

Bupa Wise Choice Health Insurance Scheme 保柏智康健醫療保障計劃



Application Form 申請表

Please ensure your completed application form is received by Bupa at least **5 working days prior to the end of month** so as to effect the cover on the 1st day of the following month. Please also make sure you have enclosed your full Subscription and a copy of HKID Card / passport. If the Proposed Member is under the age of 18, please attach a copy of Birth Certificate / guardian proof. If applicable, All Applicants are subject to underwriting. 如欲合約在下月一號生效，請將填妥的申請表連同正確的保費及香港身份證 / 護照副本於月底前最少五個工作天寄回保柏。如準會員為18歲以下，請附上出生證明書 / 監護人證明副本(如適用)。所有申請必須經過保柏核保始能生效。 Any amendments to this form should be endorsed. A copy of the application form will be sent to you together with membership pack for your record. 本申請表上如有任何更改，請於更正資料旁邊的空白位置簽署作實。本申請表副本將會連同會員證書等資料一併寄出供閣下保留。

For Bupa use only 保柏專用

Contract No. 合約編號: _____

Effective Date 生效日期: _____

Please complete both sides of the form IN ENGLISH AND BLOCK LETTERS and return it to Bupa.
請以英文正楷填妥本申請表之正頁及背頁，並寄回保柏。

Personal Details of Applicant 申請人資料 (Please complete a separate application form for each Proposed Member. Applicant should be a parent or guardian if the Proposed Member is below 18 years old. 請為每一位準會員填寫一份申請表。如準會員為18歲以下，申請人必須為準會員之父母或監護人)

Surname 姓	Given Name (same as HKID Card) (與香港身份證相同) 名	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	Marital Status** 婚姻狀況
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	Marital Status** 婚姻狀況 <input type="radio"/> Single 單身 <input type="radio"/> Married 已婚 <input type="radio"/> With children 有子女
Country of Residence 居住國家 (if not Hong Kong 如非香港)	Mobile Phone No. 手提電話號碼	Home Phone No. 住宅電話號碼	Personal E-mail Address 個人電郵地址		
Home Fax No. 住宅傳真號碼	Office Phone No. 公司電話號碼	Office Fax No. 公司傳真號碼	Office E-mail Address 公司電郵地址		

** Provision of information is voluntary 提供此等資料屬自願性質

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
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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

e-Service 電子服務

I hereby understand and agree that all documents related to this scheme will be in electronic format (if available) and no printed copy will be provided. 本人明白並同意以電子形式(如有)收取所有與此計劃有關的文件，書面形式將不提供。

e-notification (if any) sent to (choose one) 以此電郵地址收取電子通知(如有)(任選其一) Office E-mail Address 公司電郵地址 Personal E-mail Address 個人電郵地址

Details of Proposed Member 準會員資料

Proposed Member 準會員 (Please tick either one 請選擇其中一項並加✓號)	(A) Surname 姓	(B) Given Name 名 (Same as HKID Card/Birth Certificate 與香港身份證/出生證明書相同)	(C) Sex 性別	(D) HKID Card No. / Birth Certificate No.* 香港身份證/出生證明書號碼*	(E) Date of Birth 出生日期 DD 日 MM 月 YY 年	Height 身高 cm 公分	Weight 體重 kg 公斤	Smoker 吸煙者 <input type="radio"/> Yes 是 <input type="radio"/> No 否	Business Nature 業務性質	Job Position 職位
<input type="radio"/> Same as the applicant 與申請人相同	If the Proposed Member is the same as the applicant, you are not required to fill in (A) to (E). 如準會員與申請人相同，您無須填寫(A)至(E)項。									
<input type="radio"/> Child 子女										

The insurer of the current group medical indemnity insurance scheme 現時實報費銷團體醫療保險計劃之承保公司

The company which pays for this group medical indemnity insurance scheme# 支付此實報費銷團體醫療保險計劃之公司#

* If the Proposed Member is your child, please submit a copy of his/her birth certificate. 如準會員為貴子女，請遞交子女出生證明書副本。

Please submit valid proof of group coverage accepted by Bupa. 請遞交為保柏接納的團體保障有效證明。

Choice of Cover 投保項目 (Please tick as appropriate 請選擇並加「✓」號)

Core Benefit 主要保障 <input checked="" type="checkbox"/> Hospital and Surgical Benefit 住院及手術保障	Benefit Level 保障等級 (choose one 任選其一) <input type="radio"/> Plan 計劃 1 Private 私家房 <input type="radio"/> Plan 計劃 2 Semi-private 半私家房 <input type="radio"/> Plan 計劃 3 Ward 大房
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Total Subscription paid with Application 連同申請表繳付之保費總額 HKS 港幣

