

Bupa MyBasic VHIS Plan Application Form

保柏自願醫保計劃申請表



To ensure your cover can take effect on the first day of the following month, please send us the completed application form at least 5 working days prior to the end of the month. Applications are subject to underwriting.

如欲合約在下月一號生效，請將填妥的申請表於月底前最少5個工作天寄回保柏。所有申請必須通過核保始能生效。

If there is insufficient space provided for your answer or information given in this Application form, please continue on a separate sheet of paper, specifying the section to which your answer relates, and add your signature with date.

如本申請表未能提供足夠空間填寫，請另加紙張提供說明所涉部份並附加簽署與日期。

Please complete this form in **ENGLISH and BLOCK LETTERS**. Please tick as appropriate.
請以**英文正楷**填妥本申請表，並於適用地方加「✓」號。

All Ages described in this form refer to the Age as at the Policy Effective Date.

本申請表內所有歲數以保單生效日之歲數計算。

For Bupa use only 保柏專用	Reference No. : 參考編號	_____
	Policy Effective Date 生效日期:	DD 日 MM 月 YYYY 年

Medical Protection Needs Assessment 醫療保障需要評估

(Please note: The following questions are to evaluate the suitability of the insurance product(s) under this application based on your needs and circumstances. Application can be suspended or rejected in case of suitability mismatch. 請注意：以下問題旨在評估此投保申請下的保險產品的適合性，以滿足閣下的需要及情況。如出現保險產品與閣下保障需要錯誤的情況，投保申請可被暫緩或拒絕。)

Question 問題 1 What is/are your objective(s) for purchasing the medical insurance policy? (tick one or more) 請問你投保此醫療保單的目的是? (可選一項或多項)

- Option 選擇1: For the expenses of hospitalisation 為應付住院開支
- Option 選擇2: For the financial need when suffer from critical illness 為應付患上危疾時的經濟需要
- Option 選擇3: For the long term care and financial needs in case of permanent total disability 為永久完全傷殘時的長期醫療保健及經濟需要
- Option 選擇4: For the expenses of outpatient visits and other medical needs (such as dental, vision benefit, etc) 為應付門診或其他醫療所需 (例如牙醫、眼科等)

Question 問題 2 Which type(s) of medical insurance you are looking for? (tick one or more) 請問你會考慮投保哪一類型的醫療保單呢? (可選一項或多項)

- Option 選擇1: Indemnity (cover the eligible expenses by the policy) 彌償式賠償 (即按保單規定之合資格開支提供實報實銷式的賠償)
- Option 選擇2: Non-indemnity (a payment based on a sum insured amount by the policy) 非彌償式賠償 (即按保單訂明的保額作出賠償)

Personal Details of Policy Holder 保單持有人資料 (Policy Holder's Age must be 18 years or above 保單持有人年齡必須為18歲或以上)

Title 稱謂 Name of Policy Holder (same as HKID Card) 保單持有人姓名 (與香港身份證相同)

Mr 先生 Surname 姓 _____

Mrs 太太 _____

Ms 女士 Given Name 名 _____

Miss 小姐 _____

HKID Card No. / Passport No. 香港身份證號碼 / 護照號碼 _____

Sex 性別 M 男 F 女

Date of Birth 出生日期 DD 日 MM 月 YYYY 年

Contact Details of Policy Holder 保單持有人聯絡資料

Correspondence Address* 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

Email Address# 電郵地址# _____

Contact No. 聯絡電話 _____ Fax No. 傳真號碼 _____ Mobile No. 流動電話號碼 _____

Successive Policy Holder (Optional) 繼任的保單持有人 (可選擇填寫)

Please state the successive Policy Holder in case you pass away 請列明在你身故的情況下繼任的保單持有人

Surname 姓 _____

Given Name 名 _____

HKID Card No. / Passport No. 香港身份證號碼 / 護照號碼 _____ Relationship with Proposed Insured Person^ 與準受保人關係^ _____

* 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。

You can access our e-Services through **myBupa**, our online and mobile platform, to view and download some of your policy-related documents. To access these e-documents**, you are required to register for a **myBupa** account and provide an email address where you will receive email notifications when a document is ready for you to access from your **myBupa** account. You will no longer receive hard copy of these documents by post.

To help save our planet, Bupa encourages communications through electronic means. This will be the default option for our future communications with you after your insurance policy has been set up. However, if you wish to receive a hard copy of all documents by post, please contact your insurance consultant to let us know your preference.

