

Bupa Crystal Health Insurance Scheme

保柏晶彩寶醫療保障計劃





Credit Card Authorisation Form 信用卡付款授權書

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	Fax No. 傳真號碼
Membership No. (16 digits) 會員編號 (16位數字)	Email Address 電郵地址

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，請填妥此表授權書及簽署於“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 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 Crystal Health Insurance Scheme for the applicant / Subscriber. (Mr / Mrs / Ms) 本人同意及承擔以下人士之全數應繳之保柏晶彩寶醫療保障計劃保費金額		with HKID Card No. (先生 / 太太 / 女士) _____ 香港身份證號碼 _____	
Cardholder's Signature 持卡人簽署 X	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 Crystal Membership No. 保柏晶彩寶會員編號：		Authorised Code 授權代碼：	
Subscription 保費 (HKS 港幣)：		Date 日期：	

Bupa (Asia) Limited 保柏(亞洲)有限公司

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