

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後交回保柏。

### Conditions of Reinstatement 復效申請條款

- Subscribers may apply to reinstate their Contract within three (3) months from the due date of the unpaid Subscription.  
投保人可於保費到期日起計3個月內申請將合約復效。
- Approval of reinstatement is subject to satisfactory evidence of insurability and/or additional financial and medical information of the Member that is provided at the Subscriber's expense. Please note that no cover will be provided during the lapsed period.  
合約復效須提供保柏滿意的投保健康證明及/或會員財政及身體狀況的資料，並須經保柏批核，有關費用由投保人支付。會籍失效期間不會提供任何保障。
- Please complete, sign and return this original Application together with a cheque for the payment of the outstanding subscription to Bupa. If reinstatement is not approved, Bupa will return the cheque to you.  
請填妥、簽署復效申請表格正本連同逾期保費之支票一併寄回保柏。若合約復效申請不獲批准，保柏將會向您退回此支票。

### Subscriber's Information 投保人資料

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
Subscription amount submitted with this form HK\$ 連同此申請表附上之保費 (港幣)	Cheque no.: 支票號碼
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 與投保人關係	Reason for paying Subscription on behalf of the Subscriber 代投保人支付保費的原因

### Health Declaration 健康聲明

**Important notes 重要資料：**  
Please ensure you have answered all the questions below before signing this Application. Please note that Members will not be eligible for claims resulting from the non-disclosure of health information. 簽署本申請表前，請回答以下所有問題。任何未經填報的健康狀況而引致的索償申請，將不獲接納。

- Last consultation 最近一次求診資料：  
Date 日期 \_\_\_\_\_ Reason 原因 \_\_\_\_\_  
Result 結果 \_\_\_\_\_  
Name and address of the doctor 醫生姓名及地址 \_\_\_\_\_
- Have your natural parents or siblings had diabetes; breast, cervical, ovarian, colon, or other cancer(s); high blood pressure, heart problems, stroke, haemochromatosis, Huntington Disease (Huntington's Chorea), polycystic Kidney disease or any other hereditary disease(s)? (Please provide relationship, condition, age at onset and/or age at death (if applicable).  
閣下的父母或兄弟姊妹有否患有糖尿病；乳癌、子宮頸癌、卵巢癌、腸癌、或其他癌症；高血壓、心臟疾病、中風、血色素沉著症、亨廷頓舞蹈病、多囊腎症或其他遺傳病？請提供關係、狀況、病發年齡及/或死亡年齡（如適用）。  Yes 是  No 否
- So far as you know have you ever had and/or been treated for and/or been told you had any of the following diseases or disturbance?  
就閣下所知，閣下曾否患有及/或被提及患有以下疾病或機能失調及/或因此接受治療？  
3.1 Any chest pain\*, heart disease or problems of the blood vessels (e.g. rheumatic fever, raised blood pressure, high blood cholesterol, angina, irregular heart beat, murmur, heart attack, etc.)?  Yes 是  No 否  
任何胸痛\*、心臟病或其它血管疾病（例如：風濕性熱、高血壓、膽固醇高、心絞痛、心律不整、心臟雜音、心臟病發作等）？  
3.2 Any chest or breathing complaint\* (e.g. asthma, bronchitis, tuberculosis, persistent hoarseness or cough or other respiratory problems, etc.)?  Yes 是  No 否  
任何胸部或呼吸問題\*（例如哮喘、支氣管炎、結核、持久沙啞或咳嗽、或其他呼吸器官疾病）？  
3.3 Any complaint of the digestive system\* (e.g. hepatitis or hepatitis carrier, gallstones, gastric ulcer, esophageal reflux, polyps, bowel or rectal bleeding, etc.)?  Yes\* 是  No 否  
任何消化系統問題\*（例如肝炎或肝炎帶菌者、膽石、消化道潰瘍、胃酸倒流、息肉、直腸出血等）？  
3.4 Any diseases of the genital urinary system (e.g. Blood or protein in urine, kidney stones, nephritis or nephropathy, renal failure, prostate disorders, ovarian cysts, endometriosis, etc.)?  Yes 是  No 否  
任何泌尿生殖系統疾病（例如血尿或蛋白尿、腎石、腎炎或腎病、腎功能衰竭、前列腺疾病、卵巢囊腫、子宮內膜異位等）？  
3.5 Any neurological or mental disorders\* (e.g. epilepsy\*, impairments of hearing, speech, or vision, prolonged headache, convulsions, depression, stroke, paralysis, multiple sclerosis, Parkinson's disease, Alzheimer's disease, etc.)?  Yes 是  No 否  
任何神經或精神性疾病\*（例如癲癇\*、聽力/語言/視力受損、長期頭痛、痙攣、抑鬱、中風、癱瘓、多發性硬化、帕金森氏病、老年癡呆症等）？  
3.6 Any endocrine disorders (e.g. diabetes\*, pituitary disorder, thyroid disorder, etc.)?  Yes 是  No 否  
任何內分泌疾病（例如糖尿病\*、腦垂體疾病、甲狀腺疾病等）？  
3.7 Chronic pain or other problem in your neck or back\*, ankylosing spondylitis\*, sciatica\*, muscle or joint disorders, gout, rheumatism, systemic lupus erythematosus, or other physical disability?  Yes 是  No 否  
慢性頸腰痛或脊椎病變\*、強直性脊椎炎\*、坐骨神經痛\*、肌肉關節病變、痛風、類風濕、紅斑狼瘡、或其它身體殘疾？  
3.8 Cancer, tumour, lumps, cyst, disorder of lymph gland, anaemia, leukaemia, other disorder of blood?  Yes 是  No 否  
癌症、腫瘤、腫塊、囊腫、皮膚病變、淋巴腺的疾病、貧血、白血病、其他與血有關的疾病？  
3.9 Venereal disease, AIDS, AIDS-related conditions, any blood test for HIV virus?  Yes 是  No 否  
性病、愛滋病、與愛滋病有關的疾病、曾接受愛滋病毒血液測試？
- Have you ever used drugs such as stimulants, hallucinogens, narcotics or other controlled substance other than prescribed by a physician, or been counselled, treated or arrested for excessive use of alcohol or drugs?  
您曾否服用藥物如興奮劑、迷幻藥、麻醉藥或其他並非由醫生處方的受管制藥物，或因酗酒或吸毒而接受輔導、治療或被捕？  Yes\* 是  No 否
- Within the past seven years have you had any:  
過去七年內閣下曾否：  
5.1 diagnostic test such as X-ray, electrocardiogram, genetic test or blood test, biopsies, ultrasonogram?  Yes 是  No 否  
接受診斷檢驗如X光、心電圖、遺傳基因檢驗、血液檢驗、活體切片檢查或超音波檢查？  
5.2 illness, operation, medical advice or hospital treatment not mentioned above?  Yes 是  No 否  
患有上文並未提及的疾病、並需接受手術、醫療建議或留院治療？  
5.3 pension and/or claimed payment for any sickness, accident or injury?  
因疾病、意外或受傷而取得賠償及/或退休金？  Yes 是  No 否
- Has your weight changed more than 11 lbs/5kgs in the past year?  
過去一年內，閣下的體重曾否有11磅或5公斤以上的增減？  Yes 是  No 否
- Are you currently taking any medication?  
閣下目前是否有服用任何藥物？  Yes 是  No 否



