保泰團體保險計劃

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」

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 部份：概要 — 關於本計劃的重要資料及數字
	(b) 保障簡介 (i) 第 2 部份：承保事項 — 你擁有哪些保障以及保障何時適用 (ii) 第 3 部份：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份以及部分詞語的涵義。	(a) 你的責任與權利 (i) 第 5 部份：如何確保本協議有效 (ii) 第 6 部份：你可以對本協議作出哪些更改
	(b) 第 7 部份：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 部份：主要用語及定義 — 闡述本協議中的部分詞語的涵義

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協議。
2. **受保名單** – 載列保單承保人士及其保障。

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。

計劃內容

第 1 章：計劃簡介

第 1 部分: 概要

本部分概述此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**受保名單**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**受保名單**有任何變動。

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，直至你或我們取消保單（分別參見第 6.5 條及第 7.7 條）或保單終止（參見 7.6 條）為止。

1.1.2 承保項目

本計劃提供三個計劃級別，分別代表不同級別的保障。以下為本計劃下不同保障的概述，而受保人實際享有的保障則視乎其適用的計劃級別。

如果受保人在本計劃生效期間身故，我們將向受益人支付一筆過的金額以作身故保障 – 見第 2.2 條。

我們也承保受保人由於治療傷病或牙科服務而產生的合資格費用，當中包括：

- 住院及接受治療（「住院治療」）或在診所或日間手術中心接受外科手術（「日間手術」）- 參見第 2.3 條；及
- 在診所向註冊醫生、註冊中醫師、註冊物理治療師、註冊脊醫、註冊專科醫生及運動治療師求診（「門診」）- 參見第 2.4 條；及
- 在牙科診所向註冊牙醫求診（即「牙科服務」）- 參見第 2.5 條。

此外，作為保健保障，我們也承保受保人享用指定身體檢查計劃所產生的費用 – 參見第 2.6 條。

更多保障詳情參見第 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。

除第 2.4 條的門診保障、第 2.5 條的牙科保障及第 2.6 條保健保障的只賠償於網絡下產生的費用外，本計劃在全球範圍適用。

1.1.3 承保金額

如果受保人符合身故保障資格並身故（參見第 2.1.1 條），我們將向受益人作出金額相等於保障額的賠償。

我們就住院治療及日間手術費用的各保障項目設有賠償上限。該等上限通常稱為賠償限額，一般以「每次就診」、「每保單年度」、「每項手術」或「每日」為單位。每個保單年度的就診次數及總賠償金額亦有限制。

就門診及牙科, 我們承保超出自付額的費用。

就保健保障，我們承保指定的身體檢查計劃而產生的全部費用。

實際的保障金額及限額載列於你的保障概要（參見第 1.2 條）。

1.2 保障概要

本部分載列本計劃下不同保障的簡述，而受保人實際享有的保障則視乎其適用的計劃級別。

保障範圍	**身故** — 在受保人身故的情況下向受益人支付相等於保障額的金額。 **住院及日間手術** — 賠償醫療所需的傷病治療的實際費用，包括住院治療及日間手術。 **門診** — 賠償由註冊醫生、註冊中醫師、註冊物理治療師、註冊脊醫、註冊專科醫生和運動治療師提供的傷病治療的實際費用。 **牙科** — 賠償牙科服務的實際費用，包括口腔檢查和洗牙。 **保健** — 賠償指定的身體檢查計劃的實際費用。
保障地區	**全球**，惟門診、牙科及保健保障只保障於的網絡下產生的費用。
賠償方式	**一筆過賠償（適用於身故保障）** — 1. 在受保人身故的情況下我們向受益人支付一筆過的賠償。 **實報實銷（適用於住院及日間手術保障）** — 1. 我們按照下表的保障項目及賠償限額，賠償實際開支。 2. 每項合資格費用最多只按一項保障項目作出賠償。 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。 **由受保人直接支付（適用於門診及牙科保障）** — 1. 受保人按照下表的治療或服務，直接向網絡診所支付自付額。我們會承保餘下的開支，受保人不需進行任何索償程序。 **由我們直接支付（適用於保健保障）** — 1. 我們會按照下表直接向網絡診所支付指定身體檢查計劃的費用。受保人不需向網絡診所支付費用，亦不需進行任何索償程序。

計劃級別	入門級別	成長級別	企業級別
資格要求	**所有** 僱員 / 配偶 / 子女 / 父母 **無年齡限制**	僱員 /配偶: **64 歲**或以下; 子女: 15 天至 **18 歲**	僱員 /配偶: **64 歲**或以下; 子女: 15 天至 **18 歲**
人壽保障	**保障額**		
(a) **身故保障**	**$3,000**	**$20,000**	**$50,000**
住院及日間手術保障	**賠償限額**		
(b) **病房及膳食**	不適用	(b) 至 (i) : - 合資格費用的 **80%**; - 每保單年度合共 **$20,000** (b) 及 (d) : 每保單年度各 **180 日** (i) : 住院 / 日間手術**前最多 1 次**門診及 出院 / 日間手術**後 90 日內最多 3 次**跟進門診	(b)至(i) : - 合資格費用的 **80%**; - 每保單年度合共 **$50,000** (b) 及 (d) : 每保單年度各 **180 日** (i) : 住院 / 日間手術**前最多 1 次**門診及 出院 / 日間手術**後 90 日內最多 3 次**跟進門診
(c) **住院雜項開支**			
(d) **主診醫生巡房費**			
(e) **深切治療**			
(f) **外科醫生費**			
(g) **麻醉科醫生費**			
(h) **手術室費**			
(i) **入院前或出院後 / 日間手術前後門診護理**			
(j) **香港公立醫院住院現金**		每日**$200**； 每保單年度 **180 日**	每日**$500**； 每保單年度 **180 日**
(k) **日間手術現金保障**		每次手術**$200**	每次手術**$500**

(l) **特別獎賞** — 適用於當受保人先從其他保險公司所提供的保險計劃中得到部分或全數賠償		每日**$200**； 每保單年度 **180 日**	每日**$500**； 每保單年度 **180 日**
門診保障 [1]	**自付額; 賠償限額**		
(m) **普通門診**	**會員專享價** [2]； **無限**門診次數	**會員專享價** [2]； **無限**門診次數	**會員專享價** [2]； **無限**門診次數
(n) **中醫門診** — 中藥、針灸及跌打			
(o) **物理治療**			
(p) **脊骨療法**			
(q) **專科門診**			
(r) **運動治療**			
牙科保障 [1]	**自付額; 賠償限額**		
(s) **牙科門診** — 口腔檢查及洗牙	**會員專享價** [2]； **無限**門診次數	**會員專享價** [2]； **無限**門診次數	**會員專享價** [2]； **無限**門診次數
保健保障 [1]	**賠償限額**		
(t) **身體檢查** [3] — 指定身體檢查計劃	不適用	**全數**保障； 每保單年度 **1 次**	**全數**保障； 每保單年度 **1 次**

1 門診、牙科及保健保障只承保網絡下的費用。

2 適用於各醫療專業人士的會員專享價各有不同，並會不時變更。請參閱客戶平台以獲取最新資訊。

3 請參閱客戶平台以獲取有關身體檢查計劃的資訊。

第 2 部分：承保事項

本部分載列本計劃下不同保障的簡述，而受保人實際享有的保障則視乎其適用的計劃級別。
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 當受保人在本計劃生效期間身故，我們將按照第 2.2 條賠償身故保障。

