hospital Cash Benefit (HC)

New Daily Benefit _____

Select Top-Up Medical Plan (TUR)

☐ Class I (Private) ☐ Class II (Semi-private) ☐ Class III-1 (Ward) ☐ Class III-2 (Ward)

Hospital & Surgical Benefit

☐ HS09 ☐ HSC9

☐ Class I (Private) ☐ Class II (Semi-private) ☐ Class III (Ward)

☐ Class I Plus (Private) ☐ Class II Plus (Semi-private) ☐ Class III Plus (Ward)

Personal Protection / Accident

Juvenile Accident Protector

☐ JAP New Sum Assured _____

Optional Benefit
☐ JAPMB* New Sum Assured _____

* JAPMB cannot be applied alone without JAP.

The One Accident Protector (FNA form (NB205) is required)

☐ PAR10 ☐ PAR20 New Sum Assured _____

Personal Accident Benefit

☐ PAADD New Sum Assured _____

Optional Benefit
☐ PAMB* New Sum Assured _____
☐ PAWAI* New Sum Assured _____

* PAWAI and PAMB cannot be applied alone without PAADD.

Others

Waiver of Premium Benefit ☐ WPB

Multi-Select Term

☐ MS1R ☐ MS15R
☐ MS5R ☐ MS20R
☐ MS10R ☐ MS25R

New Sum Assured _____

Lady's Partner Plan - Female Cover

☐ LDFML New Sum Assured _____

Optional Benefit
☐ LDPGY* New Sum Assured _____
☐ LDFCP* New Sum Assured _____

* LDPGY and LDFCP cannot be applied alone without LDFML.

2. **Change of Sum Assured/ Notional Amount/Rider**

Effective Month _____ / _____
mm yyyy

Basic Plan/Rider	New Addition ^	Deletion #	Increase ^	Reduce #	New Sum Assured/ Notional Amount/Class
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____

^ New addition or increase of sum assured/notional amount or upgrade of benefit requires to submit"Statement of Insurability" for the application. Please submit NB428 "Standardized Underwriting Questionnaire for Chubb VHIS" if applying VHIS product.

^ New addition or increase of sum assured for product(s) with cash value requires to submit proposal.

Rider deletion or reduction of sum assured/notional amount, NO back-dating is allowed. If the effective month is not specified, the request will be effective on the next premium due date or on the specified date as stated in product provisions of specific products.

Target Healthcare Needs

(Only applicable to application of critical illness and/or medical insurance product. Apart from the mentioned products, please submit Financial Needs Analysis form.)

If you are considering critical illness and/or medical insurance product(s) to meet your objective of preparation for healthcare needs, what type(s) of the following critical illness and/or medical insurance product(s) will you consider to purchase? (You may tick one or more)

☐ Product offering a lump sum payout if I were to be diagnosed with a critical or specific illness.

☐ Product Reimbursing relevant medical expenses if I need to be hospitalized or undergo a surgery.

☐ Product providing small regular payouts during the period of hospitalization to compensate relevant loss or other expenses.

I confirm that I have conducted an assessment on the insurance product(s) to be purchased by me in order to ensure that I am able to pay the required premiums.

Questions 3-20 are applicable for INSURED only

3. Employer's name: _____

4. Present occupation: _____

5. Exact duties: _____

6. What is your monthly earned remuneration in average for the past 12 months? (Gross earnings excluding investment income less business expenses but before tax)
   Insured's monthly salary (HK$): _____

7. Do you have any in-force or pending insurance with other insurer(s) (new application or reinstatement) ? If "Yes", please state amount/sum assured and currency.

	Insurer	Life	Critical Illness	Disability Income	Hospital Income	Weekly Accident Indemnity	Accident Insurance	Date of Issue (mm/yyyy)
☐ Yes ☐ No								

	Yes	No
8. Have your policy(ies) ever been voided/non-renewed or you ever been refused for applying insurance or reinstatement of it, or been offered a policy different in plan, term, amount/sum assured or premium from that applied for with other insurer(s)? If "Yes", please give name of insurer, date of application, amount/sum assured and the reason. Details: _____	☐	☐
9. Do you participate or intend to participate in any hazardous activities whether related to your work or recreation? If "Yes", please complete and submit the appropriate questionnaire(s).	☐	☐
10. Do you intend to travel outside of Hong Kong (including business trips and study) except holidays? If "Yes", what is the purpose of the trip, for how long will you be away, what is the destination and how often will you go per year? Details: _____	☐	☐

