Bupa Crystal Health Insurance Scheme Registration Variation Form
保柏晶彩寶醫療保障計劃更改登記申請表

Please complete this form in **ENGLISH AND BLOCK LETTERS**. Please tick as appropriate. 請以**英文正楷**填妥本表格，並於適用地方加「✔」號。

To protect your interest, please return this original form with your signature to Bupa. 為保障閣下的權益，請將本表格正本簽署然後交回保柏。

Membership No. (16 digits)
會員號碼 (16位數字)

Subscriber's Name (same as HKID Card) 投保人姓名 (與香港身份證相同)

Surname
姓

Given Name
名

Types of Changes 更改項目 (Please tick the change(s) and fill in the details as required 請選擇更改部份並填妥所需資料)

☐ I. Change of Benefit 更改保障 (Health Declaration and Questionnaire must be completed for new choice with item marked with "＊"). The new benefit will be effective on the date of renewal, if approved. 有「＊」號的新選項必須填寫健康聲明及問卷。一經批核，新保障將於續保日生效。)

*** Please tick the NEW choice 請於新選擇之空格內加上 "✔" 號**

Hospital and Surgical Benefit 住院及手術保障		☐ Change to 改為：	☐ 100% reimbursement 十足賠償
Optional Benefit : 自選保障項目	1. Clinical Benefit 門診保障	☐ *Add 增加	
		☐ Change to 改為：	☐ 100% reimbursement 十足賠償
		☐ Cancel 取消	
	2. Hospital Cash Benefit 住院現金保障	☐ *Add 增加	☐ Cancel 取消

* If the Benefit after the change is higher than the Benefit the Member is entitled to before the change, Benefit is payable as per the Benefit before the change in relation to any illnesses or injuries covered under this Contract that commenced before Contract Effective Date. 若會員的新保障額較前保障額為大，所有在合約生效日前已患疾病或損傷將根據前保障額作賠償。

Payment Method 繳付保費方法

☐ Credit Card 信用卡

Please attach a completed Credit Card Authorisation Form
請連同填妥之信用卡付款授權書寄回

☐ II. Change of Bank Account for Reimbursement 更改支付賠償之銀行戶口

Claims payment will be reimbursed by autopay only 賠償款項只以自動轉賬方式支付。

I hereby agree and authorise Bupa (Asia) Limited to reimburse claims payment to the account below. 本人同意及授權保柏（亞洲）有限公司轉賬賠償款項於以下戶口。

Account Holder's Name (Same as recorded on bank account statement / passbook)
戶口持有人姓名 (與銀行結單 / 存摺相同)

HKID Card No.
香港身份證號碼

Personal Hong Kong savings / current account number (HK$ only) 個人香港儲蓄 / 往來銀行戶口號碼（只限港幣）

Bank Name
銀行名稱

Bank No.
銀行編號

Account No.
戶口號碼

If the above account holder is not the Subscriber, please fill in the following information. 若上述之戶口持有人並非投保人，請填寫以下資料。

Relationship with the Subscriber or Member* (Applicable to spouse, parents or children only)
與投保人或會員*關係（只適用於配偶、父母或子女）

* Please delete if inappropriate 請刪除不適用者

☐ III. Application for e-Services 申請電子服務

☐ I hereby agree to use e-Services through **myBupa**, an online and mobile platform, to view and download some of my policy-related documents. To access these e-documents*, I am required to register for a **myBupa** account and provide an email address in Section V below where I will receive email notifications when a document is ready for me to access from my **myBupa** account. I understand that I will no longer receive hard copy of these documents by post.

If you have already provided your email address to us, we will send email notifications to your email address on our record. If you want to update your email address, please provide a new email address in Section V below.

* Please refer to https://www.bupa.com.hk/en/customer-care/mybupa/ for the latest list of e-documents available on **myBupa**. This list is subject to change.

☐ 本人現同意使用 **myBupa** 網上及手機的電子服務，以查閱及下載與本人保單相關的部分文件。要查閱這些電子文件*，本人須登記 **myBupa** 帳戶，並於以下第五部分提供電郵地址。當文件已上載於我的 **myBupa** 帳戶後，我便會收到電郵通知。本人明白將不會以郵寄方式收到這些保單文件的印刷本。

如你曾經向我們提供電郵地址，我們會根據紀錄中的電郵地址發出電郵通知。如你想更新電郵地址，請於以下第五部分提供新的電郵地址。

* 有關上載於 **myBupa** 的最新電子文件清單，請參考 https://www.bupa.com.hk/tc/customer-care/mybupa/，此清單會不時更改。

☐ IV. Change of Account Number for Credit Card Payment 更改信用卡付款戶口號碼 (Credit Card Authorisation Form must be completed) (請填寫信用卡付款授權書)

☐ Yearly by Credit Card
以信用卡年繳

please attach a newly completed Credit Card Authorisation Form
請連同新填妥之信用卡付款授權書寄回

PAMVT

OP/BCNRV/0922

V. Change of Correspondence Address / Telephone no. / Email Address 更改通訊地址 / 電話號碼 / 電郵地址

New Correspondence Address** 新通訊地址** (Please complete in ENGLISH and BLOCK LETTERS 請以英文正楷填寫)

Flat 單位 / Room 室 / Floor 層數

Block 座 / Building 大廈 / Mansion 閣 / House 樓 / Estate 屋苑

Street 街 / Road 道

District 地區 ☐ HK 香港 ☐ Kln 九龍 ☐ NT 新界

New Email Address 新電郵地址

New Contact No. 新聯絡電話 New Fax No. 新傳真號碼 New Mobile No. 新流動電話號碼

** P. O. Box, hotel address and overseas address are not acceptable. 郵政信箱、酒店地址及海外地址恕不接納。

For any Member who becomes a US Permanent Resident[1], please complete Section VI Change of Members Details. For any change of address to US, Subscriber is also required to fill in Section VI to declare for all members if they are US permanent Resident.
如任何會員成為了美國永久居民[1]，請填妥第六部分之更改會員資料。如新更改的通訊地址為美國，投保人亦須為所有會員填寫第六部分以聲明他們是否美國永久居民。

Notes 注意:
1. "Permanent Resident" shall mean a person residing in a country who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in that country.
「永久居民」指居於某國家並且身為該國公民或根據適用法律獲許在該國永久性居留及工作的人士。

