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BOWTIE 癌症醫保計劃
戰癌 300

想索償？請電郵至 cs@bowtie.com.hk，隨時與我們聯絡。

如需其他協助，請致電 3008-8123，或登入網站 www.bowtie.com.hk 與我們即時交談。

「香港製造」

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歡迎加入 Bowtie。

我們感謝你的信任。

這是你的保單協議。你與 Bowtie 必需達成法律協議這份保單才能生效。這可保障你、其他保單持有人和我們的利益。

Bowtie 深信保險應該要以用家為本，條款要清晰及透明。因此，我們致力將本協議的條款編寫得簡單易明，方便你了解保障的內容。以下是本協議的大綱：

第 1 章 **計劃簡介** 載列你的保障及索償方法。	(a) 第 1 部分：概要 — 關於本計劃的重要資料及數字
	(b) 保障簡介 (i) 第 2 部分：承保事項 — 你擁有哪些保障以及保障何時適用 (ii) 第 3 部分：不保事項 — 不受保障的情況
	(c) 第 4 部份：索償方法 —索償須知
第 2 章 **你與 Bowtie 達成有效法律協議的條件** 載列你在本計劃下的責任及權利、組成法律協議的其他部分以及部分詞語的涵義。	(a) 你的責任及權利 (i) 第 5 部分：如何確保本協議有效 (ii) 第 6 部分：你可以對本協議作出哪些更改
	(b) 第 7 部分：令本協議成為有效法律協議的其他條件 — 構成本協議的其他法律條款及細則
	(c) 第 8 部分：主要用語和定義 — 闡述本協議中部分詞語的涵義

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請務必於我們的電子平台檢閱以下文件，這些文件連同此保單協議構成了你的計劃：

1. **保單資料頁 —** 載列你向我們提供的資料。我們是根據這些資料為你度身定制出本計劃。

以下文件對你的協議亦十分重要：

1. **我們的使用條款** — 載列你與我們就使用我們的電子平台及其他服務達成的合約。
2. **我們的私隱政策** — 載列我們如何使用及保護你的資料。

請立即透過我們的電子平台細閱所有文件，以確保你明白及滿意你的保障。若你有任何疑問，請透過 hello@bowtie.com.hk 或其他客戶服務渠道與我們聯絡。

Bowtie 致力環保及實現無紙化，因此我們會盡量採用電子通訊。請定期更新你的聯絡方法，包括你的電郵地址及手機號碼，以便我們在需要時與你聯絡，為你提供最新資訊。

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計劃內容

第 1 章：計劃簡介 6

第 1 部分： 概要 7

1.1 保障簡介 7

1.2 保障概要 9

第 2 部分： 承保事項 14

2.1 受保障的情況 14

2.2 確診檢查及監察檢查 16

2.3 住院及日間手術保障 17

2.4 治療及藥物 19

2.5 其他賠償 20

2.6 恩恤身故保障 21

第 3 部分： 不保事項 22

3.1 不保事項 22

第 4 部分： 索償方法 25

4.1 索償通知 25

4.2 提交索償證據 25

4.3 身體檢驗 25

4.4 其他保險 26

第 2 章：你與 Bowtie 達成有效法律協議的條件 27

第 5 部分： 如何確保本協議有效 28

5.1 我們倚賴你所提供的資訊 28

5.2 錯誤申報年齡及 / 或性別 28

5.3 錯誤申報吸煙習慣 29

5.4 保費的繳交、欠繳及寬限期 29

5.5 居住地的變更 29

第 6 部分： 你可以對本協議作出哪些更改 30

6.1 計劃持有人 30

6.2 變更計劃的擁有權 30

6.3 向誰作出賠償 31

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6.4 更改受益人 31
6.5 在冷靜期內取消保單 32
6.6 在冷靜期後取消保單 32
6.7 保證續保權 32
第 7 部分： 令本協議成為有效法律協議的其他條件 33
7.1 可執行協議 33
7.2 遵守細則 33
7.3 詮釋 33
7.4 修改 33
7.5 付款貨幣 34
7.6 終止 34
7.7 致我們的通知 34
7.8 我們發出的通知 34
7.9 寬免 34
7.10 無第三者權利 35
7.11 代位追討權 35
7.12 法律訴訟 35
7.13 規管法律及仲裁 35
7.14 遵守法律 36
第 8 部分： 主要用語和定義 37

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第 1 章：計劃簡介

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第 1 部分： 概要

本部分概述本計劃的性質及主要特色。你的保障受本文件其餘部分所載的計劃條款及細則規限。

1.1 保障簡介

1.1.1 受保人

本計劃承保**保單資料頁**內指定的受保人。請你務必適時更新向我們提供的資料，特別是當你及 / 或受保人發生重要人生大事，例如搬離香港。

只要你按時繳交保費及遵守本計劃條款及細則，你將獲得本協議列明的保障。保單自保單生效日起生效，直至你取消保單（分別參見第 6.5 及 6.6 條） 或保單終止（見第 7.6 條）為止。

1.1.2 承保項目

我們承保受保人確診出癌症引致的醫療費用，當中包括：

(a) 診斷測試以檢查及確認受保人患有受保癌症，如化驗、電腦斷層掃描及組織病理學檢查等 — 參見第 2.2.1(a)條；

(b) 治療費用如手術及藥物、住院、標靶治療及免疫治療等 — 參見第 2.3 及 2.4 條；及

(c) 治療跟進及復原，如完成積極治療後五(5)年內的跟進診治及化驗、重建手術及物理治療及等 — 參見第 2.2.1(b)、2.4 及 2.5 條。

保單的目的是為你保障由癌症所引致的醫療費用，因此，如診斷檢查未能確認受保人患有受保癌症，有關檢查將不受保障。於保單生效日前診斷出、或保單生效日起九十(90)日內出現的癌症亦不受保障。

更多保障詳情請參見第 2 部分。請你務必了解你可能不受保障的情況，詳情請參見第 3 部分。

保單在全球範圍適用。

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1.1.3 承保金額

我們就保單的累積賠償額設有上限。該等上限通常稱為保障限額，一般以「每保單」或「每次」為單位。本計劃亦會就個別項目的就診次數設有限制。由首次確診出受保癌症起每三(3)年，以及整個保單生效期間的累積總賠償金額亦有限制。

實際的賠償限額載列於你的保障概要（請參見第 1.2 條）。

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1.2 保障概要

保障範圍	**因受保癌症而接受的醫療服務** — 賠償因受保癌症而接受必須的醫療服務所產生的實際費用。
保障地區	**全球**
賠償方式	**實報實銷** — 1. 我們按照下表的保障項目及賠償限額，賠償由受保癌症引致的實際醫療開支。 2. 每項合資格費用最多只按一項保障項目作賠償。 3. 若受保人從任何其他途徑索償部分或全部的開支，我們只會為餘下的開支作賠償。
等候期	**90 日** — 於保單生效日起 90 日內出現的癌症將不受保障。
賠償限額	上限一：保障項目 (a) – (i) 設有**限制條件**，保障項目 (o) – (u) 及 (v) 設有**賠償限額** — 下一部分會說明各保障項目。 上限二：於首次確診患上受保癌症的日期起計的三(3)年內**$1,000,000** 港元 上限三：於上文上限二所述的三(3)年後，每三(3)年 **$1,000,000** 港元 上限四：每保單 **$3,000,000** 港元 **只要保單的累積賠償仍未達到上述上限，Bowtie 將全數保障所有保障項目。** — 下一部分會說明 Bowtie 如何提供保障。

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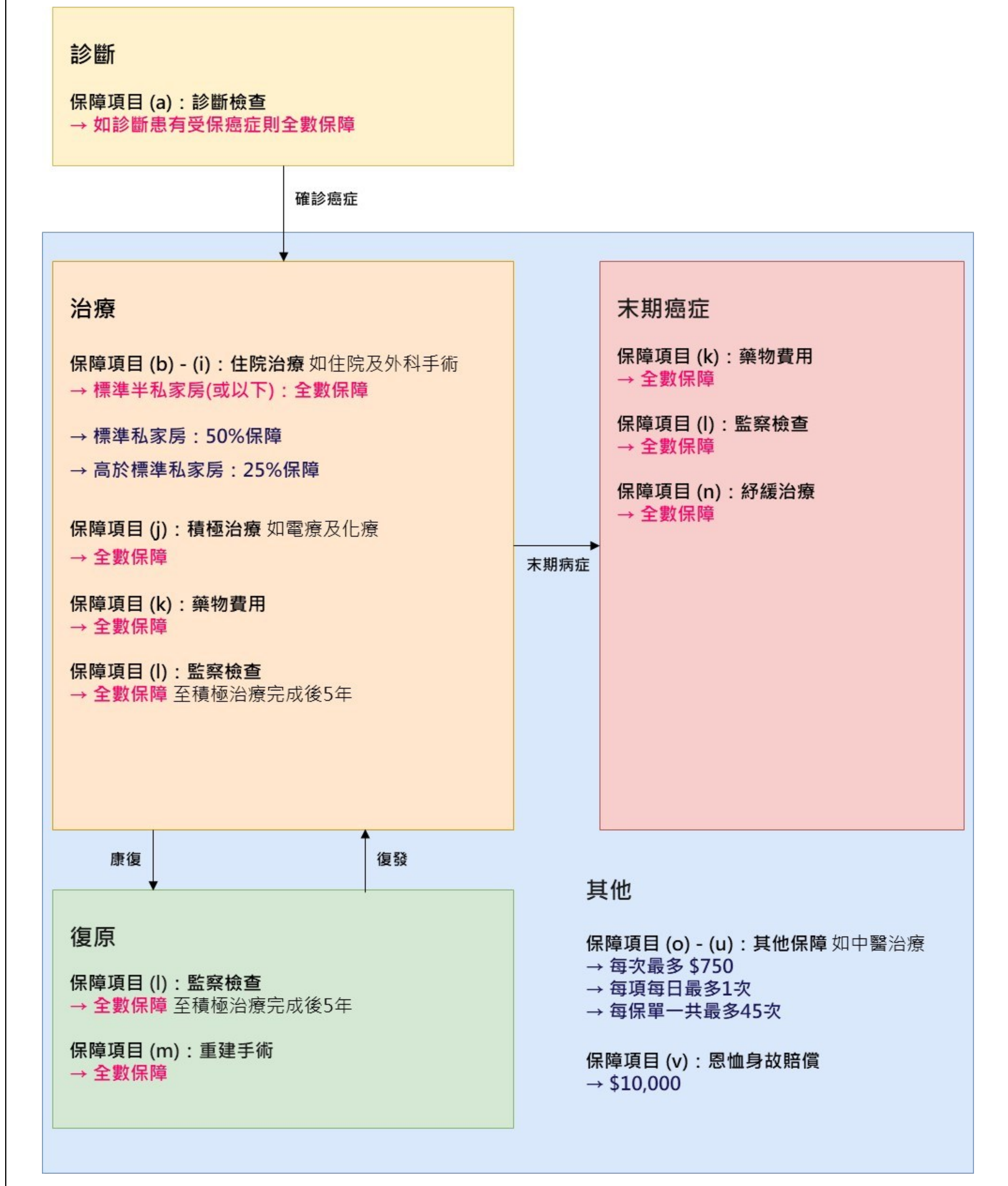
下圖簡述了各保障項目如何在不同的癌症階段提供保障：



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保障項目及限制（如有）	癌症階段
Bowtie **全數保障：** **(a) 確診檢查（如診斷患有受保癌症）**— 包括但不限於化驗、放射測試（X 光檢查、超聲波檢查、電腦掃描、磁力共振掃描、正電子放射斷層造影）、細針抽取細胞檢查（細胞學或組織病理學）、或切除活組織檢查（組織病理學）。	**診斷**
Bowtie **於指定條件下全數保障：** **(b) 病房及膳食** **(c) 主診醫生巡房費** **(d) 專科醫生費** **(e) 深切治療** **(f) 住院雜項開支** **(g) 外科醫生費** **(h) 麻醉科醫生費** **(i) 手術室費** 條件為： • **入住標準半私家房（或以下級別）：全數保障** • **入住標準私家房：保障合資格費用的 50%** • **入住標準私家房以上級別的病房：保障合資格費用的 25%** — 例如：受保人入院期間的合資格費用為 HK$10,000，而受保人入住標準私家房以上級別的病房，則實際可獲賠償為： HK$10,000 x 25% = HK$2,500	**治療**
Bowtie **全數保障：** **(j) 積極治療** — 包括但不限於電療、化療、標靶治療、激素治療及免疫療法。	**治療**

