

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。

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
	Email Address 電郵地址

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。
If the Subscriber has been changed and you choose to pay your Subscription by autopay, please complete a new Direct Debit Authorisation Form.
若您更改投保人及選擇以自動轉賬繳付保費，請重新填妥直接付款授權書。

I. Membership Transfer 會籍轉移

I hereby apply to transfer the existing membership for the below Member to the Scheme indicated in Part II with effective from this year's Contract Anniversary Date
本人現申請為下列會員現有之會籍由本年度之合約周年日起轉移至以下第二部份所示之保障計劃。

Membership No. (16 digits) 會員編號 (16 位數字)	Member's Name 會員姓名
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II. Choice of Scheme 投保計劃

Please choose one only and put a "✓" as appropriate 請選擇一項並加上「✓」號

Bupa CarePro Health Insurance Scheme
保柏卓康健醫療保障計劃

Bupa Care Kid Health Insurance Scheme
保柏童康健醫療保障計劃
(For Member aged below 18 只適用於18歲以下之會員)

III. Types of Changes 更改項目

If you opt for any change in the benefit or payment method in the new scheme, please complete this section. Otherwise, the benefits and payment method of the new scheme will be the same as the existing scheme.
若您選擇於轉移至新計劃時更改保障項目或繳付保費方法，請填妥本部份。否則，新計劃的保障項目及繳付保費方法將會與現有的計劃相同。

A. Change of Benefit 更改保障

(Member must complete Part 2 of the Health Declaration if you choose any item with a "*". The Benefit will be effective on the date of transfer if approved by Bupa. 若您選擇的項目有「*」號，您必須填寫健康聲明的第二部份。新保障獲保柏批核後，將於新合約生效日期起生效。)

* Please tick the NEW plan 請於新計劃之空格內加上「✓」號

Plan 1 計劃一 Private 私家房 Plan 2 計劃二 Semi-Private 半私家房 Plan 3 計劃三 Ward 大房

Addition / Cancellation of Optional Benefit 增加或取消自選保障項目

<input type="checkbox"/> Clinical Benefit 門診保障	<input type="checkbox"/> * Add 增加	<input type="checkbox"/> Cancel 取消
<input type="checkbox"/> Hospital Cash Benefit 住院現金保障	<input type="checkbox"/> * Add 增加	<input type="checkbox"/> Cancel 取消
<input type="checkbox"/> Supplementary Major Medical Benefit 附加醫療保障	<input type="checkbox"/> * Add 增加	<input type="checkbox"/> Cancel 取消

* If the Member chooses a higher Benefit Level Plan upon transfer, Member is entitled to original Benefit Level of the Contract before transfer for any illnesses or injuries covered before the new Contract Effective Date. 若會員轉移會籍後選擇較高的保障計劃，所有在新合約生效日前已患疾病或損傷將以前保障額作賠償。

B. Change of Payment Method 更改繳付保費方法

Application must be made 3 weeks before the Contract Effective Date
必須於合約生效日三星期前申請

Payment Mode 繳付保費形式	Payment Method 繳付保費方法	Remarks 備註
<input type="checkbox"/> Yearly 年繳	<input type="checkbox"/> Autopay 自動轉賬	Please attach a cheque made payable to "Bupa (Asia) Limited" for 1 st year Subscription with a completed Direct Debit Authorisation Form (請填妥直接付款授權書，連同首年保費之支票交回本公司，支票抬頭人為「保柏(亞洲)有限公司」)
	<input type="checkbox"/> Cheque 支票 Bank Name 銀行名稱 _____ Cheque No. 支票號碼 _____	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」)
	<input type="checkbox"/> Credit Card 信用卡	Please attach a completed Credit Card Authorisation Form (請連同填妥之信用卡付款授權書寄回)
<input type="checkbox"/> Monthly 月繳	<input type="checkbox"/> Autopay 自動轉賬	Please attach a cheque made payable to "Bupa (Asia) Limited" for first 2 months' Subscription with a completed Direct Debit Authorisation Form (請填妥直接付款授權書，連同首兩個月保費之支票交回本公司，支票抬頭人為「保柏(亞洲)有限公司」)

