

# Bupa Civil Servants Health Insurance Scheme Registration Variation Form

## 保柏公務員醫療保障計劃更改登記申請表



Please complete this form in **ENGLISH AND BLOCK LETTERS**. Please tick as appropriate. 請以**英文正楷**填寫妥本表格，並於適用地方加「✓」號。

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

Tel No.  
電話號碼

Fax No.  
傳真號碼

Membership No. (16 digits)  
會員編號 (16位數字)

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 請選擇更改部分並填妥所需資料)

#### I. Change of Benefit 更改保障 (Health Declaration must be completed for plan upgrade or benefit addition (marked with "\*"). The new benefit will be effective on the date of renewal, if approved. 如選擇提升計劃等級或增加保障(註有「\*」號)，必須填寫健康聲明。一經批核，新保障將於續保日生效。)

\* Please tick the **NEW plan** 請於新計劃之空格內加上“✓”號

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

- Option 選擇 1  
100% reimbursement on  
Hospital and Surgical Benefit  
賠償100%住院及手術保障費用

- Option 選擇 2  
80% reimbursement on  
Hospital and Surgical Benefit  
賠償80%住院及手術保障費用

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

Supplementary Major Medical Benefit 附加醫療保障

\*Add 增加

Cancel 取消

Clinical Benefit 門診保障

\*Add 增加

Cancel 取消

Bupa Worldwide Assistance Programme 保柏國際援助計劃

Add 增加

Cancel 取消

\* If you choose to add or upgrade your Benefit (marked with "\*"), all eligible medical expenses for the medical conditions that occurred before such change will be reimbursed according to your previous Benefits. 如選擇增加或提升保障(註有「\*」號)，所有在更改前已患傷病之合資格醫療費用將根據舊有保障賠償。

### Payment Method 繳付保費方法

Cheque 支票 Bank Name 銀行名稱

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」

Cheque No. 支票號碼

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

# 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 and levy on behalf of the Subscriber  
代投保人支付保費及徵費的原因

### II. Application for e-Services 申請電子服務

I hereby agree to use e-Services on **myBupa**, an online and mobile platform, to view and download some of my policy-related documents. To access these e-documents\*, I am required to register for a **myBupa** account and provide an email address in Section III below where I will receive email notifications when a document is ready for me to access from my **myBupa** account. I understand that I will no longer receive hard copy of these documents by post.

If you have already provided your email address to us, we will send email notifications to your email address on our record. If you want to update your email address, please provide a new email address in Section III below.

\* Please refer to <https://www.bupa.com.hk/en/customer-care/mybupa/> for the latest list of e-documents available on **myBupa**. This list is subject to change.

本人現同意使用 **myBupa** 網上及手機的電子服務，以查閱及下載與本人保單相關的部分文件。要查閱這些電子文件\*，本人須登記 **myBupa** 帳戶，並於以下第三部分提供電郵地址。當文件已上載於我的 **myBupa** 帳戶後，我便會收到電郵通知。本人明白將不會以郵寄方式收到這些保單文件的印刷本。

如您曾經向我們提供電郵地址，我們會根據紀錄中的電郵地址發出電郵通知。如您想更新電郵地址，請於以下第三部分提供新的電郵地址。

\* 有關上載於 **myBupa** 的最新電子文件清單，請參考 <https://www.bupa.com.hk/tc/customer-care/mybupa/>，此清單會不時更改。

### III. 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 / HK / NT  
九龍 / 香港 / 新界

New Telephone No.  
新電話號碼

Home / Office  
住宅 / 公司

Mobile Phone  
手提電話

Fax No. (Home / Office)  
傳真號碼 (住宅 / 公司)

New Email Address  
新電郵地址

\*\* P. O. Box, hotel address and overseas address are not acceptable. 郵政信箱、酒店地址及海外地址恕不接納。

For any Member who becomes a US Permanent Resident<sup>1</sup>, please complete Section V Change of Members Details. For any change of address to US, Subscriber is also required to fill in Section V to declare for all members if they are US permanent Resident.