** 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.



PAAPP

^ Applicable to spouse/child/parents/parents-in-law/siblings/spouse's siblings/grandparents/grandparents-in-law/grandchild/domestic partner/domestic partner's child/domestic partner's parents

你可透過 **myBupa** 網上及手機的電子服務查閱及下載與你保單相關的部分文件。要查閱這些電子文件**，你須登記 **myBupa** 帳戶，並提供電郵地址。當文件已上載於你的 **myBupa** 帳戶後，你便會收到電郵通知。你將不會以郵寄方式收到這些保單文件的印刷本。

為了拯救我們的地球，保柏鼓勵通過電子方式進行溝通。這將會是我們未來在設立你的保單時與你溝通的默許選擇。但是，如果你希望通過郵寄方式收到所有文件的列印本，請聯絡你的保險顧問讓我們了解你的選擇。

** 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。

^ 適用於配偶/子女/父母/配偶的父母/兄弟姊妹/配偶的兄弟姊妹/祖父母/配偶的祖父母/孫子女/同居伴侶/同居伴侶的子女/同居伴侶的父母

Details of Proposed Insured Person 準受保人資料 (Age must be between 15 days - 80 years inclusive 年齡必須為15日至80歲(包括首尾歲數))

Myself 本人

(Details as page 1 資料如同第一頁)

Place of Residence¹

居住地¹

Or

Proposed Insured Person 準受保人

Proposed Insured Person's Name (same as HKID Card/Passport/Birth Certificate) 準受保人姓名 (與香港身份證/護照/出生證明書相同)

Surname

姓

Given Name

名

HKID Card No./Passport No./Birth Certificate No.

香港身份證號碼/護照號碼/出生證明書號碼

Sex

性別

M 男

F 女

Date of Birth

出生日期

DD 日

MM 月

YYYY 年

Relationship with Policy Holder[^]

與保單持有人關係[^]

Place of Residence¹

居住地¹

[^] Applicable to spouse/child/parents/parents-in-law/siblings/spouse's siblings/grandparents/grandparents-in-law/grandchild/domestic partner/domestic partner's child/domestic partner's parents

¹ The above Place of Residence will be used to determine the validity and coverage of the Policy. Please inform Bupa immediately in writing if the proposed Insured Person has changed the Place of Residence.

[^] 適用於配偶/子女/父母/配偶的父母/兄弟姊妹/配偶的兄弟姊妹/祖父母/配偶的祖父母/孫子女/同居伴侶/同居伴侶的子女/同居伴侶的父母

¹ 上述居住地將用於確定保單的有效性和保障範圍。如任何準受保人已更改居住地，請立即以書面通知保柏。

Choice of Cover 投保項目

Bupa MyBasic VHIS Plan 保柏自願醫保計劃

VHIS Certification Number 自願醫保認可產品編號：

S00020-01-000-02

For Bupa use only 保柏專用

Standard Premium
標準保費

Discount amount,
if any
折扣總額 (如有)

Levy
保費徵費

Total premium and
levy paid (HKD)
保費及保費徵費
總額 (港元)

Verified by
核實：

Please tick this box if you would like to receive coverage for Pre-existing Conditions with Premium Loading.³

請剔取此項，如你需要以附加保費獲得投保前已有病症的保障。³

³ We may have to exclude some medical conditions from your cover because of the medical history declared. We may be able to offer you an option to cover some of these excluded medical conditions with Premium Loading. If you choose this option, we may contact you to collect additional information for assessment.

³ 我們可能會因你所申報的病歷而將一些病症列為不獲保障項目。我們或能讓你以繳付附加保費將某些不獲保障病症納入保障範圍。如你選擇此項，我們或會聯絡你以索取額外資料以作審核。

Premium Payment Method 繳付保費方法

Payment Frequency 繳付保費形式	Payment Method 繳付保費方法	Remarks 備註
<input type="checkbox"/> Yearly 年繳	<input type="checkbox"/> 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
	<input type="checkbox"/> Autopay from Bank 銀行自動轉賬 (From renewal payment only 續保繳費起適用)	Please attach a cheque made payable to "Bupa (Asia) Limited" for the 1st year's premium and levy with a completed Direct Debit Authorisation Form 請填妥 直接付款授權書 ，連同首年保費及保費徵費之支票交回本公司，支票抬頭人為「保柏(亞洲)有限公司」
<input type="checkbox"/> Monthly 月繳	<input type="checkbox"/> 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
	<input type="checkbox"/> Autopay from Bank 銀行自動轉賬	Please attach a cheque made payable to "Bupa (Asia) Limited" for the first 2 months' premium and levy with a completed Direct Debit Authorisation Form 請填妥 直接付款授權書 ，連同首兩個月保費及保費徵費之支票交回本公司，支票抬頭人為「保柏(亞洲)有限公司」

Bank Account for Reimbursement 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 (HKD only) 個人香港儲蓄 / 往來銀行戶口號碼 (只限港元)