VI. Change of Particulars of existing Subscriber or Member 更改現有投保人或會員的資料

Subscriber 投保人

Membership No. 會員號碼 ☐☐☐☐☐☐☐☐ — ☐☐☐☐☐☐☐☐

New Name of Subscriber (same as HKID Card/Passport) 投保人的新姓名 (與香港身份證/護照相同)

Surname 姓

Given Name 名

New HKID Card No./Passport No.*** 新香港身份證號碼 / 護照號碼

Place of Residence# 居住地

US Permanent Resident[1] 美國永久居民 ☐ Yes是 ☐ No否

*** Please submit the copy of HKID Card / Passport to Bupa. 請連同香港身份證 / 護照副本交回保柏。

Your Spouse/Domestic Partner 你的配偶/同居伴侶[2]

Membership No. 會員號碼 ☐☐☐☐☐☐☐☐ — ☐☐☐☐☐☐☐☐

New Name of Spouse/Domestic Partner[2] (same as HKID Card/Passport) 配偶/同居伴侶[2]的新姓名 (與香港身份證/護照相同)

Surname 姓

Given Name 名

New HKID Card No./Passport No.*** 新香港身份證號碼 / 護照號碼

Place of Residence# 居住地

US Permanent Resident[1] 美國永久居民 ☐ Yes是 ☐ No否

*** Please submit the copy of HKID Card / Passport to Bupa. 請連同香港身份證 / 護照副本交回保柏。

Your Child 你的子女

Membership No. 會員號碼 ☐☐☐☐☐☐☐☐ — ☐☐☐☐☐☐☐☐

New Name of Child (same as HKID Card/Birth Certificate) 會員的新姓名 (與香港身份證/出生證明書相同)

Surname 姓

Given Name 名

New HKID Card No./Birth Certificate No.*** 新香港身份證號碼 / 出生證明書號碼

Place of Residence# 居住地

US Permanent Resident[1] 美國永久居民 ☐ Yes是 ☐ No否

*** Please submit the copy of HKID Card / birth certificate to Bupa. 請連同香港身份證 / 出生證明書副本交回保柏。

Unless otherwise specified by Member in writing, Inter Partner Assistance Hong Kong Limited will consider Hong Kong as the Place of Residence of all Members and repatriate relevant Members to Hong Kong when Medically Necessary. 除非會員特別以書面通知，國際救援（亞洲）有限公司將設定香港為所有會員之居住地，於有醫療需要時送返有關會員回香港。

1. "Permanent Resident" shall mean a person residing in a country who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in that country.
「永久居民」指居於某國家並且身為該國公民或根據適用法律獲許在該國永久性居留及工作的人士。

2. Domestic partner shall mean civil partner, or the person (of same or different sex), with whom the Subscriber lives with in a continuous, committed, exclusive relationship during which period neither the Subscriber nor that person was or is married to or partnered with any other person.
同居伴侶指民事結合的伴侶或與投保人共同生活，並保持持續，忠誠以及唯一的關係的人士 (不論同性或異性)，而期間投保人或該人士並沒有和其他人士成婚或結合。

VII. Addition of Dependant(s) 增加受供養人 (Health Declaration and Questionnaire must be completed 必須填寫健康聲明及問卷)

Your Spouse/Domestic Partner 你的配偶/同居伴侶[3] (must be aged 18 to 59. 年齡必須介乎18至59歲。)

Spouse's/Domestic Partner's [3] Name (same as HKID Card/Passport) 配偶/同居伴侶[3]的姓名 (與香港身份證/護照相同)

Surname
姓

Given Name
名

HKID Card No. / Passport No.*** ☐ M 男 ☐ F 女 Date of Birth 出生日期 DD 日 MM 月 YYYY 年
香港身份證號碼 / 護照號碼

Place of Residence#
居住地

US Permanent Resident[1, 2] ☐ Yes是 ☐ No否
美國永久居民

*** Please submit the copy of HKID Card / Passport to Bupa. 請連同香港身份證 / 護照副本交回保柏。

Your Child 你的子女 (unmarried children must be aged below 18 years or below 23 years if in full-time education. 未婚子女年齡必須為18歲以下或23歲以下之全日制學生。)

Child's Name (same as HKID Card/Birth Certificate) 子女姓名 (與香港身份證/出生證明書相同)

Surname
姓

Given Name
名

HKID Card No. / Birth Certificate No.*** ☐ M 男 ☐ F 女 Date of Birth 出生日期 DD 日 MM 月 YYYY 年
香港身份證號碼 / 出生證明書號碼

Place of Residence#
居住地

US Permanent Resident[1, 2] ☐ Yes是 ☐ No否
美國永久居民

*** Please submit the copy of HKID Card / birth certificate to Bupa. 請連同香港身份證 / 出生證明書副本交回保柏。

Your Child 你的子女 (unmarried children must be aged below 18 years or below 23 years if in full-time education. 未婚子女年齡必須為18歲以下或23歲以下之全日制學生。)

Child's Name (same as HKID Card/Birth Certificate) 子女姓名 (與香港身份證/出生證明書相同)

Surname
姓

Given Name
名

HKID Card No. / Birth Certificate No.*** ☐ M 男 ☐ F 女 Date of Birth 出生日期 DD 日 MM 月 YYYY 年
香港身份證號碼 / 出生證明書號碼

Place of Residence#
居住地

US Permanent Resident[1, 2] ☐ Yes是 ☐ No否
美國永久居民

*** Please submit the copy of HKID Card / birth certificate to Bupa. 請連同香港身份證 / 出生證明書副本交回保柏。

Unless otherwise specified by Member in writing, Inter Partner Assistance Hong Kong Limited will consider Hong Kong as the Place of Residence of all Members and repatriate relevant Members to Hong Kong when Medically Necessary. 除非會員特別以書面通知，國際救援（亞洲）有限公司將設定香港為所有會員之居住地，於有醫療需要時送返有關會員回香港。

Notes 注意:

1. "Permanent resident" shall mean a person residing in a country who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in that country.
「永久居民」指居於某國家並且身為該國公民或根據適用法律獲許在該國永久性居留及工作的人士。
2. Application for addition of member is not allowed if the proposed Member's Place of Residence is USA. This restriction is applicable if the member coverage effective date is on or after 1 Jan 2017.
如準會員居住地是美國，增加會員的申請將不獲接納。此限制只適用於會員的保障生效日期為2017年1月1日或以後。
3. Domestic partner shall mean civil partner, or the person (of same or different sex), with whom the Subscriber lives with in a continuous, committed, exclusive relationship during which period neither the Subscriber nor that person was or is married to or partnered with any other person.
同居伴侶指民事結合的伴侶或與投保人共同生活，並保持持續，忠誠以及唯一的關係的人士 (不論同性或異性)，而期間投保人或該人士並沒有和其他人士成婚或結合。

VIII. Other Changes 其他更改 (Please specify the details 請詳細列明)

Health Declaration and Questionnaire 健康聲明及問卷

Important Note 重要事項

During the insurance application process, it's important that you act with utmost good faith and disclose all material facts related to the proposed Member / Insured Person to Bupa. If you are uncertain as to whether a fact is material, then it should be disclosed. If you fail to disclose or misrepresent a material fact and this causes Bupa to accept the risk, this will raise questions about your entitlement to insurance benefits. Consequences may include termination of your policy or reduction of entitlement to claims payments in all or part.

在保險申請過程中，務必以至高誠信向保柏披露有關準會員/受保人所有重要事實。如果你不確定某個事實是否重要，則應將其披露。如你未能披露或錯誤陳述重要事實，而導致保柏承擔有關風險，這將影響你所享有的保障。其結果可能包括終止你的保單；或減少全部或部分你所獲得的賠償。

(i) This questionnaire collects health-related information solely for the purpose of underwriting which is a process for Bupa to evaluate the health risk of the applicants and decide the application results. The underwriting process that Bupa adopts should be fair and reasonable, and Bupa should explain the application results if requested by the customers.
此問卷收集與健康相關的資料僅作為核保之用途，而核保是保柏評估申請人之健康風險及決定申請結果的程序。保柏採用的核保程序應為公平合理，並會因應客戶要求解釋申請結果。

(ii) As the applicant, you are required to provide Bupa with complete and accurate information requested in this questionnaire to the best of your knowledge and belief. Based on the information provided, Bupa may have follow-up questions or enquiries that require you to provide further information for underwriting purpose.
作為申請人，你需要盡其所知所信，按本問卷中要求向保柏提供完整及準確的資料。保柏根據你提供的資料，可能會提出跟進問題或查詢而需要你進一步提供資料以作核保之用。

(iii) If there are any changes to or updates of the information provided in this questionnaire after the time of submission of this application and before you receive the Policy, you are required to notify Bupa in a timely manner. 若你在提交本申請表後至你收到保單前的期間就本問卷中提供的資料有任何改變或更新，你需要及早通知保柏。

(iv) Even after an insurance policy has been issued upon successful application, the insurance coverage for the proposed Member / Insured Person may be affected or the policy may be terminated, voided or rescinded, or claims may be repudiated by Bupa, if you have not provided Bupa with complete and accurate information to the best of your knowledge and belief according to (ii), or if you have not notified Bupa on any changes to or updates of the information in time according to (iii).
即使已成功投保並獲簽發保單，若你未按(ii)所述盡其所知所信向保柏提供完整及準確的資料，或未按(iii)所述就資料的任何改變或更新而及早通知保柏，準會員/受保人的保險保障可能會受到影響，保柏亦可能因此終止、作廢或撤銷有關保單，或拒絕賠償。

Guidance Note in completing the questionnaire 填寫問卷指引

If your answer to any of the questions in Section A below is "Yes", please proceed to answer the relevant follow-up questions in Health Questionnaire - Section B.
若以下甲部任何一項問題之答案為「是」者，請於健康問卷 - 乙部回答相關的跟進問題。

You do not need to disclose information regarding the medical conditions or treatments below –
Cold / flu / sore throat, gastroenteritis / food poisoning (fully recovered), indigestions (no investigations required), acne, muscle sprained (fully recovered), thrush, routine scan / blood test for pregnancy (normal result), routine cervical smear (normal result), routine health check (normal result), preventive vaccination, Hormonal Replacement Therapy (menopause), infertility treatment or uncomplicated pregnancy, myopia / hyperopia / astigmatism / presbyopia.

你無需披露以下健康狀況或治療 -
傷風/感冒/喉嚨痛、腸胃炎/食物中毒 (已痊癒)、消化不良 (無需檢查)、痤瘡、肌肉扭傷 (已痊癒)、鵝口瘡、常規產前掃描 / 血液檢驗 (檢驗結果正常)、常規子宮頸細胞塗片檢驗 (檢驗結果正常)、常規健康檢查 (檢查結果正常)、預防疫苗、荷爾蒙補充治療 (更年期)、不育治療或胎兒生長情況正常的懷孕、近視 / 遠視 / 散光 / 老花。

You are required to provide Bupa with complete and accurate information requested in this questionnaire to the best of your knowledge and belief, including any and all medical information which are known or ought to be known by Bupa in any previous insurance application and medical claims.
你需要盡其所知所信，按本問卷中要求向保柏提供完整及準確的資料，包括在之前的任何保險申請和醫療索償中保柏已知或應該知道的任何及所有醫療資料。

Health Questionnaire – Section A 健康問卷 – 甲部

	Name of applicant 申請人姓名	Name of proposed Member/ Insured Person 準會員/受保人姓名	Name of proposed Member/ Insured Person 準會員/受保人姓名	Name of proposed Member/ Insured Person 準會員/受保人姓名
Height 身高#	cm 厘米 / feet 呎 inches 吋	cm 厘米 / feet 呎 inches 吋	cm 厘米 / feet 呎 inches 吋	cm 厘米 / feet 呎 inches 吋
Weight 體重#	kg 公斤 / pounds(lbs) 磅	kg 公斤 / pounds(lbs) 磅	kg 公斤 / pounds(lbs) 磅	kg 公斤 / pounds(lbs) 磅
Do you (or proposed Member/Insured Person) smoke# or have you (or proposed Member/Insured Person) smoked# in the last one year? 你(或準會員/受保人)有沒有吸煙#或在過去一年內曾否吸煙#?	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
1. In the last 3 years, have you (or proposed Member/ Insured Person) ever had or been advised to have any regular or ongoing (such as monthly, every 2 months, half-yearly, annually) follow-up consultations or medical care with a healthcare professional (such as specialist doctor, physiotherapist, psychiatrist) for any disease or other medical condition? 在過去三年內，你(或準會員/受保人)是否曾經或被建議定期或持續(例如每月、每兩個月、每半年、每年)為任何疾病或健康狀況接受專業醫護人員 (例如專科醫生、物理治療師、精神科醫生)的跟進診治或醫療護理？	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否

