聯豐亨保險有限公司
Luen Fung Hang Insurance Company Limited

澳門宋玉生廣場 398 號中航大廈四樓
No.398 Alameda Dr. Carlos D'Assumpcao,
Edificio CNAC, 4-Andar, Macau.
Tel: (853) 28700033 Fax: (853) 28700088
Website: http://www.luenfunghang.com
E-mail: info@luenfunghang.com

醫療服務提供者職業民事責任強制保險投保書

Compulsory Professional Liability Insurance for Healthcare Providers Proposal Form

自然人
Natural Person

請閣下在填寫本投保書前先閱讀以下投保須知事項。
Please read the following note before you complete the proposal.

1. 披露責任 YOUR DUTY OF DISCLOSURE

在與保險公司訂立保險合同前，閣下有責任向保險公司披露有關任何會影響保險公司考慮可否接受投保、及/或制定條款的一切閣下已知悉、或合理預期應該知悉的信息。閣下在續保、擴展、更改或恢復保險合同前亦對保險公司負有提供相同信息之披露責任。
Before you enter into any contract of general insurance with an insurer, you have a duty to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms. You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of general insurance.

該披露責任不包括以下信息 Your duty does not require disclosure of a matter:

- 降低保險公司承保的風險 that diminishes the risk to be undertaken by the insurer;
- 屬於普通知識 that is of common knowledge;
- 保險公司已知悉，或其業務日常營運下應該知悉 that your insurer knows or, in the ordinary course of his business, ought to know;
- 已獲保險公司豁免披露責任的範圍 as to which compliance with your duty is waived by the insurer.

違反披露責任 Non-disclosure
若閣下不遵守披露責任，保險公司可減少保險合同之賠償責任或終止保險合同。If you fail to comply with your duty of disclosure, the insurer may be entitled to reduce his liability under the contract in respect of a claim or may cancel the contract.
若有關違反披露屬於欺詐行爲，保險公司可決定保險合同由起始日期失效。If your non-disclosure is fraudulent, the insurer may also have the option of avoiding the contract from its beginning.

2. 索償基礎保單 **CLAIMS MADE POLICY**

根據索償基礎保單的條款規定，在保險期限內若閣下接獲任何索償或知悉任何索償意圖的通知或閣下意識可能出現引致索償的情況發生或閣下合理預期引致閣下被索償的情況，則閣下必須立即通知保險公司，該通知並且必須在適用於該保險期限內之保險合同內提出。THE TERMS AND CONDITIONS of a Claims Made Policy provide that, if a claim is made against you or any notice of an intention to make a claim against you is received or circumstances come to your attention which are likely to cause a claim to be made against you or which you should reasonable expect to cause a claim to be made against you during the term of the Policy then you must immediately notify Underwriters thereof. This notification must be given during the term of the Policy for the Policy to apply.

有關引致索償或可能索償之事件或情況，必須發生在保險證明書上的追溯日之後及有關保障金額適當。閣下於本保險合同的責任爲在保險期限內向保險公司通知關於任何索償或可能索償或閣下知悉可能引致索償情況或事件或閣下合理預期可能引致的索償。上述的通知必須在閣下被提起或接獲索償或在知悉後盡快通知保險公司。The time of happening of the acts or circumstances which give rise to a claim or possible claim is not of relevance provided they occur after the retroactive date stated on the Certificate of Insurance and the relevant sum insured is adequate. Your obligation under the Policy is to communicate to Underwriters during the term of the Policy a claim, notice of a possible claim or circumstance or act which comes to your attention and which may give rise to a claim or which you should reasonably expect may give rise to a claim as soon as is reasonably possible after such is made, received or has come to your attention.

本保險合同不承保在保險合同到期日後所作出之任何索償。請注意維持有效保險的需要或安排持續保障的重要性。Upon expiry of the Policy no further claims can be made thereunder and the need to maintain insurance or to arrange run off coverage is essential.

3. 最大誠信原則 **UTMOST GOOD FAITH**

本保險以最大誠信原則爲基礎，保險公司及投保人/被保險人各方相互均必須遵守及以最大誠信原則對待本保險的任何事項。This Insurance is a contract based on the utmost good faith requiring the Insurer(s) and the Proposer / Insured(s) to act towards each other with the utmost good faith in respect of any matter arising in relation to this insurance.

(以上中文譯本只供參考，一切以英文爲準。Chinese translation is for reference only. Please refer to English version for details.)

