

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 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

### Types of Changes 更改項目 (Please tick the change(s) and fill in the details as required 請選擇更改部份並填妥所需資料)

#### I. Addition of Dependant 增加受供養人 (Health Declaration must be completed 必須填寫健康聲明)

Spouse must be aged 18 to 59, and unmarried child(ren) must be aged under 18 or below 23 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18歲以下或23歲以下之全日制學生  
\*\* For spouse, please submit the copy of HKID Card / Passport; for child, please submit the copy of birth certificate to Bupa. 請連同配偶之香港身份證 / 護照副本及子女出生證明書副本交回保柏。

	Surname 姓 (Same as HKID Card / Birth Certificate 與香港身份證 / 出生證明書相同)	Given Name 名	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	Weight 體重 (kg公斤)	Height 身高 (cm公分)	Smoker (Y / N) 吸煙者 (是/否)	Country of Residence* (if not HK) 居住國家* (如非香港)
Spouse 配偶									
Child 子女									
Child 子女									

\* 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。

#### II. Change of Benefit 更改保障 (Health Declaration must be completed for new choice with item marked with "\*\*". The new benefit will be effective on the date of renewal, if approved. 有["\*"]號的新選項必須填寫健康聲明，一經批准，新保障將於續保日生效。)

Please tick the NEW choice 請於新選項之空格內加上「✓」號

##### Hospital and Surgical Benefit 住院及手術保障

Change to 改為:  100% reimbursement 十足賠償\*

##### Optional Benefit: 1. Clinical Benefit 門診保障 自選保障項目

Add as 增加為\*:  100% reimbursement 十足賠償

Change to 改為:  100% reimbursement 十足賠償\*

Cancel 取消

##### 2. Hospital Cash Benefit 住院現金保障

Add 增加\*  Cancel 取消

\* If the Benefit after the change is higher than the Benefit the Member is entitled to before the change, Benefit is payable as per the Benefit before the change in relation to any illnesses or injuries covered under this Contract that commenced before Contract Effective Date. 若會員的新保障額較前保障額為大，所有在合約生效日前已患疾病或損傷將根據前保障額作賠償。

Subscription submitted with this form HK\$  
連同此申請表附上之保費港幣

by Cheque - Cheque No.:  
以支票繳付 - 支票號碼

by Credit Card - Please enclose with a 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

by Interest-Free Instalment Payment - Please enclose with a completed Interest-Free  
Installment Plan Application Form  
以月供免息分期付款 - 請寄回已填妥之免息分期付款計劃申請表格

If the cheque issuer is not the Subscriber or Member, please fill in the following information. 若支票發出人並非投保人或會員，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

#### III. Change of Bank Account for Reimbursement 更改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
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##### 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
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If the above account holder is not the Subscriber, please fill in the following information. 若上述之戶口持有人並非投保人，請填寫以下資料。

Relationship with the Subscriber 與投保人關係	Reason for receiving claims payment on behalf of the Subscriber 代投保人收取賠款的原因
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#### IV. Application for e-Statement Service 申請電子結算表服務

I hereby agree to receive an e-Statement notification to access my electronic claims statement / shortfall invoice. I understand that no printed copy of claims statement / shortfall invoice will be issued thereafter.

本人現同意收取電子結算表通知以取得本人之電子賠償單 / 差額通知書。本人明白日後將不會再獲發書面形式之賠償單 / 差額通知書。  
e-statement notification sent to the email address stated in section VI below (choose one)  Office email address  Personal email address  
以下列第六項(VI)所示的電郵地址收取電子結算表通知 (任選其一) 公司電郵地址 個人電郵地址

#### V. Change of Account Number for Credit Card 更改信用卡戶口號碼

Yearly by Credit Card (please attach a newly completed Credit Card Authorisation Form)  
以信用卡年繳 (請連同新填妥之信用卡付款授權書寄回)



