

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。

### Conditions of Reinstatement 復效申請條款

- Subscribers may apply to reinstate their Contract within three (3) months from the due date of the unpaid Subscription.  
投保人可於保費到期日起計3個月內申請將合約復效。
- Approval of reinstatement is subject to satisfactory evidence of insurability and/or additional financial and medical information of the Member that is provided at the Subscriber's expense. Please note that no cover will be provided during the lapsed period.  
合約復效須提供保柏滿意的投保健康證明及/或會員財政及身體狀況的資料，並須經保柏批准，有關費用由投保人支付。會籍失效期間不會提供任何保障。
- Please complete, sign and return this original Application together with a cheque for the payment of the outstanding subscription to Bupa. If reinstatement is not approved, Bupa will return the cheque to you.  
請填妥、簽署復效申請表格正本連同逾期保費之支票一併寄回保柏。若合約復效申請不獲批准，保柏將會向您退回此支票。

### Subscriber's Information 投保人資料

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
Subscription amount submitted with this form HK\$ 連同此申請表附上之保費 (港幣)	Cheque no.: 支票號碼
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 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

### Health Declaration 健康聲明

**Important notes 重要資料：**  
Please ensure you have answered all the questions below before signing this Application. Please note that Members will not be eligible for claims resulting from the non-disclosure of health information. 簽署本申請表前，請回答以下所有問題。任何未經填報的健康狀況而引致的索償申請，將不獲接納。

- Last consultation 最近一次求診資料：  
Date 日期 \_\_\_\_\_ Reason 原因 \_\_\_\_\_  
Result 結果 \_\_\_\_\_  
Name and address of the doctor 醫生姓名及地址 \_\_\_\_\_
- Have your natural parents or siblings had diabetes; breast, cervical, ovarian, colon, or other cancer(s); high blood pressure, heart problems, stroke, haemochromatosis, Huntington Disease (Huntington's Chorea), polycystic Kidney disease or any other hereditary disease(s)? (Please provide relationship, condition, age at onset and/or age at death (if applicable).  
閣下的父母或兄弟姊妹有否患有糖尿病；乳癌、子宮頸癌、卵巢癌、腸癌、或其他癌症；高血壓、心臟疾病、中風、血色素沉著症、亨廷頓舞蹈病、多囊腎症或其他遺傳病？請提供關係、狀況、病發年齡及/或死亡年齡（如適用）。  Yes 是  No 否
- So far as you know have you ever had and/or been treated for and/or been told you had any of the following diseases or disturbance?  
就閣下所知，閣下曾否患有及/或被提及患有以下疾病或機能失調及/或因此接受治療？  
3.1 Any chest pain\*, heart disease or problems of the blood vessels (e.g. rheumatic fever, raised blood pressure, high blood cholesterol, angina, irregular heart beat, murmur, heart attack, etc.)?  Yes 是  No 否  
任何胸痛\*、心臟病或其它血管疾病（例如：風濕性熱、高血壓、膽固醇高、心絞痛、心律不整、心臟雜音、心臟病發作等）？  
3.2 Any chest or breathing complaint\* (e.g. asthma, bronchitis, tuberculosis, persistent hoarseness or cough or other respiratory problems, etc.)?  Yes 是  No 否  
任何胸部或呼吸問題\*（例如哮喘、支氣管炎、結核、持久沙啞或咳嗽、或其他呼吸器官疾病）？  
3.3 Any complaint of the digestive system\* (e.g. hepatitis or hepatitis carrier, gallstones, gastric ulcer, esophageal reflux, polyps, bowel or rectal bleeding, etc.)?  Yes\* 是  No 否  
任何消化系統問題\*（例如肝炎或肝炎帶菌者、膽石、消化道潰瘍、胃酸倒流、息肉、直腸出血等）？  
3.4 Any diseases of the genital urinary system (e.g. Blood or protein in urine, kidney stones, nephritis or nephropathy, renal failure, prostate disorders, ovarian cysts, endometriosis, etc.)?  Yes 是  No 否  
任何泌尿生殖系統疾病（例如血尿或蛋白尿、腎石、腎炎或腎病、腎功能衰竭、前列腺疾病、卵巢囊腫、子宮內膜異位等）？  
3.5 Any neurological or mental disorders\* (e.g. epilepsy\*, impairments of hearing, speech, or vision, prolonged headache, convulsions, depression, stroke, paralysis, multiple sclerosis, Parkinson's disease, Alzheimer's disease, etc.)?  Yes 是  No 否  
任何神經或精神性疾病\*（例如癲癇\*、聽力/語言/視力受損、長期頭痛、癲癇、抑鬱、中風、癱瘓、多發性硬化、帕金森氏病、老年癡呆症等）？  
3.6 Any endocrine disorders (e.g. diabetes\*, pituitary disorder, thyroid disorder, etc.)?  Yes 是  No 否  
任何內分泌疾病（例如糖尿病\*、腦垂體疾病、甲狀腺疾病等）？  
3.7 Chronic pain or other problem in your neck or back\*, ankylosing spondylitis\*, sciatica\*, muscle or joint disorders, gout, rheumatism, systemic lupus erythematosus, or other physical disability?  
慢性頸腰痛或脊椎病變\*、強直性脊椎炎\*、坐骨神經痛\*、肌肉關節病變、痛風、類風濕、紅斑狼瘡、或其它身體殘疾？  Yes 是  No 否  
3.8 Cancer, tumour, lumps, cyst, disorder of skin, disorder of lymph gland, anaemia, leukaemia, other disorder of blood?  
癌症、腫瘤、腫塊、囊腫、皮膚病變、淋巴腺的疾病、貧血、白血病、其他與血有關的疾病？  Yes 是  No 否  
3.9 Venereal disease, AIDS, AIDS-related conditions, any blood test for HIV virus?  
性病、愛滋病、與愛滋病有關的疾病、曾接受愛滋病毒血液測試？  Yes\* 是  No 否
- Have you ever used drugs such as stimulants, hallucinogens, narcotics or other controlled substance other than prescribed by a physician, or been counselled, treated or arrested for excessive use of alcohol or drugs?  
您曾否服用藥物如興奮劑、迷幻藥、麻醉藥或其他並非由醫生處方的受管制藥物，或因酗酒或吸毒而接受輔導、治療或被捕？  Yes\* 是  No 否
- Within the past seven years have you had any:  
過去七年內閣下曾否：  
5.1 diagnostic test such as X-ray, electrocardiogram, genetic test or blood test, biopsies, ultrasonogram?  Yes 是  No 否  
接受診斷檢驗如X光、心電圖、遺傳基因檢驗、血液檢驗、活體切片檢查或超音波檢查？  
5.2 illness, operation, medical advice or hospital treatment not mentioned above?  Yes 是  No 否  
患有上文並未提及的疾病、並需接受手術、醫療建議或留院治療？  
5.3 pension and/or claimed payment for any sickness, accident or injury?  
因疾病、意外或受傷而取得賠償及/或退休金？  Yes 是  No 否
- Has your weight changed more than 11 lbs/5kgs in the past year?  
過去一年內，閣下的體重曾否有11磅或5公斤以上的增減？  Yes 是  No 否
- Are you currently taking any medication?  
閣下目前是否有服用任何藥物？  Yes 是  No 否