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 Policy Holder/Insured Person*, please fill in the following information. 若上述之戶口持有人並非保單持有人/受保人*，請填寫以下資料。

Relationship with the Policy Holder/Insured Person* 與保單持有人/受保人* 關係
(Applicable to spouse, parents or children only 只適用於配偶、父母或子女)

*Please delete if inappropriate 請刪除不適用者

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 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。

- 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。
- 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。
- 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。
- Even after an insurance policy has been issued upon successful application, the insurance coverage for the proposed 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)、瘡癤、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之任何及所有醫療資料。

Health Questionnaire - Section A 健康問卷 - 甲部

Height 身高# _____ cm 厘米 OR 或 _____ feet 呎 _____ inches 吋

Weight 體重# _____ kg 公斤 OR 或 _____ pounds(lbs) 磅

Do you (or proposed Insured Person) smoke# or have you (or proposed Insured Person) smoked# in the last one year?
你(或準受保人)有沒有吸煙#或在過去一年內曾否吸煙#?

Yes 是 No 否

Not required for proposed 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)。

Health Questionnaire – Section A 健康問卷 – 甲部

<p>1. In the last 3 years, have you (or proposed 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？</p>	<p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p>
<p>2. In the last 3 years, have you (or proposed 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(或準受保人)是否曾經或被建議接受檢查(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)？ If the answer is “Yes”, do your (or proposed Insured Person) investigation result(s) include the followings? 如果答案屬「是」，你(或準受保人)的檢查結果是否包括下列情況？</p> <p>(a) Abnormal test result is advised 檢驗結果異常</p> <p>(b) You (or proposed Insured Person) are still awaiting test / test result 你(或準受保人)正等候檢驗或檢驗結果</p> <p>(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)</p>	<p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p>
<p>3. In the last 5 years, have you (or proposed 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？</p>	<p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p>
<p>4. In the last 5 years, have you (or proposed Insured Person) been admitted into a hospital? 在過去五年內，你(或準受保人)是否曾入住醫院？</p>	<p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p>
<p>5. In the last 5 years, have you (or proposed 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)？</p>	<p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p>
<p>6. Apart from anything you (or proposed Insured Person) have already disclosed in Questions 1 - 5, do you (or proposed Insured Person) have any of the following conditions? 除了你(或準受保人)在第1至5項問題中已披露的資料外，你(或準受保人)是否有下列情況？</p> <p>(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</p> <p>(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</p> <p>(c) Other medical conditions or other sign and symptom (such as lump, headache, persistent coughing, chest pain or epigastric pain) that you (or proposed 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</p> <p>(d) In the last 1 year, you (or proposed 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</p>	<p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p>
<p>7. Have you (or proposed Insured Person) ever been diagnosed with any of the following diseases or medical conditions? 你(或準受保人)是否曾被確診下列疾病或健康狀況？</p> <p>(a) Cancer or carcinoma in situ 癌症或原位癌</p> <p>(b) Brain tumor 腦部腫瘤</p> <p>(c) Heart disease 心臟疾病</p> <p>(d) Stroke (including transient ischemic attack (TIA)) 中風(包括短暫性腦缺血，俗稱「小中風」)</p> <p>(e) Hypertension 高血壓</p> <p>(f) Diabetes mellitus or impaired glucose tolerance 糖尿病或葡萄糖耐量異常</p> <p>(g) Prolapsed intervertebral disc or degenerative spine conditions 椎間盤突出或脊椎退化性疾病</p> <p>(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</p> <p>(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)</p> <p>(j) Multiple sclerosis 多發性硬化症</p> <p>(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)</p>	<p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p> <p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p>
<p>For proposed insured children aged 6 or below only 適用於六歲或以下之準受保兒童</p>	
<p>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？</p>	<p><input type="checkbox"/> Yes是 <input type="checkbox"/> No否</p>

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。

	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.
 如果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

The Policy Holder and the proposed Insured Person hereby declare that:

I apply for the health insurance plan (the "Plan") stated in this application form (the "Application"). If I am making an Application for a proposed Insured Person under the Age of 18, I have been duly authorised by the guardian of the proposed Insured Person to make this Application.

I confirm that I have selected this insurance plan of my own free will. I further confirm that the product features of the Plan were able to fulfil my/ proposed Insured Person's current medical protection needs, financial situation and premium affordability.

