Bupa Pre-authorisation Form
保柏醫療初步保障審核表格

Email 電郵 preauthapp@bupa.com.hk Fax No. 傳真 (852)3973 6966 Plesae complete this form and send to Bupa by email or fax 請填妥此表格並電郵或傳真至保柏

Part I - To be Completed IN FULL by Member 第一部分 - 由會員填寫全部資料

Insured's Name 受保人姓名	Date of Birth 出生日期 (DD日 / MM月 / YY年)
BOC Life Policy No. 中銀人壽保單編號	Tel No. 電話號碼
Bupa Membership No. 保柏會員編號	

Authorisation and Declaration 授權及聲明

I hereby declare that the below information given is true and correct. I hereby authorise any medical practitioner, hospital, clinic, by whom or where I / the Member have been observed or treated or any insurance company or organisation that has any records or health information concerning me / the Member for any reason, to give full particulars thereof including prior medical history to Bupa. A copy of this authorisation shall be considered as effective and valid as the original.

I understand and agree that all personal and medical information relating to me / the Member contained in this pre-authorisation application will be used by Bupa for the purpose of (1) processing this application and providing subsequent services; (2) processing any claims analysis and / or medical, identity or other insurance-related checks; (3) data matching, statistics, research, reporting and auditing; (4) communication with me about this pre-authorisation; (5) exercising the right to determine indebtedness, collecting and recovering amounts owning by me or any person who has provided any security or undertaking for my liabilities; and (6) satisfying any applicable legal or regulatory requirements. I agree that such information may be transferred for the above purposes to any of the following parties (within or outside Hong Kong): any of the private hospital(s) specified below, Bupa's group companies, any insurance intermediaries as authorised by myself and Bupa, any re-insurance companies authorised by Bupa, any claims investigation companies, any service providers providing services to Bupa, any association or federation relating to the insurance industry, and any person or organisation as required by law.

Consequences of non-provision of personal information: I understand that Bupa may be unable to process this application if I fail to provide any information requested in this application or otherwise by Bupa.

My rights in respect of my personal information: I understand that (1) under the Personal Data (Privacy) Ordinance, I shall have the right to request access to and correction of any personal information concerning me provided to Bupa, by writing to Bupa's Data Protection Officer at 6/F, Tower 2, The Quayside, 77 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong. (2) I also have the right to request Bupa to cease using my Personal Information for direct marketing purposes by writing to Bupa's Data Protection Officer, by registering on line at http://www.bupa.com.hk/unsubscribe.asp or by calling the Customer Care team.

The detailed version of Bupa "Personal Information Collection Statement" may be obtained on Bupa's website at http://www.bupa.com.hk/eng/Others/legal-notices.aspx.

本人謹此聲明，以下所填報之一切資料，均屬真確無訛。本人謹此授權任何為本人 / 會員觀察或治療的醫生、醫院、診所，或持有本人及 / 或會員健康或任何資料之保險公司或機構將本人及 / 或會員之資料（包括病歷）交予保柏，本授權書之副本與正本具同等效力。

本人明白及同意保柏透過此初步保障審核申請收集之本人 / 會員之個人及健康資料，可供保柏用作以下用途(1)處理此申請及提供有關服務；(2)處理任何索償分析及 / 或與醫療、身份或其他保險有關的查核；(3)資料核對、統計研究、報告及審計；(4)就此初步保障審核與本人聯絡；(5)行使本公司向閣下或屬下會員提供保險和相關服務及產品而享有的權利，例如釐定欠付閣下或閣下拖欠的任何款項的金額，及向閣下或任何已為閣下的債務提供任何擔保或承諾的人士，追收和收回拖欠的任何款項；及(6)遵守任何法例或監管要求。

本人同意該等資料可因上述用途提供予下述任何各方（不論在香港境內或境外）：任何下述之醫院、保柏的集團公司、任何由本人及保柏授權的保險代理人、任何由保柏授權的再保險公司、賠償調查公司、任何向保柏提供服務的供應商機構、與保險業相關之團體及任何法律要求的任何人士及團體。

未能提供個人資料的後果：本人明白若本人不能提供此申請或保柏要求的其他資料，保柏不能處理此申請。

有關個人資料的權利：本人明白(1)根據個人資料（私隱）條例，本人有權就查閱及修正保柏所持有關於本人的任何個人資料致函保柏之保障資料主任，地址為：香港九龍觀塘海濱道77號海濱匯第2座6樓。(2)本人亦可透過網站 http://www.bupa.com.hk/unsubscribe.asp 進行登記或致電保柏客戶服務專線，以要求保柏停止將本人的個人資料作直接市場推廣用途。

有關個人資料收集聲明之詳情，請參閱保柏之網站 http://www.bupa.com.hk/chi/Others/legal-notices.aspx

Signature of Insured / Guardian
受保人 / 監護人簽署

X .....

