

Bupa HealthPlus Health Insurance Scheme Registration Variation Form

保柏悦康健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。

Membership No. (16 digits)
會員號碼 (16位數字)

Subscriber's Name (same as HKID Card) 投保人姓名 (與香港身份證相同)

Surname
姓

Given Name
名

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. Change of Benefit 更改保障

Applicable to existing Member. 適用於現有會員。

Member's Name 會員姓名		Deductible 墊底費# (港幣 HK\$)			Optional Benefit 自選額外保障			
Surname 姓	Given Name 名	0 ^①	12,000 ^①	40,000	Clinical Benefit 門診保障		Dental Benefit 牙科保障	
					Add 增加 ^②	Cancel 取消	Add 增加	Cancel 取消
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

^① Health Declaration is required if you apply to lower the Deductible. Your Application will be subject to underwriting. The new Benefit will be effective on the date of Contract Anniversary Date, if approved. 如選擇降低墊底費，必須填寫健康聲明，有關申請必須通過核保。一經批核，新保障將於合約週年日生效。

^② Health Declaration is required if you apply to add the Clinical Benefit. Your Application will be subject to underwriting. The new Benefit will be effective on the date of Contract Anniversary Date, if approved. The new Benefit will only cover eligible medical conditions that commenced after such Contract Anniversary Date. 如選擇新增門診保障，必須填寫健康聲明，有關申請必須通過核保。一經批核，新保障將於合約週年日生效，並只保障於合約周年日後出現的合資格病症。

Please note that you can't apply to reduce your deductible amount within 24 months of the contract effective date or any previous change in deductible. 請注意，您不可於合約生效日起或距離上次更改墊底費後的24個月內申請減低墊底費金額。

II. Payment Method 繳付保費方法

<input type="checkbox"/> 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="checkbox"/> 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」

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 (Applicable to spouse, parents or children only) 與投保人關係 (只適用於配偶、父母或子女)
Reason for paying subscription and levy on behalf of the Subscriber 代投保人付保費及保費徵費的原因

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 (Same as recorded on bank account statement / passbook)
戶口持有人姓名 (與銀行結單 / 存摺相同)

HKID Card No.
香港身份證號碼

Personal Hong Kong savings / current account number (HK\$ only) 個人香港儲蓄 / 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

If the above account holder is not the Subscriber or Member, please fill in the following information. 若上述之戶口持有人並非投保人或會員，請填寫以下資料。

Relationship with the Subscriber (Applicable to spouse, parents or children only) 與投保人關係 (只適用於配偶、父母或子女)
Reason for receiving claims payment on behalf of the Subscriber 代投保人收取賠款的原因



PAMVT

■ IV. Application for e-Services 申請電子服務

I hereby agree to use e-Services through **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 V 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 V 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，並於以下第五部分提供電郵地址。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，請於以下第五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。

■ V. Change of Correspondence Address / Telephone no. / Email Address 更改通訊地址 / 電話號碼 / 電郵地址

New Correspondence Address** 新通訊地址** (Please complete in ENGLISH and BLOCK LETTERS 請以英文正楷填寫)

Flat 單位 / Room 室 / Floor 層數

Block 座 / Building 大廈 / Mansion 閣 / House 樓 / Estate 屋苑

Street 街 / Road 道

District 地區

HK 香港 Kln 九龍 NT 新界

New Email Address 新電郵地址

New Contact No. 新聯絡電話

New Fax No. 新傳真號碼

New Mobile No. 新流動電話號碼

** 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 Resident¹ please complete Section VI Change of Members Details. For any change of address to US, Subscriber is also required to fill in Section VI 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¹，請填妥第六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六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。

