

# The Global Health Supreme Plan

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A global  
healthcare  
solution  
for **HSBC** Customers

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# Introduction

Dear Valued Customer,

We at HSBC always stay ahead of global development in terms of banking and other customer services in order to offer our customers the best opportunities to maximize their gains. These benefits are not only financially sound but also give you the peace of mind and security to enjoy life to the fullest.

With this in mind, HSBC has now joined hands with Aviva Singapore to offer you an unique and competitive global healthcare product. The Global Health Supreme Plan will be locally serviced by Senaratne Associates Ltd. This strategic partnership revolutionizes health insurance and gives you a strong healthcare plan that would reach beyond the shores of Sri Lanka.

Details of this health insurance scheme are included in this brochure. If you have any further questions you may contact us on the special telephone numbers listed for your convenience on page 7 of our brochure and we will be pleased to assist you.

With best wishes,

Sarit Wijeyekoon  
Head of Personal Financial Services

# One Solution for all your needs by Aviva Global Health Supreme Plan

## A personal healthcare protection applicable around the world

Global Health is an international medical insurance plan offered by Aviva. The Supreme Plan enclosed provides comprehensive care ranging from maternity, care for chronic illnesses and even elective treatment for you. The Global Health Supreme Plan offered by Aviva outlines the benefit specifically for HSBC customers in Sri Lanka.

The Global Health Supreme Plan allows you to choose how, when, where and by whom you are treated. In the event that appropriate medical treatment is not available where you are, arrangements can be made for you to receive treatment at the nearest hospital as soon as possible.

The focus of Global Health is to ensure that we provide you, the insured with every convenience. As such emergency assistance and evacuation is only a telephone call away using the 24-hour hotline. Additionally Aviva will expedite treatment and arrange for payment guarantees or direct settlement with the hospital, provided the hospital you have chosen is in agreement with this scheme.

## Global Health Benefits

- > **Generous Global Cover**  
Aviva offers one of the most generous international health insurance plans available, with up to - US\$ 1,500,000 cover per year with no deductibles. This gives you and your family global access to first class medical care -wherever you are.
- > **Elective Treatment**  
You and your family have the flexibility to choose how, when , where and by whom you are treated, except in the USA or Canada.
- > **Home Country Treatment**  
You and your family can elect to receive treatment in your home country, or anywhere in the world except USA and Canada.
- > **Chronic Care - Full Coverage**  
Aviva offers full coverage for any chronic illness. For example, diabetes or kidney conditions which originate after you or your family are insured with Aviva. This is an important feature to consider when comparing the benefits of Global Health with other local and international plans.
- > **Pre-existing Conditions**  
Pre-existing conditions will be considered subject to satisfactory declaration and medical screening.
- > **Global Payment Guarantee**  
Aviva provides global payment guarantees so that you do not have to pay hospitals or make suitable credit card deposits directly to hospitals or emergency medical evacuation services.
- > **Transportability**  
For dependents located outside Sri Lanka, AVIVA will determine a premium which will be applied to members based overseas.
- > **24-Hour Dedicated Help-line**  
Aviva provides a help-line that you can call - for assistance at anytime, day or night. The highly trained multi-lingual medical staff will guide and assist you in times of crisis.

*For those interested to obtain a cover inclusive of USA and Canada please make the request and a quote will be obtained on your behalf for your confirmation.*

## Emergency Assistance

### International Payment Guarantees

If you contact the Emergency Assistance Centre in advance with the relevant information, Aviva will provide you with global payment guarantees avoiding any direct payments to the hospital and/or emergency medical evacuation services.

### Emergency Medical Advice & Assistance

The Emergency Assistance Centre will provide telephone assistance such as medical advice, evaluation, referral and hospital admission.

### Emergency Medical Evacuation Services

In the event of an emergency medical evacuation, the insured patient will be transported to the nearest suitable hospital. Repatriation of remains is also covered under this policy.