Method of Payment 繳付保費方法 (Please tick as appropriate 請選擇並加「✓」號)

Payment Mode 繳付保費形式	Payment Method 繳付保費方法	Remarks 備註
<input type="radio"/> Yearly 年繳	<input type="radio"/> Autopay 自動轉賬	Please attach a cheque made payable to 'Bupa (Asia) Limited' for 1st 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="radio"/> 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="radio"/> 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="radio"/> Monthly 月繳	<input type="radio"/> 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 applicant, please fill in the following information. 若支票發出人並非申請人，請填寫以下資料。

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

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 / 或索償申請不合資格作審核 / 賠償。

- 1) At any time during the past seven years from the time of this Application, has the applicant / Proposed Member: 由申請計劃前的過去七年內，申請人 / 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、未完全康復之創傷或確診為乙型肝炎帶菌者? Yes No
- 1.2 exhibited any of the following symptoms in a repeated / persistent way? 曾反覆 / 持續出現以下病徵? Yes No
 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?
- 1.3 received any in-patient treatment / operation / physiotherapy? 曾接受任何入院診治 / 手術 / 物理治療? Yes No
- 1.4 had any medical investigations / examinations or is there a foreseeable need for these in future? 曾接受任何醫療檢查 / 檢驗或預期在將來有此需要? Yes No
- 1.5 taken any regular medications? 曾定期服用藥物? Yes No
- 2) Was the Proposed Member(s) born before 37 weeks or after 42 weeks of pregnancy? (Applicable to dependant aged 15 days 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15日至24個月的準會員) Yes No

If the applicant / Proposed Member 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. with attachment 另有附頁

如果申請人 / 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。

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 聲明

I, on behalf of myself / the Member, acknowledge that Benefit is not payable under Bupa Wise Choice 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 in this Application and accepted by Bupa. I declare that I am / the Member is covered under Hospital and Surgical Benefit of a group medical indemnity insurance scheme. I understand that if I am / the Member is not covered under such group policy on the effective date of this Contract, the cover under this Contract will be invalid. I also declare that, to the best of my knowledge and belief, the statements contained in this Application 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 cost. I have read and agreed to be bound by the terms and conditions of the Contract of this Scheme and I agree that this Health Declaration and the answers given in this Application shall be the basis of the Contract between me and Bupa.

本人謹此代表本人 / 會員，確認根據保柏智康健醫療保障計劃（「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，除非本人在本申請表內已詳細列出並獲得保柏接納。本人聲明，本人 / 會員現時持有實報實銷的團體醫療保障計劃，當中包括住院及手術保障。本人明白若本人 / 會員於此合約生效日期時並非受保於該團體保單，此合約的保障將失效。本人亦聲明，就本人所知所信，本申請表上填報之一切資料，均屬真實完整。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與保柏之間所訂合約之根據。

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 Member listed in this Application under this Scheme who is 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歲以下會員作出聲明及簽署。

Applicant's Signature 申請人簽署

Date 日期 (DD / MM / YY 日 / 月 / 年)

X

(Name 姓名: _____)

X

Agent's / Broker's / Telesales' Name (if applicable and must be completed by 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 Wise Choice Health Insurance Scheme 保柏智康健醫療保障計劃

Direct Debit Authorisation Form 直接付款授權書

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，請填妥此表格及簽署於“X”位置，並連同此表格正本及繳付保費的支票交回保柏。

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. 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.	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。		
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.	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。		
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).	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 / 吾等願共同及各自承擔全部責任。		
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.	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。		
This authorisation shall have effect until further notice.	本授權書將繼續生效直至另行通知為止。		
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 and Branch Name 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
			X
My / Our address as recorded on Statement / Passbook 本人 / 吾等在結單 / 存摺上之地址			Date 日期 (DD / MM / YY 日 / 月 / 年)
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 applicant / Subscriber, please fill in the following information. 若戶口持有人並非申請人 / 投保人，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	
For bank use only 銀行專用			Signature Verified 核實簽署

Notes:

- The box marked 'Membership No.' to be completed by Bupa.
- The signature on this authorisation form must be the same as the signature of your Bank Account.

附註:

- 會員編號一欄由保柏填寫。
- 在此授權書內之簽署模式必須與閣下之銀行戶口內之簽署相符。

Bupa Wise Choice Health Insurance Scheme 保柏智康健醫療保障計劃

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. 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="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, please fill in the following information. 若信用卡持有人並非申請人 / 投保人，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 Wise Choice 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智康健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)	
X			
For Bupa use only 保柏專用 Bupa Wise Choice Membership No. 保柏智康健會員編號: Subscription 保費 (HKS 港幣):		Authorised Code 授權代碼: Date 日期:	