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Bowtie **全數保障：** **(k) 藥物費用** — 包括但不限於止嘔藥、抗排斥藥、止暈藥及止痛藥。	**治療** **末期癌症**
Bowtie **全數保障：** **(l) 監察檢查** — 保障對治療的反應及 / 或監察康復進度的跟進費用，包括： • 診治 • 化驗 • 影像檢查程序 • 篩查測試。	**治療** **末期癌症** **復原**
Bowtie **全數保障：** **(m) 重建手術** — 保障因受保癌症而進行的頭部及 / 或乳房重建手術。	**復原**
Bowtie **全數保障：** **(n) 紓緩治療** — 保障以門診形式進行的紓緩治療以紓緩或減輕受保癌症的症狀。	**末期癌症**

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Bowtie 保障： **(o) 中醫治療，針炙及中藥** **(p) 營養師諮詢** **(q) 物理治療** **(r) 職業治療** **(s) 言語治療** **(t) 心理輔導及藥物** **(u) 家中看護** — 任何時段只限由 1 位合格護士提供護理。 並設有以下限額： • **一共 45 次** • **每次 $750** • **每項目每日一次** 另外亦提供 **$10,000**： **(v) 恩恤身故賠償**	**其他**

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第 2 部分： 承保事項

本部分載列你的保障。下一部分（即第 3 部分）說明我們在哪些情況下不予承保。

2.1 受保障的情況

2.1.1 當符合以下條件(a)、(b)及(c)時，我們將按照第 2.2 至 2.5 條賠償合資格費用：

(a) 受保人：

(i) 罹患**受保癌症**或其併發症；

及

(ii) 該受保癌症於**保單生效日起計的 90 日後出現**（癌症出現是指當受保人就癌症接受檢查、診斷或治療，或其病徵已顯現）；

及

(iii) 該受保癌症或其併發症需要**以下任何一項治療**：

(1) 以下任何一項（如第 2.2 條所載）：

a) 確診檢查；

b) 積極治療期間及完成日起計五(5)年內的監察檢查；

(2) 住院治療或日間手術（如第 2.3 條所載）；

(3) 以下任何一項（如第 2.4 條所載）：

a) 積極治療；

b) 紓緩治療；

c) 藥物治療；

d) 重建手術；

(4) 由註冊醫生書面建議的以下任何一項（如第 2.5 條所載）：

a) 中醫治療；

b) 營養師諮詢；

c) 物理治療；

d) 職業治療；

e) 言語治療；

f) 心理輔導；

g) 家中看護。

及

(b) 合資格費用是：

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(i) 在本**計劃生效期間**產生；

及

(ii) 用於符合以下條件的醫療服務：

(1) 僅提供給**受保人而非任何其他人**；及

(2) 如下文第 2.2 至 2.5 條所載；及

及

(iii) **合理及慣常**。

及

(c) 應賠償的合資格費用金額不超過以下任何一項：

(i) 醫療服務的**實際費用**；

(ii) **保障概要中列出的限額**（如第 1.2 條所載）。

2.1.2 病房級別調整

本計劃內所有保障均不限制醫院病房級別的選擇。

然而，若受保人於住院期間入住高於標準半私家房級別之病房，本保單就第 2.3 條（住院及日間手術保障）於相關住院治療所支付的賠償金額將由本應支付的金額的按比例降低。該比例列於下表：

受保人入住的病房級別	就第 2.3 條所支付的賠償金額的百份比
標準普通房	100%
標準半私家房	100%
標準私家房	50%
高於標準私家房	25%

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2.2 確診檢查及監察檢查

2.2.1 根據上文第 2.1 條應賠償的確診檢查及監察檢查之合資格費用如下：

(a) **確診檢查**

於註冊醫生監督下在醫院或以門診方式進行確診檢查的費用。

為免存疑，不論相關的測試 / 程序之結果，任何並非因確定受保癌症的存在、性質或範圍之一般健康檢查的費用並不會受保。

(b) **監察檢查**

監察受保人對治療的反應及 / 或監察康復進度的費用，包括：

(i) 診治；
(ii) 化驗；
(iii) 影像檢查程序；及
(iv) 篩查測試。

本保障賠償積極治療中及完成積極治療日起計五(5)年內的費用。為免存疑，非直接因受保癌症而進行的一般健康檢查將不會受保。

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2.3 住院及日間手術保障

2.3.1 根據上文第 2.1 條應賠償的住院醫療服務及日間手術之合資格費用如下：

(a) **病房及膳食**

醫院收取的膳宿費用，但不包括下文(d)條所載的深切治療服務費。

(b) **主診醫生巡房費**

主診註冊醫生為受保人診症所收取的費用。

(c) **專科醫生費**

專科醫生為受保人診症所收取的費用。該診症必須經主診註冊醫生書面建議。

(d) **深切治療**

受保人入住深切治療部期間的深切治療服務費。

(e) **住院雜項開支**

雜項開支如下：

(i) 往返醫院的救護車服務；

(ii) 施行麻醉及／或提供氧氣；

(iii) 輸血行政費；

(iv) 在住院或任何日間手術期間服用的處方藥物、靜脈注射、敷料及石膏模；

(v) 在出院時或完成日間手術後處方，以供其後四(4)週內使用的藥物；

(vi) 下文(h)條界定的手術室費以外的額外手術用具、儀器及裝置；

(vii) 下文(h)條界定的手術室費以外的醫療用即棄用品、消耗品、儀器及裝置；

(viii) 第 2.2 條界定的確診檢查以外的診斷成像服務，包括超聲波及 X 光以及其分析；

(ix) 化驗及其報告，包括為外科手術／住院治療程序或日間手術而進行的病理學檢查；

(x) 租用輔助步行器具及輪椅的費用；及

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(xi) 住院期間的物理治療、職業治療及言語治療。

(f) **外科醫生費**

主診外科醫生進行手術所收取的費用。

(g) **麻醉科醫生費**

當上文(f)條的外科醫生費可獲賠償，本保障將賠償與手術相關的麻醉科醫生費。

(h) **手術室費**

當上文(f)條的外科醫生費可獲賠償，本保障將賠償在手術期間使用手術室、治療室及／或康復室的費用。

在手術室內需個別收費的額外手術用具、儀器及裝置則將僅按上文(e)條賠償。

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2.4 治療及藥物

2.4.1 根據上文第 2.1 條應賠償的治療及藥物之合資格費用如下：

(a) **積極治療**

以門診形式由註冊醫生進行積極治療的諮詢及治療所產生的費用，包括但不限於電療、化療、標靶治療、激素治療、免疫療法、質子治療及日間手術。

為免存疑，於電療中產生的合資格費用包括電療前的計劃會診費用及以電療為目的而使用的消耗品。

(b) **紓緩治療**

以門診形式由註冊醫生進行紓緩治療的費用。

(c) **藥物費用**

由註冊醫生就積極治療或紓緩治療而處方藥物的費用，包括但不限於止嘔藥、抗排斥藥、止暈藥及止痛藥。因積極治療或紓緩治療而需服用的長期藥物亦會獲賠償。

(d) **重建手術**

由主診註冊醫生書面建議，在頭部或乳房進行的整型或重建手術的費用，包括任何植入物費用。有關手術必須為接著之前因治療受保癌症而在頭部或乳房進行的手術，並必須是醫療所需以重新回復身體的機能或面貌。純粹為獨立牙科修復手術概不承保。

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2.5 其他賠償

2.5.1 根據上文第 2.1 條應賠償的其他醫療服務之合資格費用如下：

(a) **中醫治療，針炙及中藥**

以門診形式接受註冊中醫治療，包括針炙及由註冊中醫處方的中藥的費用。

(b) **營養師諮詢**

以門診形式接受註冊營養師診治的費用。

(c) **物理治療**

以門診形式接受註冊物理治療師診治的費用。

(d) **職業治療**

以門診形式接受註冊職業治療師診治的費用。

(e) **言語治療**

以門診形式接受註冊言語治療師診治的費用。

(f) **家中看護**

受保人在受第 2.3 條保障的住院或手術後，接受由最多一(1)位合格護士在受保人家中提供的護理服務所產生的費用。有關護理必須直接與該住院及 / 或手術有關連。

(g) **心理輔導及藥物**

以門診形式接受註冊心理學家或註冊精神科醫生進行心理輔導及處方藥物的費用。

2.5.2 上文第 2.5.1 條中提述的合資格費用受限於第 1.2 條保障概要所載的賠償限額。

2.5.3 上文第 2.5.1 條中提述的合資格費用不包括第 2.3 條中提述的合資格費用，因此在住院及日間手術期間產生的所有費用不會於本第 2.5 條下賠償。

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2.6 恩恤身故保障

2.6.1 在本計劃生效期間，一旦受保人身故，不論是由於意外或自然原因導致，本保障將按照第1.2 條保障概要列明的金額作出賠償。

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第 3 部分： 不保事項

3.1 不保事項

3.1.1 除第 2.6 條下的恩恤身故保障外，本計劃不會賠償直接或間接、全部或部分因以下任何一項引致的費用：

(a) **純為診斷程序的住院：**純粹為接受診斷程序或專職醫療服務而住院所招致的全部（或部分）費用。惟若按註冊醫生書面建議，該等程序或服務為醫療所需，且以為日症病人提供醫療服務的方式無法有效地進行，因而必須住院，則不屬此項；

(b) **未確診癌症：**受保人在未有確診患有癌症而進行任何形式的治療；

(c) **一般身體檢查：**並非進行與受保癌症有關之一般體格檢查（無論該等檢查結果是否呈陽性）、療養、托護或休養護理；或第 2.2.1 條所列明以外，用作預防受保癌症或在沒有病徵或沒有患癌紀錄下進行的癌細胞審查或檢查；

(d) **疫苗：**預防癌症的疫苗；

(e) **非醫療服務：**非醫療服務，包括但不限於探訪者用餐、收音機、電話、影印、稅項、個人物品、醫療報告收費及其他類似項目；

(f) **未經證實的治療：**任何醫療實驗，未經證實或非主流醫療技術、程序、治療，或尚未由接受治療的當地政府、相關機構及 / 或當地認可醫學會批准之新型藥物或幹細胞治療；

(g) **基因測試以鑑定癌症的遺傳性**：用以鑑定癌症的遺傳性的基因測試；

(h) **投保前已有病症或先天性病症：**包括任何受保人十七 (17) 歲前已出現徵狀或病徵或已診斷的先天性之癌症；

(i) **以整容為目的：**以美容或整容為目的的醫療服務；惟第 2.4.1(d)條列明之醫療服務則不屬此項；

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(j) **視力矯正：**矯正視力或屈光不正的服務，而該等視力問題可透過驗配眼鏡或隱形眼鏡矯正，包括但不限於眼部屈光治療、角膜激光矯視手術(LASIK)，以及任何相關的檢測、治療程序及服務；

(k) **HIV 及愛滋病：**任何與人類免疫缺乏病毒(HIV)及／或其任何相關疾病（包括愛滋病及／或其任何突變、衍生或變異）並存的癌症（及其併發症）；

(l) **已獲賠償：**費用已獲任何法律，或任何政府、公司或其他第三方提供的醫療或保險計劃賠償的任何傷患治療；

(m) **毒品及非法活動：**因以下任何一項原因產生或導致的癌症（及其併發症）：

(i) 倚賴或過量服用藥物、酒精、毒品或類似物質（或受其影響）；

(ii) 參與非法活動；

(iii) 違法或企圖違法；

(iv) 性病及經由性接觸傳染的疾病或其後遺症（HIV 及其相關的傷病除外）；

(n) **非處方的藥物：**任何並非由註冊醫生處方的麻醉藥、非處方藥物及營養補充品；

(o) **核、生物及化學活動：**核、生物及化學相關活動引致的癌症（及其併發症）。這包括但不限於任何核燃料，或核燃料或核武器燃燒產生的核廢料造成的核裂變、核聚變、電離輻射或放射性污染；或任何核、化學或生物恐怖主義行為，包括但不限於使用核、生物或化學武器或制劑；及

(p) **精神疾病：**精神紊亂、心理或精神疾病、行為問題或人格障礙；惟第 2.5.1(g)條列明之醫療服務則不屬此項。

3.1.2 若我們因向你提供任何保障而面臨任何制裁，則我們將不會提供保障，且無須根據本計劃賠償任何索償或提供任何保障。

3.1.3 若受保人於保單簽發日起計一(1)年內自殺，不論當時神智正常或失常，我們的責任將僅限於退還已繳交的保費。

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3.1.4 若我們以本第 3 部分為由指稱任何損失、損害、費用或開支不受本計劃保障，則相反舉證責任應由你承擔。