8. Have you smoked cigarettes within the past 12 months? If Yes, please state:  Yes 是  No 否  
閣下在過去十二個月內曾否吸煙? 如「有」, 請註明:  
a. Average no. of cigarettes daily? 每日平均吸煙的支數? \_\_\_\_\_  
b. For how many years have you smoked? 閣下已吸煙多少年? \_\_\_\_\_

9. Do you take alcohol on a regular basis?  Yes\* 是  No 否  
閣下有否飲用酒精的習慣?

10. For juvenile Member under the age of 2 years 只適用於兩歲以下的兒童會員  Yes 是  No 否  
a. Weight at birth 出生體重 lbs 磅 / ozs 安士 / kgs 公斤 \_\_\_\_\_  
b. Had the Member been confined in hospital for more than 5 days since birth? If Yes, please give reason 自出生日起計, 如留院超過五天, 請說明原因: \_\_\_\_\_  
c. Were there any birth difficulties, RH problem, congenital deformed limbs, "blue baby", lack of mental development or Down's syndrome? 曾否出現難產, 因子問題, 先天性肢體畸形, 青紫嬰兒, 缺乏正常心智發展或唐氏綜合症等徵狀? \_\_\_\_\_

Questions 11 to 15 are to be completed for female Member 第11至15題只適用於女性會員

11. Have you ever had or been told to have, or been treated for any disease /disorder of the cervix, uterus or the breast?  Yes 是  No 否  
閣下曾否或被建議就子宮頸、子宮、乳房疾病接受治療?

12. Have you ever had or have been advised to have, or are you intending to have tests or treatment of the breast such as mammogram, an ultrasound or surgery, etc?  Yes 是  No 否  
閣下曾否或被建議或打算就乳房接受檢查或治療如乳房X光、超音波或手術?