To provide you with these services, Aviva has teamed up with International SOS Pte Ltd, a specialist medical assistance organisation based in Singapore which has an extensive Global Network of Alarm Centre's. You may call for assistance at anytime, day or night and the highly-trained, multi-lingual staff and co-ordinator doctors will guide you in times of crisis.

To give you complete peace of mind, Aviva provides you valuable emergency assistance via a 24-hour hotline specially dedicated to Global Health customers.

## Global Health Premium Rates

### Important Notes:

Please find below the product information on Aviva Global Health Supreme Plan.

If in doubt please seek advice from a qualified adviser.

Buying health insurance products that are not suitable for you may impact your ability to finance your future healthcare needs.

As the Global Health product is underwritten by Aviva Singapore the scheme will be governed by the laws of Singapore.

## Global Health Supreme Plan Benefits

(All figures are in US\$)	Supreme Plan
Annual Limits per insured person	\$ 1,500,000
<b>CORE BENEFITS</b>	
<b>(1) HOSPITAL &amp; RELATED SERVICES</b>	
In-house accommodation upto standard single private bed, surgery, treatment, facilities and services	In full
Cancer treatment (in/out patient)	In full
Kidney Dialysis (in/out patient)	In full
Physiotherapy treatment	In full
In-patient Psychiatric treatment (after 10 months from inception)	\$ 10,000
Day Surgery	In full
Casualty ward accident and emergency services	In full
Hospital accommodation for accompanying parent (for insured child below age 18)	In full
Local Ambulance services	In full
Home nursing care following discharge from hospital (max 26 weeks per policy year)	In full
Daily hospital cash per night for non-paying patient (max 30 days disability)	\$ 150
<b>(2) ORGAN TRANSPLANTATION</b>	
Operation costs for kidney, heart, liver, lung and bone marrow transplants (excl costs of obtaining donor organs)	In full
<b>(3) EMERGENCY MEDICAL EVACUATION AND REPATRIATION</b>	
Medical evacuation and repatriation	In full
Repatriation of mortal remains	In full
Compassionate travel	In full
Cost of return economy air ticket for insured patient	\$ 2,000
Emergency medical advise & assistance	Provided
International travel assistance and services	Provided
<b>(4) MATERNITY (12 MONTHS WAITING PERIOD FROM COMMENCEMENT OF INSURED MEMBER'S COVER)</b>	
Costs of normal delivery, medical recommended cesarean	\$ 2,000

## Annual Premium

The premium payable is based on the age as at the date of underwriting and acceptance by Aviva of the person to be insured. After the age of 65, the premiums will be determined by Aviva upon confirmation of underwriting and acceptance.

### Annual Premium

Core Benefits 1 - 4	Worldwide exclude USA & Canada
0 - 64 years	US \$ 999
65 - 85 years	On application subject to a full medical check up

*The above mentioned premiums are valid until 30th April 2011*

**For your convenience HSBC has enabled a 12 months instalment scheme for payment of this premium. If you need further assistance, please speak to a HSBC customer service representative to assist you in the matter.**

*Please note that the premium will be prorated on a daily basis in the event the policy is obtained after 01st May 2010.*

### Who is eligible to apply?

- (a) HSBC customers residing in Sri Lanka and below the age of 65. Any new applicant age 65 and above will be subject to full medical check-up (on applicant's own expense), underwriting and acceptance by Aviva.
  - (b) Dependent Children - A parent could (on behalf of a child) apply for cover of a child if he /she is at least 15 days old (or from the date of discharge after birth of the child from a hospital – which ever is later), provided the parent is also insured with Aviva.
- It should be noted that all Claims would be handled by AVIVA Ltd.
  - The Bank assumes no responsibility for the quality of service/product provided by the Insurer and cannot be held responsible for same.
  - In the event of a dispute arising out of this program the same should be addressed directly with Aviva Singapore.