■ VI. Change of Particulars of Subscriber / Member 更改投保人 / 會員資料

*** For spouse, parents, parents-in-law and child aged over 18 or above, please submit the copy of HKID Card / Passport; for child aged below 18, please submit the copy of HKID card/birth certificate to Bupa. 請連同配偶、父母、配偶父母和18歲或以上之子女之香港身份證 / 護照副本及18歲以下之子女之香港身份證 / 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 (New) 名(新)	Membership No. 會員編號	Sex 性別	HKID Card/Birth Certificate No./Passport*** 香港身份證 / 出生證明書號碼 / 護照***	Date of Birth 出生日期 DD / MM / YY 日 / 月 / 年	Country of Residence# (if not in HK) 居住國家#(如非香港)	US Permanent Resident ¹ 美國永久居民 ¹
<input type="checkbox"/> Subscriber 投保人								<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
<input type="checkbox"/> Spouse 配偶 / Domestic Partner 同居伴侶 ²								<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
<input type="checkbox"/> Child 子女 1								<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
<input type="checkbox"/> Child 子女 2								<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
<input type="checkbox"/> Subscriber's father 投保人之父親								<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
<input type="checkbox"/> Subscriber's mother 投保人之母親								<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
<input type="checkbox"/> Subscriber's father-in-law 投保人配偶之父親								<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
<input type="checkbox"/> Subscriber's mother-in-law 投保人配偶之母親								<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否

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。

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. Domestic partner shall mean civil partner, or the person (of same or different sex), with whom the Subscriber lives with in a continuous, committed, exclusive relationship during which period neither the Subscriber nor that person was or is married to or partnered with any other person.

同居伴侶指民事結合的伴侶或與投保人共同生活，並保持持續、忠誠以及唯一的關係的人士(不論同性或異性)，而期間投保人或該人士並沒有和其他人士成婚或結合。

VII. Addition of Member(s) 增加會員 (Health Declaration must be completed 必須填寫健康聲明)

Please ensure that you have 遞交表格時請謹記:

- enclosed a copy of the HKID Card / Passport for each proposed Member aged 18 or above.
連同每位18歲或以上之準會員的香港身份證 / 護照副本。
- enclosed a copy of the HKID Card / birth certificate for each proposed Member aged below 18.
連同每位18歲以下之準會員的香港身份證 / 出生證明書副本。
- enclosed a copy of the marriage certificate for addition of newlywed spouse during the contract year.
在合約年度內新增之新婚配偶須連同結婚證書副本。
- enclosed a copy of the birth certificate of newlywed spouse for addition of parents-in-law during the contract year.
在合約年度內新增之新婚配偶父母須連同新婚配偶的出生證明書副本。

Please complete proposed Member's details only. 請只填寫準會員之資料。

	Surname 姓	Given Name 名 (Same as HKID Card / Birth Certificate 與香港身份證 / 出生證明書相同)	Sex 性別	HKID Card / Birth Certificate No. 香港身份證 / 出生證明書號碼	Date of Birth 出生日期 DD / MM / YY 日 / 月 / 年	US Permanent Resident 1,2 美國永久居民 1,2
<input type="checkbox"/> Subscriber 投保人	Details as above / 資料同上					
<input type="checkbox"/> Spouse 配偶 / Domestic Partner 同居伴侶 ³						<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
<input type="checkbox"/> Child 子女 1 ^①						<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
<input type="checkbox"/> Child 子女 2 ^①						<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
<input type="checkbox"/> Subscriber's father 投保人之父親						<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
<input type="checkbox"/> Subscriber's mother 投保人之母親						<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
<input type="checkbox"/> Subscriber's father-in-law 投保人配偶之父親						<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
<input type="checkbox"/> Subscriber's mother-in-law 投保人配偶之母親						<input type="checkbox"/> Yes是 <input type="checkbox"/> No否

Choice of Cover 投保項目

Please tick as appropriate. 請於適用地方加「✓」號。

	Core Benefit & Benefit Level 主要保障及保障級別	Option to Cover Pre-existing Conditions 保障已存在疾病之選擇 ^④	Hospital and Surgical Benefit 住院及手術保障			Optional Benefit 自選額外保障	
			Deductible 墊底費 (港幣 HK\$)			Clinical Benefit 門診保障	Dental Benefit 牙科保障
			0	12,000	40,000		
<input type="checkbox"/> Subscriber 投保人	<input checked="" type="checkbox"/> Hospital and Surgical Benefit 住院及手術保障	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spouse 配偶 / Domestic Partner 同居伴侶 ³		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child 子女 1 ^①		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child 子女 2 ^①		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Subscriber's father 投保人之父親	<input checked="" type="checkbox"/> Semi-private 半私家房	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Subscriber's mother 投保人之母親		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Subscriber's father-in-law 投保人配偶之父親		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Subscriber's mother-in-law 投保人配偶之母親		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