2.1.2 當符合以下條件(a)、(b)及(c)時，我們將按第 2.3 條保障住院治療及日間手術的合資格費用：

(a) 受保人：

(i) 罹患傷病；及

(ii) 因傷病需要接受第 2.3 條所載的住院治療或日間手術；

(b) 合資格費用是：

(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) 如第 2.3 條所載；及

(iii) 合理及慣常。

(c) 可獲賠償的合資格費用金額不超過以下任何一項：

(i) 住院治療及日間手術的實際費用；及

(ii) 第 1.2 條保障概要中列明的限額。

2.1.3 當符合以下條件(a)、(b)及(c)時，我們將按第 2.4 條保障門診醫療服務的合資格費用：

(a) 受保人：

(i) 罹患傷病；及

(ii) 因傷病需要接受第 2.4 條所載的以下任何一項門診醫療服務：

(1) 普通門診；

(2) 中醫門診；

(3) 物理治療；

(4) 脊骨療法；

(5) 專科門診；

(6) 運動治療。

(b) 合資格費用是：

(i) 在本計劃生效期間產生；

(ii) 在網絡下產生；及

(iii) 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) 如第 2.4 條所載；及

(iv) 合理及慣常。

(c) 可獲賠償的合資格費用金額等於第 2.4 條中提述的門診醫療服務的實際費用減去第 1.2 條保障概要中列明的自付額。

我們將直接支付可獲賠償的合資格費用金額予相關網絡診所。受保人支付自付額後不需再進行任何索償程序。

2.1.4 當符合以下條件(a)、(b)及(c)時，我們將按第 2.5 條保障牙科服務的費用：

(a) 受保人接受第 2.5 條所載的以下任何一項牙科服務：

(i) 口腔檢查；

(ii) 洗牙。

(b) 費用是：

(i) 在本計劃生效期間產生；

(ii) 在網絡下產生；及

(iii) 用於符合以下條件的牙科服務：

(1) 僅提供給受保人而非任何其他人；及

(2) 如第 2.5 條所載；及

(iv) 合理及慣常。

(c) 可獲賠償的費用金額等於第 2.5 條中提述的牙科服務的實際費用減去第 1.2 條保障概要所載的自付額。

我們將直接支付可獲賠償的費用金額予相關網絡診所。受保人支付自付額後不需再進行任何索償程序。

2.1.5　當符合以下條件(a)、(b)、(c)、(d)及(e)時，我們將按第 2.6 條全數承保指定身體檢查計劃的費用：

(a) 費用在本計劃生效期間產生；

(b) 費用在網絡下所產生；

(c) 服務僅提供給受保人而非任何其他人；

(d) 可獲賠償的費用不超過第 1.2 條保障概要中列明的限額；

(e) 可獲賠償的費用金額等於第 2.6 條中提述的身體檢查的實際費用。

我們將直接支付可獲賠償的費用金額予相關網絡診所。受保人不需支付任何費用予網絡診所，亦不需進行任何索償程序。

2.2 人壽保障

2.2.1 本保障將支付金額相等於第 1.2 條所載的保障額作為身故保障。

2.3 住院及日間手術保障

2.3.1 根據第 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) 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(g)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(g)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) 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；

(x) 租用輔助步行器具及輪椅的費用；及

(xi) 住院期間的物理治療、職業治療及言語治療。

(c) 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。

(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) 外科醫生費

主診外科醫生進行手術所收取的費用。

(f) 麻醉科醫生費

當上文(e)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。

(g) 手術室費

當上文(e)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(b)條賠償。

(h) 入院前或出院後 / 日間手術前後門診護理

本保障將賠償以下合資格費用 – 1) 門診或急症後的住院或日間手術;及 2) 在出院或日間手術後，由主診註冊醫生提供或書面建議的跟進門診，有關門診必須與需要住院或進行日間手術的傷病直接有關。

本 2.3 條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普通房級別的病房，就相關住院實際可獲賠償的金額將降低至本應可獲賠償的以下比率：

受保人入住的病房級別	就住院可獲賠償金額的百分比
標準普通房	100%
標準半私家房	50%
高於標準半私家房	25%

例如：
受保人受保於成長級別而入院期間的相關合資格費用為$10,000，而受保人入住高於標準半私家房級別的病房，則實際可獲賠償為： $10,000 x 25% x 80% = $2,000。而該保單年度剩餘的保障賠償限額將為：$20,000 - HK$2,000 = $18,000。

2.3.2 當第 2.3 條的保障可獲賠償，並符合相應的條件時，以下(a)、(b)及(c) 項下保障可獲賠償：

(a) 香港公立醫院住院現金

受保人於香港公立醫院住院。

(b) 日間手術現金保障

受保人以日間手術方式進行任何手術。

(c) 特別獎賞

受保人受其他保險公司所提供的任何其他個人或團體償款保險計劃之保障，而該等其他保險公司部分或全數支付賠償後，我們方作出賠償。

2.4 門診保障

2.4.1 根據第 2.1 條應賠償的門診醫療服務之合資格費用如下：

(a) 普通門診

註冊醫生就門診診治所收取的費用。

(b) 中醫門診

註冊中醫師就門診診治所收取的費用，包括中藥、針炙及跌打治療的費用。

(c) 物理治療

註冊物理治療師就門診診治所收取的費用。

(d) 脊骨療法

註冊脊醫就門診診治所收取的費用。

(e) 專科診症

註冊專科醫生就門診診治所收取的費用。

(f) 運動治療

運動治療師就門診診治所收取的費用。

2.4.2 第 2.4 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所產生的所有費用不於第 2.4 條下賠償。

2.5 牙科保障

2.5.1 根據第 2.1 條應賠償的牙科服務之費用如下：

(a) 牙科門診

註冊牙醫就口腔檢查及洗牙所收取的費用。

2.5.2 第 2.5 條中提述的費用不包括第 2.3 條中提述的合資格費用，因此住院及日間手術所產生的所有費用不於第 2.5 條下賠償。

2.6 保健保障

2.6.1 根據第 2.1 條應賠償的保健保障之費用如下：

(a) 身體檢查

於網絡診所進行指定身體檢查所收取的費用。

第 3 部分：不保事項

3.1 不保事項

3.1.1 除第 2.2 條下的身故保障外，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) **投保前已有病症；**

(b) **純粹的診斷程序：**純粹為接受診斷程序或專職醫療服務而住院或日間手術所招致的全部（或部分）費用。這包括但不限於 X-光、先進掃描、化驗及物理治療；

(c) **療養、監護療養或靜養；**

(d) **非醫療服務：**非醫療服務，包括但不限於訪客膳食、收音機、電話、影印、稅務、個人物品、醫療報告收費等；

(e) **HIV 及愛滋病：**任何疾病、傷病、毒素或感染。這包括感染任何人類免疫缺乏病毒(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；

(f) **精神障礙：**精神障礙、心理或精神病、行為問題或人格障礙；

(g) **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；

(h) **疫苗：**疫苗接種、免疫、注射、預防藥物或預防性護理；

(i) **分娩：**驗孕或其後的分娩，墮胎、流產或任何以上事項引致的併發症；節育或恢復生育；不育治療包括體外受精或任何其他人工授孕方法；男性或女性的絕育；性障礙包括但不限於陽萎；

(j) **整容：**以美容或整容為目的；

(k) **替代治療：**包括但不限於指壓、推拿、催眠、按摩治療及香薰治療；

(l) **先天性疾病：**受保人十七 (17) 歲前已出現症狀或病徵或已診斷的的先天性疾病；

(m) **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治療；

(n) **毒品、自殺及非法活動：**因倚賴、過量服用，或受以下任何一項影響而產生或導致的傷病：

(i) 藥物、酒精、毒品或類似物質；

(ii) 故意自殘身體；

(iii) 企圖或威脅自殺，不論神智清醒與否；

(iv) 參與非法活動 ；

(v) 違法或企圖違法或拒捕；及

(vi) 性病和性傳播疾病或其後遺症（愛滋人體免疫力缺乏(HIV)病毒及其相關傷病除外）；

(o) **非處方藥物及保健品：**非由註冊醫生處方的麻醉藥、非處方藥物及營養補充品;

(p) **武裝部隊：**參加任何武裝部隊或維和活動；

(q) **核、生物及化學活動：**核、生物及化學相關活動引致的傷病。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

(r) **戰爭及恐怖主義：**革命及戰爭（不論宣戰與否）、恐怖主義行為。

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 若我們指稱任何損失、損害、費用或開支因本條而不受本計劃保障，則相反舉證責任應由你承擔。

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。提出索償的權利受限於本計劃條款及細則。

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　若證明通知無法在合理可能的情況下按第 4 或 4.1.2 條（如適用）發出，及該通知已在合理可能的情況下盡快發出，則索償不會失效。