***For further information please contact  
the local service agent for Aviva Singapore -  
Senaratne Associates Ltd. on:***

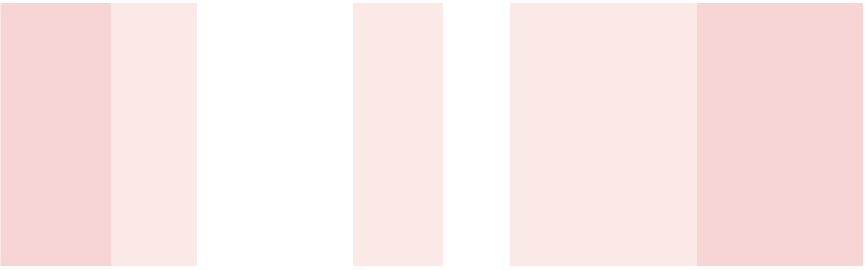
**5 642 932**  
**077 350 11 70**

(Hotlines are operative from 9 am to 5 pm Monday to Friday)

***sfs@sengroup.com***

***Or you may contact us on:***

<b>Premier Hotline</b>	<b>4472272</b>
<b>Advance Hotline</b>	<b>4472243</b>
<b>Platinum Hotline</b>	<b>4472275</b>
<b>Gold Hotline</b>	<b>4472242</b>





# HEALTH DECLARATION FORM

For Official Use Only																			
Group Policy No.:																			
<table border="1" style="width:100%; height:20px;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>																			
Date: _____																			

**IMPORTANT NOTE: Pursuant to Section 25(5) of the Insurance Act (Cap.142), you are to disclose in this form, fully and faithfully, all the facts which you know or ought to know, otherwise, nothing may be payable under the Policy.**

Name & Address of Proposer: \_\_\_\_\_

Plan Type: **HSBC Supreme Plan**

Contact Details - Home : \_\_\_\_\_ Work : \_\_\_\_\_ E-mail : \_\_\_\_\_

**(A) PROPOSER'S PARTICULARS**

Full Name of Proposed Insured in Block (as shown in NRIC - underline <u>surname</u> )				Nationality	Country of Residence	Height (cm)	Weight (kg)
NRIC / Passport No.	Date of Birth	Sex Male / Female #	Marital Status	Occupation - Exact Duties			

**(B) DEPENDANTS' INFORMATION (Please ignore this section if dependants are not covered)**

Relationship	Name	Occupation	NRIC / Passport No.	Nationality	Country of Residence	Sex	Date of Birth DD / MM / YY	Height (cm)	Weight (kg)
Dependant 1									
Dependant 2									
Dependant 3									
Dependant 4									

**(C) HEALTH QUESTIONS**

(Note: Any alteration in this form must be signed.)

	Proposer		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Have you ever had or been told to have or been treated for:										
a. epilepsy / fits, stroke, paralysis / weakness of limb, prolonged headache, nervous breakdown, depression or any other nervous / mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. cataract, ear infection / discharge or any other disorders of eye, ear, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. asthma, bronchitis, persistent cough, coughing with blood, pneumonia, tuberculosis, breathing complaints / discomfort or any other lung disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. raised cholesterol, high blood pressure, heart attack, mitral valve prolapse or other heart valve disorders, breathlessness, fast heart rate, chest pain, or any disease or disorders of the heart?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. diabetes mellitus, thyroid disorders or any endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. jaundice, hepatitis B carrier or any form of hepatitis, liver or gallbladder disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. slipped disc, backache, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. any sexually transmitted disease, e.g. syphilis, gonorrhoea, non-specific urethritis, herpes, HIV infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. endometriosis, fibroids, cysts, breast lumps, abnormal pap smear, irregular or painful menstruation or any other disorders of the female organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. anaemia, haemophilia or any disorders of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. any other illnesses, congenital or hereditary disorders, any hospitalisation or physical injuries not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you smoked in the last 12 months? If 'Yes', please state number of years and the number of sticks per day.										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Insured Person</b>		<b>No. of years</b>		<b>No. of sticks/day</b>					
	Proposer									
	Dependant 1									
	Dependant 2									
	Dependant 3									
	Dependant 4									
3. Do you consume alcohol? If 'Yes', please state the type, quantity and frequency.										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Insured Person</b>		<b>Type</b>	<b>Quantity</b>	<b>Frequency (per week)</b>					
	Proposer									
	Dependant 1									
	Dependant 2									
	Dependant 3									
	Dependant 4									