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醫療服務提供者職業民事責任強制保險投保書

Compulsory Professional Liability Insurance for Healthcare Providers Proposal Form

(以索償爲基礎 Claims Made Basis)

自然人
Natural Person

閣下必須確切回答以下所有問題。如問題之答案爲沒有時，請註明 "沒有"
It is essential that all questions be answered fully. If the answer to any question is None, state "None'.

1	投保人姓名 Full name of applicant: 英文 English: _____ 中文 Chinese: _____ 地址 Address: _____ 電子郵箱 Email: _____ 聯絡電話 Tel. no.:_____
2	被保險人姓名(請附上身份證副本及名片) Full name of Insured (Please submit ID copy and Name Card): 英文 English: _____ 中文 Chinese: _____ 牌照註冊編號 License No.:_____ 牌照到期日 Expiry date of License: _____ (請附上牌照副本 Please submit License copy) 牌照類別 Professional title of the License: _____ 執業地址 Practicing Address: _____
3	閣下於何處取得學歷 Where did you graduate: _____ a) 獲取專業資格學位 (請附上副本) Degree of designation obtained (Please submit copy) _____ b) 獲取專業資格日期 Date of designation obtained _____
4	閣下屬於哪一些專業組織成員? Of what professional organizations are you a member? _____
5	a) 已執業多久? How long have you been practicing?_____ b) 閣下屬於下列哪一項醫療範疇：Which of the following medical disciplines you are belonging to: (1)☐中醫生 Traditional Chinese Medicine Practitioner ☐中醫師 Masters of Traditional Chinese Medicine ☐藥劑師 Pharmacist ☐藥房技術助理 Pharmacy Technical Assistant ☐按摩師 Massage Therapist ☐針灸師 Acupuncturist ☐診所輔助技術員 Diagnostic and Therapeutic Aids Technician ☐脊醫(不施行手術) Chiropractor(Non-procedure) ☐牙科醫師 Odontologista ☐護士 Nurse ☐治療師 Therapist: 類型 Type _____ (2) (i) ☐普通科醫生(不施行手術)不包括以下(2)(ii)，(3)(i)及(ii) General Practitioner (Non-procedure) excluding below (2)(ii), (3)(i) and (ii) (ii) 醫生(不施行手術)包括以下 Doctor (non-procedure) consisting of below: ☐心臟科 Cardiology ☐麻醉師 Anesthetist ☐眼科 Ophthalmologist ☐意外及急症科 Accident & Emergency ☐放射科及放射治療科 Radiology & Radiotherapy ☐牙科醫生 Dentist ☐耳鼻喉科 Otorhinolaryngologist ☐醫務化驗師 Medical Technologist (3) (i) ☐施行外科手術醫生(不包括以下(ii)高風險類) General Surgery (excluding below (ii) High Risks) (ii) 高風險類包括以下 High Risks consisting of below: ☐婦科 Gynaecology ☐產科 Obstetrics ☐心臟科手術 Cardiothoracic Surgery ☐神經外科手術 Neurosurgery ☐脊椎手術 Spine Surgery ☐美容矯形類手術 Cosmetic/Aesthetic risk Surgery ☐抽脂手術 Liposuction Surgery ☐整形復原手術及管脈科手術 Plastic & Reconstruction Surgery and Vascular Surgery ☐整形外科手術 Orthopaedic Surgery (4)☐其他 Others: _____