保單持有人和準受保人謹此聲明：

本人提出此申請表（「此申請」）中列明之醫療保障計劃（「計劃」）之申請。如準受保人年齡未滿18歲，本人已獲準受保人的監護人正式授權為準受保人提出此申請。

本人確認本人所選之保險計劃乃按照本人之獨立意願而決定。本人並確認計劃的產品內容符合本人/準受保人現時的醫療保障需求、財務狀況及保費承擔能力。

Coverage and Pre-existing Conditions 保障及已有病症

I declare that, to the best of my knowledge and belief the information provided in this Application or in support of this Application (including to any Bupa appointed Medical Examiner) ("Information") is true, accurate and complete. I understand that (1) all Information forms the basis and becomes a part of the Policy; (2) failure to provide Bupa with full, complete and accurate Information may result in Bupa having the right to treat the Policy as if it had not existed, or refusing to pay all or part of a claim; and (3) failure to provide full, complete and accurate Information in respect of the Insured Person may affect the cover for that Insured Person.

If I am making this Application on behalf of the proposed Insured Person under the Age of 18, all Information disclosed on behalf of the proposed Insured Person has been verified by me as true and correct. I acknowledge that the knowledge of proposed Insured Person is imputed to my knowledge.

I acknowledge that benefit is not payable under the Plan for any costs of treatment arising from any existing illnesses, injuries or other conditions which has been treated or diagnosed or manifested with signs and symptoms that should be reasonably aware before the Policy Effective Date of the Plan (or, if applicable, the date as referred in the Endorsement Letter if switching from an existing Bupa Health Insurance Scheme) unless complete details are fully disclosed in this Application and accepted by Bupa. I understand that I am required to notify Bupa immediately if the health condition of the proposed Insured Person has changed at any time after the submission of this Application and before the Policy Effective Date of the Plan.

In respect of the Eligible Expenses arising from unknown pre-existing illness, injuries or other conditions that the proposed Insured Person was not aware and would not reasonably have been aware before the Policy Effective Date of the Plan (or, if applicable, the date as referred in the Endorsement Letter if switching from an existing Bupa Health Insurance Scheme), I acknowledge that the benefits (if payable) under this Plan will be subject to the waiting period and reimbursement percentage as stated in the Policy.

In the event the pre-existing medical conditions have been disclosed in the Application and accepted by Bupa, Bupa may apply a Premium Loading to cover that specific condition(s) and the percentage of Premium Loading shall be notified to me in writing. Bupa may apply Case-based Exclusion(s) due to a pre-existing condition or any other factor that may affect the insurability of the proposed Insured Person.

I acknowledge that Bupa may terminate the cover for the proposed Insured Person with immediate effect if the law of the country in which the proposed Insured Person is located, or the proposed Insured Person's Place of Residence or nationality, including but not limited to USA and Japan, or any other law which applies to Bupa or the Policy, prohibits the provision of healthcare cover by Bupa to local nationals, residents or citizens. I further declare that the proposed Insured Person is not US permanent residents. I understand that I am obliged to immediately notify Bupa in writing if the proposed Insured Person becomes a permanent resident of USA during the Policy 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.

本人聲明，就本人所知所信，本申請表上（包括向任何保柏委託的醫護人士）提供或予以支持有關申請的一切資料（「資料」），均屬真實、準確及完整。本人明白(1)所有資料將成為簽發保單的基礎並成為保單一部分；(2)如未有向保柏提供真實、準確及完整的資料，保柏有權將本人的保單視為不存在或拒絕支付全部或部分的索償；及(3)如未有為準受保人提供真實、準確及完整的資料，將會影響該準受保人之保障。

如本人代表年齡未滿18歲的準受保人提出此申請，所有代表準受保人透露的所有資料已經本人核實為真實及正確。本人確認準受保人所知之事被視為本人所知之事。

本人確認凡在保單生效日（或從現有保柏醫療保障計劃轉換至本計劃的批注信件中列明之日期，如適用）前因已接受治療或被確診或已察覺或理應察覺病徵或症狀的已有病症、損傷或其他病況而引致之醫療費用，除非本人在本申請表內已詳細列出並獲得保柏接納，有關費用一律不予賠償。本人明白如在提交本申請後和本計劃保單生效日之前的任何時間，準受保人的健康狀況有任何改變，本人需要立即通知保柏。

關於準受保人在保單生效日（或從現有保柏醫療保障計劃轉換至本計劃的批注信件中列明之日期，如適用）之前未能察覺及理應不察覺的已有病症、損傷或其他病況而引致之合資格費用，本人確認此計劃下的保障將受限於保單列明的等候期及賠償百分比。

如已有病症已於申請表內披露並獲保柏接納承保，保柏會徵收附加保費以保障有關個別病況，將徵收的附加保費率將會以書面通知本人。保柏亦可按已有病症或任何其他影響準受保人可保性的因素而加設的個別不保項目。

本人確認如準受保人的所在國家或其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保單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，保柏可終止相關準受保人的保障並立即生效。本人此外聲明準受保人並非美國永久居民。本人明白如準受保人如於保單年度期間成為美國永久居民，本人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。

Personal Data and Information Disclosure 個人資料及資訊披露

I consent to Bupa using and disclosing the personal data provided in this Application and other personal data it collects about me, for the purposes set out in and in accordance with the Personal Information Collection Statement on the last page of this Application.