4.2 提交索償證據

4.2.1　除非我們另有說明，否則你 / 受保人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 / 受保人你承擔。

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及受保人公平，若你或受保人提出的索償在任何方面具有欺詐性、缺乏根據、不正確、不完整或誤導，或你或受保人隱瞞任何資訊或與任何第三方串謀獲取本計劃的保障，我們有權即時取消本計劃。在任何這些情況下，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或任何受保人作出的任何賠償。

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，相關費用由你承擔。

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。

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，以及你不遵從有關要求的後果。

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有關人士的資格及 / 或適用的計劃級別，及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無效。若我們在本 5.1.2 條下宣佈本計劃無效，我們將按比例退還本計劃無效期間收到的已繳保費。

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　若在投保申請或登記程序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有關級別及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本應不符合我們任何計劃級別的承保要求，我們有權宣佈他於本計劃下的登記無效。在此情況下，我們的責任僅限於退還相關已繳保費，不計利息。

5.2.2　在根據本計劃受理任何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，相關費用由你承擔。

5.3 保費的繳交、欠繳及寬限期

5.3.1 所有保費應於保費到期日或之前向我們繳交。首筆保費須在保單生效日或之前向我們繳交。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。

5.3.2 在每個保單年度開始時，該保單年度的保費，即所有受保人個人保費的總和，將根據適用的保費率、受保人的年齡及其計劃級別計算。最終保費將在每個保單年度結束時或保單終止日計算（以較早日期為準），以反映自上一個計劃週年日後發生的任何實際變化。保費調整將由你支付（或退還予你）。我們可以在給予提前至少三十（30）天通知後，隨時向你收取此保費調整。

5.3.3 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。

5.4 居住地的變更

5.4.1 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，則你或受保人必須在其居住地變更後三十(30)日內通知我們。

5.4.2 收到通知後，我們將立即終止該受保人的保障，並將於保單年度結束時連同保費調整（如有）退還終止當時已繳交但未到期的保費，不計利息。

5.4.3 若你或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

5.5 主要營業地點的變更

5.5.1 若你不再以香港為主要營業地點，你必須在三十(30)日內通知我們。

5.5.2 收到通知後，我們將立即終止保單，並將退還終止當時已繳交但未到期的保費，不計利息。

5.5.3 若你未能通知我們你不再以香港為主要營業地點，而你或任何受保人在此後提出索償，則我們不會作出任何賠償。

第 6 部分：你可以對本計劃作出哪些更改

本部分載列你作為本計劃的持有人可作出的更改，包括為僱員及 / 或家屬登記為受保人，及更改受益人。

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法人。任何你授權的個人可以代表你行使該等權利或特權。

6.1.2 你或任何受保人不得轉讓本計劃及其下的任何保障。

6.2 向誰作出賠償

6.2.1 我們向你、受保人、受益人或任何你所指示並經我們同意的第三方支付的賠償，應視為已向你支付的賠償。

6.2.2 當我們按照 6.2.1 條所述方式向上述人士賠付本計劃下的保障後，即應視為我們已妥善且完全履行本計劃規定的責任。

6.3 更改受益人

6.3.1 在本計劃生效期間，且在法律允許的限度內，你或受保人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) 你或受保人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

(b) 我們已透過電子或書面通知確認該更改；及

(c) 受保人在確認通知書之日在世。

6.4 登記你的僱員或其家屬為受保人

6.4.1 在本計劃生效期間，你可以申請登記任何僱員及 / 或其家屬為受保人。

---

[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。**

6.4.2 若能滿足第 1.2 條中的資格要求，所有僱員及 / 或其家屬必須登記為核心計劃級別下的受保人；若未能滿足第 1.2 條中的資格要求，則有關僱員及 / 或其家屬將登記為附屬計劃級別下的受保人（如有）。

6.4.3 如果你希望為某人登記加入本計劃，你應在該人士符合本計劃保障資格後的三十一（31）天內申請。否則，我們有權在接受其登記前要求該人士提交醫療證明, 證明其身體健康。我們接受登記後，該人士將由符合資格之日起被視為受保人，並自該日起享有本計劃下的保障。

6.4.4 若有僱員在本計劃下為另一名僱員的家屬，則雙方都將被視為本計劃下的僱員。

6.4.5 若受保人在本來應該受保之日未有在職工作，該受保人的權益將遞延至其重新在職工作。我們有權在確認該人士享有保障之前要求其提交醫療證明, 證明其身體健康。

6.5 取消保單

6.5.1 只要提前至少三十（30）天通知我們，你可以隨時取消本計劃。

6.5.2 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繳費日，並受保人的保障在此日期前仍然有效。保費調整將由你支付（或退還予你），以反映自上一個計劃週年日後**受保名單**之變動。

6.6 續保權

6.6.1 你可透過在每個計劃週年日前按續保時適用的保費率繳交相關保費續保本計劃，而無需簽發新的保單合約，前提是：

(a) 在計劃週年日，百分之一百（100%）合資格參與核心計劃級別的僱員均已登記為核心計劃級別下的受保人；及

(b) 核心計劃級別下的已登記僱員不少於三（3）名。

6.6.2 我們有權不續保本計劃及在續保日修改本計劃的保費。

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（或你及 / 或受保人的代理人）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 本計劃的所有標題、標題介紹、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 除非另有說明，否則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。

7.5 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) 根據第 5.3 條終止本計劃；

(b) 核心計劃級別下的已登記僱員少於三（3）名。

7.6.2 作為僱員的受保人的保障在下以情況自動終止，以最先者為準：

(a) 本計劃的終止或取消；

(b) 受保人被終止僱用；

(c) 受保人服兵役（陸軍、海軍或空軍）；

(d) 適用於受保人的已付費的保障期結束。

7.6.3 作為家屬的受保人的保障在下以情況自動終止，以最先者為準：

(a) 本計劃的終止或取消；

(b) 因其關係而使本計劃承保受保人的僱員被終止僱用；

(c) 受保人服兵役（陸軍、海軍或空軍）；

(d) 適用於受保人的已付費的保障期結束；

(e) 受保人不再為家屬；

(f) 受保人身故。

7.6.4 在本計劃生效期間，根據第 1.2 條所載的資格要求，若任何受保人喪失核心計劃級別的資格，以下將由下個計劃週年日起適用及生效：

(a) 如果你早前已選擇了附屬計劃級別，受保人的適用計劃級別將自動改為附屬計劃級別；

(b) 如果你早前沒有選擇附屬計劃級別，該人士將不再為受保人，並會從**受保名單**中刪除。

7.6.5 你必須在受保人不再符合本計劃的資格後的三十一（31）天內向我們作出取消保障的通知。在受保人喪失資格當日，保障將停止。保費調整（如有）將作出相應的計算。

7.6.6 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。

7.7 取消保單

7.7.1 只要我們提前至少三十 （30）天按照你告知我們的最新聯絡方法以電子方式通知你，我們有絕對權利隨時取消或終止本計劃。通知載明的終止時間或取消生效日期及時間將被視為本計劃期的結束。我們將向你收取（或退還）取消或終止當時之保費調整及已繳交但未到期的保費。

7.8 致我們的通知

7.8.1 你必須以電子或書面方式，發出所有給予我們的通知。

7.9 我們發出的通知

7.9.1 我們將按照保單持有人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，保單持有人應被視為於傳送日期和時間正式接獲。

7.10 寬免

7.10.1 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。

7.10.2 任何寬免必須經你及我們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。

7.11 無第三者權利

7.11.1 任何非本計劃合約方的人士或實體（包括但不限於任何受保人或受益人），不能按《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。