11. Please provide the following information of the physician of the Insured last visited.

    a. Full name of the physician: _____

    b. Address: _____

    c. Phone no.: _____

    d. Last consultation date (dd / mm / yyyy): _____ /_____ /_____

    e. Consultation reason, diagnosis and recovery date: _____

	Yes	No
12. a. Height: _____ m _____ cm / _____ ft _____ inch		
b. Weight: _____ kg / _____ lb		
c. Have you experienced weight loss of more than 5kgs (11lbs.) during the past 12 months? If "Yes", please state exact weight loss amount and the reason.	☐	☐
13. This question is applicable **<u>for female only</u>**. (Applicable to age 12 or above)		
a. In the past 10 years, have you ever had or been told to have or been treated for, or intending to be treated for disorder of pelvic organs, breast, menses or pregnancy? Are you now pregnant? If "Yes", please state the expected delivery date.	☐	☐
b. Have you ever had, or been told to have, or are you intending to have mammogram, ultrasound of breast or pelvis, pap smear, cone biopsy or colposcopy?	☐	☐
c. Have you ever had complications of pregnancy during gestation in the past 10 years (e.g. ectopic pregnancy, miscarriage, disseminated intravascular coagulation, diabetes or hypertension, etc.)?	☐	☐
14. This question is applicable **<u>for juvenile only</u>**. (Applicable to age on or below 15)		
a. Was the child's birth premature or postmature	☐	☐
b. Any special care needed after birth?	☐	☐
c. Has the child had any physical defects or shown any sign of slow physical or mental development?	☐	☐
15. Have any of your parents or siblings died or suffered from blood disease, liver disease (including hepatitis B carrier), heart or polycystic kidney disease, stroke, diabetes, hypertension, cancer, AIDS or known hereditary disease? If "Yes", please provide the relationship with Insured, name of disease together with the onset age. (i) Relationship: _____ (ii) Disease(s): _____ (iii) Onset age: _____	☐	☐
16. a. Do you drink alcohol on regular basis? If "Yes", please provide the type and unit of alcohol consumed per week? Type: _____ Unit of consumption per week: _____	☐	☐
b. Do you take or have you ever taken any narcotics or habit forming drugs or been treated or consulted for alcohol? If "Yes", please provide details.	☐	☐
c. Do you use or have you ever used any tobacco products in the past 12 months? If "Yes", please complete (1) average daily consumption; and (2) number of years. If ceased in consuming any tobacco products, please also provide the termination cause and date. Average daily consumption: _____ Number of years: _____ Termination cause and date: _____	☐	☐
17. Have you ever had or been told to have or been treated for or intending to be treated for any of the following diseases or conditions:		
a. Disease or disorder of circulatory system, including cardiovascular system and lymphatic system, e.g. chest discomfort, palpitation, raised blood pressure, rheumatic fever, heart attack, shortness of breath or dyslipidemia?	☐	☐
b. Disease or disorder of respiratory or endocrine system, e.g. asthma, persistent hoarseness or cough, diabetes, thyroid disease or disorder?	☐	☐
c. Disease or disorder of digestive system such as jaundice, ulcer, colitis, disorder of stomach, liver disease or disorder (including hepatitis : please specify the exact type), bowels, gall bladder disease or disorder?	☐	☐
d. Disease or disorder of genitourinary system or reproductive organs, e.g. abnormal urine or bladder, prostate, breasts, uterus, uterus cervix or kidney disease or disorder?	☐	☐
e. Disease or disorder of eye or other sensory organs, dizziness, convulsions, epilepsy, neuritis, paralysis, stroke, mental or other nervous system disease or disorders?	☐	☐
f. Deformity, lameness or amputation, arthritis, gout or spinal cord, systemic lupus erythematosus, other musculoskeletal or autoimmune disease or disorders?	☐	☐
g. Cancer, tumour, cyst, any disease or disorders of skin, lymph node or blood?	☐	☐
h. Sexually transmitted disease or HIV infection?	☐	☐
18. In the past 5 years, do you plan to attend, or are you currently attending or have been advised to, attended any hospital, clinic or doctor for any investigating (other than routine health check) or diagnostic test (e.g. cholesterol, AIDS, hepatitis including hepatitis B, anaemia etc)?	☐	☐
19. Other than covered above, have you ever had, or are you currently awaiting, or have been advised to, or do you intend to be counselled, tested, medically advised or treated in connection with any other illness, disease, signs and symptoms or disorder for more than 7 days, or undertaking operation, medical advice or hospitalization for more than 3 days?	☐	☐

20. Supplement

If the answer for Questions 12-19 is/are "Yes", please give details in Question 20.