The Policy Holder further confirms to have obtained consent from the proposed Insured Person (or the guardian, if applicable) for me to provide Bupa, and for Bupa to provide me, with health and medical information and other personal data regarding the proposed Insured Person for the purposes of this Application, and the continuance of the Policy, including renewal.

I acknowledge that Bupa reserves the right to ask for submission of more details of health status or medical reports of the proposed Insured Person at my own cost. I also authorise any medical practitioner, hospital, clinic, by whom or where the proposed Insured Person has been observed or treated or any insurance company or organisation that has any records or health information concerning the proposed Insured Person 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 acknowledge that Bupa has discretion to appoint Registered Medical Practitioners, Hospitals, Qualified Nurses, cancer centres, day-case centres, diabetic centres, wellness centres and other service providers to provide health and care services, credit facilities for Eligible Expenses and to do all things and acts incidental to such appointment for the proposed Insured Person. I 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 by me against any such service provider appointed by Bupa.

本人同意保柏可以使用並披露此申請表內或其他途徑所收集關於本人的個人資料，用作根據本申請表最後一頁的「個人資料收集聲明」內所陳述的用途。

保單持有人此外確認，本人已向準受保人（或其監護人，如適用）取得同意，本人可向保柏以及保柏可向本人於申請及延續（包括續保）此保單時提供有關準受保人的健康醫療資訊及其他個人資料。

本人確認保柏有權要求提供更多有關準受保人之健康狀況及醫療報告，一切費用由本人支付。本人並且授權任何為準受保人觀察或治療的醫生、醫院、診所，或持有準受保人健康或任何資料之保險公司或機構將準受保人之全部資料（包括病歷）呈交予保柏，本授權書之副本與正本具同等效力。

本人確認保柏可酌情委任註冊西醫、醫院、合資格護士、癌症中心、日症中心、糖尿病中心、保健中心及其他服務供應商以提供醫療服務、合資格醫療費用之墊支服務及有關該委任所需之服務予準受保人。本人確認並同意有關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。就準受保人向有關保柏所委任的服務供應商所作出之申索，保柏一概不會負責。

Policy and Eligibility for Tax Deduction 保單及稅務扣減的資格

I agree to be bound by the terms and conditions of the Policy of this Plan, which will be provided to me if this Application is approved.

I acknowledge that the Policy 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 Policy. I further authorise Bupa to deduct the premium payments from my designated bank account / credit card (where applicable) upon renewal. If I want to cancel the Policy in future, I will need to inform Bupa in writing at least 30 days before the renewal date.

I acknowledge that the premium paid under this Plan shall not be automatically entitled to tax deduction even this Application is approved by Bupa. I understand that I am required to fulfil the conditions and assessment criteria imposed by the Inland Revenue Department and any applicable laws (which may amend from time to time), which include but not limited to allowable relationship for dependant, age/disability/full-time education requirement, date and amount of qualifying premium paid, in order to enjoy any tax deduction.

Policies purchased for grandchild, domestic partner (i.e. civil partner, or the person with whom the Policy Holder lives in a continuous, committed, exclusive relationship during which period neither the Policy Holder or that person were or are married to or partnered with any other person) and domestic partner's child/parents are not eligible for tax deductions.

本人同意遵守計劃保單之各條款及細則，該保單將會於此申請獲批後提供予本人。

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保單條款規定，否則保單將會每年自動續保。本人並授權保柏在續保時於本人指定的銀行賬戶/信用卡（如適用）扣取保費。如本人將來想取消保單，須於續保日30天前以書面通知保柏。

(P.T.O.)

Declaration and Authorisation (Cont.) 聲明及授權 (續)

本人明白即使此申請已獲保柏接納，本計劃下已繳付的保費並不會自動享有稅務扣減。本人明白本人須符合稅務局及任何適用的法律（可不時修改）所規定的條件及評估標準方可享有稅務扣減，包括但不限於認可的受供養人、年齡/殘疾/全日制學生資格，以及支付合資格保費的金額及日期。

本人為孫子女、同居伴侶（同居伴侶指民事結合的伴侶或與保單持有人共同生活，並保持持續、忠誠以及唯一的關係的人士，而期間保單持有人或該人士並沒有和其他人士成婚或結合）和同居伴侶的子女/父母所購買的保單並不符合稅務扣減的資格。

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 understand, acknowledge and agree that, as a result of me 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 further understand that the above agreement is necessary for Bupa to proceed with the Application.