7.12 代位追討權

7.12.1 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，所涉及費用由我們承擔。

7.12.2 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。

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

7.13 法律訴訟

7.13.1 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。

7.13.2 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。

7.14 規管法律及仲裁

7.14.1 本計劃受香港法律管轄及闡釋。

7.14.2 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。

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

7.15 遵守法律

7.15.1 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。

7.15.2 如果我們根據第 7.15.1 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。

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

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：

「意外」	是指在本計劃生效期間因暴力、意外、外在及可見因素引致的突發及不可預見事件，該等事件完全超出受保人的控制。
「在職工作」	是指就僱員而言，具有在正常安排的工作日履行其工作的所有常規職責的能力；就家屬而言，具有執行其正常日常活動的能力。
「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，當中列明包括保障項目及最高賠償限額。
「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。
「自付額」	是指受保人在提出索償時須承擔的部分費用。為免存疑，自付額並非指當實際費用超出本計劃條款及細則下的賠償限額時，受保人須支付的任何金額。
「住院」	是指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。如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，則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、被確診或獲知悉；或 (b) 任何於出生後六(6)個月內出現的新生嬰兒異常。
「核心計劃級別」、「附屬計劃級別」	是指**保單資料頁**中你分別選擇為「核心計劃級別」及「附屬計劃級別」的計劃級別，或於客戶平台顯示的相關不時修訂。

「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。
「牙科」或「牙科服務」	是指由註冊牙醫於診所內提供的牙科服務。
「家屬」	是指合法配偶、合法未婚子女及合法父母。
「傷病」	是指不適、疾病或受傷，包括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或其他載列於第 1.2 條的服務所需費用。
「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，而所需的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。
「僱員」	是指你僱用的全職僱員。
「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。
「受傷」或「傷患」	是指受保人完全因意外而非涉及任何其他原因所引致的身體受傷，並且有證據表明體表有可見挫傷或傷口，或內部挫傷、傷口或受傷，或該等受傷的組合。
「住院病人」	是指住院的人，而住院治療是指為住院病人提供的醫療服務。
「受保人」	是指計劃條款及細則所保障，並在**受保名單**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。
「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。
「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) 根據受傷的症狀及發現或診斷及治療判斷為必需、適當及一致； (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、醫生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。

「網絡」　是指我們在本計劃下指派提供醫療服務的醫療服務提供者。

「門診」　是指為非住院及在私人診所、醫院門診部或醫院深切治療部接受醫療服務的人；門診治療是指私人診所、醫院門診部或醫院深切治療部提供向門診病人提供的醫療服務。

「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。

「計劃週年日」　是指於本計劃仍然生效時，保單生效日後每年與保單生效日相同的那一日。

「計劃級別」、「入門級別」、「成長級別」、「企業級別」　是指本計劃下的特定保障組合，受限於第 1.2 條保障概要中規定的特定資格及年齡要求。「入門級別」、「成長級別」及「企業級別」是指在保障概要中載列的相關保障組合。

「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**、**受保名單**及任何補充文件。

「保單生效日」　是指本計劃條款及細則生效的第一日並在**保單資料頁**中載明為「保單生效日」的日期。

「保單簽發日」　是指首次簽發本計劃條款及細則並在**保單資料頁**中載明為「保單簽發日」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) 病症已被確診；

(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。

「訂明診斷成像檢測」　是指以下任何一項：

(a) 電腦斷層掃描（「CT」掃描）；

(b) 磁力共振掃描（「MRI」掃描）；

(c) 正電子放射斷層掃描（「PET」掃描）；

(d) PET–CT 組合；及

(e) PET–MRI 組合。

「合理及慣常」

是指就治療的收費而言，對情況類似的人士（例如同性別及相近年齡），就類似傷病提供類似治療、服務或物料時，不超過當地相關醫療服務供應者收取的一般收費範圍的水平。合理及慣常的收費水平由我們合理及絕對真誠地決定。合理及慣常的收費在任何情況下不應超過實際費用。

我們將參照以下任何或所有資料（如適用）以釐定合理及慣常收費

(a) 由保險或醫學業界進行的治療或服務費用統計及調查；

(b) 公司內部或業界的索償統計；

(c) 政府憲報；

(d) 提供治療、服務或物料當地的其他相關參考資料。

「註冊中醫師」、「註冊物理治療師」、「註冊脊醫」及「註冊牙醫」

是指獲得香港政府認可的有關註冊機構，若該治療在香港以外進行，在香港境外的司法管轄區內（由我們絕對真誠及合理地認為）具有同等效力的團體合法認可就其專業稱銜的專業領域執行服務的人士。

若該人士未能按上述條件獲得認可，我們可酌情作出合理的判斷，決定該人士是否仍被視為符合資格及已註冊。

儘管有上述規定，在任何情況下，「註冊中醫師」、「註冊物理治療師」、「註冊脊醫」及「註冊牙醫」均不包括下列人士 – 受保人、保單持有人、或保單持有人及 / 或受保人的保險中介人、僱主、僱員、直系親屬或業務夥伴（除非事先經我們以電子方式或書面批准）。

「註冊醫生」、「註冊專科醫生」、「外科醫生」及「麻醉科醫生」

是指符合以下資格的西醫：

(a) 具有正式資格並已按《醫療註冊條例》（香港法例第 161 章）在香港醫務委員會註冊，或在香港境外的司法管轄區內（由我們絕對真誠及合理地認為）具有同等效力的團體註冊；及

(b) 在香港或香港境外的司法管轄區，經當地法例許可提供相關醫療服務。

若該醫生未能按香港法例或在香港以外的司法管轄區具有同等效力的團體註冊（由我們絕對真誠及合理地決定），我們有權作出合理的判斷，以決定該醫生是否仍被視為符合資格及已註冊。

	儘管有上述規定，在任何情況下，「註冊醫生」、「註冊專科醫生」、「外科醫生」及「麻醉科醫生」均不包括下列人士 – 受保人、保單持有人、或保單持有人及 / 或受保人的保險中介人、僱主、僱員、直系親屬或業務夥伴（除非事先經我們以電子方式或書面批准）。
「續保」	是指本計劃條款及細則按其條款不曾中斷地繼續承保。
「制裁」	是指聯合國的任何決議，或香港、加拿大、歐盟、英國或美利堅合眾國的貿易或經濟制裁、法律或法規。
「不適」或「疾病」	是指正常健康狀態因受到病理偏差而出現的生理、心理或醫療狀況，包括但不限於受保人有否出現病徵或症狀的情況，亦不論是否已確診。
「標準保費」	是指我們向你就本計劃保障所收取的基本保費，適用於所有同一類別保單。保費可按受保人的年齡、性別及 / 或生活方式等因素進行調整。
「標準半私家房」	是指在醫院內設有共用浴室的單人或雙人房間。
「標準普通房」	是指在醫院內級別低於標準半私家房的病房類型。
「保障額」	是指當符合身故保障資格的受保人身故時，根據適用計劃級別及保障概要而需向相關受益人支付的金額。
「補充文件」	是指任何對本計劃條款及細則作出增刪、修改或取替的文件。補充文件包括但不限於附加於本計劃並一併簽發的批注、附加契約、附錄或附表。
「我們」、「我們的」或「Bowtie」	是指保泰人壽保險有限公司。
「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」的人士。

BOWTIE GROUP INSURANCE PLAN

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

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 your interests, as well as other Policy Holders' and ours.

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 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 need to make a claim
Chapter 2 **What makes this a valid and legal agreement between you and Bowtie** Sets out your responsibilities and options 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

It is very important that you check the following documents on our electronic platform which, taken together, 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.
2. **Insured List** – This specifies who are covered under this Policy and their respective benefit entitlement.

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 tries 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.

What your Plan contains

Chapter 1: What your Plan is

Part 1: Summary

This part summarizes the nature and key features of your plan. Your coverage is subject to 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 group of Insured Person named in **Insured List**. It is important that you keep the information you have with us up-to-date, especially if there are changes to **Insured List**.

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 or we cancel it (see Sections 6.5, and 7.7 respectively) or it is terminated (see Section 7.6).

1.1.2 What is covered?

This Plan offers three Plan Levels providing different level of benefits. Below provides a general description of the benefits offered under this Plan, the actual benefits entitled to the Insured Person will be subject to his applicable Plan Level.

We pay a lumpsum amount to the Beneficiary as death benefit in the event that the eligible Insured Person dies while the Plan is effective and in force – see Section 2.2.