如任何會員成為了美國永久居民<sup>1</sup>，請填妥第五部分之更改會員資料。如新更改的通訊地址為美國，投保人亦須為所有會員填寫第五部分以聲明他們是否美國永久居民。

#### Notes 注意：

1. "Permanent Resident" shall mean a person residing in a country who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in that country. US for this purpose shall include the USA and the Commonwealth of Puerto Rico. 「永久居民」指居於某國家並且身為該國公民或根據適用法律獲許在該國永久性居留及工作的人士。美國為此包括美國及波多黎各自由邦。



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**IV. Change of Account Number for Credit Card Payment 更改信用卡付款戶口號碼** (Credit Card Authorisation Form must be completed) (請填寫信用卡付款授權書)

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

**V. Change of Member(s) Details 更改會員資料**

	Surname 姓	Given Name 名 (Same as HKID Card / Birth Certificate 與香港身份證 / 出生證明書相同)	Membership No. 會員號碼	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			Country of Residence# (if not in HK) 居住國家*(如非香港)	US Permanent Resident <sup>1</sup> 美國永久居民 <sup>1</sup>
						DD日	MM月	YY年		
Subscriber 投保人										<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
Spouse 配偶										<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
Child 子女										<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
Child 子女										<input type="checkbox"/> Yes是 <input type="checkbox"/> No否

† For spouse, please submit the copy of HKID Card / Passport; for child, please submit the copy of birth certificate / HKID Card 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 / 香港身份證副本交回保柏。

# 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. (If you opt for Bupa Worldwide Assistance Programme)  
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。（如選擇保柏國際援助計劃）

**Notes 注意：**

1. "Permanent Resident" shall mean a person residing in a country who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in that country. US for this purpose shall include the USA and the Commonwealth of Puerto Rico.  
「永久居民」指居於某國家並且身為該國公民或根據適用法律獲許在該國永久性居留及工作的人士。美國為此包括美國及波多黎各自由邦。

**VI. Addition of Dependant(s) 增加受供養人**

Spouse must be aged 18 to 64, and unmarried child(ren) must be aged below 18 or below 25 if in full-time education. 配偶年齡必須介乎18至64歲及未婚子女年齡必須為18歲以下或25歲以下之全日制學生。

	Surname 姓	Given Name 名 (Same as HKID Card / Birth Certificate 與香港身份證 / 出生證明書相同)	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			Country of Residence# (if not in HK) 居住國家*(如非香港)	US Permanent Resident <sup>1,2</sup> 美國永久居民 <sup>1,2</sup>
					DD日	MM月	YY年		
Spouse 配偶									<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
Child 子女									<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
Child 子女									<input type="checkbox"/> Yes是 <input type="checkbox"/> No否

\*\*\*For spouse, please submit the copy of HKID Card / Passport; for child, please submit the copy of birth certificate / HKID Card 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 / 香港身份證副本交回保柏。

# 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. (If you opt for Bupa Worldwide Assistance Programme)  
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。（如選擇保柏國際援助計劃）

**Notes 注意：**

1. "Permanent Resident" shall mean a person residing in a country who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in that country.  
US for this purpose shall include the USA and the Commonwealth of Puerto Rico.

「永久居民」指居於某國家並且身為該國公民或根據適用法律獲許在該國永久性居留及工作的人士。美國為此包括美國及波多黎各自由邦。

2. Application for addition of member is not allowed if the proposed Member's Country of Residence is USA, United States Minor Outlying Islands, Virgin Islands, U.S. OR Commonwealth of Puerto Rico. This restriction is applicable if the member coverage effective date is on or after 1 Jan 2017.  
如準會員居住國家是美國、美國本土外小島嶼、美屬維爾京群島或波多黎各自由邦，增加會員的申請將不獲接納。此限制只適用於會員的保障生效日期為2017年1月1日或以後。

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

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## Health Declaration 健康聲明

### Important Note 重要事項

Please Answer Yes or No to every question in Health Declaration - Section A.

請於所有「健康聲明 - 甲部」中問題回答「是」或「否」。

If you answer Yes to any of the questions, you have to provide the details of the medical conditions in Health Declaration - Section B. You do not need to tell us about your history of common cold or flu or upper respiratory tract infections. Female (proposed) Member does not need to tell us about your history of childbirth.

如果您就任何問題的回答為「是」，您須於「健康聲明 - 乙部」提供有關疾病之詳情。您無須告知我們傷風、感冒、上呼吸道感染之病史。女性(準)會員也不用告知我們有關分娩的紀錄。

If you do not provide us with information required in the health declaration, we may terminate your cover or it may stop us from paying your claims.