Not required for proposed Member/Insured Person below 18 years old. For the purpose of this question, the meaning of "smoking" includes but is not limited to cigarettes, cigars, tobacco pipes, chewing tobacco and the use of nicotine replacement products (such as e-cigarettes).
18歲以下之準會員/受保人無需填寫。「吸煙」在此問題的含義包括但不限於香煙、雪茄、煙斗、嚼煙及使用尼古丁補充劑產品(例如電子煙)。

(P.T.O. 請轉下一頁)

Health Declaration and Questionnaire (Cont.) 健康聲明及問卷 (續)

	Name of applicant 申請人姓名	Name of proposed Member/ Insured Person 準會員/受保人姓名	Name of proposed Member/ Insured Person 準會員/受保人姓名	Name of proposed Member/ Insured Person 準會員/受保人姓名
2. In the last 3 years, have you (or proposed Member/ Insured Person) ever had or been advised to undergo investigations (such as blood or urine test, ECG, X-ray, ultrasound, CT scan, MRI, PET scan, HIV test, Hepatitis B test, Hepatitis C test)? 在過去三年內，你(或準會員/受保人)是否曾接受或曾被建議接受檢查(例如驗血、驗尿、心電圖、X光、超聲波、電腦掃描、磁力共振、正電子掃描、愛滋病測試、乙型肝炎測試、丙型肝炎測試) ?	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
If the answer is "Yes", do your (or proposed Member/ Insured Person) investigation result(s) include the followings? 如果答案屬「是」，你(或準會員/受保人)的檢查結果是否包括下列情況？				
(a) Abnormal test result is advised 檢驗結果異常	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(b) You (or proposed Member/Insured Person) are still awaiting test / test result 你(或準會員/受保人)正等候檢驗或檢驗結果	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(c) Medical advice has been sought or treatment is required for the test result (such as liver cyst / brain cyst / joint degeneration or calcification / lung or breast or thyroid calcification discovered on imaging test, that may not require immediate treatment) 就檢驗結果已尋求醫療意見或需要接受治療(例如一些未必需要即時治療的情況如肝囊腫/ 腦囊腫/ 關節退化或鈣化/ 於成像檢測中發現肺部或乳房或甲狀腺出現鈣化)	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
3. In the last 5 years, have you (or proposed Member/ Insured Person) been advised by your doctor to take any medications (such as to be taken daily / once per week / as needed as directed by doctor) for a continuous period of more than 1 month? 在過去五年內，你(或準會員/受保人) 是否曾被醫生建議定期(例如按醫生指示每日/ 每週一次/ 有需要時) 服用為期超過一個月的處方藥物？	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
4. In the last 5 years, have you (or proposed Member/ Insured Person) been admitted into a hospital? 在過去五年內，你(或準會員/受保人) 是否曾入住醫院？	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
5. In the last 5 years, have you (or proposed Member/ Insured Person) undergone a surgical procedure (including endoscopy or biopsy) without being admitted into a hospital? 在過去五年內，你(或準會員/受保人) 是否曾在非住院情況下接受外科程序 (包括內窺鏡檢查或活組織化驗) ?	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
6. Apart from anything you (or proposed Member/ Insured Person) have already disclosed in Questions 1 -5, do you (or proposed Member/Insured Person) have any of the following conditions? 除了你 (或準會員/受保人) 在第1至5項問題中已披露的資料外，你 (或準會員/受保人) 是否有下列情況?				
(a) Unintentional weight loss by more than 5 kg (11 lbs) over past 1 year 在過去一年內，體重無故地減少了5公斤 (11磅)以上	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(b) Abnormal bleeding (such as vaginal bleeding, rectal bleeding, nose bleeding or coughing up of blood) for at least one month 不正常出血 (例如陰道出血、便血、流鼻血或咳血)至少一個月	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(c) Other medical conditions or other sign and symptom (such as lump, headache, persistent coughing, chest pain or epigastric pain) that you (or proposed Member/Insured Person) are seeking or intend to seek medical advice 其他健康狀況或病徵及症狀(例如腫塊、頭痛、持續 咳嗽、胸痛或上腹痛) 而正在或打算尋求醫療意見	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(d) In the last 1 year, you (or proposed Member/ Insured Person) had or have been required to have follow-up consultation with a healthcare professional (such as specialist doctor, physiotherapist, psychiatrist) for any medical condition or sign and symptom 在過去一年內，你(或準會員/受保人)有任何健康狀況或病徵及症狀曾經接受或需要接受專業醫護人員(例如專科醫生、物理治療師、精神科醫生)的跟進診治	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否

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Health Declaration and Questionnaire (Cont.) 健康聲明及問卷 (續)

	Name of applicant 申請人姓名	Name of proposed Member/ Insured Person 準會員/受保人姓名	Name of proposed Member/ Insured Person 準會員/受保人姓名	Name of proposed Member/ Insured Person 準會員/受保人姓名
7. Have you (or proposed Member/Insured Person) ever been diagnosed with any of the following diseases or medical conditions? 你(或準會員/受保人) 是否曾被確診下列疾病或健康狀況？				
(a) Cancer or carcinoma in situ 癌症或原位癌	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(b) Brain tumor 腦部腫瘤	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(c) Heart disease 心臟疾病	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(d) Stroke (including transient ischemic attack (TIA)) 中風 (包括短暫性腦缺血，俗稱「小中風」)	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(e) Hypertension 高血壓	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(f) Diabetes mellitus or impaired glucose tolerance 糖尿病或葡萄糖耐量異常	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(g) Prolapsed intervertebral disc or degenerative spine conditions 椎間盤突出或脊椎退化性疾病	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(h) Diseases or medical conditions requiring a medical device or prosthesis to be implanted within the body 需要植入醫療儀器或義肢的疾病或健康狀況	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(i) Mental health conditions (such as depression, anxiety, schizophrenia, eating disorders, or bipolar disorders) 精神健康狀況(例如抑鬱、焦慮、精神分裂、飲食失調或躁狂抑鬱症)	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(j) Multiple sclerosis 多發性硬化症	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
(k) Congenital conditions (medical, physical or mental abnormalities that existed at the time of or before birth) 先天性疾病 (指於出生時或之前已存在的醫學、生理或精神上的異常)	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否
For proposed insured children aged 6 or below only 適用於六歲或以下之準受保兒童				
8. Was the proposed insured child born before 37th week of pregnancy? 準受保兒童是否於懷孕第37週前出生？	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否	☐ Yes是 ☐ No否