We also cover the Insured Person for Eligible Expenses incurred due to treatment of a Disability or Dental Services. These include:

- Staying in a Hospital and receiving treatment (i.e. as an Inpatient) or undergoing surgical procedures in a clinic or Day Case Procedure center (i.e. as a Day Patient) - see Section 2.3; and
- Seeing a Registered Medical Practitioner, Registered Chinese Medicine Practitioner, Registered Physiotherapist, Registered Chiropractor, Registered Specialist, and sports therapist in a clinic (i.e. as an Outpatient) - see Section 2.4; and
- Seeing a Registered Dentist in a Dental clinic (i.e. Dental Services) - see Section 2.5.

Further, we cover the Insured Person for the expenses incurred for designated health check-up plan as wellness benefit – see Section 2.6.

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

This Plan covers the Insured Person worldwide, except that Outpatient benefits under Section 2.4, Dental benefit under Section 2.5 and wellness benefit under Section 2.6 below only cover expenses incurred under the Network.

1.1.3 How much is covered?

In the event that the Insured Person eligible to death benefit dies (see Section 2.1.1 below), we provide dollar amounts equal to the Sum Insured to the Beneficiary.

For Inpatient and Day Patient expenses, we provide coverage up to certain dollar amounts for each category. These amounts, often known as benefit limits, are generally applied on either a “per visit”, “per Policy Year”, “per surgery” or “per day” basis. There may also be a limit to the number of visits and total benefit that is applied each Policy Year.

For Outpatient and Dental expenses, we provide coverage beyond the amount of Co-Payment for each category.

For wellness benefit, we fully cover the expenses incurred for the designated health check-up plan.

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

1.2 Benefit Summary

This part provides a general description of the benefits offered under this Plan, the actual benefits entitled to the Insured Person will be subject to his applicable Plan Level.

Coverage	**Death** — Sum Insured payable to the Beneficiary in the event of death. **Inpatient and Day Case Procedure** — cover actual expenses for Medically Necessary treatments of a Disability, including Inpatient treatments and Day Case Procedure. **Outpatient** — cover actual expenses for treatments of a Disability provided by Registered Medical Practitioner, Registered Chinese Medicine Practitioner, Registered Physiotherapist, Registered Chiropractor, Registered Specialist and sports therapist. **Dental** — cover actual expenses for Dental Services, including oral examination, scaling and polishing. **Wellness** — cover actual expenses for designated health check-up plan.
Area cover	**Worldwide**, except that Outpatient, Dental and wellness benefits only cover expense incurred under the Network.
Claim method	**Lumpsum (applicable to death benefit)** — 1. We will pay in lumpsum to the Beneficiary in the event of death. **Reimbursement (applicable to Inpatient and Day Case Procedures benefits)** — 1. We will reimburse the actual expenses incurred up to the benefit limit(s) set out in the table below. 2. One Eligible Expenses item will only be reimbursable under one benefit item. 3. If the Insured Person is entitled to reimbursement of all or part of Inpatient and Day Case Procedure expenses from other sources and has been so reimbursed, we will only be liable for an amount in excess of the amount recovered from such other source. **Direct settlement by Insured Person (applicable to Outpatient and Dental benefits) —** 1. Insured Person will directly pay the amount of Co-Payment to the relevant Network clinic for the treatment or service it provides according to the table below. We will cover the rest and the Insured Person will not need to carry out any claim procedure. **Direct settlement by us (applicable to wellness benefit) —** 1. We will directly pay the expenses of the designated health check-up plan to the relevant Network clinic according to the table below. The Insured Person will not need to pay to the relevant Network clinic and will not need to carry out any claim procedure.

Plan Level	Startup Level	Growth Level	Enterprise Level
Eligibility requirements	**All** Employee / spouse / child / parents **No Age limit**	Employee / spouse: **Age 64** or below; Child: 15 days to **Age 18**	Employee / spouse: **Age 64** or below; Child: 15 days to **Age 18**
Life insurance benefit	**Sum Insured**		
(a) **Death benefit**	**$3,000**	**$20,000**	**$50,000**
Inpatient and Day Case Procedure benefits	**Benefit limit**		
(b) **Room and board**	Not Applicable	(b) to (i): **- 80%** of Eligible Expenses; **-** Total **$20,000** per Policy Year (b) & (d): **180 days** per Policy Year respectively (i): **1 prior visit** and **3 follow-up visits** within 90 days after discharge from Hospital or completion of Day Case Procedure	(b) to (i): **- 80%** of Eligible Expenses; - Total **$50,000** per Policy Year (b) & (d): **180 days** per Policy Year respectively (i): **1 prior visit** and **3 follow-up visits** within 90 days after discharge from Hospital or completion of Day Case Procedure
(c) **Confinement miscellaneous charges**			
(d) **Attending doctor's visit fee**			
(e) **Intensive care**			
(f) **Surgeon's fee**			
(g) **Anaesthetist's fee**			
(h) **Operating theatre charges**			
(i) **Pre- and post- Confinement/Day Case Procedure outpatient care**			
(j) **Hospital Cash for Confinement in Hong Kong public Hospital**		**$200** per day; **180 days** per Policy Year	**$500** per day; **180 days** per Policy Year
(k) **Day Case Procedure cash benefit**		**$200** per surgical procedure	**$500** per surgical procedure

(l) **Special bonus** — applicable when Insured Person first obtains partial or full reimbursements under insurance plans offered by other insurance company(ies)		**$200** per day; **180 days** per Policy Year	**$500** per day; **180 days** per Policy Year
Outpatient benefits[1]	**Co-Payment; Benefit limit**		
(m) **General consultation**	**Member exclusive price**[2]; **Unlimited** number of visits	**Member exclusive price**[2]; **Unlimited** number of visits	**Member exclusive price**[2]; **Unlimited** number of visits
(n) **Chinese medicine practitioner consultation** — herbal, acupuncture and bonesetting			
(o) **Physiotherapy**			
(p) **Chiropractic treatment**			
(q) **Specialist consultation**			
(r) **Sports therapy**			
Dental benefit[1]	**Co-Payment; Benefit limit**		
(s) **Dental consultation** — oral examination, scaling and polishing	**Member exclusive price**[2]; **Unlimited** number of visits	**Member exclusive price**[2]; **Unlimited** number of visits	**Member exclusive price**[2]; **Unlimited** number of visits
Wellness benefit[1]	**Benefit limit**		
(t) **Health check-up**[3] — designated health check-up plan	Not Applicable	**Fully** covered; **1 time** per Policy Year	**Fully** covered; **1 time** per Policy Year

1 Outpatient, Dental and wellness benefits only cover expenses incurred under the Network.

2 Member exclusive price varies by practitioners and is subject to change from time to time. Please refer to the customer portal for latest information.

3 Please refer to the customer portal for details of the health check-up plan.

Part 2: What is covered

This part provides a general description of the benefits offered under this Plan, the actual benefits entitled to the Insured Person will be subject to his applicable Plan Level.

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 death benefit as set out in Section 2.2, when the Insured Person dies while the Plan is effective and in force.

2.1.2 We will cover the Eligible Expenses for Inpatient Medical Services and Day Case Procedure as set out in Sections 2.3, where the conditions set out in (a), (b) and (c) below are met:

(a) The Insured Person:
  (i) suffers from a Disability; and
  (ii) the Disability requires Inpatient Medical Services or Day Case Procedure as set out in Section 2.3;

(b) The Eligible Expenses are:
  (i) incurred while the Plan is effective and in force; and
  (ii) for Medical Services:
    (1) provided only to the Insured Person and no one else; and
    (2) as set out in Sections 2.3 below; and
  (iii) Reasonable and Customary.

(c) The amount of Eligible Expenses payable does not exceed any of the following:
  (i) the actual costs for Inpatient Medical Services and Day Case Procedure; and
  (ii) the limits as stated in the Benefit Summary in Section 1.2.

2.1.3 We will cover the Eligible Expenses for Outpatient Medical Services as set out in Sections 2.4, where the conditions set out in (a), (b) and (c) below are met:

(a) The Insured Person:
  (i) suffers from a Disability; and
  (ii) the Disability requires any of the following Outpatient Medical Services as set out in Section 2.4:
    (1) general consultation;
    (2) Chinese medicine practitioner consultation;
    (3) physiotherapy;
    (4) chiropractic treatment;
    (5) specialist consultation;
    (6) sports therapy.

