

# BUPA CARE HEALTHNET HEALTH INSURANCE SCHEME APPLICATION FORM

## 保柏康健網醫療保障計劃申請表



To ensure your cover can take effect on the first day of the following month, please send us the completed application form at least 5 working days prior to the end of the month. Applications are subject to underwriting.

如欲合約在下一月一號生效，請將填妥的申請表於月底前最少5個工作天寄回保柏。所有申請必須通過核保始能生效。

Please complete this form in **ENGLISH and BLOCK LETTERS**. Please tick as appropriate.  
請以**英文正楷**填妥本申請表，並於適用地方加「✓」號。

For Bupa use only 保柏專用

Contract No. 合約編號: \_\_\_\_\_

Effective Date 生效日期: \_\_\_\_\_

### Personal Details of Applicant 申請人資料 (Applicant must be aged 18 to 59 years 申請人年齡必須為18至59歲)

Surname 姓	Given Name (Same as HKID Card) 名(與香港身份證相同)	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 DD 日 MM 月 YY 年	Height 身高 cm 公分 ft 尺	Weight 體重 kg 公斤 lb 磅	Marital Status (Optional) 婚姻狀況(可選擇填寫) <input type="checkbox"/> Single 單身 <input type="checkbox"/> Married 已婚 <input type="checkbox"/> With children 有子女	Smoker 吸煙者 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
Home Address 住宅地址	Flat / Room 單位 / 室 Bldg. / Mansion / House 大廈 / 樓 Court / Estate / Street 閣 / 屋苑 / 街道 District 地區	Floor 層數	Block 座	Correspondence Address 通訊地址 (If different from Home Address 如與住宅地址不同)	Flat / Room 單位 / 室 Bldg. / Mansion / House 大廈 / 樓 Court / Estate / Street 閣 / 屋苑 / 街道 District 地區	Floor 層數	Block 座	Kln / HK / NT 九龍 / 香港 / 新界
Country of Residence 居住國家* (If not in Hong Kong 如非香港)	Business Nature 業務性質	Home / Office Phone No. 住宅 / 公司電話號碼		E-mail Address 電郵地址*				
	Job Position 職位	Home / Office Fax No. 住宅 / 公司傳真號碼		Mobile Phone No. 手提電話號碼				

\* Unless requested below, Bupa will send the claims statement and Shortfall invoice, if applicable, by email only. No printed copy will be provided.  
除非特別提出以下要求，保柏會以電郵形式發送電子賠償單和差額通知書(如適用)，而不會提供列印本。

Please send me printed copies of the claims statement and Shortfall invoice, if applicable. 請將賠償單和差額通知書(如適用)之列印本寄給本人。

\* Unless otherwise specified by Member in writing, Inter Partner Assistance Hong Kong Limited 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)有限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。

### Application for Family Member(s) 家庭投保 (If applicable 如適用)

	Surname 姓	Given Name 名 (Same as HKID Card / Birth Certificate 與香港身份證 / 出生證明書相同)	Sex 性別	HKID Card No. / Birth Certificate No. 香港身份證號碼 / 出生證明書號碼	Date of Birth 出生日期 (DD/MM/YY日/月/年)	Height 身高 cm 公分 ft 尺	Weight 體重 kg 公斤 lb 磅	Smoker (Yes/No) 吸煙者(是/否)	Subscription Due 應繳保費金額
Applicant 申請人	(Details as above / 資料同上)								
Dependant(s) 受保家人	Spouse 配偶					cm 公分 ft 尺	kg 公斤 lb 磅		
	Child 子女					cm 公分 ft 尺	kg 公斤 lb 磅		
	Child 子女					cm 公分 ft 尺	kg 公斤 lb 磅		
	Child 子女					cm 公分 ft 尺	kg 公斤 lb 磅		

Spouse must be aged 18 to 59 years and unmarried children must be aged 15 days to 17 years or below 23 years 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15日至17歲或23歲以下之全日制學生。

Total Annual Subscription 按年保費總額  
HK\$ 港幣 \_\_\_\_\_

### Choice of Cover 投保項目

Core Benefit 主要保障 <input checked="" type="checkbox"/> Hospital and Surgical Benefit 住院及手術保障 + Clinical Benefit 門診保障	Optional Benefit 自選額外保障 <input type="checkbox"/> Hospital Cash Benefit 住院現金保障 <input type="checkbox"/> Supplementary Major Medical Benefit 附加醫療保障	Benefit Level 保障等級 (Choose one 任選其一) <input type="checkbox"/> Plan 計劃 1 Private 私家房 <input type="checkbox"/> Plan 計劃 2 Semi-private 半私家房 <input type="checkbox"/> Plan 計劃 3 Ward 大房
---	---	--