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 behalf of the Subscriber _____
與投保人關係 _____ 代投保人支付保費的原因 _____

IV. Subscription Information 保費資料

Subscription submitted with this form 連同此申請表附上之保費

by Cheque 以支票繳付 HKS 港幣 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, 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 behalf of the Subscriber _____
與投保人關係 _____ 代投保人支付保費的原因 _____



V. 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 read the following questions and statements carefully before answering. 請在回答前詳閱以下問題及描述。

If you are applying Transfer to the same or a lower level benefit, please complete Part 1 only. Otherwise, please complete both Part 1 and 2.
若您申請轉移到相同或較低保障級別，請填寫第一部份；否則，請填寫第一及第二部份。

(Note: 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：請於簽署本健康聲明前，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。)

Part 1 第一部份

At any time before this Transfer Application, has/have the Members been treated or diagnosed to have the following conditions?

在申請轉移計劃前，會員曾否被診斷患有或因下列疾病而接受治療？

- Malignancy including cancer, sarcoma, leukemia, etc.
惡性腫瘤包括癌症、肉瘤、白血病等
- Kidney (renal) disease
腎病

Yes 是	No 否
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

Part 2 第二部份

At any time during the past seven years from the time of this Application, has the Member:

由申請計劃前的過去七年內，會員是否：

- 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未完全康復之創傷？
- 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？
- received any in-patient treatment / operation / physiotherapy?
曾接受任何入院診治/手術/物理治療？
- had any medical investigations / examinations?
曾接受任何醫療檢查/檢驗？
- taken any regular medications?
曾定期服用藥物？

Yes 是	No 否
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<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).

如果您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。

with attachment
另有附頁

Symptoms / Diagnosis 病徵 / 診斷	Investigation / Treatment / Operation / Medication 檢查 / 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

Declaration 聲明

I, on behalf of myself and/or the Member declare that, to the best of my knowledge and belief, the statements contained in this form are true and complete. I acknowledge that Bupa reserves the right to ask for submission of more details of health status or medical reports of me / the Member as listed in this application at my own costs. I 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 is approved by Bupa. I agree that the answers given in this form shall be the basis of the Contract between me and Bupa.

I understand that subject to Bupa's approval of membership transfer, eligible claims related to any sicknesses or injuries that was covered under the previous contract and commenced before the effective date of coverage under the new Contract will be payable up to the benefit items of the contract with the lower Benefit level.

本人謹此代表本人及/或會員，就本人所知所信，本申請表上填報之一切資料，均屬實完整。本人確認保柏有權要求提供更多有關於本申請表內所列之本人/會員之健康狀況及醫療報告，一切費用由本人支付。本人已細讀並同意於保柏已批准轉保後遵守保柏卓康健/保柏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與保柏之間所訂立新合約之根據。本人明白如經保柏批核的會籍轉移，一切於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，將根據前合約或新合約內所載之保障項目，以較低者為準，作出賠償。

Personal Information Collection Statement 個人資料收集聲明

Purposes: I understand and agree that all personal information relating to me / the 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 purposes 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 / the 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 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 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 further understand that (1) under the Personal Data (Privacy) Ordinance, I shall have the right to request access to and correction of any personal information concerning me / the 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 from time to time; and (2) I 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/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/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: 本人明白若本人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: 本人明白(1)根據個人資料(私隱)條例，本人有權查閱及修正保柏所持有關於本人/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，地址為香港鰂魚涌華蘭路25號大昌行商業中心18樓，或按保柏不時通知本人的其他途徑遞交；及(2)本人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 proposed Member(s) listed in this application under this Scheme who is under the age of 18.