(b) The Eligible Expenses are:
  (i) incurred while the Plan is effective and in force;

(ii) incurred under the Network; and
(iii) for Medical Services:
(1) provided only to the Insured Person and no one else; and
(2) as set out in Section 2.4 below; and
(iv) Reasonable and Customary.

(c) The amount of Eligible Expenses payable equals the actual costs for the Outpatient Medical Services as set out in Section 2.4 minus the amount of Co-Payment as stated in the Benefit Summary in Section 1.2.
We will settle the amount of Eligible Expenses payable directly with the relevant Network clinic. The Insured Person, after paying the amount of Co-Payment, will not need to carry out any claim procedure.

2.1.4 We will cover the expenses for Dental Services as set out in Section 2.5, where the conditions set out in (a), (b) and (c) below are met:

(a) The Insured Person receives any of the following Dental Services (as set out in Section 2.5):
(i) oral examination;
(ii) scaling and polishing.
(b) The expenses are:
(i) incurred while the Plan is effective and in force;
(ii) incurred under the Network; and
(iii) for Dental Services:
(1) provided only to the Insured Person and no one else; and
(2) as set out in Section 2.5 below; and
(iv) Reasonable and Customary.

(c) The amount of expenses payable equals the actual costs for the Dental Services as set out in Section 2.5 minus the amount of Co-Payment as stated in the Benefit Summary in Section 1.2.
We will settle the amount of expenses payable directly with the relevant Network clinic. The Insured Person, after paying the amount of Co-Payment, will not need to carry out any claim procedure.

2.1.5 We will fully cover expenses for a designated health check-up as set out in Section 2.6, where the conditions set out in (a), (b), (c), (d) and (e) below are met:

(a) The expenses are incurred while the Plan is effective and in force.
(b) The expenses are incurred under the Network.
(c) The service is provided only to the Insured Person and no one else.
(d) The amount of expenses payable does not exceed the limit as stated in the Benefit Summary in Section 1.2.
(e) The amount of expenses payable equals the actual costs for the health check-up as set out in Section 2.6.
We will settle the amount of expenses payable directly with the relevant Network clinic. The Insured Person will not need to pay the Network clinic and will not need to carry out any claim procedure.

2.2 What is your life insurance benefit

2.2.1 Death benefit payable shall be the Sum Insured as stated on the Benefit Summary as set out in Section 1.2.

2.3 What are your Inpatient and Day Case Procedure benefits

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

(a) Room and board

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

(b) Confinement miscellaneous charges

Miscellaneous charges for:

(i) Road ambulance service to and/or from a 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 (g) below;
(vii) Disposables, consumables, equipment and devices of a medical nature, that are not operating theatre charges as defined in (g) below;
(viii) Diagnostic Imaging Services, including ultrasound and X-ray, and their interpretation;
(ix) Laboratory examinations and reports;
(x) Rental of walking aids and wheelchairs; and
(xi) Physiotherapy, occupational therapy and speech therapy during Confinement.

(c) Attending doctor's visit fee

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

(d) Intensive care

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

(e) Surgeon's fee

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

(f) Anaesthetist's fee

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

(g) Operating theatre charges

Where a Surgeon's fee is payable under (e) 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 (b) above.

(h) Pre- and post-Confinement/Day Case Procedure outpatient care

Eligible Expenses for 1) Outpatient visit or Emergency consultation resulting in a Confinement or Day Case Procedure and 2) follow-up Outpatient visit to, or recommended in writing by, the attending Registered Medical Practitioner provided that the Outpatient visit is directly related to and as a result of the condition arising from the same cause necessitating such Confinement or Day Case Procedure.

All benefits described under this Section 2.3.1 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 level higher than Standard Ward Room, the actual amount of any benefits payable for the Confinement shall be reduced to a percentage of the benefit that would otherwise have been payable. This percentage is set out in the following table:

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

For example:
If the Insured Person is covered under Growth Level and confined in a room of Above Standard Semi-Private Room level, and the relevant Eligible Expenses incurred during Confinement is $10,000, the actual benefit payable will be: $10,000 x 25% x 80% = $2,000. The remaining Policy Year benefit limit will be: $20,000 - $2,000 = $18,000.

2.3.2 Where benefits are payable under Section 2.3.1, the benefits set out in (a), (b) and (c) below shall also be payable when the respective conditions are met:

(a) Hospital Cash for Confinement in Hong Kong public Hospital

Payable when the Insured Person is Confined in a Hong Kong public Hospital.

(b) Day Case Procedure cash benefit

Payable when the Insured Person undergoes any surgical procedure as a Day Case Procedure.

(c) Special bonus

Payable when the Insured Person is covered by any other individual or group hospital indemnity insurance plans offered by other insurance company(ies), and we reimburse only after partial or full reimbursement has been paid by such other insurance company(ies).

2.4 What are your Outpatient benefits

2.4.1 Eligible Expenses for Outpatient Medical Services payable pursuant to Section 2.1 are as follows:

(a) General consultation

The charges for Outpatient consultations provided by a Registered Medical Practitioner.

(b) Chinese Medicine Practitioner consultation

The charges for Outpatient consultations including herbal, acupuncture and bonesetting treatment provided by a Registered Chinese Medicine Practitioner.

(c) Physiotherapy

The charges for Outpatient treatments provided by a Registered Physiotherapist.

(d) Chiropractic treatment

The charges for Outpatient treatments provided by a Registered Chiropractor.

(e) Specialist consultation

The charges for Outpatient consultations provided by a Registered Specialist.

(f) Sports therapy

The charges for Outpatient treatments provided by a sports therapist.

2.4.2 Eligible Expenses referred to in Section 2.4.1 excludes Eligible Expenses referred to in Section 2.3.1, such that all expenses incurred during Confinement and Day Case Procedures shall not be reimbursed under Section 2.4.1.

2.5 What is your Dental benefit

2.5.1 Expenses for Dental Services payable pursuant to Section 2.1 are as follows:

(a) Dental consultation

The charges for oral examination, scaling and polishing provided by a Registered Dentist.

2.5.2 Expenses referred to in Section 2.5.1 exclude Eligible Expenses referred to in Section 2.3.1, such that all expenses incurred during Confinement and Day Case Procedures shall not be reimbursed under Section 2.5.1.

2.6 What is your wellness benefit

2.6.1 Expenses for wellness benefit payable pursuant to Section 2.1 are as follows:

(a) Health check-up

The charges for designated health check-up performed at the Network clinics.

Part 3: What is not covered

3.1 What are the exclusions

3.1.1 Except for the death benefit under Section 2.2, no payment will be made under the Plan for expenses caused directly or indirectly, wholly or partly by any of the following:

(a) **Pre-existing Condition(s)**;

(b) **Solely diagnostic procedures**: the whole (or part) of the Confinement or Day Case Procedure solely for the purpose of diagnostic procedures or allied health services. This includes, but is not limited to, X-Ray, advanced imaging, laboratory tests and physiotherapy;

(c) **Convalescence, custodial, rest care and sanitaria care**;

(d) **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;

(e) **HIV and AIDS**: any illness, Disease, ptomaines or infection. This includes infection with any Human Immunodeficiency Virus (HIV) and/or any HIV-related illness including AIDS and/or any mutations, derivations or variations thereof;

(f) **Mental disorders**: mental disorder, psychological or psychiatric conditions, behavioural problems or personality disorder;

(g) **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;

(h) **Vaccines**: vaccinations, immunization, injections, preventive medication or preventive care;

(i) **Childbirth**: diagnostic of pregnancy or resulting childbirth, abortion, miscarriage or any complications from the above; birth control of reversal of birth control; infertility including in-vitro fertilization or any other artificial method of inducing pregnancy; sterilization; sexual dysfunction including but not limited to impotence and the like;

(j) **Cosmetic treatments**: beautification or cosmetic purposes;

(k) **Alternative treatments**: including but not limited to acupressure, Tui Na, hypnotism, rolfing, massage therapy and aroma therapy;

(l) **Congenital Conditions**: congenital conditions that gave rise to signs or symptoms, or was diagnosed, before the Insured Person attains seventeen (17) years of age;

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

(n) **Drugs, suicide and illegal activities**: Disability arising from, or consequential upon the dependence, overdose or influence of any of the following:

(i) drugs, alcohol, narcotics or similar drugs or agents;
(ii) intentional self-inflicted injuries;
(iii) attempted or threatened suicide, while sane or insane;
(iv) illegal activity;
(v) violation or attempted violation of the law, or resistance to arrest; and
(vi) venereal and sexually transmitted Disease or its sequelae (except for HIV and its related Disability);

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

(p) **Armed forces**: participation in any armed force or peace-keeping activities;

(q) **Nuclear, biological, and chemical activities**: Disability arising from nuclear, biological, and chemical related activities. This includes 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

(r) **War and terrorism**: revolutions and war (declared or undeclared), acts of terrorism.