如您在健康聲明部分沒有提供所需資料，您的保障可能會被終止或您可能不獲支付賠償。

### Health Declaration - Section A

#### 健康聲明 - 甲部

	Name of applicant 申請人姓名	Name of proposed Member 準會員姓名	Name of proposed Member 準會員姓名	Name of proposed Member 準會員姓名
Height 身高****	cm公分 / ft尺	cm公分 / ft尺	cm公分 / ft尺	cm公分 / ft尺
Weight 體重****	kg公斤 / lb磅	kg公斤 / lb磅	kg公斤 / lb磅	kg公斤 / lb磅
Smoker 吸煙者****	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
1. In the last 3 years, has the (proposed) Member had: a) consultation or medical investigations (eg scans or blood tests) for any medical condition(s) or symptoms which have continued for 2 weeks or more, and/or occurred more than once during the period; b) consultation or medical investigations as a result of abnormal findings from medical investigations###; or c) consultation by a specialist for two times or more for the same medical condition(s)? 在過去三年內，(準)會員是否曾： a) 因任何持續兩星期或以上，以及/或因任何出現多於一次的病症或症狀而就診或接受醫療檢查(如掃描及血液檢驗)； b) 因醫療檢查結果異常而就診或接受醫療檢查###；或 c) 因同一病症接受兩次或以上的專科醫生診治？	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>
2. In the last 5 years, has the (proposed) Member ever taken / been advised to take any medication prescribed by a doctor regularly for a continuous period of longer than 1 month? 在過去五年內，(準)會員是否曾定期服用/曾被建議定期服用為期超過一個月的醫生處方藥物？	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>
3. In the last 7 years, has the (proposed) Member been admitted to hospital, had an operation or a procedure? 在過去七年內，(準)會員是否曾住院，接受手術或治療程序？	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>
4. In the last 6 months, has the (proposed) Member had any undiagnosed symptoms, or currently undergoing medical investigations or awaiting results for the said symptoms? 在過去六個月內，(準)會員是否曾有任何未被診斷的症狀，或現正因有關症狀進行醫療檢查或等待檢查結果？	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>
5. Has the (proposed) Member had a history of cancer, heart condition, stroke or joint replacement; or are there any medical devices (eg shunts for draining fluids from the brain, pins and plates for fixation of broken bones) currently in your body? (準)會員是否曾有癌症、心臟病、中風或關節置換的病史；或現在體內有任何醫療儀器(如導引腦積水的分流器，及固定骨折的骨釘和骨板等)？	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>
Applicable to (proposed) Member aged 15 days to 24 months only. 此問題只適用於年齡介乎15日至24個月的(準)會員：				
6. Was the (proposed) Member born before 37 weeks or after 42 weeks of pregnancy? (準)會員是否於懷孕37周前或42周後出生？	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>	Yes 是 No 否 <input type="checkbox"/> <input type="checkbox"/>

\*\*\*\* Not required for Proposed Member(s) below 18 years old. 18歲以下之準會員無需填寫。

### For proposed Members aged 17 and below, this includes abnormalities in growth development (e.g. height and weight) 於十七歲或以下準會員，此包括生長發育異常(如身高、體重等)

### Health Declaration - Section B

#### 健康聲明 - 乙部

	Medical condition 病症	Medical condition 病症	Medical condition 病症
Name of applicant / (proposed) Member 申請人 / (準)會員姓名			
Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected (eg right knee, left eye). 請盡可能準確註明患上何種疾病或病患。如適用，請說明受影響的身體部位(例如右膝，左眼)。			
When did the symptoms start? 何時開始出現徵狀？			
What investigations did you have? Please include dates, type of investigations (eg MRI, blood test) and their results. 您曾接受何種檢查？ 請註明日期、檢查種類(如磁力共振、驗血)及其結果。			
What treatment did you have? Please include treatment period, type of treatment and their details (eg name of medication, name of procedure or surgery) 您曾接受何種治療？ 請註明接受治療時期、治療種類及其詳情(如藥物名稱、治療程序及手術名稱)			
When was the treatment completed? 何時完成治療？			
Have you made a full recovery? (Yes/No) 您是否已完全康復？(是/否)			

If you have any medical reports or reports of investigations, please enclose them and put a tick in the box.