本人明白、確知及同意，保柏會就本人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。

本人亦明白保柏必須取得本人以上的同意，才可以處理其保險申請。

Personal Information Collection Statement 個人資料收集聲明

(i) I have read and understood the Personal Information Collection Statement included in this application form. I have also brought the Personal Information Collection Statement to the attention of the proposed Insured Person (or the guardian if applicable) and confirmed the understanding and agreement to it. I consent to the transfer of my personal data within or outside of Hong Kong for the purposes and to the types of transferee as set out in the Personal Information Collection Statement; and

本人已細閱並明白本申請表所述的「個人資料收集聲明」。本人亦已促使準受保人（或其監護人，如適用）留意「個人資料收集聲明」並確認明白及同意有關內容。本人同意就「個人資料收集聲明」所述用途視乎情況提供本人的個人資料至香港境內外予「個人資料收集聲明」所載的資料承讓人；及

(ii) I consent to Bupa using my personal data, including my name, contact details, gender, health and family status, to send me marketing communications (including by email, SMS or instant messenger) as described in the Personal Information Collection Statement, including in relation to insurance (such as premium discounts), wellness, rewards, loyalty or privileges programmes and related product and services. I understand that I have the right to request Bupa to cease using my personal data for direct marketing purposes by emailing customercare@bupa.com.hk or calling the Bupa Customer Care helpdesk on 2517 5333.

本人同意保柏使用本人之個人資料，包括本人的姓名、聯絡方法、性別、健康及家庭狀況，向本人傳送根據「個人資料收集聲明」所述包括保險(例如保費折扣)、健康、獎賞、會員忠誠或優惠計劃及其相關的產品及服務的市場推廣資訊(包括以電郵、手機短訊或即時通訊)，並明白本人有權透過聯絡保柏的客戶服務專線(電郵至 customercare@bupa.com.hk或致電2517 5333)，要求保柏停止將本人的個人資料用作直接市場推廣用途。

Cancellation Rights and Refund of Premium(s) within Cooling-off Period 冷靜期內取消保單的權利及退還保費

I understand that I have the right to cancel the policy and obtain a refund of any premium(s) and levy paid by giving a written notice to Bupa (Asia) Limited. I understand that to exercise this right, the notice of cancellation must be signed by me and received directly by Bupa (Asia) Limited at 6/F, Tower 2, The Quayside, 77 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong within the cooling-off period. I understand that the cooling-off period is the period of 21 days immediately following either the day of delivery of the policy or the cooling-off notice to me or my nominated representative (whichever is the earlier). I understand that the cooling-off notice is a notice that will be sent to me or my nominated representative by Bupa (Asia) Limited to notify me of the cooling-off period around the time the policy is delivered.

本人明白本人有權以書面通知要求保柏(亞洲)有限公司取消保單並獲退還所有已繳保費及保費徵費。本人明白為行使這項權利，該取消保單的通知必須由本人簽署並由保柏(亞洲)有限公司在香港九龍觀塘海濱道77號海濱匯第2座6樓於冷靜期內直接收到。本人明白冷靜期為緊接保單或冷靜期通知書交付予本人或本人的指定代表之日起計的21天的期間(以較早者為準)。本人明白冷靜期通知書是由保柏(亞洲)有限公司在交付保單時致予本人或本人的指定代表的一份通知書，以就冷靜期一事通知本人。

I, as the Policy Holder, understand that I declare and sign on behalf of the proposed Insured Person listed in this Application under this Plan who is under the Age of 18.

本人茲申請為保單持有人，明白本人代表此計劃申請表內列出之18歲以下準受保人作出聲明及簽署。

I understand that no cover will be payable under the Policy unless this Application is approved and premium 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，保柏方按保單支付保障。

<p>Policy Holder's Signature 保單持有人簽署</p> <p>X</p> <p>(Full Name 姓名)</p>	<p>Signed in Hong Kong on 於香港簽署之日期</p> <p>DD 日 MM 月 YYYY 年</p>	<p>Proposed Insured Person's Signature (Age 18 years old or above) 準受保人簽署 (18歲或以上)</p> <p>X</p> <p>(Full Name 姓名)</p>	<p>Signed in Hong Kong on 於香港簽署之日期</p> <p>DD 日 MM 月 YYYY 年</p>
<p>Agent's / Broker's / Telesales' Name (If applicable and must be completed by the Policy Holder) 代理人 / 經紀 / 營業代表姓名 (如適用及必須由保單持有人填寫)</p>	<p>Agent's / Broker's / Telesales' Contact Tel No. 代理人 / 經紀 / 營業代表聯絡電話號碼</p>		
<p>Agent's / Broker's / Telesales' Code 代理人 / 經紀 / 營業代表編號</p>	<p>Agent's / Broker's / Telesales' Email Address 代理人 / 經紀 / 營業代表電郵地址</p>		