Health Questionnaire – Section B 健康問卷 – 乙部

If you answer Yes to any of the questions in Section A above, please provide additional information as applicable below.
如果你就以上甲部任何一項問題之答案為「是」者，請在以下適用的問題提供更多資料。

Name of applicant / proposed Member / Insured Person 申請人 / 準會員 / 受保人姓名	Question No. 題號 _____ Medical condition 病症	Question No. 題號 _____ Medical condition 病症	Question No. 題號 _____ Medical condition 病症
1. Disease / medical condition / sign and symptom 疾病/健康狀況/病徵及症狀			
2. Date of first occurrence of sign and symptom 首次出現病徵及症狀的日期			
3a. Treatment / investigations / tests / scans that have been performed 已進行的治療/檢查/測試/掃描 3b. Date of such treatment / investigation / tests / scan 有關治療/檢查/測試/掃描日期			
4. Present condition (such as whether fully recovered, follow up action / medication / next follow up date) 現況 (例如是否已完全康復、有否跟進/服用跟進藥物/下次覆診日期)			
5. Date of last follow-up medical consultation / treatment 最後覆診/治療日期			

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Health Declaration and Questionnaire (Cont.) 健康聲明及問卷 (續)

Name of proposed Member / Insured Person 準會員 / 受保人姓名	Question No. 題號 _____ Medical condition 病症	Question No. 題號 _____ Medical condition 病症	Question No. 題號 _____ Medical condition 病症
1. Disease / medical condition / sign and symptom 疾病 / 健康狀況 / 病徵及症狀			
2. Date of first occurrence of sign and symptom 首次出現病徵及症狀的日期			
3a. Treatment / investigations / tests / scans that have been performed 已進行的治療 / 檢查 / 測試 / 掃描 3b. Date of such treatment / investigation / tests / scan 有關治療 / 檢查 / 測試 / 掃描日期			
4. Present condition (such as whether fully recovered, follow up action / medication / next follow up date) 現況 (例如是否已完全康復、有否跟進 / 服用跟進藥物 / 下次覆診日期)			
5. Date of last follow-up medical consultation / treatment 最後覆診 / 治療日期			

Name of proposed Member / Insured Person 準會員 / 受保人姓名	Question No. 題號 _____ Medical condition 病症	Question No. 題號 _____ Medical condition 病症	Question No. 題號 _____ Medical condition 病症
1. Disease / medical condition / sign and symptom 疾病 / 健康狀況 / 病徵及症狀			
2. Date of first occurrence of sign and symptom 首次出現病徵及症狀的日期			
3a. Treatment / investigations / tests / scans that have been performed 已進行的治療 / 檢查 / 測試 / 掃描 3b. Date of such treatment / investigation / tests / scan 有關治療 / 檢查 / 測試 / 掃描日期			
4. Present condition (such as whether fully recovered, follow up action / medication / next follow up date) 現況 (例如是否已完全康復、有否跟進 / 服用跟進藥物 / 下次覆診日期)			
5. Date of last follow-up medical consultation / treatment 最後覆診 / 治療日期			

If you have any medical reports or reports of investigations, please enclose them and put a tick in the box.
如你有任何醫療報告或醫療檢查報告，請隨此表格同時附上，並請於空格加「✓」號。

☐ With attachment
另有附頁

Declaration and Authorisation 聲明及授權

I / We acknowledge that Benefit is not payable under Bupa Crystal Health Insurance Scheme ("Scheme") for any costs of treatment arising from any existing illnesses, injuries or other conditions presented before the Coverage Commencement Date unless complete current details are fully disclosed by me / us in this Application and accepted by Bupa (Asia) Limited ("Bupa"). I / We declare that, to the best of my / our knowledge and belief, the statements contained in this Application are true and complete. I / We acknowledge that Bupa reserves the right to ask for submission of more details of health status or medical reports of me / us and the dependant(s) as listed in this Application at my / our own cost. I / We also authorise any medical practitioner, hospital, clinic, by whom or where I / we have been observed or treated or any insurance company or organisation that has any records or health information concerning me / us 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 / We have read and agreed to be bound by the terms and conditions of the Contract of this Scheme and I / we agree that this Health Declaration and Questionnaire and the answers given in this Application shall be the basis of the Contract between me / us and Bupa.

I / We acknowledge that the Contract shall be renewed automatically on a yearly basis unless it is not renewed by giving notice to Bupa or according to the terms of the Contract. I / We further authorise Bupa to deduct the subscription payments from my / our designated bank account / credit card (where applicable) upon renewal. If I / we want to cancel the Contract in future, I / we will need to inform Bupa in writing at least 10 days before the Contract Anniversary Date.

I / We acknowledge that Bupa has discretion to appoint Registered Medical Practitioners, Registered Chinese Medicine Practitioners, Hospitals, Physiotherapists, Chiropractors, Qualified Nurses, cancer centres, day case centres, diabetic centres, dental centres, wellness centres, imaging and laboratory centres and other service providers to provide CrystalNet Benefit and to do all things and acts incidental to such appointment for the Member(s). I / We acknowledge and agree that such appointment shall be made on such terms and conditions as Bupa shall think fit at its absolute discretion. Bupa shall not be liable for any claim whatsoever which may be made against CrystalNet Service Providers by the Member(s).

I / We acknowledge that Bupa may terminate the cover of relevant Members with immediate effect if the law of the country in which any of the Members is located, or the Member's Place of residence or nationality, including but not limited to USA and Japan, or any other law which applies to Bupa or the Contract, prohibits the provision of healthcare cover by Bupa to local nationals, residents or citizens. I / We further declare that I / we are not US permanent residents. I / We understand that I / we am/are obliged to immediately notify Bupa in writing if any of the Members become a permanent resident of USA during the Contract Year. For the above purpose, 'permanent resident' shall mean a person residing in a country who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in that country.