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bowtie

第 4 部分： 索償方法

本部分載列就本計劃提出索償的具體要求。

4.1 索償通知

4.1.1 所有涉及身故的索償均必須立即通知我們。

4.1.2 其他索償必須在受保事件發生後九十(90)日內提交給我們。

4.1.3 若證明以下條件符合，則索償不會因未能按照第 4.1.1 及 4.1.2 條的要求發出通知而失效：

(a) 無法在合理可能的情況下發出按要求發出通知；及

(b) 已在合理可能的情況下盡快發出通知。

4.2 提交索償證據

4.2.1 除非我們另有說明，否則你必須在受保事件發生後九十(90)日內提交我們要求的證明文件、表格及資料，相關費用須由你承擔。

4.2.2 我們有權索取支持索償的任何額外證據，包括但不限於載列費用明細的任何文件及單據正本。

4.2.3 為保證對其他保單持有人公平，若你提出的索償在任何方面具有欺詐性、缺乏根據、不正確、不完整或具誤導性，或你隱瞞任何資訊或與任何第三方串謀獲取本計劃的保障，我們有權宣佈本計劃自保單生效日起無效。在此情況下，我們於本計劃下的責任僅限於退還已繳保費，不計利息，並有權追討已支付給你的賠償。若我們保留本計劃，我們亦有權向你追討我們已經就任何不合資格的索償向你作出的任何賠償。

4.3 身體檢驗

4.3.1 我們有權索取任何額外證據並要求受保人接受身體檢驗。若受保人身故，我們可能會在適當及法律允許的情況下要求進行屍體剖驗。一切相關費用須由你承擔。

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4.4 其他保險

4.4.1 若你及 / 或受保人除本計劃外亦受一份或多份其他保單保障，你將有權根據任何其他保單或本計劃提出索償。若你或受保人已從任何該等其他保單索償全部或部分費用，則我們只會對任何其他保單未賠付的索償及 / 或保障金額（如有）作出賠償。

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第 2 章：你與 Bowtie 達成有效法律協議的條件

第 5 部分： 如何確保本協議有效

本部分載列你作為本計劃持有人須承擔的責任，包括當你及 / 或受保人變更居住地及職業時必須採取的措施，以及你不採取有關措施的後果。

5.1 我們倚賴你所提供的資訊

5.1.1 我們倚賴你在投保申請中提供的資料以決定是否接受該投保申請。我們亦倚賴該等資料來決定是否在本計劃中加設個別不保項目及 / 或徵收附加保費。我們會將投保申請中的所有陳述視為申述而非保證。

5.1.2 若投保申請中遺漏了事實或包含重大不正確或不完整的事實，我們有權宣佈本計劃自保單生效日起無效。在此情況下，我們於本計劃下的責任僅限於退還已繳保費，不計利息，而我們有權追討已支付給你的賠償。

5.1.3 若你的保費是基於不正確或不完整的資料所訂出，而我們及後認為有必要基於正確及完整的資料調整保費，我們將向你收集（或退還）有關差額，並有可能在本計劃中加設個別不保項目及 / 或徵收附加保費。有關改動將追溯自保單生效日起適用。

5.2 錯誤申報年齡及 / 或性別

5.2.1 若在投保申請中錯誤申報受保人的年齡及 / 或性別，我們將根據正確的年齡及性別調整本計劃應賠償的金額。我們將在根據本計劃作出任何賠償時作出以下調整：

(a) 若原本應收取較高的保費，我們將依據按受保人的正確年齡及性別本應繳交的保費，相應扣減賠償金額。

(b) 若原本應收取較低的保費，我們將退還任何多繳的保費，不計利息。

(c) 若受保人的正確年齡及性別不符合我們的承保要求，我們有權宣佈本計劃自保單生效日起無效。在此情況下，我們於本計劃下的責任僅限於退還已繳保費，不計利息，而我們有權追討已支付給你的賠償。

5.2.2 在根據本計劃受理任何投保申請、索償或作出任何賠償時，我們有權索取令我們信納的證據以證明受保人的年齡，相關費用須由你承擔。

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5.3 錯誤申報吸煙習慣

5.3.1 本計劃乃基於受保人申報的吸煙習慣簽發。若受保人於提交投保申請之日為吸煙者，卻未在投保申請中披露此事，則我們有權宣佈本計劃自保單生效日起無效。在此情況下，我們於本計劃下的責任僅限於退還已繳保費，不計利息，而我們有權追討已支付給你的賠償。

5.4 保費的繳交、欠繳及寬限期

5.4.1 在受保人在世時，應於保費到期日或之前向我們繳交所有保費。

5.4.2 在繳交首筆保費後，若未能於保費到期日或之前繳交後續保費，將視為欠繳保費。

5.4.3 我們將給予保單持有人三十一(31)日繳交保費的寬限期，由每期保費的到期日起計。本計劃於寬限期內仍然有效，惟我們不會支付任何賠償，直至保費已獲繳清。若在寬限期屆滿後保單持有人仍未繳清保費，本計劃即於最初未繳保費的到期日起終止。

5.5 居住地的變更

5.5.1 若受保人遷居到香港境外的城市或國家，並擬永久或至少連續 183 日居留該地，則受保人必須在其居住地變更後三十(30)日內通知我們。

5.5.2 收到通知後，我們將立即終止保單，並將不計利息發還已就不承保日子所繳交的保費。

5.5.3 若受保人未能通知我們其居住地的變更，並在此後提出索償，則我們不會作出任何賠償。

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第 6 部分： 你可以對本協議作出哪些更改

本部分載列你作為本計劃的持有人可作出的更改，包括更改持有人及受益人。

6.1 計劃持有人

6.1.1 你是唯一有權行使本計劃提供的任何權利或特權的人。

6.2 變更計劃的擁有權

6.2.1 你可以通知我們要求轉讓本計劃的擁有權，是否批准轉讓由我們酌情決定。

6.2.2 任何擁有權變更均在我們批准該變更，並以電子或書面通知你及受讓人後才生效。

6.2.3 若保單持有人身故，本計劃的擁有權應轉移給保單持有人的遺產管理人或遺囑執行人。

6.2.4 就對本計劃擁有權的轉讓而言：

(a) 根據第 6.2.1 條進行的轉讓，應以我們收到準受讓人同意接受本計劃條款及細則規限的協議作為條件；及

(b) 根據第 6.2.3 條進行的轉讓，應以我們收到令我們滿意的證據證明你已身故，及準受讓人同意受本計劃條款及細則規限的協議作為條件。

6.2.5 自擁有權變更的生效日起，受讓人即成為保單持有人，並將受所有計劃條款及細則規限。受讓人將成為本計劃的絕對擁有人，並負責繳交保費，包括任何未繳保費。

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6.3 向誰作出賠償

6.3.1 於受保人在世期間，本計劃的所有保障（身故保障除外）均應賠償給你，若你身故則納入你的遺產。

6.3.2 除非適用法律另有規定，否則一旦受保人身故，本計劃的任何身故保障均將賠償給受益人。若當時已沒有在世受益人，則若你在世，身故保障及所有其他保障（如有）將賠償給你，否則將納入你的遺產。

6.3.3 當我們按照本 6.3 條所述方式向上述人士賠付本計劃下的身故保障及所有其他保障後，即應視為我們已妥善且完全履行本計劃規定的責任。

6.4 更改受益人

6.4.1 在本計劃生效期間，且在法律允許的限度內，你可以透過電子或書面通知，向我們遞交指定的表格，以更改指定受益人。當滿足以下所有條件後，受益人的更改才視作有效：

(a) 我們已電子或書面確認該更改；及

(b) 你能夠提供令我們信納的充分證據，證明未有法定或其他信託出現或設立；[1]及

(c) 你及受保人在確認受益人更改之日均在世；及

(d) 該更改得到我們簽發的批註證明。

[1]此舉是為在根據《已婚者地位條例》第 13 條產生法定信託時保護受益人的地位。

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6.5 在冷靜期內取消保單

6.5.1 你可以在冷靜期內取消本計劃，並取回全數保費退款，前提是：

(a) 我們在保單簽發日起二十一(21)日內，收到你要求我們取消本計劃的電子或書面通知；及

(b) 在上文(a)條所述的二十一(21)日內，沒有已支付、將支付或待支付的賠償。

6.5.2 上述權利並不適用於續保。

6.5.3 若你根據上文第 6.5.1 條取消本計劃：

(a) 我們會將本計劃視為自保單生效日起失效；

(b) 你將獲發還全數已繳交的保費；及

(c) 我們無須根據本計劃條款及細則承擔任何賠償責任。

6.6 在冷靜期後取消保單

6.6.1 只要提前至少十(10)個工作日通知我們，你可以隨時取消本計劃。

6.6.2 在收到你的取消通知後，計劃取消的生效日為通知期後的下個計劃週月日，你的保障在該計劃週月日前仍然有效。

6.7 保證續保權

6.7.1 若符合以下條件，你保證有權在受保人在世期間續保本計劃：

(a) 你一直遵守所有計劃條款及細則；

(b) 你接受我們在續保時對計劃條款及細則作出的更改，而該更改是我們根據當時適用於所有與本計劃相同或大體相似的計劃的條款及細則而制定。

6.7.2 除非另有規定，否則標準保費並非固定，在計劃條款及細則的規限下，我們有權在續保時根據當時適用於受保人年齡的標準保費率修改或調整標準保費。

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第 7 部分： 令本協議成為有效法律協議的其他條件

本部分載列你與 Bowtie 之間達成有效法律協議所需的其他重要資訊。

7.1 可執行協議

7.1.1 本計劃是一份保險單，是你（保單持有人）與我們（Bowtie，作為保險人）之間具有法律約束力的協議。只要你全數繳交首期保費，或者我們通知你已獲豁免首期保費，本計劃將於保單生效日生效。

7.2 遵守細則

7.2.1 在我們根據本計劃履行任何法律責任支付任何款項前，你及 / 或受保人（或你的代理人）必須妥為遵守及履行所有計劃條款及細則中要求你及 / 或受保人應履行或應遵守的任何事項。

7.3 詮釋

7.3.1 在本計劃中，按本計劃解釋所需，表示男性性別的用詞，其含義將包括女性性別；單數用詞的含義將包括複數，反之亦然。

7.3.2 除非另有說明，否則本計劃的所有標題、概要及圖表均作方便參考之用，不應影響本計劃的詮釋。

7.3.3 所列時間均為香港時間。除非另有說明，否則本計劃中的一天或幾天是指日曆日。

7.3.4 除另行釋義外，本計劃內的詞彙需以本計劃第 8 部分所載涵意詮釋。

7.3.5 若本計劃條款及細則的中文及英文版本存有歧義，將會以英文版本作準。

7.4 修改

7.4.1 除非經我們正式授權的人員簽發（包括以電子方式簽署）批注證明，否則本計劃的任何變更（或對本計劃的任何條款或細則的任何寬免）均不具有約束力。

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7.5 付款貨幣

7.5.1 在本計劃下的任何應付款額將以港元支付。任何以外幣索償的合資格費用，須按我們所選擇的合理外幣匯率兌換成港元。我們概不對任何匯率相關損失承擔任何法律責任。

7.6 終止

7.6.1 本計劃將在以下情況自動終止，以最先者為準：

(a) 受保人身故；

(b) 根據第 5.4 條終止本計劃；及

(c) 按本計劃支付的賠償總額達到終身保障限額之日。

7.6.2 除非另有說明，否則本計劃的終止不應影響在終止之前產生的任何索償。在本計劃終止後支付或接受任何保費，不應對我們產生任何法律責任，但我們將退還任何該等保費。

7.7 致我們的通知

7.7.1 你必須以電子或書面方式，發出所有我們要求你給予我們的通知。

7.8 我們發出的通知

7.8.1 我們將按照你告知我們的最新聯絡方法，以電子方式發出本計劃的任何通知。對於任何按照上述方式發出的通知，你將被視為於傳送日期和時間正式接獲。

7.9 寬免

7.9.1 你或我們（合約雙方）就另外一方違反本計劃任何條文作出的寬免，將不會視作為日後違反本計劃的同一條文或任何其他條文的寬免。任何一方不行使或延遲行使本計劃下的任何權利時，亦不會視作為放棄該權利。