Reminder 提醒你

To help us process your Application quickly, please ensure that you have:

- enclosed payment of the correct premium and levy and a copy of your HKID Card or Passport
- initialled any amendments on this application form
- enclosed a copy of the HKID Card, Passport or the birth certificate of the Proposed Insured Person

我們想更快地助你完成申請，因此請你在遞交申請表時謹記：

- 連同正確之保費及保費徵費與你的香港身份證或護照副本
- 於任何更改之處簽署作實
- 連同準受保人的香港身份證、護照或出生證明副本

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")

Please refer to Bupa's website <http://www.bupa.com.hk> for the glossary of terms used in this Statement.

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

- 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.
- 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.
- 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.
- The Company may collect, use or disclose personal information relating to you, or the Member, for the following purposes:**
 - processing, assessing and determining any Applications for insurance products and services;
 - 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;
 - 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;
 - 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;
 - provision and design of products and services of the Company;
 - 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;
 - 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;
 - 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
 - making disclosure to satisfy the requirements of any laws, rules and regulations, codes of practice, guidance notes or guidelines binding on the Company.
- 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:**
 - the Company's group companies ("Group Company");
 - any insurance adjusters, agents and brokers;
 - any re-insurance companies authorised by the Company;
 - employers (for members of corporate policy only);
 - healthcare professionals and hospitals;
 - 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);
 - any actual or proposed assignee, transferee, participant or sub-participant of all or a substantial part of the Company's rights or business; and
 - 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.
- 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:
 - Insurance, medical, healthcare, wellness, personal development, beauty, lifestyle, entertainment, financial, and related services and products;
 - rewards, benefits, discounts, member activities, loyalty or privileges programmes and related services and products; and
 - 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.
- Under and in accordance with the terms of the Ordinance, you have the following rights:**
 - to check whether the Company holds personal information relating to you or the Member and to access such personal information;
 - to require the Company to correct any personal information relating to you or the Member which is inaccurate;
 - 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
 - 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

- 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.
- For any enquiries about this Statement, please do not hesitate to contact our Customer Care helpdesk at 2517 5333.
- Nothing in this Statement shall limit the rights of customers under the Ordinance.
- 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」)

請參閱保柏網站 <http://www.bupa.com.hk> 有關本聲明中使用的詞彙定義。

遵照條例,本公司特通知閣下以下事項:

- 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)。
- 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。
- 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。
- 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:**
 - 處理、評估、決定任何保險產品及服務之申請;
 - 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;
 - 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;
 - 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;
 - 提供及設計本公司的產品及服務;
 - 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;
 - 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;
 - 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
 - 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。
- 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:**
 - 本公司的集團公司(「集團公司」);
 - 任何由本公司授權的保險理算人、代理及經紀;
 - 任何由本公司授權的再保險公司;
 - 僱主(只適用於團體保單之會員);
 - 醫護專業人員及醫院;
 - 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土)、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);
 - 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
 - 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。
- 本公司只會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):
 - 保險、醫療、康復、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;
 - 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
 - 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。
- 根據有關條例中的條款,閣下有權:**
 - 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;
 - 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;
 - 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
 - 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
- 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。
- 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。
- 本聲明不會限制客戶在條例下所享有之權利。
- 中英文本如有歧義,概以英文為準。

Bupa MyBasic VHIS Plan Credit Card Authorisation Form

保柏自願醫保計劃信用卡付款授權書



Policy Holder's Name 保單持有人姓名

Surname

姓

Given Name

名

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 Policy 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 Policy. I hereby authorise and direct Bupa (Asia) Limited to automatically debit the premium and levy due from my credit card account on an annual / monthly 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保單條款規定，否則保單將會每年自動續保。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/每月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 Policy Holder/Insured Person*, please fill in the following information. 若信用卡持有人並非保單持有人/受保人*，請填寫以下資料。

Relationship with the Policy Holder/Insured Person* 與保單持有人/受保人*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 premium and levy due of Bupa MyBasic VHIS Plan for the Policy Holder as listed in this form.