本人 / 吾等確認根據「保柏晶彩寶」醫療保障計劃（「計劃」）規定，凡在保障開始日前因已患之疾病、損傷或其他病況而引致之醫療費用，一律不予賠償，除非本人 / 吾等在本申請表內已詳細列出並獲得保柏（亞洲）有限公司（「保柏」）接納。本人 / 吾等聲明，就本人 / 吾等所知所信，本申請表上填報之一切資料，均屬實完整。本人 / 吾等確認保柏有權要求提供更多有關本人 / 吾等及於本申請表內所列出之受供養人之健康狀況及醫療報告，一切費用由本人 / 吾等支付。本人 / 吾等並且授權任何為本人 / 吾等觀察或治療的醫生、醫院、診所，或持有本人 / 吾等健康或任何資料之保險公司或機構將本人 / 吾等之全部資料（包括病歷）呈交予保柏，本授權書之副本與正本具同等效力。本人 / 吾等已細讀並同意遵守此計劃之各條款及細則，並同意本申請表內之健康聲明及問卷及回答作為本人 / 吾等與保柏之間所訂合約之根據。

本人 / 吾等明白除非收到本人 / 吾等給予保柏的通知不再續保或因根據合約條款規定不獲續保，否則合約將會每年自動續保。本人 / 吾等並授權保柏在續保時於本人 / 吾等指定的銀行賬戶或信用卡(如適用)扣取保費。如本人 / 吾等將來想取消合約，須於合約週年日10天前以書面通知保柏。

本人 / 吾等確認保柏可酌情委任註冊西醫、註冊中醫、醫院、物理治療師、脊醫、合資格護士、癌症中心、日症中心、糖尿病中心、牙科診所、保健中心、影像及化驗中心及其他服務供應商以提供晶彩寶網絡保障及有關該委任所需之服務予會員。本人 / 吾等確認並同意有關此委任之條款及細則決定乃基於保柏以其認為合適的情況下而作出。就會員向有關晶彩寶網絡服務供應商所作出之申索，保柏一概不會負責。

本人 / 吾等確認如會員的所在國家或會員的居住地或國籍所屬國家的法律(包括但不限於美國和日本)或任何其他對保柏或本合約適用的法律禁止保柏向當地國民、居民或公民提供醫療保障，保柏可終止相關會員的保障並立即生效。本人 / 吾等此外聲明本人 / 吾等並非美國永久居民。本人 / 吾等明白如任何會員如於合約年度期間成為美國永久居民，本人 / 吾等有責任立即以書面通知保柏。「永久居民」指居於某國家並且身為該國公民或根據適用法律獲許在該國永久性居留及工作的人士。

Applicable to Application through authorised insurance broker 適用於透過獲授權保險經紀進行之申請

I / We understand, acknowledge and agree that, as a result of me / us purchasing and taking up the policy to be issued by Bupa, Bupa will pay the authorised insurance broker commission during the continuance of the policy including renewals, for arranging the said policy. I / We further understand that the above agreement is necessary for Bupa to proceed with the Application.

本人 / 吾等明白、確知及同意，保柏會就本人 / 吾等購買及接受其簽發的保單，於保單有效期內（包括續保期）向負責安排有關保單的獲授權保險經紀支付佣金。本人 / 吾等亦明白保柏必須取得本人 / 吾等以上的同意，才可以處理其保險申請。

I, as the Subscriber, understand that I declare and sign on behalf of the dependant(s) listed in this Application under this Scheme who is / are under the age of 18.

本人作為投保人，明白本人代表此計劃申請表內列出之18歲以下受供養人作出聲明及簽署。

I understand that no cover will be payable under the Contract unless this Application is approved and subscription is received in full by Bupa (Asia) Limited ("Bupa").
本人明白此申請表被保柏（亞洲）有限公司（「保柏」）批核及保費全額收妥後，保柏方按合約支付保障。

Subscriber' s Signature 投保人簽署 X (Full Name 姓名)	Signed in Hong Kong on 於香港簽署之日期 DD 日 MM 月 YYYY 年	Member's Signature (Aged 18 or above) 年滿18歲或以上之會員簽署 X (Full Name 姓名)	Signed in Hong Kong on 於香港簽署之日期 DD 日 MM 月 YYYY 年
Member's Signature (Aged 18 or above) 年滿18歲或以上之會員簽署 X (Full Name 姓名)	Signed in Hong Kong on 於香港簽署之日期 DD 日 MM 月 YYYY 年	Member's Signature (Aged 18 or above) 年滿18歲或以上之會員簽署 X (Full Name 姓名)	Signed in Hong Kong on 於香港簽署之日期 DD 日 MM 月 YYYY 年

Agent's / Broker's / Telesales' Name (if applicable and must be completed by Subscriber) 代理人 / 經紀 / 營業代表姓名（如適用及必須由投保人填寫）	Agent's / Broker's / Telesales' Code 代理人 / 經紀 / 營業代表編號
	Agent's / Broker's / Telesales' Contact Tel. No. 代理人 / 經紀 / 營業代表聯絡電話號碼

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Bupa Crystal Health Insurance Scheme
Credit Card Authorisation Form
保柏晶彩寶醫療保障計劃信用卡付款授權書

Membership No. (16 digits)
會員號碼 (16位數字)

Subscriber's Name 投保人姓名
Surname
姓

Given Name
名

If you choose to return this form by mail, please photocopy the 'Personal Information Collection Statement' on the back of this page for your reference. This information can also be found on our website.
若你選擇郵寄此表格，請複印背頁的「個人資料收集聲明」以作將來參考之用。你亦可於我們的網頁隨時瀏覽有關資料。

If credit card payment is chosen as the payment method, please complete this form, sign where marked "X" and return this form to Bupa by mail or by fax. If you have faxed this form to Bupa, please do not return it to us by mail again.
若選擇以信用卡付款，請填妥此表格及簽署於「X」位置，並交回保柏。若你已傳真此表格給我們，請無須寄回此表格。

☐ Visa ☐ MasterCard

Cardholder's Name 持卡人姓名

HKID Card No. 香港身份證號碼

Credit Card Account No. 信用卡戶口號碼

Credit Card Expiry Date 信用卡到期日 MM 月 YY 年

I acknowledge that the Contract shall be renewed automatically on a yearly basis unless it is not renewed by giving notice to Bupa or according to the terms of the Contract. I hereby authorise and direct Bupa (Asia) Limited to automatically debit the subscription and levy due from my credit card account on a yearly basis until further notice.
本人明白除非收到本人給予保柏的通知不再續保或因根據合約條款規定，否則合約將會每年自動續保。本人茲授權保柏(亞洲)有限公司自動從本人的信用卡戶口每年支付應繳保費及保費徵費金額，直至另行通知。

