

**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。**

Subscriber's Name 投保人姓名	Day Time Contact Tel. No. 日間聯絡電話號碼
Membership No. (16 digits) 會員編號 (16 位數字)	Fax No. 傳真號碼
	Email Address 電郵地址

### 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 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，一經批核，新保障將於續保日生效。)

\* Please tick the NEW plan 請於新計劃之空格內加上「✓」號

Plan 1 計劃一 Private 私家房       Plan 2 計劃二 Semi-Private 半私家房       Plan 3 計劃三 Ward 大房

**Addition / Cancellation of Optional Benefit 增加或取消自選保障項目**

<input type="radio"/> Clinical Benefit 門診保障 <input type="radio"/> * Add 增加 <input type="radio"/> Cancel 取消	<input type="radio"/> Other 其他： <input type="radio"/> * Add 增加 _____ <input type="radio"/> Cancel 取消 _____
<input type="radio"/> Hospital Cash Benefit 住院現金保障 <input type="radio"/> * Add 增加 <input type="radio"/> Cancel 取消	
<input type="radio"/> Supplementary Major Medical Benefit 附加醫療保障 <input type="radio"/> * Add 增加 <input type="radio"/> 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以前保障額作賠償。

Subscription submitted with this form HKS \_\_\_\_\_  
連同此申請表附上之保費港幣

by Cheque 支票繳付      Cheque no.: \_\_\_\_\_       by Credit Card - Please enclose with completed Credit Card Authorisation Form  
以信用卡繳付 - 請寄回已填妥之信用卡付款授權書

If the cheque issuer is not the Subscriber, please fill in the following information. 若支票發出人並非投保人，請填寫以下資料。

Relationship with the Subscriber \_\_\_\_\_      Reason for paying Subscription on behalf of the Subscriber \_\_\_\_\_  
與投保人關係      代投保人支付保費的原因

**II. Application for e-Statement Service 申請電子結算表服務**

I hereby agree to receive an e-Statement notification to access my electronic claims statement / shortfall invoice. I understand that no printed copy of claims statement / shortfall invoice will be issued thereafter.  
本人現同意收取電子結算表通知以取得本人之電子賠償單 / 差額通知書。本人明白日後將不會再獲發書面形式之賠償單 / 差額通知書。

e-statement notification sent to the email address stated in section III below (choose one)       Office email address       Personal email address  
以下列第三項(III)所示的電郵地址收取電子結算表通知 (任選其一)      公司電郵地址      個人電郵地址

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

New Address : 新地址	Flat / Room 單位 / 室	Floor 層數	Block 座
	Bldg. / Mansion / House 大廈 / 樓	Court / Estate / Street 閣 / 屋苑 / 街道	
	District 地區	Kln. / H.K. / N.T. 九龍 / 香港 / 新界	
New Telephone No. : 新電話號碼	Home : 住宅	Office : 公司	Mobile Phone : 手提電話
			Fax No. : 傳真號碼
New Email Address : 新電郵地址	Personal : 個人	Office : 公司	

**IV. Change of Subscriber / Member Details 更改投保人 / 會員資料**

Please submit a copy of identity proof to Bupa for details update 請連同身份證明文件副本交回保柏以更新資料

	Surname 姓 (Same as HKID Card / Passport 與香港身份證 / 護照相同)	Given Name 名	Sex 性別	HKID Card No. / Passport No. * 香港身份證號碼 / 護照號碼*	Date of Birth 出生日期 D M YY 日 月 年	Country of Residence* (if not HK) 居住國家* (如非香港)
Subscriber 投保人						
Member 會員						

# Unless otherwise specified by Subscriber in writing, Inter Partner Assistance (IPA) will consider Hong Kong as the Country of Residence of the Member and repatriate the Member to Hong Kong when Medically Necessary. 除非投保人特別以書面通知，國際救援(亞洲)公司將設定香港為會員之居住國家，於有醫療需要時送返會員回香港。



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


**Health Declaration 健康聲明** 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。

Please ensure you have completed all the details in the Members Information section before signing this Health Declaration. Please note that Members will not be eligible for claims resulting from the non-disclosure of health information.