8. Have you smoked cigarettes within the past 12 months? If Yes, please state:  Yes  No 否  
閣下在過去十二個月內曾否吸煙? 如「有」, 請註明:  
a. Average no. of cigarettes daily? 每日平均吸煙的支數? \_\_\_\_\_  
b. For how many years have you smoked? 閣下已吸煙多少年? \_\_\_\_\_

9. Do you take alcohol on a regular basis?  Yes\*是  No 否  
閣下有否飲用酒精的習慣?

10. For juvenile Member under the age of 2 years 只適用於兩歲以下的兒童會員  Yes  No 否  
a. Weight at birth 出生體重 lbs 磅 / ozs 安士 / kgs 公斤 \_\_\_\_\_  
b. Had the Member been confined in hospital for more than 5 days since birth? If Yes, please give reason 自出生日起計, 如留院超過五天, 請說明原因: \_\_\_\_\_  
c. Were there any birth difficulties, RH problem, congenital deformed limbs, "blue baby", lack of mental development or Down's syndrome? 曾否出現難產, 因子問題, 先天性肢體畸形, 青紫嬰兒, 缺乏正常心智發展或唐氏綜合症等徵狀? \_\_\_\_\_

Questions 11 to 15 are to be completed for female Member 第11至15題只適用於女性會員

11. Have you ever had or been told to have, or been treated for any disease /disorder of the cervix, uterus or the breast?  Yes  No 否  
閣下曾否或被建議就子宮頸、子宮、乳房疾病接受治療?

12. Have you ever had or have been advised to have, or are you intending to have tests or treatment of the breast such as mammogram, an ultrasound or surgery, etc?  Yes  No 否  
閣下曾否或被建議或打算就乳房接受檢查或治療如乳房X光、超音波或手術?