### Payment Method 繳付保費方法

Payment Frequency 繳付保費形式 Yearly 年繳	Payment Method 繳付保費方法 <input type="checkbox"/> Cheque 支票 Bank Name 銀行名稱 _____ Cheque No. 支票號碼 _____ <input type="checkbox"/> Credit Card 信用卡 <input type="checkbox"/> Interest-free Instalment Payment 免息分期付款	Remarks 備註 Please attach a cheque made payable to "Bupa (Asia) Limited" 請將支票交回本公司，支票抬頭人為「保柏(亞洲)有限公司」 Please attach a completed Credit Card Authorisation Form 請連同填妥之信用卡付款授權書寄回 Please attach a completed Interest-free Instalment Plan Application Form 請連同填妥之免息分期付款計劃申請表格寄回
---------------------------------------	--	--

If the cheque issuer is not the applicant or Proposed Member, please fill in the following information. 若支票發出人並非申請人或準會員，請填寫以下資料。

Relationship with the applicant 與申請人關係  
Reason for paying Subscription on behalf of the applicant 代申請人支付保費的原因

### Bank Account for Reimbursement 支付賠償之銀行戶口

Claims payment will be reimbursed by autopay only. 賠償款項只以自動轉賬方式支付。

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。

Account Holder's Name 戶口持有人姓名 \_\_\_\_\_ HKID Card No. 香港身份證號碼 \_\_\_\_\_

Personal local savings / current account number (HK\$ only) 個人本地儲蓄 / 往來銀行戶口號碼 (只限港幣)

Bank Name 銀行名稱 \_\_\_\_\_ Bank No. 銀行編號 \_\_\_\_\_ Account No. 戶口號碼 \_\_\_\_\_

If the above account holder is not the applicant, please fill in the following information.

若上述之戶口持有人並非申請人，請填寫以下資料。

Relationship with the applicant 與申請人關係  
Reason for receiving claims payment on behalf of the applicant 代申請人收取賠款的原因



PAAPP

## Health Declaration 健康聲明

Please note that non-disclosure of health information may result in the Contract being void and / or claims ineligible for assessment / reimbursement.  
請注意：任何未經披露之健康狀況均有機會導致合約無效及 / 或索償申請不符合資格作審核 / 賠償。

1 At any time during the past seven years from the time of this Application, has / have the applicant / Proposed Member(s):  
由申請計劃前的過去七年內，申請人 / 準會員是否：

- |  |                                |                               |
|--|--------------------------------|-------------------------------|
| 1.1 had any chronic or recurrent diseases, injuries not completely recovered or diagnosed as a Hepatitis B carrier?<br>曾患有任何慢性或復發性疾病、未完全康復之創傷或確診為乙型肝炎帶菌者？  | Yes 是 <input type="checkbox"/> | No 否 <input type="checkbox"/> |
| 1.2 exhibited any of the following symptoms in a repeated / persistent way? 曾反覆 / 持續出現以下病徵？<br>Fever, headache, dizziness, chest pain or discomfort, shortness of breath, 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>發燒、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、腹瀉、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="checkbox"/>       | <input type="checkbox"/>      |
| 1.3 received any in-patient treatment / operation / physiotherapy? 曾接受任何入院診治 / 手術 / 物理治療？  | <input type="checkbox"/>       | <input type="checkbox"/>      |
| 1.4 had any medical investigations / examinations or is there a foreseeable need for these in future? 曾經接受任何醫療檢查 / 檢驗或預期在將來有此需要？   | <input type="checkbox"/>       | <input type="checkbox"/>      |
| 1.5 taken any regular medications? 曾定期服用藥物？  | <input type="checkbox"/>       | <input type="checkbox"/>      |
| 2 Was(Were) the Proposed Member(s) born before 37 weeks or after 42 weeks of pregnancy? (Applicable to the Proposed Member(s) aged 15 days to 24 months only)<br>準會員是否於懷孕37周前或42周後出生? (只適用於年齡介乎15日至24個月的準會員)   | <input type="checkbox"/>       | <input type="checkbox"/>      |