注意：簽署本健康聲明前，請填妥會員資料部份。請注意，任何因未經填報之健康狀況而引致之索償申請，將不獲接納。

At any time during the past seven years from the time of this Application, has/have the Member(s):

由申請計劃前的過去七年內，會員是否：

- |  |                       |                       |
|--|-----------------------|-----------------------|
|  | Yes 是                 | No 否                  |
| 1. had any chronic or recurrent diseases or injuries not completely recovered?<br>曾患有任何慢性或復發性疾病或未完全康復之創傷？  | <input type="radio"/> | <input type="radio"/> |
| 2. had exhibited any of the following symptoms in a repeated / persistent way?<br>曾反覆/持續出現以下病徵？<br>Fever, headache, dizziness, chest pain or discomfort, shortness of breath, blood spitting, hoarseness or cough, night sweating, loss of consciousness, seizure, indigestion, vomiting, abdominal pain, diarrhea, jaundice, blood in the stool or urine, abnormal vaginal bleeding, dysuria, incontinence, allergy, back and/or leg pain, joint pain /swelling, or unintentional body weight change in the past 12 months, etc.?<br>發熱、頭痛、頭暈、胸痛或胸部不適、氣促、血痰(吐血)、聲嘶或咳嗽、夜間出汗、失去知覺、抽搐、消化不良、嘔吐、腹痛、肚瀉、黃疸、血尿或血便、異常陰道出血、排尿困難、失禁、敏感、腰腿痛、關節痛/腫脹或過去12個月非意圖增減之體重變化等？ | <input type="radio"/> | <input type="radio"/> |
| 3. received any in-patient treatment / operation / physiotherapy?<br>曾接受任何入院診治/手術/物理治療？  | <input type="radio"/> | <input type="radio"/> |
| 4. had any medical investigations / examinations?<br>曾接受任何醫療檢查/檢驗？   | <input type="radio"/> | <input type="radio"/> |
| 5. taken any regular medications?<br>曾定期服用藥物？  | <input type="radio"/> | <input type="radio"/> |

If your answer is YES to any of the above questions, please give details of the medical condition in the space provided below, and provide a copy of the relevant medical report(s).

如果你就以上任何問題的回答為「是」，請列出有關詳情，並提供相關的醫療報告副本。

with attachment  
另有附頁

Symptoms / Diagnosis 病徵 / 診斷	Treatment / Operation / Medication 治療 / 手術 / 藥物	Date of Onset / Recovery 病發日期 / 痊癒日期	Degree of Recovery 痊癒程度	Name, Address and Tel. No. of Doctor 醫生姓名、地址及電話號碼

I, on behalf of the Member, acknowledge that Benefit is not payable under Bupa Care Kid 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 in this Application and accepted by Bupa. I declare that, to the best of my knowledge and belief, the statements contained in this Application are true and complete. Bupa reserves the right to ask for submission of more details of health status or medical reports of the Member at my own cost. I have read and agreed to be bound by the terms and conditions of the Contract of this Scheme and I agree that this Health Declaration and the answers given in this Application shall be the basis of the Contract between me and Bupa.

I understand that all my and the Member's personal information collected or held by Bupa is provided and may be held, used, and disclosed by Bupa or individuals / organisations associated with Bupa, appointed agent / broker, if applicable, or any selected third party (within or outside of Hong Kong, including reinsurance and claims investigation companies and industry associations / federations) for the purposes of processing this Application and providing subsequent services and claims analysis for this or providing any other insurance products and services, direct marketing, and data matching, and to communicate with me for such purposes. I shall have the right to access and request correction of any personal information concerning me and the Member held by Bupa; and request for such access and correction can be made to the Personal Data Privacy Officer of Bupa at 18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong.

I, as the Subscriber, understand that I declare and sign on behalf of the Member.

本人代表會員，知道根據保柏童康健醫療保障計劃（「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，除非本人在本申請表內已詳細列出並獲得保柏接納。本人聲明，就本人所知所信，本申請表上填報之一切資料，均屬實完整。保柏有權要求提供更多會員之健康狀況及醫療報告，一切費用由本人支付。本人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回答作為本人與保柏之間所訂合約之根據。

本人明白保柏可保留、使用或透露保柏所收集或持有之所有關於本人及會員的個人資料，及給予與保柏有關的人士 / 機構、獲委任之保險代理人 / 經紀（如適用）或任何被揀選的第三者（在香港境內或境外，包括再保險及賠償調查公司，及有關的行業協會或聯會），用作處理本申請及索償分析用途或提供售後服務或任何其他保險產品及服務、直接促銷及資料核對等用途，及因此等用途與本人聯絡。本人將有權索閱及修正保柏所持有之任何關於本人及會員的個人資料；有關索閱及修正資料可致函保柏（亞洲）有限公司香港鰂魚涌華蘭路25號大昌行商業中心18樓「個人資料私隱主任」收。

本人作為投保人明白此申請乃本人代表會員之聲明及簽署。

Subscriber's Signature 投保人簽署

Date 日期

X

(Name 姓名: \_\_\_\_\_)

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Agent's / Broker's / Telesales' Name (if applicable and must be completed by Subscriber) 代理人 / 顧問 / 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 / 顧問 / 營業代表編號
	Agent's / Broker's / Telesales' Name and Contact Tel. No. 代理人 / 顧問 / 營業代表聯絡電話號碼