本人作為投保人，明白本人代表此計劃申請表內列出之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 (DD / MM / YY 日/月/年)

X
(Name 姓名: _____)

X

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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

Bupa CarePro / Bupa Care Kid Health Insurance Scheme

保柏卓康健/保柏童康健醫療保障計劃

Direct Debit Authorisation Form
直接付款授權書

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

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，請填妥此授權書及簽署於 "X" 位置並連同支票交回保柏。

Name of party to be credited (The Beneficiary) 收款之一方 (受益人)	Bank No. 銀行編號	Branch No. 分行編號	Account No. to be credited 收款戶口號碼
Bupa (Asia) Limited	0 0 4	4 9 9	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/吾等願共同及各別承擔全部責任。 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 Names and Branch 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		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
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 Subscriber, please fill in the following information 若戶口持有人並非投保人，請填以下資料。			
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	
For bank use only 銀行專用			Signature Verified 核實簽署

Note: 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銀行戶口內之簽署相符。

Bupa CarePro / Bupa Care Kid Health Insurance Scheme

保柏卓康健/保柏童康健醫療保障計劃

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.

Note: 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，請填妥此授權書及簽署於 "X" 位置並交回保柏。若您傳真此表格給我們，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 Subscriber, please fill in the following information. 若信用卡持有人並非投保人，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	
<input type="radio"/> I hereby confirm to pay the Subscription due of Bupa CarePro / Bupa Care Kid Health Insurance Scheme for the Subscriber (Mr / Mrs / Ms) 本人同意及承擔以下人士之全數應繳之保柏卓康健/童康健醫療保障計劃保費金額 (先生 / 女士 / 小姐)			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 CarePro / Bupa Care Kid Membership No. 保柏卓康健/保柏童康健會員編號:		Authorised Code 授權代碼:	
Subscription 保費 (HKS 港幣):		Date 日期:	