If the applicant / any one of the Proposed Members answered YES to any of the above questions, please give details of the medical condition(s) in the table below and also provide a copy of the relevant medical report(s). If the space below is insufficient, please fill in the Supplementary Health Declaration Form.  
如果申請人 / 任何一位準會員，就以上任何問題的回答為「是」，請於下表列出有關詳情，並請提供相關的醫療報告副本。如表格不敷應用，請另填寫補充健康聲明表。

Name 姓名	Applicant 申請人	Proposed Member 準會員	Proposed Member 準會員
Symptom / Diagnosis 病徵 / 診斷			
Investigation and its result / Treatment / Operation / Medication 檢查及其結果 / 治療 / 手術 / 藥物			
Date of onset 病發日期			
Date of recovery 痊癒日期			
Fully recovered (Yes / No?) 已完全康復 (是 / 否?)			
Name, Address and Tel. No. of Doctor 醫生姓名、地址及電話號碼			

## Declaration and Authorisation 聲明及授權

I / We acknowledge that Benefit is not payable under Bupa Care HealthNet 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 / 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. I / We acknowledge that 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 this Application at my / our own cost. I / We have read and agreed to be bound by the terms and conditions of the Contract of this 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 hereby authorise Bupa to appoint Registered Medical Practitioners, Physiotherapists, Chiropractors, dental centres, wellness centres as well as imaging and laboratory centres to provide HealthNet 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 HealthNet Service Providers by the Member(s).

本人 / 吾等確認根據「保柏健康網」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 / 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。本人 / 吾等確認保柏有權要求提供更多有關本人 / 吾等及於本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 / 吾等與保柏之間所訂合約之根據。

本人 / 吾等現授權保柏代為委任註冊西醫、物理治療師、牙醫、牙科診所、保健中心及影像及化驗中心以提供「網絡保障」及有關該委任所需之服務予會員。本人 / 吾等確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而作出。就會員向有關網絡服務供應商所作出之申索，保柏一概不會負責。

## Personal Information Collection Statement 個人資料收集聲明

**Purpose:** I / We understand and agree that all personal information relating to me / any Member collected or held by Bupa, whether contained in this Application, or obtained in any claim processing procedure or otherwise from time to time, may be used by Bupa for the purpose of (1) processing this Application and providing subsequent services; (2) processing any claims analysis and / or medical or other insurance-related checks; (3) provision and design of products and services of Bupa or any of its group companies; (4) marketing of products and services of Bupa or any of its group companies (but not other persons or organisations); (5) data matching, statistics and research; (6) communication with me / any Member in relation to any of the purposes set out in this statement; and (7) satisfying any applicable legal or regulatory requirements.

**Classes of data transferees:** I / We further agree that such personal information may be transferred for the purposes as specified above to any of the following parties (within or outside Hong Kong): any group company of Bupa, any insurance intermediary as authorised by myself, any reinsurance company, any claims investigation company, any service provider providing services to Bupa, any association or federation relating to the insurance industry or any person or organisation as required by law.

**Consequences of non-provision of personal information:** I / We understand that Bupa may be unable to process this Application if I fail to provide any information requested in this Application or otherwise by Bupa.

**My rights in respect of my personal information:** I / We further understand that (1) under the Personal Data (Privacy) Ordinance, I / we shall have the right to request access to and correction of any personal information concerning me / any Member provided to Bupa; and that all such requests can be made in writing and addressed to the Personal Data Privacy Officer of Bupa at 18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong or by other means as Bupa may notify me / us from time to time; and (2) I / we can contact Bupa's Customer Care helpdesk on 2517 5333 for any enquiries about the Personal Information Collection Statement.

**Voluntary provision of additional personal information for direct marketing purposes:** I understand that information regarding my marital status is intended to be used for direct marketing purposes and that provision of such information is optional.