如您有任何醫療報告或醫療檢查報告，請隨此表格同時附上，並請於空格加「✓」號。

With attachment  
另有附頁

## Declaration 聲明

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 understand and agree that, no Hospital and Surgical Benefit nor Supplementary Major Medical Benefit will be paid for newly added dependant(s) for (i) any illnesses (except for accidental injury) sustained within 180 days from the Coverage Commencement Date of the Member(s); and (ii) the following conditions that occur during the first 12 months from the Coverage Commencement Date: cataracts, endometriosis, diseased tonsils requiring surgery, hemorrhoids, hyperthyroidism, pathological abnormalities of nasal septum or turbinates, sinus conditions requiring surgery and tumours (except skin).

I / We acknowledge that eligible Benefit is payable according to the Benefit level prior to the upgrade of Benefit level (if applicable) under Bupa Civil Servants Health Insurance Scheme ("Scheme") for any costs of treatment arising from any illnesses, injuries or other conditions commenced or presented before the Coverage Commencement Date of such upgrade (if applicable).

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 this Application at my / our own costs. I / We also authorise any medical practitioner, hospital, clinic, by whom or where I / we have been observed or treated or any insurance company or organization that has any records or health information concerning me / us for any reason, to give full particulars thereof including prior medical history to Bupa. A copy of this authorization shall be considered as effective and valid as the original. 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 acknowledge that Bupa may terminate the cover of relevant Members with immediate effect if the law of the country in which any of the proposed Member is located, or the Member's country of residence or nationality, including but not limited to US and Japan, or any other law which applies to Bupa or the Contract, prohibits the provision of healthcare cover by Bupa to local nationals, residents or citizens. I/We further declare that I/We are not US permanent residents. I/We understand that I/We am/are obliged to immediately notify Bupa in writing if any of the Members become a permanent resident of US during the Contract Year.

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，均屬實完整。

本人 / 吾等明白亦同意新增加之受供養人(i)於保障開始日後首180天內患上之任何疾病(意外除外)；及(ii)保障開始日後首12個月發生之下列疾病：白內障、子宮內膜組織形成異位、扁桃體切除手術、痔瘡、甲狀腺功能亢進、鼻中隔或鼻甲之病理異常、須動手術之竇病症及腫瘤(皮膚除外)，將不獲住院及手術與附加醫療保障之賠償。

本人 / 吾等確認根據「保柏公務員」醫療保障計劃(「計劃」)規定，凡在增加保障(如適用)的保障開始日前因已存在或出現疾病、損傷或其他病況而引致之合資格醫療費用，一律根據增加保障(如適用)前的保障等級賠償。

本人 / 吾等確認保柏有權要求提供更多有關本人 / 吾等及於本申請表內所列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 / 吾等並且授權任何為本人 / 吾等觀察或治療的醫生、醫院、診所，或持有本人 / 吾等健康或任何資料之保險公司或機構將本人之全部資料(包括病歷)呈交予保柏，本授權書之副本與正本具同等效力。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 / 吾等確認如準會員的所在國家或準會員的原居國或國籍所屬國家的法律(包括但不限於美國和日本)或任何其他對保柏或本合約適用的法律禁止保柏向當地國民、居民或公民提供醫療保障，保柏可終止相關會員的保障並立即生效。本人 / 吾等此外聲明本人 / 吾等並非美國永久居民。本人 / 吾等明白如任何會員如於合約年度期間成為美國永久居民，本人 / 吾等有責任立即以書面通知保柏。

## Personal Information Collection Statement 個人資料收集聲明

(i) I / We have read and understood the Personal Information Collection Statement on the last page of this form.

本人 / 吾等已細閱並明白本申請表最後一頁所述的「個人資料收集聲明」。

(ii) I consent to receive marketing communications from Bupa as described in the Personal Information Collection Statement, such as information on subscription discount in relation to my insurance policy and other marketing offers. I understand that I have the right to request Bupa to cease using my personal data for direct marketing purposes by emailing [customercare@bupa.com.hk](mailto:customercare@bupa.com.hk) or calling the Bupa Customer Care helpdesk on 2517 5333.