If the Cardholder is not the applicant / Subscriber / Member, please fill in the following information.
若信用卡持有人並非申請人 / 投保人 / 會員，請填寫以下資料。

Relationship with the applicant / Subscriber / Member* 與申請人 / 投保人 / 會員*關係
(Applicable to spouse, parents or children only 只適用於配偶、父母或子女)

☐ I hereby confirm to pay the subscription and levy due of Bupa Crystal Health Insurance Scheme for the applicant / Subscriber as listed in this form.
本人同意及承擔列於此表格上的申請人 / 投保人之全數應繳之「保柏晶彩寶」醫療保障計劃保費及保費徵費金額。

Cardholder's Signature 持卡人簽署

X

Contact Phone No. 聯絡電話號碼

Date 日期 DD 日 MM 月 YYYY 年

* Please delete if inappropriate 請刪除不適用者

Bupa (Asia) Limited 保柏 (亞洲) 有限公司
Address: 6/F, Tower 2, The Quayside, 77 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong
地址: 香港九龍觀塘海濱道77號海濱匯第2座6樓
Telephone 電話: (852) 2517 5333 Facsimile 傳真: (852) 2548 1848 Website 網址: www.bupa.com.hk
Bupa Hong Kong

OP/BCNRV/0922

Personal Information Collection Statement 個人資料收集聲明

Bupa (Asia) Limited (the "Company")
Personal Information Collection Statement ("Statement") relating to the Personal Data (Privacy) Ordinance (the "Ordinance")

In compliance with the Ordinance, the Company would like to inform you of the following:

1. From time to time, it is necessary for you, or other members covered under your policy (each a "**Member**"), to supply the Company with certain personal information (including where relevant, credit information and claims history) relating to you, or the Member, when you apply for insurance or financial products and services from the Company, or when you apply to make changes to your policy, or when you renew a policy.
2. **Failure to supply personal information requested by the Company may result in the Company being unable to process your Application and/or provide products, services and other related services to you, or the Member.**
3. During the course of your relationship with the Company, further personal information relating to you, or the Member, may also be collected in the ordinary course of our business, for example, when you lodge insurance claims with the Company in relation to yourself or the Member.
4. **The Company may collect, use or disclose personal information relating to you, or the Member, for the following purposes:**
   a. processing, assessing and determining any Applications for insurance products and services;
   b. offering and providing products and services to you, or the Member, and processing requests made by you, or the Member, from time to time, including but not limited to requests for addition, alteration, deletion, maintenance, management and operation of insurance benefits or insured Members;
   c. any purposes in connection with any claims made by or against or otherwise involving you, or the Member, in respect of any products and/or services provided by the Company including, without limitation, making, defending, analysing, investigating, detecting and preventing fraud (whether or not relating to the policy issued in respect of any application or claim) processing, assessing, determining, settling or responding to such claims;
   d. performing any functions and activities related to the products and/or services provided by the Company including, without limitation, audit, reporting, market research, general servicing, maintenance of online and other services, identity verification, data matching, research and statistical analysis, and reinsurance arrangements;
   e. provision and design of products and services of the Company;
   f. exercising the Company's rights in connection with provision of insurance products and services to you, or the Member, from time to time, for example, to determine any amount of indebtedness from you, and collecting and recovering owing from you or any person who has provided any security or undertaking for your liabilities;
   g. communication with you or the Member (or with you on behalf of the Member) in relation to any of the purposes set out in this Statement;
   h. enabling an actual or proposed assignee, transferee, participant or sub-participant of all or a substantial part of the Company's rights or business to evaluate the transaction intended to be the subject of the assignment, transfer, participation or sub-participation; and
   i. making disclosure to satisfy the requirements of any laws, rules and regulations, codes of practice, guidance notes or guidelines binding on the Company.
5. **Personal information collected or held by the Company relating to you, or the Member, will be kept confidential but the Company may transfer such personal information inside or outside the Hong Kong Special Administrative Region, for the purposes specified in paragraph (4) and (6) to the following classes of transferees:**
   a. the Company's group companies ("Group Company");
   b. any insurance adjusters, agents and brokers;
   c. any re-insurance companies authorised by the Company;
   d. employers (for members of corporate policy only);
   e. healthcare professionals and hospitals;
   f. any agent, contractor or third party service providers who provide administrative, telecommunications, computer, payment, data processing or storage, printing, research or other services to the Company in connection with the operation of business, (including without limitation insurers; banks; lawyers; accountants; claims investigators; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisations or other persons named in this paragraph); organisations that consolidate claims and underwriting information for the insurance industry; the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information; debt collection agencies; data processing companies; research agencies and professional advisors);
   g. any actual or proposed assignee, transferee, participant or sub-participant of all or a substantial part of the Company's rights or business; and
   h. any person to whom the Company is under an obligation to make disclosure under the requirements of any law, rules, regulations, codes of practice or guidelines binding on the Company including, without limitation, any applicable regulators, governmental bodies, industry recognised bodies, credit reference agencies, the Courts, and where otherwise required by law.
6. Only with your consent or with your indication of no objection, the Company may use your personal information collected from time to time, including name, contact details, gender, health and family status, to provide you with marketing communications (including by email, SMS or instant messenger) relating to the following products and services:
   a. insurance, medical, healthcare, wellness, personal development, beauty, lifestyle, entertainment, financial, and related services and products;
   b. rewards, benefits, discounts, member activities, loyalty or privileges programmes and related services and products; and
   c. donations and contributions for charitable and/or non-profit making purposes.

   The Company will not disclose personal information relating to you, to third parties for them to use for their own direct marketing purposes without your consent.

   For the avoidance of doubt, whether or not you consent to receive marketing communications of the type described in this paragraph 6, the Company may still communicate with you regarding the administration, features and renewal of your insurance policy.
7. **Under and in accordance with the terms of the Ordinance, you have the following rights:**
   a. to check whether the Company holds personal information relating to you or the Member and to access such personal information;
   b. to require the Company to correct any personal information relating to you or the Member which is inaccurate;
   c. to ascertain our policies and practices in relation to personal data and to be informed of the kind of personal data held by the Company, and
   d. to request the Company to cease using your personal information for direct marketing purposes.