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6	請提供閣下投保之賠償金額要求 Amount of Indemnity required: ☐ MOP500,000 ☐ MOP1,000,000 ☐ MOP2,000,000 ☐ 其他 Others MOP_____ 免賠額要求 Amount of Deductible required: MOP_____ 保險之生效日期要求 Effective date required: 由 From _____日 dd _____月 mm_____年 yyyy (共 12 個月 for 12 months) (待確定 to be confirmed)
7	a) 閣下是否受聘於任何個體或機關? Are you in the employ of any individual or firm? ☐ 是 YES ☐ 否 NO 如 "是"，請詳細註明受聘單位名稱 If "YES" explain_____ 地點 Location: _____ b) 閣下是否醫療場所的合夥人、股東、經理、董事或法定代理人? Are you a Partner, Shareholder, Manager or a Legal Representative of the Medical Institution? ☐ 是 YES ☐ 否 NO 如 "是"，請詳細註明 If "YES" explain: _____ 醫療場所牌照註冊編號 Medical Institution License No.:_____ 醫療場所名稱 Name of Medical Institution: _____ 地點 Location: _____
8	閣下是否擁有或自營診所? Do you own or operate a medical clinic? ☐ 是 YES ☐ 否 NO 若 "是" ，請註明受聘之註冊護士數目 If "YES", please advise how many registered nurses are employed_____ 診所地點 Location: _____
9	病人總數 Total number of patients i) 最近十二個月內 During the last 12 months _____ ii) 上述期間之前十二個月內 Within 12 months prior to the above period_____ iii) 估計未來十二個月內 Estimate for ensuing 12 months _____
10	a) 現時是否已具有醫療失誤保險保障? Are you currently Insured against Medical Malpractice? ☐ 是 YES ☐ 否 NO b) 如 a)答 "否" 閣下有否曾經接受該等保險保障? If the answer to a) is "NO", has this practice ever been insured? ☐ 是 YES ☐ 否 NO c) 如 a)或 b)答 "是" 請提供下述資料 If the answer to a) or b) is "YES", please provide following data - 賠償額 Amount of Cover MOP_____ - 免賠額 Amount of deductible MOP_____ - 最近期之年度保費 Last Annual Premium MOP_____ - 保單於何時失效，或現存之保單保障到期日 When lapsed or if current, the expiry date _____ - 保險公司名稱 Name of Insurer _____
11	a) 閣下有否曾被任何保險公司拒絕、取消受保或拒絕續保有關執業事務之保障? Has any application for insurance in respect of the practice to be covered ever been declined, cancelled or renewal refused? ☐ 是 YES ☐ 否 NO 如 "是"，請詳細註明 If "YES" explain _____ b) 有否曾被附加任何特別條款? Have any special terms ever been imposed? ☐ 是 YES ☐ 否 NO 如 "是"，請詳細註明 If "YES" explain _____
12	a) 閣下有否曾經因爲醫療失誤而被索償? Have any claims of medical malpractice ever been made against you? ☐ 是 YES ☐ 否 NO 若 "是" ，請提供每宗索償事件之詳情。If "YES", please provide details of each claim. _____ b) 閣下有否察覺到可有任何情況因爲醫療失誤而引致有可能被索償事件，閣下認爲自己是否須要承擔責任? Are you aware of any circumstances which may give rise to claims against you for medical malpractice, whether you consider yourselves liable or not? ☐ 是 YES ☐ 否 NO 若 "是" ，請提供詳情。If "YES", please give full details. _____ 註：有關 a)及 b)項所提及之事件項目將不包括在保障範圍內。 Note: Coverage will be excluded for incident items mentioned in response to a) and b) above.

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聲明及收集個人資料聲明

本人/我們茲聲明於本投保書內所載之陳述及細項均屬確實無訛。本人/我們並同意本投保書聯同其他本人/我們所提供之資料均會成爲日後保單之基礎及其中一部份。於保障開始前，即保險合約生效前，倘發生任何有關此等實情之關鍵性變更，本人/我們保證當如實通知承保人。簽署本投保書並不約束投保人及保險公司對於保障之生效力。
本人/我們明白及同意：
1. 本人/我們於本投保書內之陳述乃真確無訛，可作爲簽發保單之根據。
2. 本投保書是本人/我們在澳門特別行政區內簽署，如有任何訛騙或資料失實，本人/我們及/或被保險人之保障有失效之虞。
3. 本人/我們同意接受「醫療服務提供者職業民事責任強制保險」保單上所訂的條款及細則。
4. 本人/我們同意「聯豐亨保險有限公司」(“聯豐亨”)保留一切有關投保書接納與否之權利。
5. 本人/我們明白必須繳付保費後，聯豐亨對本人/我們及/或被保險人之保險責任始行生效。

您提供的資料，爲聯豐亨保險有限公司(“本公司”)提供保險業務所需，並可能使用於下列目的：
1. 處理及審批您的保險申請或您將來提交的保險申請；
2. 執行您保單的行政工作及提供與您保單相關的服務；
3. 分析或調查、處理及支付您保單有關的索償；
4. 發出繳交保費通知及向您收取保費及欠款；
5. 任何與保險有關的產品或服務的任何更改、變更、取消或續期；
6. 就以上用途聯絡您；
7. 本公司行使任何代位權；
8. 其它與上述用途有直接關係的附帶用途；及
9. 遵循適用法律、規則、規例、實務守則或指引規定的要求，或協助相關本地或海外的政府、監管機構執法或進行調查，包括但不限於美國《海外帳戶稅收合規法案》和跨政府協議。

本公司亦可因應上述用途將您的個人資料移轉予下列各方(包括澳門境內或境外)：
1. 就上述用途，向本公司提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問(包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商)；
2. 處理索賠個案的理賠師、理賠調查員及醫療顧問；
3. 追討欠款的收數公司或索償代理；
4. 保險資料服務公司及信貸資料服務公司；
5. 再保公司及再保經紀；
6. 本公司的法律及專業業務顧問；
7. 任何金融服務供應商的「行業協會或聯會」。
8. 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；
9. 澳門金融管理局；及
10. 法例要求或許可的政府機關。