Bank No. 銀行編號	Bank Name in English 銀行名稱 (英文)	Bank Name in Chinese 銀行名稱 (中文)
008	ABN AMRO BANK N.V.	荷蘭銀行
011	AMERICAN EXPRESS BANK LIMITED	美國運通銀行
028	ASIA COMMERCIAL BANK LIMITED	亞洲商業銀行有限公司
049	BANGKOK BANK PUBLIC COMPANY LIMITED	盤谷銀行
009	BANK OF AMERICA (ASIA) LIMITED	美國銀行(亞洲)有限公司
055	BANK OF AMERICA, NATIONAL ASSOCIATION	美國銀行
014	BANK OF CHINA (HONG KONG) LIMITED <i>(Previously known as YIEN YIEH COMMERCIAL BANK LTD)</i>	中國銀行(香港)有限公司 (前稱「鹽業銀行」)
012	BANK OF CHINA (HONG KONG) LIMITED <i>(Previously known as BANK OF CHINA HONG KONG BRANCH)</i>	中國銀行(香港)有限公司 (前稱「中國銀行」香港分行)
064	BANK OF CHINA (HONG KONG) LIMITED <i>(Previously known as HUA CHIAO COMMERCIAL BANK LTD)</i>	中國銀行(香港)有限公司 (前稱「華僑商業銀行」)
030	BANK OF CHINA (HONG KONG) LIMITED <i>(Previously known as KINCHENG BANKING CORPORATION)</i>	中國銀行(香港)有限公司 (前稱「金城銀行」)
019	BANK OF CHINA (HONG KONG) LIMITED <i>(Previously known as KWANGTUNG PROVINCIAL BANK)</i>	中國銀行(香港)有限公司 (前稱「廣東省銀行」)
070	BANK OF CHINA (HONG KONG) LIMITED <i>(Previously known as PO SANG BANK LTD.)</i>	中國銀行(香港)有限公司 (前稱「寶生銀行」)
031	BANK OF CHINA (HONG KONG) LIMITED <i>(Previously known as SIN HUA BANK LIMITED)</i>	中國銀行(香港)有限公司 (前稱「新華銀行」)
026	BANK OF CHINA (HONG KONG) LIMITED <i>(Previously known as THE CHINA & SOUTH SEA BANK LTD)</i>	中國銀行(香港)有限公司 (前稱「中南銀行」)
033	BANK OF CHINA (HONG KONG) LIMITED <i>(Previously known as THE CHINA STATE BANK LTD)</i>	中國銀行(香港)有限公司 (前稱「國華商業銀行」)
036	BANK OF CHINA (HONG KONG) LIMITED <i>(Previously known as THE NATIONAL COMMERCIAL BANK LTD)</i>	中國銀行(香港)有限公司 (前稱「浙江興業銀行」)
027	BANK OF COMMUNICATIONS	交通銀行
015	BANK OF EAST ASIA, LIMITED (THE)	東亞銀行有限公司
047	BANK OF TOKYO-MITSUBISHI, LTD.(THE)	東京三菱銀行
074	BARCLAYS BANK PLC	巴克萊銀行
056	BNP PARIBAS	法國巴黎銀行
044	CHEKIANG FIRST BANK LTD.	浙江第一銀行有限公司
039	CHIYU BANKING CORPORATION LIMITED	集友銀行有限公司
250	CITIBANK, N.A.	花旗銀行
018	CITIC KA WAH BANK LIMITED	中信嘉華銀行有限公司
040	DAH SING BANK LIMITED	大新銀行有限公司
016	DBS BANK (HONG KONG) LIMITED <i>(Previously known as DAO HENG BANK LIMITED)</i>	星展銀行(香港)有限公司 (前稱「道亨銀行有限公司」)
032	DBS BANK (HONG KONG) LIMITED <i>(Previously known as DBS KWONG ON BANK LIMITED)</i>	星展銀行(香港)有限公司 (前稱「DBS廣安銀行有限公司」)
052	DBS BANK (HONG KONG) LIMITED <i>(Previously known as OVERSEAS TRUST BANK LTD.)</i>	星展銀行(香港)有限公司 (前稱「海外信託銀行有限公司」)
017	FIRST PACIFIC BANK LIMITED	第一太平銀行有限公司
029	FORTIS BANK ASIA HK <i>(also known as WA PEI FU TONG YIN HANG)</i>	華比富通銀行
024	HANG SENG BANK LTD.	恒生銀行有限公司
004	HONGKONG AND SHANGHAI BANKING CORPORATION LIMITED (THE)	香港上海匯豐銀行有限公司
051	HONGKONG CHINESE BANK LIMITED (THE)	香港華人銀行有限公司
072	INDUSTRIAL AND COMMERCIAL BANK OF CHINA (ASIA) LIMITED	中國工商銀行(亞洲)有限公司
128	INTERNATIONAL BANK OF ASIA LTD.	港基國際銀行有限公司
007	JPMORGAN CHASE BANK	摩根大通銀行
041	LIU CHONG HING BANK LIMITED	廖創興銀行有限公司
021	MEVAS BANK LIMITED	豐明銀行有限公司
043	NANYANG COMMERCIAL BANK LIMITED	南洋商業銀行有限公司
022	OVERSEA-CHINESE BANKING CORPORATION LTD.	華僑銀行有限公司
057	OVERSEAS UNION BANK LIMITED	華聯銀行有限公司
025	SHANGHAI COMMERCIAL BANK LTD.	上海商業銀行有限公司
003	STANDARD CHARTERED BANK	渣打銀行
061	TAI SANG BANK LTD.	大生銀行有限公司
038	TAI YAU BANK LTD.	大有銀行有限公司
042	UNITED CHINESE BANK LIMITED	中國聯合銀行有限公司
071	UNITED OVERSEAS BANK LTD.	大華銀行有限公司
035	WING HANG BANK LTD.	永亨銀行有限公司
020	WING LUNG BANK LIMITED	永隆銀行有限公司

Note : The above List of Bank No. is for reference only. You should contact your bank for the bank no. if you have any doubt.
附註 上述銀行編號只供參考用途，閣下如有任何疑問，請向閣下之銀行查詢。