   Requests can be made in writing to the Company's Data Protection Officer at the following address:

   Data Protection Officer
   6/F, Tower 2, The Quayside, 77 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong
8. In accordance with the terms of the Ordinance, the Company has the right to charge a reasonable fee for the processing of any personal information access or correction request.
9. For any enquiries about this Statement, please do not hesitate to contact our Customer Care helpdesk at 2517 5333.
10. Nothing in this Statement shall limit the rights of customers under the Ordinance.
11. In case of discrepancies between the English and Chinese versions of this Statement, the English version shall prevail.

保柏（亞洲）有限公司（「本公司」）
有關個人資料（私隱）條例（「條例」）之個人資料收集聲明（「本聲明」）

遵照條例，本公司特意通知閣下以下事項：

1. 在閣下或受保於閣下保單的其他會員(每位「會員」)向本公司申請保險或金融產品及服務，或當閣下更改保單或續保時，必須不時向本公司提供閣下或會員的個人資料(包括信用資料和以往申索紀錄，如適用)。
2. **如閣下未能提供本公司所要求的個人資料，本公司可能無法處理閣下之申請及/或向閣下或會員提供保險產品、服務或其他相關服務。**
3. 本公司亦可能會在日常業務運作的過程中向閣下或會員收集更多個人資料，例如當閣下為本人或代會員向本公司提出保險索償時。
4. **本公司可能會收集、使用或披露閣下或會員的個人資料作下列用途：**
   a. 處理、評估、決定任何保險產品及服務之申請；
   b. 為閣下或會員提供保險產品及服務及處理閣下或會員不時提出的要求，包括但不限於要求增加、更改、刪除、維持及管理保障項目或受保會員；
   c. 任何有關閣下或會員對本公司所提供之保險產品及服務提出之索償，包括但不限於賠償、辯護、分析、調查、偵測及防止欺詐行為(無論是否與就此申請而簽發之保單及相關的任何申請或索償)、處理、評估、決定、解決或回應該等索償；
   d. 執行與本公司所提供的保險產品及/或服務相關的功能及活動，包括但不限於審計、報告、市場調查、一般服務和維持網上及其他服務、核實身份、資料配對、研究及統計分析及再保險之安排；
   e. 提供及設計本公司的產品及服務；
   f. 行使本公司向閣下或會員提供保險和服務時有關的權利，例如釐定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；
   g. 就任何本聲明中所述的用途與閣下或會員(或與代表會員的閣下)聯絡；
   h. 允許本公司全部或部份的權益或業務的實際或建議承讓人、受讓人、參與人或次參與人，就涉及的轉讓、出讓、參與或次參與的交易進行評估；及
   i. 為遵守任何法例之要求，或根據監管或其他機關所發出對本公司具有約束力或要求其遵守的規則、規例、實務守則、須知或指引，而作出披露。
5. **有關閣下或會員被本公司收集或持有的個人資料將會保密，但本公司可能會向以下不論在香港特別行政區境內或境外之資料承讓人轉移該等個人資料作第(4)及第(6)段列出的用途：**
   a. 本公司的集團公司(「集團公司」)；
   b. 任何由本公司授權的保險理算人、代理及經紀；
   c. 任何由本公司授權的再保險公司；
   d. 僱主(只適用於團體保單之會員)；
   e. 醫護專業人員及醫院；
   f. 任何代理人、承包商、或向本公司提供行政、電訊、電腦、付款、資料處理或儲存、印刷、研究或其他向本公司提供服務的第三方服務供應商(包括但不限於保險公司、銀行、理財顧問、律師、會計師、理賠調查員、防欺詐組織、其他保險公司(無論是直接地，或是通過防欺詐組織或本段中指名的其他人士)、為保險業界整合申索及承保資料之組織、警察、供保險業界用作分析及核對所提供的資料與既有資料的資料庫及登記冊(及其運營者)、收數公司、資料處理公司、研究服務機構及專業顧問)；
   g. 本公司的任何全部或部份的權益或業務的實際或建議承讓人、受讓人、參與人或次參與人；及
   h. 為遵守任何法例之要求，或根據監管或其他機關所發出對本公司具有約束力或要求其遵守的規則、規例、實務守則或指引，而作出披露，包括但不限於適用監管機構、政府機構、相關行業認可機構、信貸資料服務機構或法院，及在其他情況下，法律規定本公司必向其披露的人士或機構。
6. 本公司只會在得到閣下同意或表示不反對的情況下，使用閣下的個人資料如姓名、聯絡方法、性別、健康及家庭狀況，向閣下提供有關以下產品和服務的市場推廣資訊(包括以電郵、手機短訊或即時通訊)：
   a. 保險、醫療、康健、健康、個人發展、美容、生活消閒、娛樂、財務及其相關的服務及產品；
   b. 獎賞、權益、折扣、會員活動、會員忠誠或優惠計劃及其相關的服務及產品；及
   c. 為慈善及/或非牟利用途的捐款及捐贈。

   本公司將不會在沒有閣下的同意及許可下將閣下之個人資料向第三方透露，用作他們的市場推廣用途。

   為避免有疑慮，不論閣下是否同意接收以上第六點所述的市場推廣資訊類別，本公司仍然可能就閣下保單相關的行政、保障及續保事宜與閣下聯絡。
7. **根據有關條例中的條款，閣下有權：**
   a. 查核本公司是否持有閣下或會員的個人資料及查閱該等個人資料；
   b. 要求本公司改正任何有關閣下或會員的不準確的個人資料；
   c. 查明本公司對於資料的政策及處理方法和獲告知本公司持有的個人資料種類；及
   d. 要求本公司停止將閣下的個人資料作直接市場推廣用途。

   有關要求請致函本公司保障資料主任，地址如下：

   香港九龍觀塘海濱道77號海濱匯第2座6樓
   保柏（亞洲）有限公司　保障資料主任
8. 根據有關條例之條款，本公司有權就任何處理個人資料查閱或更改的要求收取合理費用。
9. 如閣下對本聲明有任何查詢，請隨時致電本公司的客戶服務專線 2517 5333。
10. 本聲明不會限制客戶在條例下所享有之權利。
11. 中英文本如有歧義，概以英文為準。