本人同意接收保柏於「個人資料收集聲明」中所述的市場推廣資訊，包括與本人保單相關的保費折扣資訊及其他推廣優惠，並明白本人有權透過聯絡保柏的客戶服務專線(電郵至 [customercare@bupa.com.hk](mailto:customercare@bupa.com.hk) 或致電2517 5333)，要求保柏停止將本人的個人資料用作直接市場推廣用途。

If you do not agree with the statement in (ii) above, please tick the box below:

如您不同意上述聲明第(ii)項，請剔取以下方格：

I understand that by ticking this box, I am opting-out from receiving marketing communications from Bupa and Bupa will not be able to provide me with information on subscription discount in relation to my insurance policy and other marketing offers.

本人明白剔取此項後，本人拒絕接收由保柏提供的市場推廣資訊，而保柏將無法提供與本人保單相關的保費折扣資訊及其他推廣優惠。

I, as the Subscriber, understand that I declare and sign on behalf of the dependant(s) listed in this 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。

**I understand that no cover will be payable under the Contract unless this Application is approved and subscription is received in full by Bupa ( Asia ) Limited ("Bupa").**

本人明白此申請表被保柏(亞洲)有限公司(「保柏」)批核及保費全額收妥後，保柏方按合約支付保障。

Subscriber's Signature 投保人簽署	Date 日期 (DD日 / MM月 / YY年)	Member's Signature (Aged 18 or above) 年滿18歲或以上之會員簽署	Date 日期 (DD日 / MM月 / YY年)
<u>X</u> (Full Name 姓名)	<u>X</u>	<u>X</u> (Full Name 姓名)	<u>X</u>
Member's Signature (Aged 18 or above) 年滿18歲或以上之會員簽署	Date 日期 (DD日 / MM月 / YY年)	Member's Signature (Aged 18 or above) 年滿18歲或以上之會員簽署	Date 日期 (DD日 / MM月 / YY年)
<u>X</u> (Full Name 姓名)	<u>X</u>	<u>X</u> (Full Name 姓名)	<u>X</u>
Telesales' Name (if applicable and must be completed by Subscriber) 營業代表姓名(如適用及必須由投保人填寫)		Telesales' Code 營業代表編號	
		Telesales' Contact Tel. No. 營業代表聯絡電話號碼	

# Bupa Civil Servants Health Insurance Scheme Credit Card Authorisation Form

## 保柏公務員醫療保障計劃信用卡付款授權書



Subscriber's Name  
投保人姓名

Subscriber's HKID Card No.  
投保人香港身份證號碼

Tel No.  
電話號碼

If you choose to return this form by mail, please photocopy the 'Personal Information Collection Statement' on the back of this page for your reference. This information can also be found on our website.

若您選擇郵寄此表格，請複印背頁的「個人資料收集聲明」以作將來參考之用。您亦可於我們的網頁隨時瀏覽有關資料。

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。

Visa

MasterCard

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月 / YY年)

I hereby authorise and direct Bupa (Asia) Limited to debit the subscription and levy 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及徵費金額，直至另行通知。

If the 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 and levy on behalf of the Subscriber  
代投保人支付保費及徵費的原因

I hereby confirm to pay the subscription and levy due of Bupa Civil Servants Health Insurance Scheme for the applicant / Subscriber as listed in this form.  
本人同意及承擔列於此表格上的申請人 / 投保人之全數應繳之「保柏公務員」醫療保障計劃保費及徵費金額。

Cardholder's Signature 持卡人簽署

Contact Phone No. 聯絡電話號碼

Date 日期 (DD日 / MM月 / YY年)

X

X

For Bupa use only 保柏專用

Bupa Civil Servants Membership No. 「保柏公務員」會員編號: \_\_\_\_\_ Authorised Code 授權代碼: \_\_\_\_\_

Subscription and levy 保費及徵費 (HK\$港幣): \_\_\_\_\_ Date 日期 (DD日 / MM月 / YY年): \_\_\_\_\_

## Personal Information Collection Statement 個人資料收集聲明

### Bupa (Asia) Limited (the "Company")

### Personal Information Collection Statement ("Statement") relating to the Personal Data (Privacy) Ordinance (the "Ordinance")

In compliance with the Ordinance, the Company would like to inform you of the following:

- From time to time, it is necessary for you, or the Member, to supply the Company with certain personal information when you apply for insurance or financial products and services from the Company, or when you apply to make changes to your policy, or when you renew a policy;
- Failure to supply personal information requested by the Company may result in the Company being unable to process your Application and/or provide products, services and other related services to you, or the Member;**
- During the course of your relationship with the Company, further personal information relating to you, or the Member, may also be collected in the ordinary course of our business, for example, when you lodge insurance claims with the Company.
- Personal information relating to you, or the Member, may be used for the following purposes:**
  - processing, assessing and determining any Applications for insurance products and services;
  - offering and providing products and services to you, or the Member, and processing requests made by you, or the Member, from time to time, including but not limited to requests for addition, alteration, deletion, maintenance, management and operation of insurance benefits or insured Members;
  - any purposes in connection with any claims made by or against or otherwise involving you, or the Member, in respect of any products and/or services provided by the Company including, without limitation, making, defending, analyzing, investigating, processing, assessing, determining or responding to such claims;
  - performing any functions and activities related to the products and/or services provided by the Company including, without limitation, audit, reporting, market research, general servicing, maintenance of online and other services, identity verification, data matching, research and statistical analysis, and reinsurance arrangements;
  - provision and design of products and services of the Company;
  - exercising the Company's rights in connection with provision of insurance products and services to you, or the Member, from time to time, for example, to determine any amount of indebtedness from you, and collecting and recovering owing from you or any person who has provided any security or undertaking for your liabilities;
  - communication with you or the Member in relation to any of the purposes set out in this Statement;
  - enabling an actual or proposed assignee, transferee, participant or sub-participant of all or a substantial part of the Company's rights or business to evaluate the transaction intended to be the subject of the assignment, transfer, participation or sub-participation; and
  - making disclosure to satisfy the requirements of any laws, rules and regulations, codes of practice, guidance notes or guidelines binding on the Company.
- Personal information collected or held by the Company relating to you, or the Member, will be kept confidential but the Company may provide such personal information inside or outside the Hong Kong Special Administrative Region, for the purposes specified in paragraph (4) and (6) to the following classes of transferees:**
  - the Company's group companies ("Group Company");
  - any insurance intermediaries authorized by you and the Company;
  - any re-insurance companies authorized by the Company;
  - any agent, contractor or third party service providers who provide administrative, telecommunications, computer, payment, data processing or storage, printing, research or other services to the Company in connection with the operation of business (including without limitation insurers, banks, lawyers, accountants, claims investigators, debt collection agencies, data processing companies, research agencies and professional advisors);
  - any actual or proposed assignee, transferee, participant or sub-participant of all or a substantial part of the Company's rights or business;
  - any person to whom the Company is under an obligation to make disclosure under the requirements of any law, rules, regulations, codes of practice or guidelines binding on the Company including, without limitation, any applicable regulators, governmental bodies, industry recognized bodies, credit reference agencies, the Courts, and where otherwise required by law.
- Only with your consent or with your indication of no objection, the Company may use your, or the Member's personal information collected from time to time, including name, contact details, gender, health and family status, to provide you, or the Member with marketing communications relating to the following of the Company, Group Company, or co-brand partner or business partner of the Company, including:
  - Insurance, medical, healthcare, financial and related services and products; and
  - donations and contributions for charitable and/or non-profit making purposes;The Company will not disclose personal information relating to you, or the Member to third parties for marketing purposes without your consent.
- Under and in accordance with the terms of the Ordinance, you have the following rights:**
  - to check whether the Company holds personal information relating to you or the Member and to access such personal information;
  - to require the Company to correct any personal information relating to you or the Member which is inaccurate;
  - to ascertain our policies and practices in relation to personal data and to be informed of the kind of personal data held by the Company, and
  - to request the Company to cease using your personal information for direct marketing purposes.

Requests can be made in writing to the Company's Data Protection Officer at the following address:

Data Protection Officer,  
18/F, Berkshire House,  
25 Westlands Road, Quarry Bay, Hong Kong

- In accordance with the terms of the Ordinance, the Company has the right to charge a reasonable fee for the processing of any personal information access or correction request.
- For any enquiries about this Statement, please do not hesitate to contact our Customer Care helpdesk at 2517 5333.
- Nothing in this Statement shall limit the rights of customers under the Ordinance.
- In case of discrepancies between the English and Chinese versions of this Statement, the English version shall prevail.