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

Part 4: How to claim

This part sets out specific requirements for making a claim under your Plan. The right to make a claim is subject to the Plan Terms and Conditions.

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 If it is shown that it was not reasonably possible to give notice pursuant to Sections 4.1.1 or 4.1.2 (as applicable), and that notice was given as soon as reasonably possible, the claim will not be invalidated.

4.2 Filing proof of claim

4.2.1 Any proof of loss must be accompanied by supporting documents, forms and information that we require, at your / the Insured Person's 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 original copies of any documents and receipts showing the itemized expenses.

4.2.3 To be fair to other Policy Holders and Insured Persons, if you or the Insured Person submit(s) a claim which is in any respect fraudulent, unfounded, incorrect or misleading, or if you or the Insured Person withhold(s) any information or conspire(s) with a third party to obtain a benefit from this Plan, we will have the right to cancel this Plan immediately. In any of these circumstances, we will also have the right to recover from you any benefit we have already paid to you or any of the Insured Persons 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. 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 other insurance policies other than this Plan, you will have the right to 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 by any such other insurance policies.

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

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, 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 the relevant person's eligibility and/or applicable Plan Level and 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 have the right to declare this Plan void. If we declare the Plan void under this Section 5.1.2, we will refund the premium we received for the period the Plan is void on a pro rata basis.

5.1.3 If your premiums are based on incorrect or incomplete information and we have to change them, 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 was misstated in the Application or enrolment procedure, the Plan Level and the amount payable by us under this Plan will be adjusted on the basis of the correct Age and sex. They 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 an Insured Person would not have satisfied our insurability requirements for any of the Plan Levels on the basis of the correct Age and sex, we have the right to declare his enrolment in this Plan void. If this happens, our liability will be limited to return the relevant premiums paid without interest.

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

5.3 Premium payment, default and grace period

5.3.1 All premiums are payable to us on or before their due dates. The payment of the first premium is due on or before the Policy Effective Date. After payment of the first premium, failure to pay a subsequent premium on or before its due date will constitute a default in premium payment.

5.3.2 At the beginning of each Policy Year, the Premium for that Policy Year, which is the sum of the individual premiums for all of the Insured Person, will be calculated according to the applicable premium rates, Ages of the Insured Person and their respective Plan Level. A final premium will also be computed at the end of each Policy Year or the date of termination, whichever is earlier, to reflect any actual changes occurred after the past Plan Anniversary. A premium adjustment will be paid by (or refunded to) you. We may collect such premium adjustment anytime by giving notice not less than thirty (30) days in advance.

5.3.3 We will 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.

5.4 Change of residency

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

5.4.2 Upon receipt of notification, we will terminate the benefits to the Insured Person immediately. The unearned portion of the premium at the time of termination will be refunded without interest together with any premium adjustment at the end of the Policy Year.

5.4.3 If you or the Insured Person fail(s) to notify us of a residency change and subsequently make(s) a claim, no benefit will be payable.

5.5 Change of principal place of business

5.5.1 You must inform us within thirty (30) days if your principal place of business is no longer Hong Kong.

5.5.2 Upon receipt of notification, we will terminate the policy immediately. The unearned portion of the premium at the time of termination will be refunded without interest.

5.5.3 If you fail to notify us that your principal place of business is no longer Hong Kong and you or any Insured Person subsequently make(s) a claim, no benefit will be payable.

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 enrolment of Employees and/or Dependants as an Insured Person and change of Beneficiaries.

6.1 Who is the owner of the Plan

6.1.1 You are the only legal person entitled to exercise any right or privilege provided under this Plan. Any individual authorized by you can act on behalf of you to exercise such right or privilege.

6.1.2 This Plan and any benefits hereunder may not be assigned by you or any Insured Person.

6.2 Whom we make payment of benefits to

6.2.1 With respect to any payment of benefits to you, the Insured Person, the Beneficiary, or to any third party as directed by you and agreed by us, the payment shall be deemed to have been made to you.

6.2.2 Payment of benefits under this Plan to the above person(s) in the manner pursuant to Section 6.2.1 shall be deemed a good and full discharge of our obligations under this Plan.

6.3 How to change the Beneficiary

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

(a) you or the Insured Person is / 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

(b) such change has been confirmed by us by way of an electronic notice or a written notice; and

(c) the Insured Person is alive at the date of such confirmation notice.

6.4 How to enrol your Employees or their Dependants as an Insured Person

[1] This is to protect the position where a statutory trust arises under section 13 of the Married Persons Ordinance (Cap. 182 of the Laws of Hong Kong).

6.4.1 While this Plan is effective and in force, you can apply for enrolment of any Employee and/or his Dependant as an Insured Person.

6.4.2 All Employees and/or their Dependants must enrol as Insured Persons under the Core Plan Level if the eligibility requirements set out in Section 1.2 are met; if the eligibility requirements set out in Section 1.2 are not met, the Employees and/or their Dependants will be enrolled as Insured Persons under the Supplementary Plan Level (if any).

6.4.3 In the event you wish to enrol a person in this Plan, you shall apply for such enrolment within thirty-one (31) days after this person becomes eligible to be covered under this Plan. Otherwise, we may request medical evidence of good health from such person before accepting the enrolment. Upon our acceptance of enrolment, that person shall be deemed to be an Insured Person starting from the day when he becomes eligible and be entitled to the benefits under this Plan starting from that day.

6.4.4 If an Employee is a Dependant of another Employee under this Plan, both will be considered as an Employee under this Plan.

6.4.5 If an Insured Person is not Actively at Work on the date he would otherwise have become insured, the entitlement of benefits of the Insured Person will be deferred to the day he returns to be Actively at Work. We may request medical evidence of good health from such person before we confirmed his entitlement to benefits.

6.5 What are your cancellation rights

6.5.1 You may cancel the Plan at any time by giving us notice not less than thirty (30) days in advance.

6.5.2 After we receive your notice, cancellation of the Plan will take effect on the next payment date after the notice period noted above expires, and the coverage for the Insured Person will remain effective before that day. A premium adjustment will be paid by (or refunded to) you to reflect any changes to **Insured List** after the past Plan Anniversary.

6.6 What is your Renewal right

6.6.1 This Plan may be Renewed, without issuance of a new policy contract, on each Plan Anniversary by payment of the relevant premium in advance based on the premium rate in force at the time of Renewal, provided that:

(a) One hundred percent (100%) of the Employees who are eligible to the Core Plan Level are enrolled as Insured Persons under the Core Plan Level on the Plan Anniversary; and

(b) The number of Employees enrolled under the Core Plan Level is not less than three (3).

6.6.2 We reserve the right not to Renew this Plan and to revise the premium payable under this Plan on the date of any Renewal.

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 and/or the Insured Person's behalf) duly observed and fulfilled 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 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 by our duly authorized officer.

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 termination of this Plan pursuant to Section 5.3;

(b) the number of Employees enrolled under the Core Plan Level is less than three (3).

7.6.2 The benefits to the Insured Person, as an Employee, shall be automatically terminated on the occurrence of the earliest of the following:

(a) the termination or cancellation of this Plan;

(b) the termination of employment of the Insured Person;

(c) the Insured Person enters military, naval or air service;

(d) end of the period for which the coverage is paid in respect of the Insured Person.