7.9.2 任何寬免必須經 Bowtie 及保單持有人雙方明確同意方可生效。合約雙方仍須履行明確寬免範圍外，本計劃所列的權利和義務。

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7.10 無第三者權利

7.10.1 任何非本計劃合約方的人士或實體（包括但不限於受保人或受益人），無權按《合約（第三者權利）條例》（香港法例第 623 章）執行任何本計劃條款及細則。

7.11 代位追討權

7.11.1 我們有權以你或受保人的名義，對或需就導致本計劃作出賠償的事故負責的第三者進行追討。我們將在按本計劃支付賠償後行使此權利，所涉及費用由本公司承擔。

7.11.2 你需為任何該等第三者過失以及我們採取的任何行動，向我們提供所有相關的資料和協助。

7.11.3 向任何該等第三者討回的款項歸我們所有，並以我們就本計劃支付的賠償金額為限。

7.12 法律訴訟

7.12.1 你不得在我們收到本計劃條款及細則要求的所有索償證明後六十(60)天內提起訴訟，追討在本計劃條款及細則下的任何索償金額。

7.12.2 在適用法律的規限下，你只能在我們對本計劃任何索償作出最終決定之日起兩(2)年內，按照法律或衡平法對本計劃作出任何追討行動。

7.13 規管法律及仲裁

7.13.1 本計劃受香港法律管轄及闡釋。

7.13.2 我們希望避免與你出現分歧，並願意與你合作解決任何分歧。因此，與本計劃有關的任何爭議、歧見或要求，包括有關本計劃的存在、有效性、詮釋、條款違反或任何其他有關非合約義務的爭議，均應按提交仲裁通知時生效的香港國際仲裁中心機構仲裁規則，轉介至香港國際仲裁中心以仲裁解決。仲裁地點為香港，法律程序應以英文進行。

7.13.3 如果你想投訴，請隨時透過電郵 cs@bowtie.com.hk 聯絡我們。

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7.14 遵守法律

7.14.1 如果本計劃在適用於你及 / 或受保人的法律下已經或將會不合法，我們有權宣告本計劃從不合法之日起失效。

7.14.2 如果我們根據第 7.14.1 條宣告本計劃失效，我們將按比例退還本計劃已就失效期間收取的保費，不計利息。

7.14.3 如本計劃的任何部分被裁定為無效或不可執行，剩餘部分仍應具有十足效力及作用。

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第 8 部分： 主要用語和定義

除另有規定，否則本計劃條款及細則中使用的字詞及表述必須按照以下所述解釋：

「積極治療」 是指為延長受保人的生命進行的介入治療，包括但不限於就受保癌症（包括其併發症（如適用））的電療、化療、標靶治療、激素治療、免疫療法、質子治療及外科手術。當中並不包括任何專為紓緩治療而給予的治療。

「年齡」 是指受保人的實際年齡。

「投保申請」 是指就本計劃向我們遞交的投保申請，包括與該投保申請有關的投保申請表格、問卷、任何已提交的文件或資料，以及已作出的陳述及聲明。這亦包括對該等資料的任何更新及改動。

「受益人」 是指在投保申請中指定為本計劃下受益人的一名或多名人士（可根據本計劃不時修訂）。

「保障概要」 是指本計劃第 1.2 條所載的保障概要，當中列明所涵蓋的保障項目及最高賠償限額。

「癌症」 是指任何經組織學診斷為惡性之腫瘤，並須有惡性細胞已不受控制地生長並侵略其他細胞組織的特徵。

就本計劃而言，癌症包括所有階段的惡性癌及原位癌，但不包括以下任何一項：

(a) 任何在組織病理學中分類為癌前病變腫瘤；
(b) 子宮頸界定的異常病變定為第一階段 (CIN I) 及第二階段 (CINII) ；及
(c) 人體免疫力缺乏病毒(HIV)感染同時存在的所有癌症。

「原位癌」 是指經病史證實並局限在侵入性前之病變，即癌細胞並無穿透基底膜，亦未侵入（即指滲入及 / 或活躍地破壞）環繞組織或氣孔。

「個別不保項目」 是指我們可按受保人的投保前已有病症或其他影響其可保性的因素，就特定的不適或疾病而加設的不承保項目，訂明在本計劃條款及細則中不受保障。

「住院」 是指：

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(a) 受保人在醫療所需的情況下，按註冊醫生的建議入住醫院以接受醫療服務。受保人必須入住醫院不少於連續六(6)小時；或

(b) 受保人因急症入住醫院進行急症治療、手術或其他醫療服務（沒有最低住院時間要求）。

住院必須以醫院發出的每日病房費單據作證明，受保人必須在整個住院期間連續留院 。

「先天性疾病」 是指：

(a) 任何於出生時或之前已存在的醫學、生理或精神上的異常，不論於出生時有關異常是否已出現、被診斷或獲知悉；或

(b) 任何於出生後六(6)個月內出現的新生嬰兒異常。

「受保癌症」 是指：

(a) 於受保人身上確診；及

(b) 於保單生效日起計九十(90)日後出現。

癌症出現是指當受保人就癌症接受檢查、診斷或治療，或當其病徵已顯現至會促使一個普通及謹慎的人尋求診斷、護理或治療的程度。若受保人與註冊醫生就癌症的病徵或徵兆或其顯現持有抵觸或不一致的意見時，我們將以註冊醫生的專業意見作準。

「受保癌症限額」 是指我們由受保人首次確診患上受保癌症起，每三 (3) 年就第 2.2 至 2.5 條所作出的最高賠償金額。如我們由本條款及保障生效起向保單持有人就第 2.2 至 2.5 條累計支付的賠償達至終身保障限額，受保癌症限額應被視為零。 此限額於第 1.2 條列明。

「日間手術」 是指受保人作為日症病人在具備康復設施的診所、日間手術中心或醫院內因檢查或治療而進行醫療所需的外科手術。

「日症病人」 是指在診所、日間手術中心或醫院（非住院性質）接受醫療服務或治療的受保人。

「確診」 是指由註冊醫生作出確定患癌的診斷，此診斷須經我們核准。

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「確診檢查」	是指： (a) 任何醫療所需的測試或檢查方法確診受保癌症，包括但不限於化驗、 X 光檢查 、電腦斷層掃描、磁力共振掃描、正電子放射斷層造影、細針抽取細胞檢查之細胞學或組織病理學檢查、或切除活組織檢查之組織病理學檢查；或 (b) 用於協助找出就受保癌症作合適化學治療藥物的基因測試。
「傷病」	是指受保癌症及任何由此而引發的併發症。
「合資格費用」	是指就傷病接受醫療服務所引致的費用。
「急症」	是指受保人需立即接受醫療服務的事件或情況，以防止受保人身故、健康遭永久損害或遭受其他嚴重健康後果。
「急症治療」	是指急症所需的醫療服務，而該醫療服務必須在急症事件或情況出現後的合理時間內進行。
「港元」	是指香港法定貨幣。
「香港」	是指中華人民共和國香港特別行政區。
「醫院」	是指按其所在地法律妥為成立及註冊為醫院的機構，為不適及受傷的住院病人提供醫療服務，並提供診斷及進行大型手術的設施與二十四 (24) 小時護理服務，而並非主要作為寧養或紓緩護理中心、戒酒或戒毒中心或同類機構。
「住院病人」	是指住院的人。而住院治療是指為住院的人提供的醫療服務。
「受保人」	是指計劃條款及細則所保障，並在**保單資料頁**中列為「受保人」的人士。
「深切治療部」	是指醫院內專為住院病人提供深切醫療及護理服務而設的部門。
「終身保障限額」	是指我們由保單生效日起向你累計支付的最高賠償限額，具體限額載於第 1.2 條的保障概要。
「醫療服務」	是指就診斷或治療受保人的傷病所提供的醫療所需服務，包括按情況所需的住院、治療、手術、檢測、檢查或其他相關服務。

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「醫療所需」	是指我們認為符合下列條件的住院、治療、手術、用品或其他醫療服務： (a) 符合傷病的症狀、有關發現或診斷及治療，並且必需及適當； (b) 符合公認的醫學標準，而非實驗性或調查性質； (c) 並非為對受保人、保單持有人、醫師或任何其他人帶來方便而提供；及 (d) 不能省卻，否則會對受保人的健康狀況產生不利影響。
「門診病人」	是指非住院的人，而門診是指為非住院的人提供的醫療服務。
「紓緩治療」	是指為改善罹患可致命受保癌症的受保人的生活質素而提供紓緩痛楚或減輕受保癌症及／或其併發症的徵兆和症狀或治療的副作用的治療，但不旨在治癒疾病。
「本計劃」	是指由我們承保及簽發的本計劃條款及細則中列明的保險單，作為你與我們之間的協議。
「計劃週月日」	是指於本計劃仍然生效時，保單生效日後每月與保單生效日相同的那一日。若該日子在月份中不存在，則指該月的最後一日。
「計劃條款及細則」	是指本計劃的第 1 部分至第 8 部分，包括**保單資料頁**及任何補充文件。
「保單生效日」	是指在**保單資料頁**中載明，本計劃條款及細則生效的第一日。
「保單簽發日」	是指在**保單資料頁**中載明，首次簽發本計劃條款及細則的日期。
「保單年度」	是指由保單生效日起計以每十二(12)個月的時期。
「同一類別保單」	是指所有具備相同計劃條款及細則及保障概要的保單 。
「投保前已有病症」	是指受保人於保單簽發日或保單生效日（以較早日期為準）前已存在的任何不適、疾病、受傷、生理、心理或醫療狀況或機能退化，包括先天性疾病。在以下情況發生時，一般審慎人士理應已可察覺到投保前已有病症： (a) 病症已被診斷； (b) 病症已出現清楚明顯的病徵或症狀；或 (c) 已尋求、獲得或接受與病症相關醫療建議或治療。
「附加保費」	是指我們因承受受保人的額外風險向你收取標準保費以外的額外保費。

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「你」、「你的」或「保單持有人」	是指本計劃的合法持有人，並於**保單資料頁**中列為「保單持有人」或擁有權轉移生效時被列為受讓人的人士。

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YOUR BOWTIE CANCER MEDICAL PLAN
Cancer Fighter – 3M

Reading this because you want to make a claim? Contact us anytime at cs@bowtie.com.hk.

If you need help with anything else, get in touch by calling us at 3008-8123 or through our live chat on our website www.bowtie.com.hk.

Proudly Made in Hong Kong

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Welcome to Bowtie.

We're glad to have you trust us.

This is your policy agreement. For this insurance to work, there needs to be a legal agreement between you and Bowtie. This protects you, as well as other policy holders and us.

At Bowtie, we believe insurance should be transparent and friendly. We want to make sure you know what you're getting, so we've tried to make this as easy-to-understand as possible. Here's an outline of the rest of this agreement:

Chapter	Parts
Chapter 1 **What your Plan is** Sets out what your insurance benefits are, and how to claim them.	(a) Part 1: Summary — key facts and figures about your Plan
	(b) What are your benefits (i) Part 2: What is covered — what benefits you have, and when they can be used (ii) Part 3: What is not covered — situations where benefits are not provided
	(c) Part 4: How to claim — what you need to know if you are to make a claim
Chapter 2 **What makes this a valid and legal agreement between you and Bowtie** Sets out your responsibilities and rights under this Plan, other parts to a legal agreement, and what certain words mean.	(a) What are your responsibilities and rights (i) Part 5: What you need to do to keep this agreement valid (ii) Part 6: What changes you can make to this Plan
	(b) Part 7: What else makes this a valid legal agreement — the other legal terms and conditions completing this agreement
	(c) Part 8: What terms mean — explains the meaning of certain capitalized words used in this agreement

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It is very important that you check the following document(s) on our electronic platform which, taken together with this document, form your Plan:

1. **Policy Schedule** - This customizes this agreement to you. It contains the information you provided us with, which we used to determine your policy.

Other documents important to your agreement are:

1. **Our terms of service** - This sets out your contract with us in using our electronic platform and other services.
2. **Our privacy policy** - This sets out how we use and protect your data.

Bowtie would strongly encourage you to read the relevant documents carefully at the start of your coverage. You can conveniently access these anytime from our electronic platform. Please make sure you are familiar with the scope of coverage to ensure you have the cover that you wanted. If you have any questions about these documents, please do not hesitate to get in touch with us at hello@bowtie.com.hk, or any of the other customer service channels we offer.

Bowtie strives to be environmentally friendly and endeavours to be paperless, so we use electronic communications as much as possible. It is essential that you keep us up-to-date with your contact information, including your email address and mobile phone number, so we can reach and update you when it's important to do so.