### 保柏(亞洲)有限公司(「本公司」)

### 有關個人資料(私隱)條例(「條例」)之個人資料收集聲明(「本聲明」)

遵照條例,本公司特通知閣下以下事項:

- 閣下或會員向本公司申請保險或金融產品及服務,或當閣下更改保單或續保時,必須不時向本公司提供個人資料;
- 如閣下未能提供本公司所要求的個人資料,本公司可能無法處理閣下之申請及/或向閣下或會員提供保險產品、服務或其他相關服務;
- 本公司亦可能會在日常業務運作的過程中向閣下或會員收集更多個人資料,例如當閣下向本公司提出保險索償時。
- 閣下或會員的個人資料可能會用作下列用途:**
  - 處理、評估、決定任何保險產品及服務之申請;
  - 為閣下或會員提供保險產品及服務及處理閣下或會員不時提出的要求,包括但不限於要求增加、更改、刪除、維持及管理保障項目或受保會員;
  - 任何有關閣下或會員對本公司所提供之保險產品及服務提出之索償,包括但不限於賠償、辯護、分析、調查、處理、評估、決定或回應該等索償;
  - 執行與本公司所提供的保險產品及/或服務相關的功能及活動,包括但不限於審計、報告、市場調查、一般服務和維持網上及其他服務、核實身份、資料配對、研究及統計分析及再保險之安排;
  - 提供及設計本公司的產品及服務;
  - 行使本公司向閣下或會員提供保險和服務時有關的權利,例如釐定閣下拖欠的任何款項的金額,及向閣下或任何已為閣下的債務提供任何擔保或承諾的人士,追收和收回拖欠的任何款項;
  - 就任何本聲明中所述的用途與閣下或會員聯絡;
  - 允許本公司全部或部份的權益或業務的實際或建議承讓人、受讓人、參與人或次參與人,就涉及的轉讓、出讓、參與或次參與的交易進行評估;及
  - 為遵守任何法例之要求,或根據監管或其他機關所發出對本公司具有約束力或要求其遵守的規則、規例、實務守則、須知或指引,而作出披露。
- 有關閣下或會員被本公司收集或持有的個人資料將會保密,但本公司可能會向以下不論在香港特別行政區境內或境外之資料承讓人提供該等個人資料作第(4)及第(6)段列出的用途:**
  - 本公司的集團公司(「集團公司」);
  - 任何由閣下及本公司授權的保險代理人;
  - 任何由本公司授權的再保險公司;
  - 任何代理人、承包商、或向本公司提供行政、電訊、電腦、付款、資料處理或儲存、印刷、研究或其他向本公司提供服務的第三方服務供應商(包括但不限於保險公司、銀行、律師、會計師、理賠調查員、收數公司、資料處理公司、研究服務機構及專業顧問);
  - 本公司的任何全部或部份的權益或業務的實際或建議承讓人、受讓人、參與人或次參與人;
  - 為遵守任何法例之要求,或根據監管或其他機關所發出對本公司具有約束力或要求其遵守的規則、規例、實務守則或指引,而作出披露,包括但不限於適用監管機構、政府機構、相關行業認可機構、信貸資料服務機構或法院,及在其他情況下,法律規定本公司必向其披露的人士或機構。
- 本公司只會在得到閣下同意或表示不反對的情況下,使用閣下或會員的個人資料如姓名、聯絡方法、性別、健康及家庭狀況,向閣下或會員提供本公司、集團公司、聯營品牌合作夥伴或業務夥伴有關以下的市場推廣資訊,包括:
  - 保險、醫療、康健、財務和相關服務及產品;及
  - 為慈善及/或非牟利用途的捐款及捐贈;本公司將不會在沒有閣下的同意及許可下將閣下或會員之個人資料向第三方透露以作市場推廣用途。
- 根據有關條例中的條款,閣下有權:**
  - 查核本公司是否持有閣下或會員的個人資料及查閱該等個人資料;
  - 要求本公司改正任何有關閣下或會員的不準確的個人資料;
  - 查明本公司對於資料的政策及處理方法和獲告知本公司持有的個人資料種類;及
  - 要求本公司停止將閣下的個人資料作直接市場推廣用途。

有關要求請致函本公司保障資料主任,地址如下:

香港鯉魚涌華蘭路25號柏克大廈18樓  
保柏(亞洲)有限公司  
保障資料主任

- 根據有關條例之條款,本公司有權就任何處理個人資料查閱或更改的要求收取合理費用。
- 如閣下對本聲明有任何查詢,請隨時致電本公司的客戶服務專線 2517 5333。
- 本聲明不會限制客戶在條例下所享有之權利。
- 中英文本如有歧義,概以英文為準。