

Please complete this form and sign on the back before returning to Bupa 請填妥本表格並於背頁簽署，然後交回保柏。

Subscriber's Name of the existing Contract 現有合約之投保人姓名	Day Time Contact Tel. No. 日間聯絡電話號碼
Subscriber's Name of the new Contract (if different from the Subscriber of the existing Contract). 新合約之投保人姓名 (如非現有合約之投保人)	Fax No. 傳真號碼
Subscriber of the new Contract must be the Member if Member's age is 18 or above. 若會員年齡為18歲或以上，新合約之投保人必須為會員本人。 Subscriber of the new Contract must be the Parent or Legal Guardian of the Member if Member's age is below 18. 若會員年齡為18歲以下，新合約之投保人必須為會員之父母或合法監護人。	

### Conversion Option 轉保權

I hereby apply to exercise the conversion option for the below Member under my existing Bupa Wise Choice Health Insurance Contract. I understand that the Benefit Level in the new contract shall not be higher than that of my current contract.  
本人現申請為下列會員行使本人現有之保柏智康健醫療保障合約之轉保權。本人明白新合約下之保障等級將不會高於現有合約之保障等級。

Membership No.(16 digits 位) 會員編號	Member's Name 會員姓名	Country of Residence* (if not HK) 居住國家* (如非香港)

# 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。

### Conversion Details 轉保詳情 Please "✓" as appropriate 請選擇並加「✓」號。

Choice of Scheme 計劃選擇	Benefit Level 保障等級
<input type="radio"/> Bupa CarePro Health Insurance Scheme 保柏卓康健醫療保障計劃 Hospital Care (Hospital and Surgical Benefit) 基本保障 (住院及手術保障)	<input type="radio"/> Plan 1 計劃 1 Private 私家房
<input type="radio"/> Bupa Care Kid Health Insurance Scheme 保柏童康健醫療保障計劃 Hospital Care (Hospital and Surgical Benefit) 基本保障 (住院及手術保障) (For Member age below 18. 只適用於18歲以下之會員。)	<input type="radio"/> Plan 2 計劃 2 Semi-private 半私家房
	<input type="radio"/> Plan 3 計劃 3 Ward 大房

Note: For conversion to the same or lower benefit level only  
附註：轉保權只適於選擇相同或較低之保障等級

### 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。本人明白其後將不會再獲發書面形式之賠償單 / 差額通知書。  
e-statement notification send to (choose one) 以此電郵地址收取電子結算表通知 (任選其一)

Office e-mail address  公司電郵地址

Home e-mail address  住宅電郵地址

### Method of Payment 繳付保費方法

<input type="checkbox"/> Yearly by Cheque / PPS / Cash 以支票 / 繳費靈 / 現金年繳 Bank Name <input type="text"/> 銀行名稱 Cheque No. <input type="text"/> 支票號碼	<i>(If cheque payment is chosen, please attach a cheque made payable to "Bupa (Asia) Limited") (若選擇以支票付款，請連同保費支票寄回，支票抬頭人為「保柏（亞洲）有限公司」)</i>	<input type="checkbox"/> Yearly by Credit Card 以信用卡年繳 Bank Name <input type="text"/> 銀行名稱 Cheque No. <input type="text"/> 支票號碼	<i>(please attach a completed Credit Card Authorisation Form) (請連同填妥之信用卡付款授權書寄回)</i>
<input type="checkbox"/> Yearly by Autopay 以自動轉賬年繳 Bank Name <input type="text"/> 銀行名稱 Cheque No. <input type="text"/> 支票號碼	<i>(please attach a cheque made payable to "Bupa (Asia) Limited" for this year's Subscription with a completed Direct Debit Authorisation Form) (請連同本年之保費支票及填妥之直接付款授權書寄回，支票抬頭人為「保柏（亞洲）有限公司」)</i>	<input type="checkbox"/> Monthly by Autopay 以自動轉賬月繳 Bank Name <input type="text"/> 銀行名稱 Cheque No. <input type="text"/> 支票號碼	<i>(please attach a cheque made payable to "Bupa (Asia) Limited" for 2 months' Subscription with a completed Direct Debit Authorisation Form) (請連同兩個月之保費支票及填妥之直接付款授權書寄回，支票抬頭人為「保柏（亞洲）有限公司」)</i>

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 Subscriber's behalf   
與投保人關係 代投保人支付保費的原因

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

# Bupa Wise Choice Health Insurance Scheme

## 保柏智康健醫療保障計劃

## Conversion Form

### 轉保申請表

I/We declare that, to the best of my/our knowledge and belief, the statements contained in this form are true and complete. I/We have read and agreed to be bound by the terms and conditions of the contract of Bupa CarePro / Bupa Care Kid Health Insurance Scheme (as appropriate) after transfer was approved by Bupa. I / We agree that the answers given in this form shall be the basis of the new 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 form 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 / We shall have the right to access and correct any of my / our personal information 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 listed in this form under this Scheme who is under the age of 18 for this Application.

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 / 吾等已細讀並同意於保柏已批准轉保後遵守保柏卓康健 / 童康健醫療保障計劃 (視乎情況而定) 之各條款及細則，並同意以本申請表內之回答作為本人 / 吾等與保柏之間所訂立新合約之根據。

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，及給予與保柏有關之人士 / 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。

本人作為投保人明白本人乃代表此申請表內列出之18歲以下會員作出聲明及簽署。

#### Subscriber's Signature of the existing Contract

現有合約之投保人簽署

#### Subscriber's Signature of the new Contract

(if different from the Subscriber of the existing Contract)

新合約之投保人簽署 (如非現有合約之投保人)

X

(Name 姓名: \_\_\_\_\_ )

Date 日期 \_\_\_\_\_

X

(Name 姓名: \_\_\_\_\_ )

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

#### For Bupa use only 保柏專用

Approved by  
批核人 \_\_\_\_\_

Date  
日期 \_\_\_\_\_

Restriction (Y/N)  
限制 (有/無) \_\_\_\_\_

Input by  
輸入者 \_\_\_\_\_

Date  
日期 \_\_\_\_\_