

Bupa Care Health Insurance Scheme

保柏樂康健醫療保障計劃

Direct Debit Authorisation Form 直接付款授權書

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 Subscription.
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的支票交回保柏。

Name of party to be credited (The beneficiary) 收款一方 (受益人) BUPA (ASIA) LIMITED	Bank No. 銀行編號 0 0 4	Branch No. 分行編號 4 9 9	Account No. 收款戶口號碼 2 1 5 0 0 2 0 0 1
I / We hereby authorise my / our below named Bank to effect transfers from my / our account to that of the above named beneficiary in accordance with such instructions as my / our Bank may receive from the beneficiary from time to time. I / We agree that my / our Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me / us. I / We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my / our account which may arise as a result of any such transfer(s). I / We agree that should there be insufficient funds in my / our account to meet any transfer hereby authorised, my / our Bank shall be entitled, in its discretion, not to effect such transfer in which event the Bank may make the usual charge and that it may cancel this authorisation at any time on one week's written notice. This authorisation shall have effect until further notice. I / We agree that any notice of cancellation or variation of this authorisation which I / we may give to my / our Bank shall be given at least two working days prior to the date on which such cancellation/variation is to take effect.		本人 / 吾等現授權本人 / 吾等之下述銀行，(根據受益人不時給予本人 / 吾等銀行之指示) 自本人 / 吾等之戶口內轉賬予上述受益人。 本人 / 吾等同意本人 / 吾等之銀行無須證實該等轉賬通知是否已交予本人 / 吾等。 如因該等轉賬而令本人 / 吾等之戶口出現透支 (或令現時之透支增加)，本人 / 吾等願共同及各自承擔全部責任。 本人 / 吾等現同意本人 / 吾等之戶口並無足夠款項支付該等授權轉賬，本人 / 吾等之銀行有權不予轉賬，且銀行可收取慣常之收費，並可隨時以一星期書面通知取消本授權書。 本授權書將繼續生效直至另行通知為止。 本人 / 吾等同意，本人 / 吾等取消或更改本授權書之任何通知，須於取消 / 更改生效日最少兩個工作天前交予本人 / 吾等之銀行。	
My / Our Bank and Branch Name 本人 / 吾等之銀行及分行名稱	Bank No. 銀行編號	Branch No. 分行編號	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	My / Our Signature(s) 本人 / 吾等之簽署 X		HKID Card No. / Passport No. 香港身份證號碼 / 護照號碼
My / Our address as recorded on Statement / Passbook 本人 / 吾等在結單 / 存摺上之地址	Date 日期 (DD / MM / YY 日 / 月 / 年)		
Debtor's Name (If other than account holder) 債務人之姓名 (若非戶口持有人)	Membership No. (Debtor's Reference) 會員編號 (債務人備註)		
If the account holder is not the applicant/Subscriber, please fill in the following information. 若戶口持有人並非申請人/投保人，請填寫以下資料。			
Relationship with the applicant/Subscriber 與申請人/投保人關係		Reason for paying Subscription on behalf of the applicant / Subscriber 代申請人/投保人支付保費的原因	
For bank use only 銀行專用			Signature Verified 核實簽署

Notes: 1. The box marked 'Membership No.' to be completed by Bupa.
2. The signature on this authorisation form must be the same as the signature of your Bank Account.

附註：1. 會員編號一欄由保柏填寫。
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。

Bupa (Asia) Limited 保柏(亞洲)有限公司
Address 地址: 18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong
香港鰂魚涌華蘭路25號大昌行商業中心18樓
Telephone 電話: (852) 2517 5175 Facsimile 傳真: (852) 2548 1848
Website 網址: www.bupa.com.hk



Bupa Care Health Insurance Scheme

保柏樂康健醫療保障計劃

Credit Card Authorisation Form 信用卡付款授權書

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。若您已傳真此表格給我們，請無須寄回此表格。

<input type="radio"/> Visa	<input type="radio"/> MasterCard	<input type="radio"/> Diners Club	<input type="radio"/> American Express
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 / YY 月 / 年)
I hereby authorise and direct Bupa (Asia) Limited to debit the Subscription due from my credit card account on a yearly basis until further notice. 本人茲授權保柏(亞洲)有限公司從本人的信用卡戶口每年支付應繳保費金額，直至另行通知。		Total Annual Subscription 年費總額 (HKS 港幣)	
If Cardholder is not the applicant/Subscriber or proposed Member, please fill in the following information. 若信用卡持有人並非申請人/投保人或準會員，請填寫以下資料。			
Relationship with the applicant / Subscriber 與申請人 / 投保人關係		Reason for paying Subscription on behalf of the applicant / Subscriber 代申請人 / 投保人支付保費的原因	
<input type="radio"/> I hereby confirm to pay the Subscription due of Bupa Care Health Insurance Scheme for the applicant / Subscriber. (Mr / Mrs / Ms) 本人同意及承擔申請人 / 投保人之全數應繳之保柏樂康健醫療保障計劃保費金額 (先生 / 太太 / 女士)		with HKID Card No. 香港身份證號碼	
Cardholder's Signature 持卡人簽署	Contact Phone No. 聯絡電話號碼	Date 日期 (DD / MM / YY 日 / 月 / 年)	
X			
For Bupa use only 保柏專用 Bupa Care Membership No. 保柏樂康健會員編號: Subscription 保費 (HKS 港幣):		Authorised Code 授權代碼: Date 日期:	

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