13. Have you ever had, or have been advised to have, or are you intending to have investigations and /or treatment of the cervix or uterus, such as a pap smear, cone biopsy, colposcopy or ultrasound, etc?  Yes 是  No 否  
閣下曾否或被建議或打算就子宮頸、子宮疾病接受檢查或治療如柏氏細胞塗片、錐形活體切片檢查、陰道鏡或超音波檢查?

14. Are you now pregnant? If yes, please state week(s) of pregnancy  Yes 是  No 否  
閣下現在是否懷孕? 若是, 請列明懷孕週數: \_\_\_\_\_

15. Have you been informed by a doctor or is there any reason to believe that your pregnancy may be abnormal?  Yes 是  No 否  
閣下曾否被醫生告知或因任何原因懷疑懷孕不正常?

For each "YES" answer for Questions 1 to 15, please identify question number and give full details, conditions, dates, duration and result. Please give full names and address of doctors, hospitals and clinics.  
如第1至15題的答案為「是」, 請註明題號並列出詳情, 如求診日期、持續時間、診斷結果、醫生、醫院、診所全名及地址等。

If you answer "YES" to questions or illnesses marked with an "\*", please fill in relevant health questionnaires.  
如標示 \* 號的問題或疾病的答案為「是」, 請填寫有關健康問卷。

### Declaration and Authorisation 聲明及授權

I hereby request that the above contract with Bupa be reinstated and I understand and agree to the Condition of Reinstatement as stipulated in this Application. I hereby declare and agree on behalf of myself and/or the Member in this Application that (1) to the best of my knowledge and belief, the statements and answers contained in this Application Form and any other questionnaires issued by Bupa, and answers given to Bupa's appointed medical examiner, are true and complete; (2) all answers to such questions, together with this application, shall form the basis and become a part of the Contract; (3) failure to disclose all relevant information may result in non-payment of a claim and/or all cover under the policy being cancelled; (4) any misrepresentation or non-disclosure of smoking habit will render the Contract void in case of claims, whether the claim is pertaining to smoking or not;

I understand that the Member's personal information collected or held by Bupa, including information given during previous applications and claims, 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 / us for such purposes. I shall have the right to access and request correction of any personal information concerning 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 hereby authorise on behalf of myself and/or the Member in this Application that (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of the Member and who has attended or may hereafter attend to the Member to disclose such information to Bupa; (2) Bupa or any of its appointed medical examiners or laboratories to perform the necessary medical assessments and tests to evaluate the health status of the Member in relation to this application and any claim arising therefrom. Bupa reserves the rights to ask for submission of more details of health status or medical reports of the Member as listed in this Application at Member's own cost. Such authorisation shall survive me and shall be irrevocable.

I, as the Subscriber, understand that I declare and sign on behalf of the Member of this Application who is aged below 18, if applicable.

本人謹此要求將上述保柏之合約復效, 並明白及同意復效申請表上列明之復效申請條款。本人謹此代表本人及/或此申請的會員在此聲明及同意(1)本申請表及其他一切由保柏發出的問卷內所作的一切陳述及答案及向保柏受委託的醫生、醫療人員提供的答案, 就本人所知所信, 均屬真實完整; (2)上述問題的所有答案及此申請表, 將成為簽發保單的根據; (3)如未有完全提供所有有關核保的資料, 將會引致賠償中索被拒賠及/或此保單之保障被撤銷; (4)任何吸煙習慣的失實陳述, 無論與索償有關與否, 均會導致合約無效。

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。

本人謹此代表本人及/或會員在此申請授權(1)任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、其他組織或人士、凡知道或持有任何有關會員之紀錄者、及/或曾診驗或可能將會診驗會員, 均可將該等資料提供給保柏; (2)保柏或任何其指定之醫生、醫療人員或化驗所, 可就投保申請表或任何與之有關賠償申請替會員進行所需之醫療評估及測試, 作為審核會員之健康狀況。保柏有權要求提供更多有關會員於本申請表所示之健康狀況及醫療報告, 一切費用由會員支付。此授權將在本人/會員身故後仍然生效及不可撤回。

本人茲申請為投保人並明白本人代表申請表內列出之18歲以下會員(如適用)作出聲明及簽署。

Subscriber's Signature 投保人簽署

Signed in Hong Kong 簽署於香港

X \_\_\_\_\_ DD 日 / MM 月 / YY 年

Please submit this Application Form to Bupa within 14 days of the above signature date.

請確保此申請表能於上述簽署日期的14天內交回保柏。

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。

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' Contact Tel. No. 代理人 / 顧問 / 營業代表聯絡電話號碼