	Proposer		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
4. Do you have a regular doctor? If 'Yes', please state the name and address of your regular doctor and the date, reason and result of last consultation. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you consulted any doctor/specialist and had investigations done (X-Ray, ultrasound, Electrocardiogram, blood or urine tests) and/or prescriptions provided for any drugs or medications for any medical conditions other than common illness e.g. flu, common cough etc? If 'Yes', please state details such as reason, date and results of test done and the diagnosis. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been recommended by a doctor to receive any medical treatment, undergo any medical tests, investigations (excluding voluntary health check-up) or any intention to consult any doctor for any reason, seek further treatment or alternative medicine? If 'Yes', please state details such as type, reason, date and results of test done and the diagnosis. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you engage in activities that will increase the likelihood of exposure to any immunity disorder such as AIDS or AIDS-related conditions or in the last 3 months had experienced the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea or unusual skin lesions? If 'Yes', please state details. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been accepted at special terms or extra premiums for any application, renewal or reinstatement of life, health or any other insurance policy? If 'Yes', please provide details on date of application and reason for special terms. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you engage or have any intention of engaging in hazardous activity or occupation such as private flying, scuba diving, motor racing, mountaineering etc? If 'Yes', please state details such as locations, frequency, depth, etc. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have any of your natural parents or siblings died or suffered from (a) heart disease, (b) high blood pressure, (c) stroke, (d) diabetes, (e) cancer, (f) kidney disease, (g) mental disorder, (h) muscular disorder, or any other hereditary disease? If 'Yes', please state relationship, condition, age of incidence of disease and age of death (if deceased).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Relationship	Condition/Cause of Death	Age at Onset	If Deceased, Age at Death

If any of the answers to Question 1 is YES, please PROVIDE COMPLETE INFORMATION and MEDICAL REPORT. If necessary, please attach a separate sheet.

Name	Sub-Qn. (Eg. a,b)	Details of Diagnosis / Treatment / Operation	Date		Name & Address of Doctor / Hospital
			From	To	