本人同意及承擔列於此表格上的保單持有人之全數應繳之保柏自願醫保計劃保費及保費徵費金額。

Cardholder's Signature 持卡人簽署

Contact Phone No. 聯絡電話號碼

Date 日期

X

DD日 MM月 YYYY年

For Bupa use only
保柏專用

Bupa MyBasic VHIS Plan Insured Person Policy No.
保柏自願醫保計劃受保人保單號碼：

Date
日期

DD日 MM月 YYYY年

Authorised Code:
授權代碼

*Please delete if inappropriate 請刪除不適用者

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Bupa MyBasic VHIS Plan Direct Debit Authorisation Form

保柏自願醫保計劃直接付款授權書



Policy Holder's Name 保單持有人姓名

Surname

姓

Given Name

名

If autopay is chosen as the payment method, please complete this form, sign where marked "X" and return the original copy to Bupa with a cheque for the premium and levy amount. 若選擇以自動轉賬付款，請填妥此表格及簽署於「X」位置，並連同此表格正本及繳付保費及保費徵費金額的支票交回保柏。

I acknowledge that the Policy 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 Policy. I hereby authorise and direct Bupa (Asia) Limited to automatically debit the premium and levy due from my account on an annual / monthly 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保單條款規定，否則保單將會每年自動續保。本人茲授權保柏(亞洲)有限公司自動從本人的戶口每年/每月支付應繳保費及保費徵費金額，直至另行通知。

Name of party to be credited (The beneficiary)

收款之一方 (受益人)

BUPA (ASIA) LIMITED

Bank No.

銀行編號

Branch No.

分行編號

Account No.

收款戶口號碼

0 2 4 7 8 7 6 2 1 7 8 8 0 0 1

I/We hereby authorise my/our above-named bank (the "Bank") to effect transfer from my/our above-mentioned account to the above-named beneficiary in accordance with such instructions as the Bank may receive from the beneficiary from time to time, provided always that the amount of any one such transfer shall not exceed the limit indicated above (if applicable).

本人(等)現授權上述之銀行(「該銀行」)，根據收款人不時給予該銀行之指示，自本人(等)上述戶口轉賬予收款人。但每次轉賬金額不得超過以上指定之限額(如適用)。

I/We agree that the Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me/us.

本人(等)同意該銀行毋須證實該等轉賬是否已通知本人(等)。

I/We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our above-mentioned account which may arise as a result of any such transfer(s).

如因該等轉賬而令本人(等)之上述戶口出現透支(或令現時之透支增加)，本人(等)會共同及各別承擔全部責任。

I/We confirm that my/our signature(s) on this authorisation is/are the same as filed with the Bank for the operation of my/our above-mentioned account to be debited for the transfer.

本人(等)確證在本授權書內之簽名，與本人(等)上述戶口於該銀行簽署紀錄完全相同。

I/We agree that should there be insufficient funds in my/our above-mentioned account to meet any transfer hereby authorised, the Bank shall be entitled, at its discretion, not to effect such transfer in which event the Bank may make the usual service charge to be paid by me/us.

本人(等)同意如上述戶口並無足夠款項支付有關轉賬，該銀行有權不予辦理且可收取有關之手續費用，該等費用一概由本人(等)支付。

I/We agree that any notice of cancellation or variation of this authorisation which I/we may give to the Bank shall be given at least two working days prior to the date on which such cancellation or variation is to take effect.

本人(等)同意取消或更改本授權書之任何通知，須於取消或更改生效日最少兩個工作天之前交予該銀行。

This authorisation shall have effect until further notice or until the above given expiry date (whichever first occurs).

本授權書將繼續生效直至另行通知為止或直至上列到期日為止(以兩者中最早之日期為準)。

My / Our Bank and Branch Name

本人 / 吾等之銀行及分行名稱

Bank No.

銀行編號

My / Our Account No.

本人 / 吾等之戶口號碼

My / Our name as recorded on Statement / Passbook 本人 / 吾等在結單 / 存摺上之姓名

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

My / Our signature(s) 本人 / 吾等之簽署

X

Date of signing 簽署日期

DD 日 MM 月 YYYY 年

My / Our address as recorded on Statement / Passbook 本人 / 吾等在結單 / 存摺上之地址

Debtor's Name (If other than account holder) 債務人之姓名 (若非戶口持有人)

Insured Person's Policy No. (Debtor's Reference) 受保人保單號碼(債務人備註)

If the account holder is not the Policy Holder / Insured Person*, please fill in the following information. 若戶口持有人並非保單持有人/受保人*，請填寫以下資料。

Relationship with the Policy Holder/Insured Person* 與保單持有人/受保人*關係
(Applicable to spouse, parents or children only 只適用於配偶、父母或子女)

For bank use only
銀行專用

Signature Verified
核實簽署

Notes: 1. The box marked "Insured Person's Policy No." is to be completed by Bupa.
2. The signature on this authorisation form must be the same as the signature of your Bank Account.
* Please delete if inappropriate

附註: 1. 受保人保單號碼一欄由保柏填寫。
2. 在此授權書內之簽署模式必須與閣下之銀行戶口內之簽署相符。
* 請刪除不適用者

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