Question no.	Reason - nature and severity of conditions (Include frequency, diagnosis, treatment, medication, surgery and results)	Onset (mm/yyyy)	Recovery (mm/yyyy)	Names and addresses of physicians, hospitals or medical facilities

Section A: Declaration & Authorization

I/WE HEREBY DECLARE AND AGREE THAT: (1) All statements and answers to all questions in this statement and any questionnaire or declarations of insurability or health answered and made in this statement including but not limited to those made/completed in any related medical examinations, whether or not written by my/our own hands are to the best of my/our knowledge and belief full, complete and true. (2) All answers to such questions, together with this statement shall form the basis and become part of the Policy issued by Chubb Life Insurance Hong Kong Limited (the "**Company**"). (3) The Company is not bound by any statement which I/we may have made to any person, including but not limited to the Agent named herein if not written or printed here. (4) I/We shall disclose to the Company any change in the health or insurability of the Insured(s) subsequent to the signing of this statement but prior to any endorsement/confirmation letter being issued AND the failure to disclose any material facts and/or circumstances relating to any change in the health or insurability of the Insured(s) shall render the contract voidable. (5) (Where applicable) Any payment made in connection with application of this Policy does not guarantee immediate approval of the coverage applied. The insurance coverage applied for shall only take effect when due premiums are paid during the lifetime and continuous good health of the Insured(s). **I/We hereby irrevocably authorize** (i) any employer, doctor, hospital, clinic, insurance company, government office or any organizations of persons who have any records, knowledge or information of me/us (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to this application for insurance, reinstatement and any claim arising therefrom; (ii) the Company or any of its appointed medical/ para-medical examiners or laboratories to perform necessary medical assessment and tests to evaluate the health status of me/us in relation to this application for insurance, reinstatement and any claim arising therefrom. This authorization shall bind the successors and assignees of me/us and remains valid notwithstanding my/our death or incapacity. A photocopy of this authorization shall be as valid as the original.

Section B: Collection of Levy by the Insurance Authority

Pursuant to the Insurance (Levy) Regulation, with effect from 1 January 2018, the policy owner under a contract of insurance issued by an authorized insurer must, each time a premium is paid, also pay to the insurer a prescribed levy for the premium. The Insurance Authority may impose on the policy owner a pecuniary penalty if such policy owner fails to pay the prescribed levy.

Section C: Personal Information Collection Statement And Consent

I/WE HEREBY ACKNOWLEDGE, DECLARE AND AGREE THAT, by signing this form, any personal information collected or held by Chubb Life Insurance Hong Kong Limited (the "Company") is provided and may be used, processed, stored, disclosed, transferred by the Company to the transferees indicated in and in accordance with the Personal Information Collection Statement set out in my/our Application For Life Insurance, which may include without limitation, any branch, subsidiary, holding company, associated company or affiliates of the Company (the "Group Companies"), its authorized agents, reinsurers, claims investigators, loss adjudicators, medical advisors, recovery agents, insurance industry associations and federations, credit reference agencies, government or judicial or regulatory bodies or any person to whom the Company is under legal and/or regulatory obligation to make disclosure, and the Company's appointed third party agents, contractors and advisors, in each case whether within or outside of Hong Kong and Mainland China. Moreover, the Company is hereby authorized to obtain access to and/or to verify any of my/our personal information with the information collected by the insurance industry associations, the federations, the government and regulatory bodies and medical personnel or organizations. I/We am/are obliged to supply the information required from me/us under this form which is a condition precedent for me/us to apply for the policy change request. Failure to supply the required information may result in the Company being unable to process the form. For more details of the Company's policies on personal information and privacy protection, please read the Company's Privacy Notice available at https://www.chubb.com/hk-en/footer/chubb-life-privacy-policy.html. Any questions regarding personal information, access to or correction of personal information should be made in writing and forwarded to The Data Protection Officer of Chubb Life Insurance Hong Kong Limited at 35/F, Chubb Tower, Windsor House, 311 Gloucester Road, Causeway Bay, Hong Kong.

NOTE :
Please do not sign on BLANK Form
Signature specimen must be consistent with that as in your policy record

* Signature of Insured

Sign Date (dd/mm/yyyy)

Signature of Policyowner

Sign Date (dd/mm/yyyy)

Signature of Assignee
(Only applicable if the policy has been assigned)

Signature of Irrevocable Beneficiary
(Only applicable if the designated beneficiary is an Irrevocable Beneficiary)

Sign Date (dd/mm/yyyy)

*** Signature is required for the person whose age is 18 or above**