**(D) DECLARATION**

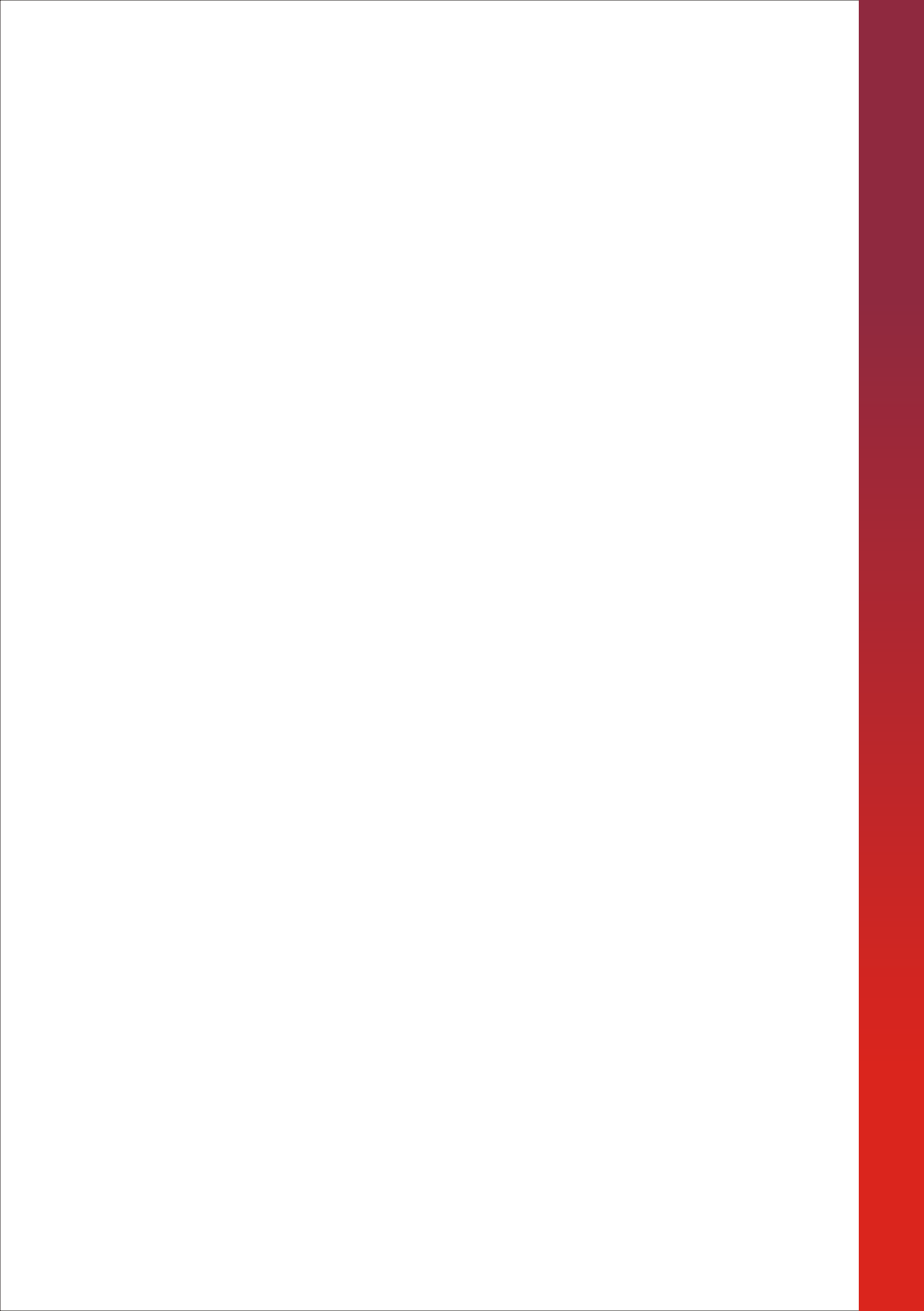
I declare that the information given above is true and complete. I agree that this application shall be the basis of the insurance coverage issued under the said Group Insurance Policy. I understand that the insurance coverage shall not become effective until it is accepted and confirmed in writing by Aviva Ltd.

I agree to inform Aviva Ltd if there is any change in the state of my and/or my dependants' health/activities between the date of this Health Declaration and the date full insurance coverage is provided by Aviva Ltd to me and/or my dependant(s). I understand that the terms of accepting me and/or my dependant(s) as a risk for insurance coverage may vary according to such information received.

I consent to Aviva Ltd seeking information from any doctor who has attended to me and/or my dependant(s) or from other insurance company to which I and/or my dependant(s) have at any time made a proposal for insurance and I authorise the giving of such information. I further authorise Aviva Ltd to give such information obtained or information contained herein for the purpose of obtaining insurance cover under the said Group Policy to the insurance intermediary / administrator of the said Group Insurance Policy.

**Only applicable to Group Medical products for all voluntary and flexible benefits: I/We confirm that I/We have received a copy of Your Guide to Health Insurance and Product Summary and have read and understood the contents of these two documents.**

Signature of Proposer	Signature of Dependants aged 16 years and above			
	Signature of Dependant 1	Signature of Dependant 2	Signature of Dependant 3	Signature of Dependant 4
Date	Date	Date	Date	Date



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This product is locally serviced by:

**Senaratne Associates Ltd.**

**Suite 408, 409, 4th Floor, Liberty Plaza,  
Colombo 3, Sri Lanka.**

**Tel: +94 11 2 573 047 Fax: +94 11 2 573 048**

**Web: [www.sengroup.com](http://www.sengroup.com)**

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