

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. Addition of Dependant 增加受供養人 (Health Declaration must be completed 必須填寫健康聲明)

Spouse must be aged 18 to 59, and unmarried child(ren) must be aged under 18 or below 23 if in full time education. 配偶年齡必須介乎18至59歲及未婚子女年齡必須為18歲以下或23歲以下之全日制學生
* For spouse, please submit the copy of HKID Card / Passport; for child, please submit the copy of birth certificate to Bupa. 請連同配偶之香港身份證 / 護照副本及子女出生紙副本交回保柏。

	Surname 姓 (Same as HKID Card / Passport 與香港身份證 / 護照相同)	Given Name 名 (與香港身份證 / 護照相同)	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	Weight 體重 (kg公斤)	Height 身高 (cm公分)	Smoker (Y / N) 吸煙者 (是/否)	Country of Residence* (if not HK) 居住國家* (如非香港)
Spouse 配偶									
Child 子女									
Child 子女									

Unless otherwise specified by Members in writing, Inter Partner Assistance (IPA) will consider Hong Kong as the Country 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)公司將設定香港為所有會員之居住國家，於有醫療需要時送返有關會員回香港。

II. 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 choice 請於新選項之空格內加上「✓」號

Hospital and Surgical Benefit 住院及手術保障	<input type="radio"/> Change to 改為:	<input type="radio"/> 100% reimbursement 十足賠償*
Optional Benefit 自選保障項目 1. Clinical Benefit 門診保障	<input type="radio"/> Add as 增加為*:	<input type="radio"/> 100% reimbursement 十足賠償
	<input type="radio"/> Change to 改為:	<input type="radio"/> 100% reimbursement 十足賠償*
	<input type="radio"/> Cancel 取消	
2. Hospital Cash Benefit 住院現金保障	<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根據前保障額作賠償。

Subscription submitted with this form HK\$ _____
連同此申請表附上之保費港幣

<input type="radio"/> by Cheque - Cheque No.: _____ 以支票繳付 - 支票號碼	<input type="radio"/> by Citibank Credit Card 12-month - Please enclose with completed 12-month interest-free monthly instalment Monthly Instalment Plan Agreement 以花旗銀行信用卡十二個月免息月 - 請寄回已填妥之十二個月免息月供分期付款計劃同意書
<input type="radio"/> 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 or member, please fill in the following information. 若支票發出人並非投保人或會員，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 _____

III. Change of Bank Account Number for Reimbursement 更改賠償銀行戶口號碼

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

Bank Name 銀行名稱	Branch Name 分行名稱	Account Holder's Name 戶口持有人姓名
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Account No 戶口號碼 _____
Bank No. 銀行編號 _____ Branch No. 分行編號 _____ Account No. 戶口號碼 _____

If the above account holder is not the Subscriber or member, please fill in the following information. 若上述之戶口持有人並非投保人或會員，請填寫以下資料。
Relationship with the Subscriber 與投保人關係 _____
Reason for receiving claims payment on behalf of the Subscriber 代投保人收取賠款的原因 _____

IV. 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 VI below (choose one) Office email address 公司電郵地址 Personal email address 個人電郵地址
以下列第六項(VI)所示的電郵地址收取電子結算表通知(任選其一)

V. Change of Account Number for Credit Card 更改信用卡戶口號碼

Yearly by Credit Card (please attach a newly completed Credit Card Authorisation Form)
以信用卡年繳 (請連同新填妥之信用卡付款授權書寄回)

IV. 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		



VII. Change of Member(s) Details 更改會員資料

For spouse, please submit the copy of HKID Card / Passport; for child, please submit the copy of birth certificate to Bupa 請連同配偶之香港身份證 / 護照副本及子女出生紙副本交回保柏

	Surname 姓 (Same as HKID Card / Passport 與香港身份證 / 護照相同)	Given Name 名	Membership No. 會員編號	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							
Spouse 配偶							
Child 子女							
Child 子女							

Unless otherwise specified by Members in writing, Inter Partner Assistance (IPA) will consider Hong Kong as the Country 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)公司將設定香港為所有會員之居住國家，於有醫療需要時送返有關會員回香港。

VIII. 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? 曾患有任何慢性或復發性疾病或不完全康復之創傷？	<input type="radio"/>	<input type="radio"/>
2. had exhibited any of the following symptoms in a repeated / persistent way? 曾反覆/持續出現以下病徵？ 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.? 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? 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? 曾接受任何醫療檢查 / 檢驗？	<input type="radio"/>	<input type="radio"/>
5. taken any regular medications? 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。

(Proposed) Member(s)' Name (準)會員姓名	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/We acknowledge that Benefit is not payable under the Bupa Crystal Health Insurance 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. I/We declare that, to the best of my/our 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 me/us and the dependant(s) as listed in the Application at my/our own cost. I/We have read and agreed to be bound by the terms and conditions of the Contract of Bupa Crystal Health Insurance Scheme and I/we agree that this Health Declaration and the answers given in this Application shall be the basis of the Contract between me/us and Bupa.
 I/We understand that all Members' 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 any other insurance products and services, direct marketing, and data matching, and to communicate with me/us for such purposes. I/We shall have the right to access and request correction of any personal information concerning the Member(s) 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/We hereby authorise Bupa to appoint Registered Medical Practitioners, Hospitals, Registered Chinese Medicine Practitioners, Physiotherapists, Chiropractors, Qualified Nurses, cancer centres, day case centres, diabetic centres, dental centres, wellness centres as well as imaging and laboratory centres 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, as the Subscriber, understand that I declare and sign on behalf of the dependant(s) listed in the Application under this Scheme who is/are under the age of 18 for this Application.
 本人/吾等知悉根據保柏晶彩寶醫療保障計劃規定，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，均屬真實完整。保柏有權要求提供更多有關本人/吾等及於申請表內所列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/吾等已細讀並同意遵守保柏晶彩寶醫療保障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/吾等與保柏之間所訂合約之根據。
 本人/吾等明白保柏可保留、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/吾等聯絡。本人/吾等將有權索閱及修正保柏所持有之任何關於會員的個人資料，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/吾等現授權保柏代為委任註冊西醫、醫院、註冊中醫、物理治療師、中醫師、合資格護士、癌症中心、日間中心、糖尿病中心、牙科診所、保健中心、影像及化驗中心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/吾等承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。
 本人作為投保人明白此申請乃本人代表申請表內列出之18歲以下受供養人之聲明及簽署。

Subscriber's Signature 投保人簽署 _____ (Name 姓名: _____) Member's Signature (aged 18 or above) 年滿18歲或以上之會員簽署 _____ (Name 姓名: _____) Member's Signature (aged 18 or above) 年滿18歲或以上之會員簽署 _____ (Name 姓名: _____) Member's Signature (aged 18 or above) 年滿18歲或以上之會員簽署 _____ (Name 姓名: _____)	Member's Signature (aged 18 or above) 年滿18歲或以上之會員簽署 _____ (Name 姓名: _____) Member's Signature (aged 18 or above) 年滿18歲或以上之會員簽署 _____ (Name 姓名: _____) Date 日期 _____
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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