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What your Plan contains

Chapter 1: What your Plan is 6

Part 1: Summary 7

1.1 Your cover in brief 7

1.2 Benefit Summary 9

Part 2: What is covered 14

2.1 When are you covered 14

2.2 What are your Cancer Diagnosis and monitoring benefits 16

2.3 What are your Inpatient and Day Case Procedure benefits 17

2.4 What are your treatment and medication benefits 19

2.5 What are your supplementary benefits 20

2.6 What is your compassionate death benefit 21

Part 3: What is not covered 22

3.1 What is excluded 22

Part 4: How to claim 24

4.1 Notice of claim 24

4.2 Filing proof of claim 24

4.3 Medical examination 24

4.4 Other insurance 24

Chapter 2: What makes this a valid and legal agreement between you and Bowtie 25

Part 5: What you need to do to keep this agreement valid 26

5.1 What information we rely on from you 26

5.2 What if there is a misstatement of Age and/or sex 26

5.3 What if there is a misstatement of smoking habit 27

5.4 Premium payment, default and grace period 27

5.5 Change of residency 27

Part 6: What changes you can make to this Plan 28

6.1 Who is the owner of the Plan 28

6.2 How to change ownership of the Plan 28

6.3 Whom we make payment of benefits to 29

6.4 How to change the Beneficiary 29

6.5 What are your cancellation rights within the cooling-off period 29

6.6 What are your cancellation rights after the cooling-off period 30

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6.7 What is your guaranteed Renewal right 30
Part 7: What else makes this a valid legal agreement **31**
7.1 Enforceable agreement 31
7.2 Compliance with conditions 31
7.3 Interpretation 31
7.4 Modifications 31
7.5 Currency 32
7.6 Termination 32
7.7 Notices to us 32
7.8 Notices from us 32
7.9 Waiver 32
7.10 No third party rights 32
7.11 Subrogation 33
7.12 Legal action 33
7.13 Governing law and arbitration 33
7.14 Compliance with law 33
Part 8: What terms mean **34**

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Chapter 1: What your Plan is

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Part 1: Summary

This part summarizes the nature and key features of your Plan. Your coverage is subject to the other Plan Terms and Conditions set out in the rest of this document.

1.1 Your cover in brief

1.1.1 Who is covered

This Plan covers the Insured Person named in the **Policy Schedule**. It is important that you keep the information you have with us up-to-date, especially if you and/or the Insured Person has important life events such as relocating outside of Hong Kong.

As long as you pay your premiums and abide by these Plan Terms and Conditions, you will receive the insurance outlined in this agreement. The policy is effective from the Policy Effective Date until the moment you cancel it (see Sections 6.5 and 6.6) or it is terminated (see Section 7.6).

1.1.2 What is covered

We cover you for medical expenses if the Insured Person is Diagnosed with Cancer(s). This includes:

- Diagnostic tests for investigation and confirmation of a Covered Cancer, including procedures such as laboratory tests, CT scans and excisional biopsy - see Section 2.2.1(a);
- Treatment costs, including surgery and medication costs, the costs for Inpatient hospital stays, as well as advanced treatments such as targeted therapy and immunotherapy - see Sections 2.3 and 2.4; and
- Follow-up costs for the monitoring, evaluation and recovery of your condition, including medical tests for up to five (5) years after the completion of Active Treatment, physiotherapy, and reconstructive surgery - Section Sections 2.2.1(b), 2.4 and 2.5.

The purpose of this policy is to help cover medical expenses if the Insured Person is definitively diagnosed with Cancer, so diagnostic tests which do not lead to a confirmed diagnosis are not covered. Cancers diagnosed before the Policy Effective Date or occur within ninety (90) days after the Policy Effective Date are also not covered.

These are explained in more detail in Part 2. It is also important that you understand the conditions under which you may not be covered, and this is explained in Part 3.

Your policy covers you worldwide.

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1.1.3 How much is covered

We will reimburse the actual medical expenses up to certain dollar amounts. These amounts, often known as benefit limits, are generally applied on either a “per policy” or “per visit” basis. There may also be a limit to the total number of visits under the Plan. There are also total benefit limits respectively for every three-year period starting from the date of first Diagnosis of the first Covered Cancer and for the entire effective period of the Plan.

The actual dollar amounts and limits are specified in your Benefit Summary (see Section 1.2).

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1.2 Benefit Summary

Coverage	**Medical Services incurred from Covered Cancer(s)** — payable for the actual expenses for necessary Medical Services which are incurred from Covered Cancer(s).
Area Cover	**Worldwide**
Claim Method	**Reimbursement** — 1. We will reimburse the actual medical expenses arising from Covered Cancer(s) according to the benefit items and limits listed in the table below. 2. Same Eligible Expenses item will only be reimbursable under one benefit item. 3. If the Insured is entitled to a refund of all or part of such expenses from other source(s), we will only be liable for an amount in excess of the amount recovered from such other source(s).
Waiting period	**90 days** — Any Cancer occurring during the first 90 days after Policy Effective Date is not covered.
Benefit Limit	Limit 1: **Conditional item benefit limits** for benefit items (a) - (i) and **item benefit limits** for benefit items (o) - (u), and (v) — Learn more about what each benefit item refers to in the next section. Limit 2: **$1,000,000** for the first 3 years from the date of Diagnosis of the first Covered Cancer Limit 3: **$1,000,000** for every 3-year period after the 3-year period noted under Limit 2 above Limit 4: **$3,000,000** per policy **Bowties fully covers all benefits items, as long as the reimbursement does not exceed the above limits.** — Learn more about how Bowtie covers them in the next section.

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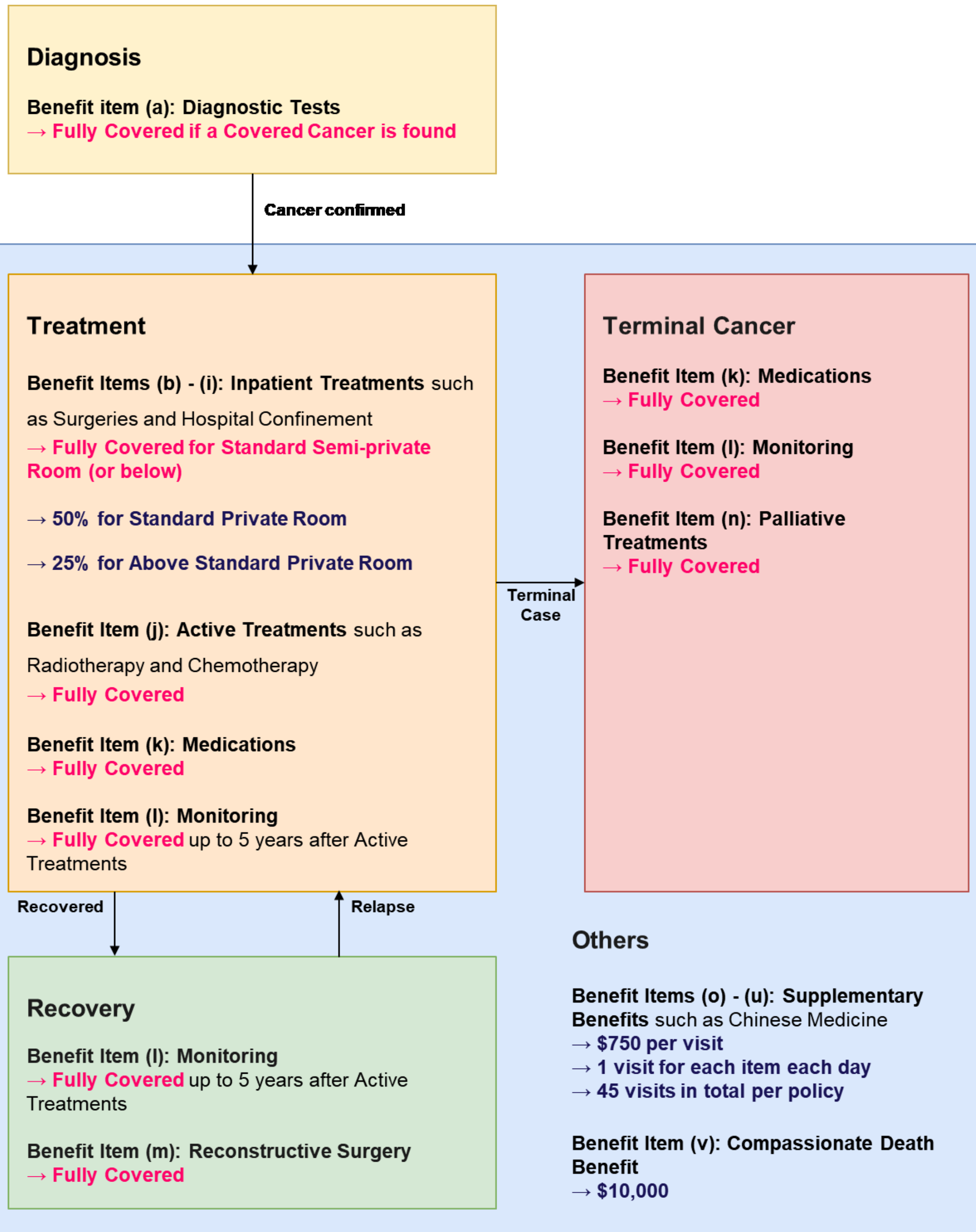
The following chart provides an overview on which benefit item would be of value to you at each Cancer phase:



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Benefit Items & Their Limits (if any)	Phase
Bowtie Fully Covers: **(a) Diagnostic Tests (if a Covered Cancer is found)** — including but not limited to Laboratory tests, Imaging (X-Ray / Ultrasound / CT / MRI / PET Scans), fine needle aspiration (cytology or histopathology), and excisional biopsy (histopathology).	**Diagnostic**
Bowtie Offers Conditional Full Coverage on: **(b) Room and board** **(c) Attending doctor's visit fees** **(d) Specialist's fees** **(e) Intensive care** **(f) Confinement miscellaneous charges** **(g) Surgeon's fees** **(h) Anaesthetist's fees** **(i) Operating theatre charges** with the following conditions: • **Semi-private Room (or below): Full Coverage** • **Standard Private Room: 50% of Eligible Expenses** • **Above Standard Private Room: 25% of Eligible Expenses** — For example, if the Insured Person is confined in a room of Above Standard Private Room level, and the Eligible Expenses incurred during Confinement is HK$10,000, the actual benefit payable after applying this adjustment will be: HK$10,000 x 25% = HK$2,500 .	**Treatment**
Bowtie Fully Covers: **(j) Active Treatments** — including but not limited to Radiotherapy, Chemotherapy, Targeted Therapy, Hormonal Therapy & Immunotherapy.	**Treatment**

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Bowtie Fully Covers: **(k) Medications** — including but not limited to Anti-nausea drugs, Anti-rejection drugs and Anti-vertigo drugs.	**Treatment** **Terminal Cancer**
Bowtie Fully Covers: **(l) Monitoring** — The charges to monitor the response to treatment, or progress of recovery and follow-up evaluations including: • consultation fees • laboratory tests • imaging procedures • screening tests.	**Treatment** **Terminal Cancer** **Recovery**
Bowtie Fully Covers: **(m) Reconstructive Surgery** — Reconstructive surgery of the head and/or breast due to a Covered Cancer.	**Recovery**
Bowtie Fully Covers: **(n) Palliative Treatments** — Outpatient consultation and treatment with the aim of relieving pain or reducing signs and symptoms of a Covered Cancer.	**Terminal Cancer**

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<table>
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Bowtie Covers:

(o) Chinese Medicine Practitioner Consultation, Acupuncture Treatment and Chinese Medicine

(p) Dietician Consultation

(q) Physiotherapy

(r) Occupational Therapy

(s) Speech Therapy

(t) Psychological Counselling and Medication

(u) Home Nursing — Maximum 1 Qualified Nurse during any given time slot.

subject to the following limits:

- **45 visits in total**
- **$750 per visit**
- **1 visit for each of the above items per day**

and offers **$10,000** for**:**

(v) Compassionate Death Benefit

</td>
<td>**Others**</td>
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Part 2: What is covered

This part sets out your benefits. The next part, Part 3, tells you when you are not covered.

2.1 When are you covered

2.1.1 We will pay the Eligible Expenses set out in Sections 2.2 to 2.5, where the conditions set out in (a), (b) and (c) below are met:

(a) The Insured Person:
- (i) suffers from a **Covered Cancer** or any complications arising from it;
  AND
- (ii) the Covered Cancer **occurs more than 90 days after the Policy Effective Date**, where a Cancer is regarded as having occurred when it has been investigated, diagnosed or treated or when its signs or symptoms have manifested;
  AND
- (iii) the Covered Cancer or its complications require(s) **any of the treatments set out below**:
  - (1) any of the following (as set out in Section 2.2):
    - a) Diagnostic Tests;
    - b) Monitoring during Active Treatment and within five (5) years from the date of completion of Active Treatment;
  - (2) Inpatient Medical Services or Day Case Procedure (as set out in Section 2.3);
  - (3) any of the following (as set out in Section 2.4):
    - a) Active Treatments;
    - b) Palliative Treatments;
    - c) Medications;
    - d) Reconstructive surgery;
  - (4) any of the following (as set out in Section 2.5) as recommended by a Registered Medical Practitioner in writing:
    - a) Chinese Medicine Practitioner consultation;
    - b) Dietician consultation;
    - c) Physiotherapy;
    - d) Occupational therapy;
    - e) Speech therapy;
    - f) Psychological counselling;
    - g) Home nursing.