**用途:** 本人 / 吾等明白及同意保柏透過此申請、任何索償程序或其他途徑不時收集或持有之所有有關本人 / 任何會員的個人資料，可供保柏作以下用途 (1) 處理此申請及提供售後服務；(2) 處理任何索償分析及 / 或與醫療或其他保險有關的查核；(3) 提供及設計保柏或其集團機構的產品及服務；(4) 推廣保柏或其集團機構的產品及服務(但不會包括其他人士或機構)；(5) 資料核對、統計及研究；(6) 就任何本聲明中所述的用途與本人 / 任何會員聯絡；及(7) 遵守法律或監管要求。

**資料承讓人的類別:** 本人 / 吾等亦同意該等個人資料可因上述用途提供予以下機構(在香港境內或境外)：任何保柏的集團機構、本人委任的保險中介人、再保險公司、賠償調查公司，為保柏提供服務的供應商機構、保險業協會或聯會、或法律要求的任何人士或團體。

**未能提供個人資料的後果:** 本人 / 吾等明白若本人 / 吾等不能提供此申請或保柏要求的其他資料，保柏不能處理此申請。

**有關個人資料的權利:** 本人 / 吾等明白(1)根據個人資料(私隱)條例，本人 / 吾等有權查閱及修正保柏所持有關於本人 / 任何會員的任何個人資料。有關要求請致函保柏個人資料私隱主任收，地址為鯉魚涌華蘭路25號大昌行商業中心18樓，或按保柏不時通知本人 / 吾等的其他途徑遞交；及(2)本人 / 吾等如對個人資料收集聲明有任何查詢，可致電保柏的客戶服務專線2517 5333。

**自願性提供額外個人資料作直銷用途:** 本人明白本人向保柏提供有關婚姻狀況的個人資料乃擬用作直銷用途，並明白本人有權選擇是否提供該等資料。

I, as the Subscriber, understand that I declare and sign on behalf of the dependant(s) listed in this Application under this Scheme who is / are under the age of 18.  
本人茲申請為投保人，明白本人代表此計劃申請表內列出之18歲以下受供養人作出聲明及簽署。

Applicant's Signature 申請人簽署		Date 日期 (DD / MM / YY 日/月/年)	
X _____ (Name 姓名: _____)			
Proposed Member's Signature (Aged 18 or above) 年滿18歲或以上之準會員簽署	Date 日期 (DD / MM / YY 日/月/年)	Proposed Member's Signature (Aged 18 or above) 年滿18歲或以上之準會員簽署	Date 日期 (DD / MM / YY 日/月/年)
X _____		X _____	
(Name 姓名: _____)		(Name 姓名: _____)	
Agent's / Broker's / Telesales' Name (If applicable and must be completed by the applicant) 代理人 / 顧問 / 營業代表姓名 (如適用及必須由申請人填寫)		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		_____	

# BUPA CARE HEALTHNET HEALTH INSURANCE SCHEME APPLICATION FORM

## 保柏康健網醫療保障計劃申請表



### For Transfer Contract Only 只供轉移合約之用

Previous Bupa Membership No.:   
前保柏會員編號：

Subject to Bupa's approval of membership transfer, eligible claims related to any sicknesses or injuries that were covered under the previous Contract and commenced before the effective date of coverage under this Contract will be payable up to the Maximum Limit of the Contract with the lower Benefit level. 如經保柏批核轉移會籍，一切於前合約受保及於本合約保障開始日前已患有之疾病或損傷之合資格賠償，將根據前合約或本合約內所載之最高賠償額，以較低者為準，作出賠償。

Applicant's Signature 申請人簽署  Date 日期 (DD / MM / YY 日 / 月 / 年)

### Reminder 提醒您

- To help us process your Application quickly, please ensure that you have:
- enclosed payment of the correct Subscription amount and a copy of your HKID Card or Passport
  - enclosed a copy of your spouse's HKID Card or Passport if your spouse enrolls
  - enclosed a copy of birth certificate for each of your children who you would like to enrol
  - initialled any amendments on this application form

我們想更快地助您完成申請，因此請您在遞交申請表時謹記：

- 連同正確之保費及您的香港身份證或護照副本
- 連同您配偶之香港身份證或護照副本（如配偶一同投保）
- 連同您子女之出生證明書副本（如子女一同投保）
- 於任何更改之處簽署作實



# BUPA CARE HEALTHNET HEALTH INSURANCE SCHEME CREDIT CARD AUTHORISATION FORM

## 保柏康健網醫療保障計劃信用卡付款授權書



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="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Diners Club	<input type="checkbox"/> 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 年保費總額 (HK\$ 港幣)

If the 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

I hereby confirm to pay the Subscription due of Bupa Care HealthNet 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「保柏康健網」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)

For Bupa use only 保柏專用

Bupa Care HealthNet Membership No. 「保柏康健網」會員編號： Authorised Code 授權代碼：  
Subscription 保費 (HK\$港幣)： Date 日期 (DD / MM / YY 日 / 月 / 年)：