7.6.3 The benefits to the Insured Person, as a Dependant, shall be automatically terminated on the occurrence of the earliest of the following:

(a) the termination or cancellation of this Plan;

(b) the termination of employment of the Employee whose relationship with the Insured Person entitles the Insured Person to be covered under this Plan;

(c) the Insured Person enters military, naval or air service;

(d) the end of the period for which the coverage is paid in respect of the Insured Person;

(e) the Insured Person ceases to be a Dependant;

(f) the death of the Insured Person.

7.6.4 If, while the Plan is effective and in force, any Insured Person becomes ineligible for the Core Plan Level according to the eligibility requirements set out in Section 1.2, the following will apply with effect from the next Plan Anniversary:

(a) if you have selected a Supplementary Plan Level, the applicable Plan Level of that Insured Person will automatically change to the Supplementary Plan Level;

(b) if you have not selected a Supplementary Plan Level, that person will cease to be an Insured Person and will be removed from **Insured List**.

7.6.5 You shall give us a notice of any cancellation of benefits for an Insured Person within thirty-one (31) days after the Insured Person becomes ineligible to be covered under this Plan. The benefits will be ceased on the day the Insured Person becomes ineligible. Premium adjustment, if any, shall be calculated accordingly.

7.6.6 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.

7.7 Cancellation

7.7.1 We have the absolute right to cancel or terminate this Plan at any time by giving you notice by electronic means to the latest contact you have notified to us not less than thirty (30) days in advance. The time of termination or the effective date and hour of cancellation stated in the notice shall be considered the end of the Plan period. Premium adjustment (if any) and the unearned portion of the premium at the time of cancellation or termination shall be paid by (or refunded to) you.

7.8 Notices to us

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

7.9 Notices from us

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

7.10 Waiver

7.10.1 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.

7.10.2 Only those waivers expressly agreed by you and us will be effective, and the rights and obligations of the parties under this Plan will remain in full force and effect except and only to the extent that they are expressly waived.

7.11 No third party rights

7.11.1 Any person or entity who is not a party to this Plan (including, but not limited to, any Insured Persons or Beneficiaries) 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.

7.12 Subrogation

7.12.1 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.

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

7.12.3 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.

7.13 Legal action

7.13.1 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 which all proof of claims as required by these Plan Terms and Conditions has been received by us.

7.13.2 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.

7.14 Governing law and arbitration

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

7.14.2 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.

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

7.15 Compliance with law

7.15.1 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.

7.15.2 If we declare the Plan void under Section 7.15.1, we will refund the premium we received for the period the Plan is void on a pro rata basis.

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

Part 8: What terms mean

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

"Accident"	shall mean a sudden and unforeseen event of violent, accidental, external and visible means which occurs entirely beyond the control of the Insured Person while this Plan is in force.
"Actively at Work"	shall mean that, with respect to an Employee, the ability to perform all regular duties of his employment on the work days normally scheduled; with respect to a Dependant, the ability to carry out his normal day-to-day activities.
"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).
"Benefits 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.
“Case-based Exclusion”	shall mean the exclusion of a particular Sickness or Disease 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.
"Co-Payment"	shall mean the part of expenses the Insured Person must contribute when making a claim. For the avoidance of doubt, Co-Payment does not refer to any amount that the Insured Person are required to pay if the actual expenses exceed the benefit limits under these Plan Terms and Conditions.
"Confinement" or "Confined"	shall mean an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for Medical Service and as an Inpatient as a result of a Medically Necessary condition for a period of no less than six (6) consecutive hours. No minimum period is required for Confinement in connection with any Emergency Treatment in a Hospital as a result of an Emergency for the performance of a surgical procedure or other Medical Service in a Hospital. Confinement shall be evidenced by a daily room charge invoiced by the Hospital and the Insured Person must stay in the Hospital continuously for the entire period of Confinement.

"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.
“Core Plan Level”, “Supplementary Plan Level”	shall mean the Plan Levels you select respectively as “Core Plan Level" and “Supplementary Plan Level” as set out in **Policy Schedule,** or as amended from time to time and as shown in the customer portal.
"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.
“Dental” or “Dental Services”	shall mean the dental services provided by a Registered Dentist in a clinic.
“Dependant”	shall mean the lawful spouse, lawful unmarried child and lawful parents.
“Disability”	shall mean a Sickness or Disease or Injury, including any and all complications arising therefrom.
"Eligible Expenses"	shall mean expenses incurred for Medical Services rendered with respect to a Disability or any other services that are covered as set out in Section 1.2.
"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 Service required in an Emergency. The Emergency event or situation, and the required Medical Service cannot be and are not separated by an unreasonable period of time.
“Employee”	shall mean a person employed by you who is working on a full time basis.
"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.

"Injury" shall mean bodily injury sustained by the Insured Person of which there is evidence of a visible contusion or wound on the exterior of the body, or of internal contusion, wound or injury, or a combination of these injuries which is solely caused by an Accident and independently of any other cause.

"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 **Insured List**.

"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.

"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.

"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 Injury;

(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 medical practitioner or any other person; and

(d) not able to be omitted without adversely affecting the Insured Person's medical condition.

"Network" shall mean the administrator of the health services providers whom we appoint to provide health services under this Plan.

"Outpatient" shall mean an Insured Person who has not been confined and who receives medical services in a private medical clinic, or in the outpatient department or emergency treatment room of a Hospital; and Outpatient medical services shall mean medical services provided to an Outpatient in a private medical clinic or in the outpatient department or emergency treatment room of a Hospital.

"Plan" shall mean the insurance policy set out in the Plan Terms and Conditions underwritten and issued by us, which is the contract between you and us.

“Plan Anniversary”	shall mean the same day and month as the Policy Effective Date in each succeeding year after the Policy Effective Date while this Plan remains in force.
"Plan Level", "Startup Level", "Growth Level", "Enterprise Level"	shall mean the specific set of benefits under this Plan which is subject to the specific eligibility and Age requirements as set out in the Benefit Summary in Section 1.2. "Startup Level", "Growth Level" and "Enterprise Level" shall mean the relevant set of benefits so described in the Benefit Summary.
"Plan Terms and Conditions"	shall mean Parts Part 1 to Part 8 of this Plan and including **Policy Schedule** , **Insured List** and any Supplement(s).
"Policy Effective Date"	shall mean the commencement date of these Plan Terms and Conditions which is specified as "Policy Effective Date" in **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** document.
“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 Benefits 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.
"Premium Loading"	shall mean the additional premium on top of the Standard Premium charged by us to you according to the additional risk assessed for the Insured Person.
"Prescribed Diagnostic Imaging Tests"	shall mean any of the followings: (a) computed tomography (“CT” scan); (b) magnetic resonance imaging (“MRI” scan); (c) positron emission tomography (“PET” scan); (d) PET-CT combined; and (e) PET-MRI combined.
"Reasonable and Customary"	shall mean, in relation to a charge for treatments, 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, e.g. of the same sex and similar Age, for a similar Disability, as reasonably determined by us in utmost good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred.

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; and/or

(d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.

"Registered Chinese Medicine Practitioner", "Registered Physiotherapist", "Registered Chiropractor" and "Registered Dentist"	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 Physiotherapist", "Registered Chiropractor" and "Registered Dentist" 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).
"Registered Medical Practitioner", "Registered 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 not duly qualified and registered under 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), we shall exercise

	reasonable judgement to determine whether such practitioner shall nonetheless be considered qualified and registered. Notwithstanding the above, in no circumstance "Registered Medical Practitioner", "Registered Specialist", "Surgeon" and "Anaesthetist" shall include the following persons – the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family Insured Person 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 in accordance with their terms 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.
"Sickness" or "Disease"	shall mean a physical, mental or medical condition arising from a pathological deviation from the normal healthy state, including but not limited to the circumstances where signs and symptoms occur to the Insured Person and whether or not any diagnosis is confirmed.
"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 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.
"Sum Insured"	shall mean the amount payable to relevant Beneficiary in the event that an Insured Person eligible to death benefit dies as determined by the applicable Plan Level and Benefit Summary.
“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 legal person who is a legal holder of this Plan and is named as the Policy Holder set out in **Policy Schedule**.