您在此授權本公司可向「行業協會或聯會」從保險業內收集的資料中查閱及/或核對您任何資料。此外，經您同意，本公司可能會以其它方式使用及披露您的個人資料。

使用資料作直接促銷
本公司擬使用您的資料作市場推廣的直接促銷。本公司會遵從《個人資料保護法》內有關直接促銷的規定。若您不同意本公司使用或提供您的資料予其他人士，藉以用於直接促銷，您應通知本公司以行使您不同意此安排的權利。

任何關於查閱及/或更正資料及/或索取關於私隱政策及所持有的資料種類的要求，及/或要求本公司不將該等個人資料用於直接促銷的用途，應以書面向本公司承保部提出，地址爲：澳門宋玉生廣場 398 號中航大廈四樓。

Declaration & Personal Information Collection Statement

I/We declare that the statements and particulars in this proposal are true and that I/We have not mis-stated or suppressed any material facts. I/We agree that this proposal together with any other information supplied by me/us, shall form the basis of any Contract of Insurance affected thereon. I/We undertake to inform the Insurers of any material alteration to these facts occurring before completion of the Contract of Insurance which is deemed to be 00:01 a.m. on the date inception. Signing this Proposal Form does nor bind the Insured or the Insurer to complete this insurance.
IT IS UNDERSTOOD AND AGREED：
1. I/We declare that the information stated in this Proposal Form is true and complete and will form the basis of this insurance.
2. I/We declare that this Proposal Form is applied and signed at Macau Special Administrative Region, in case of fraud or factual misrepresentation, the cover for me/us and/or for the Insured Person(s) may be invalidated.
3. I/We agree to accept all the terms and conditions of “Compulsory Professional Liability Insurance for Healthcare Providers” Policy.
4. I/We agree “Luen Fung Hang Insurance Company Limited” (“Luen Fung Hang”) reserves the right to accept or decline my/our application.
5. I/We understand that Luen Fung Hang’s liability for myself/ourselves and/or for the Insured Person(s) will only take effect provided that premium has been paid.

The information you provide to Luen Fung Hang Insurance Company Limited ("the Company") is collected to enable the Company to carry on insurance business and may be used for the purpose of:
1. processing and evaluating your insurance application and any future insurance application you may make;
2. administering your insurance policy and providing services in relation to your insurance policy;
3. analysis or investigating, processing and paying claims made under your insurance policy;
4. invoicing and collecting premiums and outstanding amounts from you;
5. any alterations, variations, cancellation or renewal of any insurance related product or service;
6. contacting you for any of the above purposes;
7. exercising any right of subrogation;
8. other ancillary purposes which are directly related to the above purposes; and
9. complying with applicable law, rules, regulations, codes of practice or guidelines or assisting with law enforcement purposes, investigations by policy or other government or regulatory authorities in Macau or elsewhere; including but not limited to FATCA and the IGA.

The Company may disclose your personal data for the above purposes to the following classes of transferees who may be located in Macau or outside of Macau:
1. third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist us to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors);
2. in the event of a claim, loss adjudicators, claims investigators and medical advisors;
3. in the event of default, debt collectors and recovery agents;
4. insurance reference bureaus or credit reference bureaus;
5. reinsurers and reinsurance brokers;
6. the Company's legal and professional advisors;
7. any financial services provider “industry association or federation”;
8. any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
9. the Monetary Authority of Macao; and
10. government agencies and authorities as required or permitted by law.

The Company is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the “industry association or federation” from the insurance industry. Moreover, the Company may also use and disclose your personal data otherwise with your consent.

Use of Personal Data in Direct Marketing
The Company intends to use the data subject’s data in direct marketing. The Company will comply with the provisions of the Personal Data Protection Act. If you do not wish the Company to use or provide to other persons your data for use in direct marketing, you may exercise your opt-out right by notifying the Company.

The person to whom requests for access to data and/or correction of data and/or for information regarding policies and practices and kinds of data held and/or not to use data for direct marketing purpose are to be addressed to the Underwriting Department of the Company at No.398 Alameda Dr. Carlos D’ Assumpção, Edifício CNAC, 4º Andar, Macau.

填表日期 (日/月/年)：_____ 投保人簽名：_____
Dated this (dd/mm/yyyy) Signature of the Insured:

(以上中文譯本只供參考，一切以英文爲準。Chinese translation is for reference only. Please refer to English version for details.)