(Name 姓名：)

Date 日期 (DD日 / MM月 / YY年)

Credit Card Authorisation: Applicable to Individual Policy for Hospitalisation and Clinical Operation Only 信用卡授權書 (僅適用於個人保障計劃之住院和門診手術)

Please note that a shortfall may occur if final costs for treatment exceed your plan coverage or the medical expenses are not eligible for reimbursement. This form authorises Bupa to collect any shortfall from the credit card account detailed below. The credit cardholder must be the Subscriber or the Member of this policy. Bupa will hold a HK$500 credit limit until the claim assessment is fully completed. The shortfall collection notice will be sent to you 21 days prior to the collection.

請注意若最終的治療費用超過你的保障額，或有關費用不屬於保障範圍內，此授權書將授權保柏在下列信用卡帳戶收取差額。持卡人必須為此保單之投保人或會員。保柏將保留港幣500元的信用額直至索償程序完結為止。保柏將於收取差額費用21天前郵寄結欠付款通知書通知閣下。

I hereby authorise and direct Bupa (Asia) Limited to debit the shortfall due from my credit card account.
本人授權及指示保柏（亞洲）有限公司從本人之信用卡戶口扣除到期之差額費用。

Cardholder's Signature
持卡人簽署

X .....

Date 日期 (DD日 / MM月 / YY年)

Relationship with Insured
與受保人之關係

Cardholder's Name 持卡人姓名	ID Card No. 身份證號碼	Tel No. 電話號碼
Credit Card Account No. (MasterCard / VISA)* 信用卡號碼	Credit Card Expiry Date (MM月 / YY年) 信用卡到期日	

* Credit card must be valid for at least 3 months from date of hospital admission 信用卡有效期必須多於三個月(由入院日期起計)

Part II - To be Completed IN FULL by Attending Doctor 第二部分 - 由主診醫生填寫全部資料

Diagnosis Details 診斷詳情 — **Has the Insured presented Bupa Medical Card upon consultation 受保人有否於求診時出示保柏醫療卡?** ☐ **Yes 有** ☐ **No 沒有**

Chief Complaint of the Current Consultation 是次就診之主訴 / sign and symptoms 病徵及症狀	**Onset Date 病徵出現日期 (DD日 / MM月 / YY年)**
Diagnosis 診斷	Is it a chronic / recurrent illness 是否慢性 / 復發疾病 ☐ Yes 是 First Onset Date 首次病徵出現日期 (DD日 / MM月 / YY年) ..... ☐ No 否

(Please enclose referral letter 請提供轉介信)

Diagnostic / Surgical Procedures 診斷性 / 外科手術
Non-network Specialist (if applicable) 轉介非網絡專科醫生 (如適用)

Anaesthesia 麻醉	Location 地點	Cost 費用
☐ GA 全身麻醉 ☐ MAC 監察麻醉 ☐ LA 局部麻醉 ☐ IVS 靜脈注射鎮靜	☐ Clinic 診所 ☐ Day Case 日症 ☐ Hospital OPD 醫院門診部 ☐ In-patient 住院	HKD 港幣
Date fo Treatment 治療日期	Name of Hospital / Day Case Unit 醫院 / 日症中心名稱	

Was the medical condition caused by or related to the following 此病是否與下列情況有關或引致？

☐ accidental bodily injury 身體意外受傷 ☐ congenital, hereditary, developmental condition 先天性，遺傳性或發育異常

Hospitalisation Details (if applicable) 住院詳情 (如適用) — **please tick the appropriate one**

Name of Hospital 醫院名稱	Date of Admission (DD日 / MM月 / YY年) 入院日期	Bed Class 住院級別 ☐ Private 私家房 ☐ Semi-private 半私家房 ☐ Ward 大房
		Estimated Length of Stay 預計留院日數 ..... days日

If hospitalisation is arranged for scans, diagnostic testing or a procedure, please explain why hospital stay is necessary.
如是次住院之目的為檢驗，進行診斷掃描，請說明留院之原因。

Doctor's Particulars and Signature 醫生資料及簽署

Doctor's Name 醫生姓名	Doctor's Chop & Signature 醫生蓋印及簽署	Date 日期 (DD日 / MM月 / YY年)
	X	.....

Fax No. 傳真號碼	Tel No. 電話號碼	Bupa Provider Code (if any) 保柏醫生編號 (如有)	Bupa Network Identifier (if any) 保柏網絡編號 (如有)