AND

(b) The Eligible Expenses are:
- (i) incurred while the Plan is **effective and inforce**;
  AND
- (ii) for Medical Services:
  - (1) provided only **to the Insured Person and no one else**; and
  - (2) set out in Sections 2.2 to 2.5 below;
  AND
- (iii) **Reasonable and Customary**.

AND

(c) The amount of Eligible Expenses payable does not exceed any of the following:
- (i) the **actual costs** for the Medical Services;

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(ii) the **limits as stated in the Benefit Summary** set out in Section 1.2 above.

2.1.2 Ward class adjustment

All benefits described in these Plan Terms and Conditions are not subject to any restriction in the choice of ward class in Hospital.

However, if the Insured Person is Confined in a room of a higher level than Standard Semi-Private, the amount of any benefit payable under Section 2.3 during Confinement shall be reduced to a percentage of the benefit that would otherwise have been paid. This percentage is set out in the following table:

Level of room in which the Insured Person is Confined	Percentage of benefit payable under Section 2.3 during Confinement
Standard Ward Room	100%
Standard Semi-Private Room	100%
Standard Private Room	50%
Above Standard Private Room	25%

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2.2 What are your Cancer Diagnosis and monitoring benefits

2.2.1 Eligible Expenses payable for Diagnosis and monitoring pursuant to Section 2.1 above are as follows:

(a) Diagnostic Tests

The charges for Diagnostic Tests in a Hospital or clinic under the supervision of a Registered Medical Practitioner.

For the avoidance of doubt, any charges incurred in respect of routine health screenings which are not for the specific purpose of identifying the existence, nature or extent of a Covered Cancer are not covered, regardless of the results of such screenings.

(b) Monitoring

The charges to monitor the response to treatment, or progress of recovery and follow-up evaluations including:

(i) Consultation fees;
(ii) Laboratory tests;
(iii) Imaging procedures; and
(iv) Screening Tests.

This benefit covers the monitoring and evaluation received during Active Treatment and within five (5) years from the date of completion of Active Treatment. For the avoidance of doubt, any routine health screenings which are not for the specific purpose of monitoring a Covered Cancer shall not be covered.

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2.3 What are your Inpatient and Day Case Procedure benefits

2.3.1 Eligible Expenses for Inpatient Medical Services and Day Case Procedure pursuant to Section 2.1 above are as follows:

(a) Room and board

The cost of accommodation and meal charged by the Hospital other than intensive care service charges in (d) below.

(b) Attending doctor's visit fees

The charges of the attending Registered Medical Practitioner for a consultation with the Insured Person.

(c) Specialist's fees

The charges of the Specialist for a consultation with the Insured Person. Such consultation must be recommended in writing by the attending Registered Medical Practitioner.

(d) Intensive care

The charges for intensive care services during the Insured Person’s admission to an Intensive Care Unit.

(e) Confinement miscellaneous charges

Miscellaneous charges for:

(i) Road ambulance service to and/or from the Hospital;
(ii) Anaesthetic and/or oxygen administration;
(iii) Administration charges for blood transfusion;
(iv) Medicine, drug, Intravenous (“IV”) infusions, and dressing and plaster casts prescribed and consumed during Confinement or any Day Case Procedure;
(v) Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;
(vi) Surgical appliances, equipment and devices, that are not operating theatre charges as defined in (h) below;
(vii) Disposables, consumables, equipment and devices of a medical nature, that are not operating theatre charges as defined in (h) below;
(viii) Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, that are not Diagnostic Tests charges as defined in Section 2.2;
(ix) Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure;
(x) Rental of walking aids and wheelchairs; and
(xi) Physiotherapy, occupational therapy and speech therapy during Confinement.

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(f) Surgeon's fees

The charges of the attending Surgeon’s fee for a surgical procedure.

(g) Anaesthetist's fees

Where a Surgeon's fee is payable under (f) above, the charges of the Anaesthetist in relation to the surgical procedure.

(h) Operating theatre charges

Where a Surgeon's fee is payable under (f) above, charges for the use of an operating theatre, a treatment room and/or recovery room during the surgical procedure.

Any charges for surgical appliances, equipment and devices used in the operating theatre that are separately charged shall be payable only under (e) above.

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2.4 What are your treatment and medication benefits

2.4.1 Eligible Expenses for treatments and medications payable pursuant to Section 2.1 above are as follows:

(a) Active Treatments

The charges for Outpatient consultations with a Registered Medical Practitioner and for Active Treatments, including but not limited to radiotherapy, chemotherapy, targeted therapy, hormonal therapy, immunotherapy, proton therapy and day surgery.

For the avoidance of doubt, Eligible Expenses incurred for radiotherapy include the consultation fee for the planning session and consumables specified for the purpose of radiotherapy.

(b) Palliative Treatments

The charges for Outpatient Palliative Treatments by a Registered Medical Practitioner.

(c) Medications

The charges for medications prescribed during Active Treatments or Palliative Treatments, including but not limited to anti-nausea drugs, anti-rejection drugs, anti-vertigo drugs and anodyne. Long-term medication for Active Treatments or Palliative Treatments is also covered.

(d) Reconstructive Surgery

The charges for plastic or reconstructive surgeries on the head or on the breast (including costs of any implants) to restore function or appearance following previous surgery(ies) on the head or breast done for treatment of a Covered Cancer, where such plastic or reconstructive surgeries are Medically Necessary and recommended in writing by the Insured Person’s attending Registered Medical Practitioner. Surgery solely for isolated dental restorations is excluded.

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2.5 What are your supplementary benefits

2.5.1 Eligible Expenses for supplementary Medical Services payable pursuant to Section 2.1 above are as follows:

(a) Chinese Medicine Practitioner Consultation, Acupuncture Treatment and Chinese Medicine

The charges for Outpatient consultations with a Registered Chinese Medicine Practitioner, including acupuncture treatment and Chinese medicines prescribed by the Registered Chinese Medicine Practitioner.

(b) Dietician Consultation

The charges for Outpatient consultations with a Registered Dietician.

(c) Physiotherapy

The charges for Outpatient consultations with a Registered Physiotherapist.

(d) Occupational Therapy

The charges for Outpatient consultations with a Registered Occupational Therapist.

(e) Speech Therapy

The charges for Outpatient consultations with a Registered Speech Therapist.

(f) Home Nursing

The charges for nursing service provided to the Insured Person by a maximum of one (1) Qualified Nurse in the Insured Person's home after discharge from Confinement or surgery covered in Section 2.3, where such nursing service is directly related to and as a result of the noted Confinement and/or surgery.

(g) Psychological Counselling and Medication

The charges for Outpatient consultations with a Registered Clinical Psychologist or Registered Psychiatrist for psychological counselling and prescribed medications.

2.5.2 Eligible Expenses referred to in Section 2.5.1 above are subject to the limits set out in the Benefit Schedule set out in Section 1.2 above.

2.5.3 Eligible Expenses referred to in Section 2.5.1 excludes Eligible Expenses referred to in Section 2.3, such that all expenses incurred during Confinement and Day Case Procedures shall not be reimbursed under this section.

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2.6 What is your compassionate death benefit

2.6.1 While this Plan is in force, upon the death of the Insured Person, whether due to Covered Cancer or natural causes, this benefit shall be payable in the amount as stated on the Benefit Schedule set out in Section 1.2 above.

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Part 3: What is not covered

3.1 What is excluded

3.1.1 Except for the compassionate death benefit under Section 2.6 above, no payment will be made under the Plan for expenses caused directly or indirectly, wholly or partly by any of the following:

- **(a) Confinement solely for diagnostic procedures**: the whole (or part) of the Confinement solely for the purpose of diagnostic procedures or allied health services. The exception is where a Registered Medical Practitioner confirms in writing that such procedure or service is for Medically Necessary investigation and that it cannot be effectively performed in a setting for providing Medical Services to a Day Patient, rendering Confinement necessary;

- **(b) Treatment without definitive diagnosis of Cancer:** any treatment modality undergone without a definitive diagnosis of the presence of Cancer in the Insured Person's body;

- **(c) General check-ups:** general check-up (whether with or without any positive findings(s) of Cancer on the Insured Person), convalescence, custodial or rest care not related to a Covered Cancer; screening or check-ups looking for the presence of Covered Cancer on a preventative basis or where there are no symptoms or history of Covered Cancer, except where such screening or check-ups are covered under Section 2.2.1;

- **(d) Vaccines:** vaccines for the prevention of Cancer;

- **(e) Non-medical services:** non-medical services, including but not limited to guest meals, radio, telephone, photocopy, taxes, personal items, medical report charges and the like;

- **(f) Unproven procedures:** any experimental, unproven or unconventional medical technology/ procedure/ therapy or novel drugs/ medicines/ stem cell therapy not yet approved by the government, relevant authorities and/ or recognized medical association of the country or region where the treatment is sought;

- **(g) Tests for genetic predispositions:** genetic tests undertaken to test for a genetic predisposition to Cancer;

- **(h) Pre-existing or congenital conditions:** including any congenital Cancer that gave rise to signs or symptoms, or was diagnosed, before the Insured Person attains seventeen (17) years of age;

- **(i) Cosmetic purposes:** Medical Services for beautification or cosmetic purposes, except where such Medical Services are covered under Section 2.4.1(d);

- **(j) Visual correction:** correcting visual acuity or refractive errors that can be corrected by the fitting of spectacles or contact lens. This includes, but is not limited to, eye refractive therapy, LASIK and any related tests, procedures and services;

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- **(k) HIV and AIDS:** any Cancer (and its complications) under the presence of human immunodeficiency virus (HIV) and/or any HIV-related illness including AIDS and/or any mutations, derivations or variations thereof;

- **(l) Already reimbursed:** treatment of any Disability for which expenses have been reimbursed under any law, medical program, or insurance policy provided by any government, company or other third party;

- **(m) Drugs and illegal activities**: Cancers (and its complications) arising from, or consequential upon:
  - (i) the dependence, overdose or influence of any of drugs, alcohol, narcotics or similar drugs or agents;
  - (ii) illegal activity;
  - (iii) violation or attempted violation of the law;
  - (iv) venereal and sexually transmitted disease or its sequelae (except for HIV and its related Disability);

- **(n) Medications and supplements that were not prescribed:** narcotics or over-the-counter medication and nutrient supplement not prescribed by a Registered Medical Practitioner;

- **(o) Nuclear, biological, and chemical activities:** Cancers (and its complications) arising from nuclear, biological and chemical related activities. This includes, but is not limited to, nuclear fission, nuclear fusion, ionizing radiation or contamination by radioactivity from any nuclear fuel, from nuclear waste resulted from combustion of nuclear fuels or nuclear weapons, or any act of nuclear, chemical or biological terrorism, including but not limited to the use of nuclear, biological or chemical weapons and agents; and

- **(p) Mental disorders:** mental disorder, psychological or psychiatric conditions, behavioural problems or personality disorder except where such Medical Services are covered under Section 2.5.1(g).

3.1.2 If we would be exposed to any Sanctions by providing any benefit to you, then we will not provide cover and we are not liable to pay any claim or provide any benefit under this Plan.

3.1.3 If the Insured Person dies by suicide, whether sane or insane, within one (1) year of the Policy Issuance Date, our liability will be limited to premiums paid.

3.1.4 If we allege that, by reason of this Part 3, any loss, damage, cost or expense is not covered by this Plan, then the burden of proving the contrary shall be upon you.

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Part 4: How to claim

This part sets out what is required of you for making a claim under your Plan.

4.1 Notice of claim

4.1.1 All cases of death must be notified immediately to us.

4.1.2 Other claims must be submitted to us within ninety (90) days after the covered event happens.

4.1.3 The claim will not be invalidated solely by reason of failure to give notice as required by Sections 4.1.1and 4.1.2 above if it is shown that:

(a) it was not reasonably possible to give the required notice; and

(b) notice of claim was given as soon as reasonably possible.

4.2 Filing proof of claim

4.2.1 Your proof of claim must be accompanied by supporting documents, forms and information that we require, at your expense, within ninety (90) days after the covered event, unless we specify otherwise.

4.2.2 We may require any additional proof in support of the claim, including but not limited to originals of any documents and receipts showing itemized expenses.