VI. Change of Correspondence Address / Telephone No. / Email Address 更改通訊地址 / 電話號碼 / 電郵地址					
New Address : 新地址	Flat / Room 單位 / 室	Floor 層數	Block 座	Bldg. / Mansion / House 大廈 / 樓	
	Court / Estate / Street 閣 / 屋苑 / 街道		District 地區	Kln. / H.K. / N.T. 九龍 / 香港 / 新界	
New Telephone No. : 新電話號碼	Home : 住宅	Office : 公司	Mobile Phone : 手提電話	Fax No : 傳真號碼	
New Email Address : 新電郵地址	Personal : 個人		Office : 公司		

VII. Change of Member(s) Details 更改會員資料							
** For spouse, please submit the copy of HKID Card / Passport; for child, please submit the copy of birth certificate to Bupa. 請連同配偶之香港身份證 / 護照副本及子女出生證明書副本交回保柏。							
	Surname 姓 (Same as HKID Card / Birth Certificate 與香港身份證 / 出生證明書相同)	Given Name 名	Membership No. 會員編號	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	Country of Residence* (if not HK) 居住國家* (如非香港)
Subscriber 投保人							
Spouse 配偶							
Child 子女							
Child 子女							

# 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。

VIII. Other Changes 其他更改 (Please specify the details 請詳細列明)	

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。					
Height 身高	cm公分 /	ft尺	Weight 體重	kg公斤 /	lb磅
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 (Proposed) Member(s): 由申請計劃前的過去七年內，(準)會員是否：			Yes 是	No 否	
1.1 had any chronic or recurrent diseases, injuries not completely recovered or diagnosed as a Hepatitis B carrier? 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？			<input type="radio"/>	<input type="radio"/>	
1.2 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？			<input type="radio"/>	<input type="radio"/>	
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="radio"/>	<input type="radio"/>	
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="radio"/>	<input type="radio"/>	
1.5 taken any regular medications? 曾定期服用藥物？			<input type="radio"/>	<input type="radio"/>	
2) Was(Were) the (Proposed) Member(s) born before 37 weeks or after 42 weeks of pregnancy? (Applicable to the (Proposed) Member(s) aged 0 to 24 months only) (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0至24個月的(準)會員)			<input type="radio"/>	<input type="radio"/>	
If the (Proposed) Member(s) 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(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。					With attachment 另有附頁 <input type="radio"/>
(Proposed) Member(s) Name (準)會員姓名	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 / recovery 病發日期 / 痊癒日期	Fully recovered 已完全康復 (Yes/No 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 Crystal 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 the 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, Hospitals, Registered Chinese Medicine Practitioners, Physiotherapists, Chiropractors, Qualified Nurses, cancer centres, day case centres, diabetic centres, dental centres, wellness centres as well as imaging and laboratory centres to provide CrystalNet 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 CrystalNet Service Providers by the Member(s).

本人 / 吾等確認根據保柏晶彩寶醫療保障計劃（「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 / 吾等及於申請表內所列出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、醫院、註冊中醫、物理治療師、中醫、合資格護士、癌症中心、日症中心、糖尿病中心、牙科診所、保健中心及影像及化驗中心以提供晶彩寶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。就會員向有關晶彩寶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

**Purposes:** 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 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 / 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 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 / 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.

**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及繼續提供此申請內的保險。

**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 / 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。

I, as the Subscriber, understand that I declare and sign on behalf of the dependant(s) listed in the application under this Scheme who is / are 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歲以下受供養人作出聲明及簽署。

Subscriber's Signature 投保人簽署

Member's Signature (aged 18 or above)  
年滿18歲或以上之會員簽署

Member's Signature (aged 18 or above)  
年滿18歲或以上之會員簽署

Date 日期 (DD / MM / YY 日 / 月 / 年)

X  
(Name 姓名 :

X  
(Name 姓名 :

X  
(Name 姓名 :

X

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。

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 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

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，請填寫此授權書及簽署於「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 / 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. 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)
<b>X</b>			
<b>For Bupa use only 保柏專用</b> Bupa Crystal Membership No. 保柏晶彩寶會員編號 : Subscription 保費 (HKS 港幣) :		Authorised Code 授權代碼 : Date 日期 :	