13. Have you ever had, or have been advised to have, or are you intending to have investigations and /or treatment of the cervix or uterus, such as a pap smear, cone biopsy, colposcopy or ultrasound, etc?  Yes  No 否  
閣下曾否或被建議或打算就子宮頸、子宮疾病接受檢查或治療如柏氏細胞塗片、錐形活體切片檢查、陰道鏡或超音波檢查?

14. Are you now pregnant? If yes, please state week(s) of pregnancy  Yes  No 否  
閣下現在是否懷孕? 若是, 請列明懷孕週數: \_\_\_\_\_

15. Have you been informed by a doctor or is there any reason to believe that your pregnancy may be abnormal?  Yes  No 否  
閣下曾否被醫生告知或因任何原因懷疑懷孕不正常?

For each "YES" answer for Questions 1 to 15, please identify question number and give full details, conditions, dates, duration and result. Please give full names and address of doctors, hospital and clinics.  
如第1至15題的答案為「是」, 請註明題號並列出詳情, 如求診日期、持續時間、診斷結果、醫生、醫院、診所全名及地址等。

If you answer "YES" to questions or illnesses marked with an "\*", please fill in relevant health questionnaires. 如標示 \* 號的問題或疾病的答案為「是」, 請填寫有關健康問卷。

### Declaration and Authorisation 聲明及授權

I hereby request that the above contract with Bupa be reinstated and I understand and agree to the Condition of Reinstatement as stipulated in this application. I hereby declare and agree on behalf of myself / the Member in this application that (1) to the best of my knowledge and belief, the statements and answers contained in this application form and any other questionnaires issued by Bupa, and answers given to Bupa's appointed medical examiner, are true and complete; (2) all answers to such questions, together with this application, shall form the basis and become a part of the Contract; (3) failure to disclose all relevant information may result in non-payment of a claim and/or all cover under the policy being cancelled; (4) any misrepresentation or non-disclosure of smoking habit will render the Contract void in case of claims, whether the claim is pertaining to smoking or not.

I hereby authorise on behalf of myself / the Member in this application that (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of the Member and who has attended or may hereafter attend to the Member to disclose such information to Bupa; (2) Bupa or any of its appointed medical examiners or laboratories to perform the necessary medical assessments and tests to evaluate the health status of the Member in relation to this application and any claim arising therefrom. I acknowledge that Bupa reserves the rights to ask for submission of more details of health status or medical reports of the Member as listed in this application at my own cost. Such authorisation shall survive me and shall be irrevocable.

本人謹此要求將上述保柏之合約復效, 並明白及同意復效申請表上列明之復效申請條款。本人謹此代表本人/此申請的會員在此聲明及同意(1)本申請表及其他一切由保柏發出的問卷內所作的一切陳述及答案及向保柏受委託的醫生、醫療人員提供的答案, 就本人所知所信, 均屬真實完整;(2)上述問題的所有答案及此申請表, 將成為簽發保單的根據;(3)如未有完全提供所有有關核保的資料, 將會引致賠償申索被拒絕及/或此保單之保障被撤銷;(4)任何吸煙習慣的失實陳述, 無論與索償有關與否, 均會導致合約無效。

本人謹此代表本人/此申請的會員授權(1)任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、其他組織或人士、凡知道或持有任何有關會員之紀錄者、及/或曾診驗或可能將會診驗會員, 均可將該等資料提供給保柏;(2)保柏或任何其指定之醫生、醫療人員或化驗所, 可就此投保申請表或任何與之有關的賠償申請替會員進行所需之醫療評估及測試, 作為審核會員之健康狀況。本人確認保柏有權要求提供更多有關會員於本申請表所示之健康狀況及醫療報告, 一切費用由本人支付。此授權將在本人/會員身故後仍然生效及不可撤回。

#### 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 during previous applications, 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; or maintain the insurance under 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.

**用途:** 本人明白及同意保柏透過此申請或以前的申請、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, 及繼續提供此申請內的保險。

**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。

I, as the Subscriber, understand that I declare and sign on behalf of the proposed Member 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的18歲以下會員作出聲明及簽署。

Subscriber's Signature 投保人簽署

Signed in Hong Kong on 簽署於香港

X \_\_\_\_\_

DD 日 /

MM 月 /

YY 年

Please submit this Application Form to Bupa within 14 days of the above signature date. 請確保此申請表能於上述簽署日期的14天內交回保柏。

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。

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' Contact Tel. No. 代理人 / 顧問 / 營業代表聯絡電話號碼