4.2.3 To be fair to other policy holders, <u>if you submit a claim which is in any respect fraudulent, unfounded, incorrect, incomplete or misleading, or if you withhold any information or conspire with a third party to obtain a benefit from this Plan, we may immediately declare this Plan void from the Policy Effective Date.</u> If this happens, our liability under this Plan will be limited to returning the premiums paid without interest and we may recover any benefit previously paid to you. Alternatively, we may recover from you any benefit we previously paid to you in relation to any claim which is not eligible.

4.3 Medical examination

4.3.1 We may require any additional proof and request medical examination of the Insured Person at your cost. In case of death, we may require, if appropriate and legally allowable, an autopsy at your cost.

4.4 Other insurance

4.4.1 If you and/or the Insured Person is insured by one or more insurance policies other than this Plan, you may claim under any such other insurance policies or this Plan. If, however, you or the Insured Person have already recovered all or part of the expenses from any such other insurance policies, we will only be liable for such amount of a claim and/or benefits, if any, which is not paid under any such other insurance policies.

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Chapter 2: What makes this a valid and legal agreement between you and Bowtie

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Part 5: What you need to do to keep this agreement valid

This part sets out the responsibilities you have as the owner of this Plan, including what you must do if there are changes in your residency, and what happens if you do not do what is required.

5.1 What information we rely on from you

5.1.1 We rely on the information you provided in the Application in deciding whether or not to accept the Application. We also rely on that information to decide whether or not to apply Case-based Exclusion(s) and/or Premium Loading to this Plan. We will treat all statements made in the Application to be representations and not warranties.

5.1.2 If the Application omits facts or contains materially incorrect or incomplete facts, we may declare this Plan void from the Policy Effective Date. If this happens, our liability under this Plan will be limited to returning the premiums paid without interest. We may recover any benefit previously paid to you.

5.1.3 If your premiums are based on incorrect or incomplete information and we later have to change the premiums based on the correct and complete information, we will collect (or refund) the difference, and this may include imposing Case-based Exclusion(s) and/or Premium Loading on this Plan. Such changes shall apply from the Policy Effective Date retrospectively.

5.2 What if there is a misstatement of Age and/or sex

5.2.1 If the Insured Person's Age and/or sex is misstated in the Application, the amount payable by us under this Plan will be adjusted on the basis of the correct Age and sex. The amount payable will be adjusted at the time we make any payment under this Plan:

(a) Where a higher premium would have applied, we will reduce the benefit payable based on what the premiums paid would have provided at the Insured Person's correct Age and sex.
(b) Where a lower premium would have applied, we will refund any surplus premium paid without interest.
(c) Where the Insured Person would not have satisfied our insurability requirements on the basis of the correct Age and sex, we may declare this Plan void from the Policy Effective Date. If this happens, our liability under this Plan will be limited to returning the premiums paid without interest. We may recover any benefit previously paid to you.

5.2.2 We may require proof of the Insured Person's Age to our satisfaction at your cost at the time of processing the Application and any claim or payment of any benefit under this Plan.

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5.3 What if there is a misstatement of smoking habit

5.3.1 This Plan is issued on the basis of the Insured Person's declared smoking habits. If the Insured Person is a smoker as at the date of Application, but is not disclosed in the Application, we may declare this Plan void from the Policy Effective Date. If this happens, our liability under this Plan will be limited to returning the premiums paid without interest. We may recover any benefit previously paid to you.

5.4 Premium payment, default and grace period

5.4.1 While the Insured Person is alive, all premiums are payable to us on or before their due dates.

5.4.2 After payment of the first premium, failure to pay a subsequent premium on or before its due date constitutes a default in premium payment.

5.4.3 We allow a grace period of thirty-one (31) days after the premium due date for payment of each premium. This Plan will continue to be in effect during the grace period, but no benefits shall be payable unless the premium is paid. If the premium is still unpaid in full at the expiration of the grace period, this Plan shall be terminated immediately on the date on which the unpaid premium is first due.

5.5 Change of residency

5.5.1 The Insured Person must inform us within thirty (30) days of a change of residency to a city/country outside of Hong Kong, that is proposed to last permanently or for 183 consecutive days or more.

5.5.2 Upon notification, we will terminate the policy immediately and will refund premium(s) paid for the period in which no cover will be in place without interest.

5.5.3 If the Insured Person fails to notify us of a residency change and subsequently makes a claim, no benefit will be payable.

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Part 6: What changes you can make to this Plan

This part sets out what you can change as the owner of this Plan, including changing owners and beneficiaries.

6.1 Who is the owner of the Plan

6.1.1 You are the only person entitled to exercise any right or privilege provided under this Plan.

6.2 How to change ownership of the Plan

6.2.1 You may request transfer of the ownership of this Plan by notifying us. Approval of such request is entirely at our discretion.

6.2.2 Any change of ownership shall not be effective until we have approved it and notified you and the transferee of the approval in electronic or written form.

6.2.3 If the Policy Holder dies, the ownership of this Plan shall be transferred to the administrator or executor of the estate of the Policy Holder.

6.2.4 The transfer of ownership of this Plan:

(a) in accordance with Section 6.2.1 above shall be conditional upon our receipt of the proposed transferee's consent to be bound by the Plan Terms and Conditions; and
(b) in accordance with Section 6.2.3 shall be conditional upon our receipt of satisfactory evidence of your death and the proposed transferee's consent to be bound by the Plan Terms and Conditions.

6.2.5 From the effective date of the change of ownership, the transferee will become the Policy Holder, and will be subject to all the Plan Terms and Conditions. The transferee will become the absolute owner of this Plan and be responsible for the payment of premiums, including any outstanding premiums.

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6.3 Whom we make payment of benefits to

6.3.1 During the lifetime of the Insured Person, all benefits (except death benefits) payable under this Plan will be paid to you if you are alive, or otherwise to your estate.

6.3.2 If the Insured Person dies, then any death benefit payable under this Plan will be paid to the Beneficiary (unless otherwise provided under applicable law). If no Beneficiary survives the Insured Person then the death benefit and all other benefits (if any) will be paid to you if you are alive, or otherwise to your estate.

6.3.3 Payment of the death benefit and all other benefits payable under this Plan to the above person(s) in the manner pursuant to this Section 6.3 shall be deemed a good and full discharge of our obligations under this Plan.

6.4 How to change the Beneficiary

6.4.1 While this Plan is in force, and to the extent permitted by law, you may change the designated Beneficiary by sending an electronic or written notice to us using our prescribed form. A change of Beneficiary will not be valid unless:

(a) such change has been confirmed by us in electronic or written notice; and
(b) you are able to provide sufficient evidence to satisfy us that there are no existing statutory or other trusts that have arisen or been created;[1] and
(c) both you and the Insured Person are alive at the date of such confirmation; and
(d) such change is evidenced by a written endorsement issued by us.

6.5 What are your cancellation rights within the cooling-off period

6.5.1 You may cancel the Plan and receive a full refund of premium so long as:

(a) We receive a notice from you requesting that we cancel the Plan within twenty-one (21) days after the Policy Issuance Date; and
(b) No benefit payment has been made, is to be made, or is pending during the twenty-one (21) day period noted in (a) above .

6.5.2 Your right to cancel under Section 6.5.1 above does not apply at Renewal.

6.5.3 If you cancel the Plan in accordance with Section 6.5.1 above:

(a) we will consider the Plan void from the Policy Effective Date;
(b) the premium paid will be fully refunded to you without interest;
(c) we will not be liable to make any payment under the Plan Terms and Conditions.

[1] This is to protect the position where a statutory trust arises under section 13 of the Married Persons Ordinance.

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6.6 What are your cancellation rights after the cooling-off period

6.6.1 You may cancel the Plan at any time by giving us at least ten (10) working days' notice.

6.6.2 If you give us notice under Section 6.6.1 above, we will consider the Plan void from the Plan Monthiversary after the month in which the 10-working-day period noted above expires, and your Plan will remain effective before the noted Plan Monthiversary.

6.7 What is your guaranteed Renewal right

6.7.1 You have a guaranteed right to Renew this Plan during the lifetime of the Insured Person if:

(a) you have complied with all of the Plan Terms and Conditions;
(b) you accept the changes in the Plan Terms and Conditions for Renewal that we offer having regard to the prevailing terms and conditions that we apply to the entirety of all of our customers covered under a plan that is the same or substantially similar.

6.7.2 Unless otherwise specified, the Standard Premium is not fixed, and at the time any Renewal, we may revise or adjust it according to the applicable Standard Premium rate for the Age of the Insured Person at the time of such Renewal, subject to other Plan Terms and Conditions, if any, as set out in this Plan.

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Part 7: What else makes this a valid legal agreement

This part sets out the other important information needed to form a valid and legal agreement between you and Bowtie.

7.1 Enforceable agreement

7.1.1 This Plan is an insurance policy and is a legally enforceable agreement between you as the Policy Holder and us (Bowtie) as the insurer. The Plan comes into force on the Policy Effective Date provided you have paid the full amount of the first premium or we have notified you that we have waived your first premium.

7.2 Compliance with conditions

7.2.1 It is a condition precedent to any of our liability to make any payment under this Plan that you and/or the Insured Person (or anyone acting on your behalf) duly observe and fulfil all the Plan Terms and Conditions insofar as they relate to anything to be done or complied with by you and/or the Insured Person.

7.3 Interpretation

7.3.1 In this Plan, where the context requires, words using the masculine gender shall include the feminine gender, and words referring to the singular case shall include the plural and vice-versa.

7.3.2 Unless otherwise stated, headings, heading descriptions, summary and charts in this Plan are for convenience only and shall not affect its interpretation.

7.3.3 A time of day is a reference to the time in Hong Kong. A day or days in this Plan is a reference to a calendar day, unless otherwise specified.

7.3.4 Unless otherwise defined, capitalised terms used in this Plan and certain lower-case terms shall have the meanings ascribed to them in Part 8 of the Plan.

7.3.5 If there is any inconsistency between the English and Chinese versions of the Plan Terms and Conditions, the English version shall prevail.

7.4 Modifications

7.4.1 No variation to this Plan (or any waiver of any term or condition of this Plan) will be binding unless evidenced by an endorsement signed (including signing by way of electronic signature) by our duly authorized officer.

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7.5 Currency

7.5.1 Any amount payable under this Plan will be made in HKD. Any Eligible Expenses incurred in a foreign currency shall be converted to HKD at a reasonable foreign currency exchange rate chosen by us. We are not legally responsible for any exchange rate-related losses incurred.

7.6 Termination

7.6.1 This Plan shall automatically terminate on the occurrence of the earliest of the following:

(a) the death of the Insured Person;
(b) the termination of this Plan pursuant to Section 5.4 above; and
(c) the date the total amount paid for benefits under this Plan reaches the Lifetime Benefit Limit.

7.6.2 Termination of this Plan shall be without prejudice to any claim arising prior to such termination unless otherwise stated. The payment to or acceptance of any premium hereunder subsequent to termination of this Plan shall not create any liability upon us but we will refund any such premium.

7.7 Notices to us

7.7.1 All notices that we require you to give shall be sent to us by electronic or written means.

7.8 Notices from us

7.8.1 Any notice to be given by us under this Plan shall be sent by electronic means to the latest contact you have notified to us. Any notice so served shall be deemed to have been duly received to the Policy Holder on the date and time transmitted.

7.9 Waiver

7.9.1 No waiver by you or by us (each a party) of any breach by the other party of any provision of this Plan will be construed to be a waiver of any subsequent breach of that or any other provision of this Plan and any delay or forbearance by any party in exercising any of its rights under this Plan shall not be construed as a waiver of such rights.

7.9.2 Only those waivers expressly agreed upon will be effective, and the rights and obligations of Bowtie and the Policy Holder under this Plan will remain in full force and effect except and only to the extent that they are expressly waived.

7.10 No third party rights

7.10.1 Any person or entity who is not a party to this Plan (including, but not limited to, the Insured Person or the Beneficiary) shall have no rights under the Contracts (Rights of Third Parties) Ordinance (Cap. 623 of the Laws of Hong Kong) to enforce any of the Plan Terms and Conditions.

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7.11 Subrogation

7.11.1 We will have the right to proceed, in your name or in the name of the Insured Person, against any third party who may be responsible for circumstances giving rise to a claim under this Plan. Exercising of this right will be at our own expense and after we have made a payment under this Plan.

7.11.2 You will provide us with all necessary information and assistance relating to the fault of any such third party and any action we take.

7.11.3 We will be entitled to keep the amount recovered from any such third party to the extent of the amount of benefits we have paid under this Plan.

7.12 Legal action

7.12.1 No legal action shall be brought by you to recover any claim amount payable under these Plan Terms and Conditions within the first sixty (60) days from when we have received all proof of claims required by these Plan Terms and Conditions.

7.12.2 Subject to applicable law, any action at law or in equity to recover on this Plan shall only be brought within two (2) years from the date of our final decision in respect of any claim herein.

7.13 Governing law and arbitration

7.13.1 This Plan is governed by, and shall be construed in accordance with, the laws of Hong Kong.

7.13.2 We hope to avoid disagreements with you, and prefer to work with you to settle any disagreements. Therefore, any dispute, difference or claim relating to this Plan, including the existence, validity, interpretation, breach or any other dispute regarding non-contractual obligations arising relating to this Plan, shall be referred to and finally resolved by arbitration administered by the Hong Kong International Arbitration Centre (HKIAC) under the HKIAC Administered Arbitration Rules in force when the Notice of Arbitration is submitted. The seat of arbitration shall be Hong Kong and proceedings shall be conducted in English.

7.13.3 If you would like to make a complaint, please contact us anytime at cs@bowtie.com.hk.

7.14 Compliance with law

7.14.1 We may declare this Plan void, if it is or becomes illegal under the law applicable to you and/or the Insured Person, from the date it becomes illegal.

7.14.2 If we declare the Plan void under 7.14.1 above, we will refund the premium we received for the period the Plan is void on a pro rata basis without interest.

7.14.3 In the event any part of this Plan is found to be invalid of unenforceable, the remainder shall remain in full force and effect.

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Part 8: What terms mean

Under these Plan Terms and Conditions, except as otherwise defined, words and expressions used shall have the following meanings -

“Active Treatment”	shall mean any therapeutic intervention with the aim of prolonging the Insured Person’s life, including but not limited to radiotherapy, chemotherapy, targeted therapy, hormonal therapy, immunotherapy, proton therapy and surgery for a Covered Cancer, including any complications thereof (if applicable). It does not include any treatment given solely as Palliative Treatment.
“Age”	shall mean the attained age of the Insured Person.
“Application”	shall mean the application submitted to us in respect of this Plan. This includes the application form, questionnaires, any documents or information submitted, and any statements and declarations made in relation to the application. This also includes any updates and changes to such information.
“Beneficiary”	shall mean the person or persons designated in the Application as the beneficiary under this Plan (as may be amended from time to time in accordance with this Plan).
“Benefit Summary”	shall mean the summary of benefits contained in Section 1.2 of the Plan which sets out, among others, the benefit items and maximum benefits covered.
“Cancer”	shall mean any malignant tumor positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. For the purpose of this Plan, "Cancer" shall include all stages of malignant cancer, and Carcinoma-in-situ, but will specifically exclude the following: (a) any tumour which is histologically classified as pre-malignant; (b) abnormal lesions of cervix uteri classified as cervical intra-epithelial neoplasia grade I (CIN I) and grade II (CIN II); and (c) any cancer where HIV infection is also present.
“Carcinoma-in-situ”	shall mean a histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma.
“Case-based Exclusion”	shall mean the exclusion of a particular Cancer from the coverage of these Plan Terms and Conditions that may be applied by us based on a Pre-existing Condition or factors affecting the insurability of the Insured Person.

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"Confinement" or "Confined" shall mean:

(a) an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for Medical Services as a result of a Medically Necessary condition for a period of no less than six (6) consecutive hours; or
(b) an admission of the Insured Person to a Hospital for Emergency Treatment for the performance of surgical procedures or other Medical Services (no minimum duration is required in this case),

where the Insured Person stay in the Hospital continuously for the entire period of admission and as evidenced by a daily room charge invoice issued by the Hospital.

"Congenital Condition(s)" shall mean:

(a) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or
(b) any neo-natal abnormalities developed within six (6) months of birth.

"Covered Cancer" shall mean a Cancer which:

(a) the Insured Person has been Diagnosed with; and
(b) occurs more than ninety (90) days after the Policy Effective Date. For this purpose, a Cancer is regarded as having occurred when it has been investigated, diagnosed or treated or when its signs or symptoms have manifested to the extent which will cause an ordinary prudent person to seek diagnosis, care or treatment In the event of any conflict or discrepancy of opinions relating to the signs or symptoms of a Cancer and their manifestation between a Registered Medical Practitioner and the Insured Person, the Registered Medical Practitioner's opinion prevails.

"Covered Cancer Limit" shall mean the maximum aggregate amount paid or payable by us under Sections 2.2 to 2.5 for every three (3) consecutive years starting on the date of first Diagnosis of a Covered Cancer, provided that Covered Cancer Limit shall be deemed to be zero upon the total aggregate amount paid under Sections 2.2 to 2.5 during the lifetime of the Insured Person reaching the Lifetime Benefit Limit. The amount of Covered Cancer Limit is specified in Section 1.2.

"Day Case Procedure" shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.

"Day Patient" shall mean an Insured Person receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured Person is not in Confinement.

"Diagnosis" or "Diagnosed" shall mean the definitive diagnosis of a Cancer made by a Registered Medical Practitioner and approved by us.

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"Diagnostic Test(s)"	shall mean: (a) Medically Necessary test or investigation modality leading to the Diagnosis of a Covered Cancer, including but not limited to laboratory tests, X-rays, computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), fine needle aspiration for cytology or histopathology, and excisional biopsy for histopathology; or (b) genetic testing to aid the identification of appropriate chemotherapy drugs in respect of the Covered Cancer.
"Disability"	shall mean a Covered Cancer and all complications arising therefrom.
"Eligible Expenses"	shall mean expenses incurred for Medical Services rendered with respect to a Disability.
"Emergency"	shall mean an event or situation that Medical Service is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured Person's health.
"Emergency Treatment"	shall mean Medical Services required in an Emergency, the performance of which is within a reasonable period of time from the Emergency.
"HKD"	shall mean Hong Kong dollars.
"Hong Kong"	shall mean the Hong Kong Special Administrative Region of the People's Republic of China.
"Hospital"	shall mean a lawfully operated institution licensed as a hospital for the care and treatment of injured or ill persons which provides facilities for diagnosis, major surgery and 24-hour nursing service and is not primarily a rest or convalescent home, or similar establishment or, other than incidentally, a place for treatment of alcoholics or drug addicts.
"Inpatient"	shall mean a person who is Confined; and Inpatient medical service(s) shall mean medical services provided to a person who is Confined.
"Insured Person"	shall mean any person whose risks are covered by these Plan Terms and Conditions, and named as the "Insured Person" in the **Policy Schedule**.
"Intensive Care Unit"	shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.
"Lifetime Benefit Limit"	shall mean the maximum amount of benefits payable by us to you cumulatively since the Policy Effective Date. The limit is specified in the Benefit Summary in Section 1.2 above.
"Medical Services"	shall mean Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Disability.

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"Medically Necessary"	shall mean in respect of Confinement, treatment, procedure, supplies or other medical services, which are, in our opinion – (a) required for, appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Disability; (b) in accordance with generally accepted medical practice and not of an experimental or investigative nature; (c) not for the convenience of the Insured Person, the Policy Holder, the Registered Medical Practitioner or any other person; and (d) not able to be omitted without adversely affecting the Insured Person's medical condition.
"Outpatient"	shall mean a person who is not Confined; and Outpatient medical service(s) shall mean medical services provided to a person who is not Confined.
"Palliative Treatment"	shall mean treatment intended only to improve the quality of the Insured Person's life in the case of a life threatening Covered Cancer by relieving pain or alleviating other symptoms of the Covered Cancer and/or complication(s) thereof, or the side effects of its/their treatment, without any attempt at its/their cure.
"Plan"	shall mean the insurance policy set out in the Plan Terms and Conditions underwritten and issued by us, which is the agreement between you and us.
"Plan Monthiversary"	shall mean the same day as the Policy Effective Date in each succeeding month after the Policy Effective Date while this Plan remains in force. If the day does not exist in the respective month, this shall refer to the last day of that month.
"Plan Terms and Conditions"	shall mean Part 1 to Part 8 of this Plan and including **Policy Schedule** and any Supplement(s).
"Policy Effective Date"	shall mean the first day when these Plan Terms and Conditions become effective as specified in the **Policy Schedule**.
"Policy Issuance Date"	shall mean the date of first issuance of these Plan Terms and Conditions, which is specified in the **Policy Schedule**.
"Policy Year"	shall mean each twelve-month period starting on the Policy Effective Date.
"Portfolio"	shall mean all policies of the same Plan Terms and Conditions and the Benefit Summary.
"Pre-existing Condition(s)"	shall mean, in respect of the Insured Person, any sickness, disease, injury, physical, mental or medical condition or physiological degradation, including a Congenital Condition, that has existed prior to the Policy Issuance Date or the Policy Effective Date, whichever is the earlier. An ordinary prudent person shall be reasonably aware of a Pre-existing Condition, where – (a) it has been diagnosed; (b) it has manifested clear and distinct signs or symptoms; or (c) medical advice or treatment has been sought, recommended or received relating to it.

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"Premium Loading"	shall mean the additional premium on top of the Standard Premium charged by us on you according to the additional risk assessed for the Insured Person.
"Reasonable and Customary"	shall mean, in relation to charges for Medical Services, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals with similar conditions such as of the same sex and similar Age, for a similar Disability, as reasonably determined by us in utmost good faith. In determining whether a charge is Reasonable and Customary, we will make reference to any or all of the following (if applicable) - (a) treatment or service fee statistics and surveys in the insurance or medical industry; (b) internal or industry claim statistics; (c) gazette published by the Government; (d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.
"Registered Chinese Medicine Practitioner", "Registered Clinical Psychologist", "Registered Dietician", "Registered Occupational Therapist" "Registered Physiotherapist", "Registered Psychiatrist", "Qualified Nurse" and "Registered Speech Therapist"	shall mean a person who is legally recognized to perform services in the specialist area of their titled profession by the relevant government-recognised registration body in Hong Kong, or a body of equivalent standing in at the place of treatment (as reasonably determined by us in utmost good faith) if such treatment is received outside Hong Kong. If the practitioner is neither duly recognized as specified above, we have the discretion to exercise reasonable judgement to determine whether such practitioner shall nonetheless be considered qualified and registered. Notwithstanding the above, in no circumstance "Registered Chinese Medicine Practitioner", "Registered Clinical Psychologist", "Registered Dietician", "Registered Occupational Therapist", "Registered Physiotherapist", "Registered Psychiatrist", "Qualified Nurse" and "Registered Speech Therapist" shall include the following persons – the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by us in electronic or written form).

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“Registered Medical Practitioner”, “Specialist”, “Surgeon” and “Anaesthetist”	shall mean a medical practitioner of western medicine, (a) who is duly qualified and is registered with the Medical Council of Hong Kong pursuant to the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by us in utmost good faith); and (b) legally authorized for rendering relevant Medical Service in Hong Kong or the relevant jurisdiction outside Hong Kong where the Medical Service is provided to the Insured Person If the practitioner is neither duly qualified and registered under the laws of Hong Kong nor a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by us in utmost good faith), we have the discretion to exercise reasonable judgement to determine whether such practitioner shall nonetheless be considered qualified and registered. Notwithstanding the above, “Registered Medical Practitioner”, “Specialist”, “Surgeon” and “Anaesthetist” in no circumstance shall include the following persons – the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by us in electronic or written form).
“Renewal”, “Renew”, “Renewed” or “Renewable”	shall mean renewal of these Plan Terms and Conditions without any discontinuance.
“Sanctions”	shall mean any United Nations resolutions, or the trade or economic sanctions, laws or regulations of Hong Kong, Canada, the European Union, the United Kingdom or the United States of America.
“Standard Premium”	shall mean the basic premium for the coverage under this Plan, as charged by us to you on an overall Portfolio basis, which may be adjusted in accordance with the Age, sex and/or lifestyle factors of the Insured Person.
“Standard Private Room”	shall mean a standard single occupancy room with an adjoining bathroom for the Insured Person’s use during his or her Confinement but does not include any Hospital room that has its own kitchen, dining or sitting room.
“Standard Semi-Private Room”	shall mean a single or double occupancy room in a Hospital, with a shared bath or shower room.
“Standard Ward Room”	shall mean a room type in a Hospital that is of a quality below a Standard Semi-Private Room.

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“Supplement(s)”	shall mean any document which may add, delete, amend or replace the Plan Terms and Conditions. Supplement(s) shall include but is not limited to endorsement, rider, annex, schedule or table attached and issued with this Plan.
“we”, “us”, “our” or “Bowtie”	shall mean Bowtie Life Insurance Company Limited, and “We, “Us” or “Our” will have the same meaning.
“you”, “your” or “Policy Holder”	shall mean the person who is a legal holder of this Plan and is named as the Policy Holder set out in the **Policy Schedule** or a transferee in the event there is a change of ownership that is effective; “You” or “Your” will have the same meaning.

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