① Child Members must be aged 15 days or above. Children below 10 years old must enrol under the same Contract together with the Subscriber as a Dependant.
子女年齡必須為15日或以上。10歲以下之子女須與投保人一同投保並為投保人之受供養人。投保人亦需為本合約之會員。

④ We may have to exclude some medical conditions from your cover because of the medical history declared. We may be able to offer you an option to cover some of these excluded medical conditions with additional subscription. If you wish to consider this option, please answer "Yes". We will contact you to collect additional information for assessment if this is applicable to you.
我們可能會因您所申報的病史而將一些病症列為不獲保障項目。如您在此選項回答「是」，我們或能讓您以繳付附加保費將某些不獲保障病症納入保障範圍。如能為您提供此選擇，我們會聯絡您以索取額外資料以作審核。

Notes 注意:

- "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。
- 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。
- Domestic partner shall mean civil partner, or the person (of same or different sex), with whom the Subscriber lives with in a continuous, committed, exclusive relationship during which period neither the Subscriber nor that person was or is married to or partnered with any other person.
同居伴侶指民事結合的伴侶或與投保人共同生活，並保持持續、忠誠以及唯一的關係的人士(不論同性或異性)，而期間投保人或該人士並沒有和其他人士成婚或結合。

Please note that you can't apply to reduce your deductible amount within 24 months of the contract effective date or any previous change in deductible.
請注意，您不可於合約生效日起或距離上次更改墊底費後的24個月內申請減低墊底費金額。

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

VII. 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.

如果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 Subscriber 投保人姓名	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, have you (or the proposed Member) had: 在過去三年內，您(或準會員)是否曾： a) consultation or medical investigations (e.g. 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; or 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)；或 b) consultation or medical investigations as a result of abnormal findings from medical investigations##; or 因醫療檢查結果異常而就診或接受醫療檢查##；或 c) consultation by a specialist for two times or more for the same medical condition(s)? 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, have you (or 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，您(或準會員)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, have you (or the proposed Member) been admitted to hospital, had an operation or a procedure? 在過去七年內，您(或準會員)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, have you (or 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，您(或準會員)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. Have you (or the proposed Member) had a history of cancer, heart condition, stroke or joint replacement; or are there any medical devices (e.g. shunts for draining fluids from the brain, pins and plates for fixation of broken bones) currently in your body? 您(或準會員)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"/>
Applicable for optional clinical benefit only. 此問題只適用於自選附加門診保障。				
7. Apart from the above information which you (or the proposed Member) may have already disclosed, in the last 3 years, have you (or the proposed Member) had consultation by Psychiatrist for two times or more for mental health conditions (e.g. depression, anxiety, schizophrenia, mood disorder etc.)? 除您(或準會員)於上述已經披露之健康狀況外，在過去三年內，您(或準會員)是否曾因關於精神健康狀況(例如抑鬱症、焦慮症、精神分裂症、情緒障礙等)，接受兩次或以上的精神科醫生診治？	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"/>

** 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)

VII. Health Declaration (Cont.) 健康聲明 (續)

Health Declaration - Section B 健康聲明 — 乙部

	Medical condition 病症	Medical condition 病症	Medical condition 病症
Name of Subscriber / (proposed) Member 投保人 / (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 (e.g. 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 (e.g. 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 (e.g. 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 and Authorisation 聲明及授權

I / We apply as a Member of Bupa HealthPlus Health Insurance Scheme ("Scheme") and I / we acknowledge that Benefit is not payable under this Scheme being applied for any costs of treatment arising from any existing illnesses, injuries or other conditions presented before the Coverage Commencement Date unless complete details are fully disclosed by me / us in this Application and accepted by Bupa (Asia) Limited ("Bupa").

I / We declare that, to the best of my / our knowledge and belief and, if applicable, based on information provided by the legal guardian of the proposed Member, 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 and the proposed Members as listed in this Application at my / our own cost.

I / We also authorise any medical practitioner, hospital, clinic, by whom or where I / the proposed Member have / has been observed or treated or any insurance company or organisation that has any records or health information concerning me and / or the proposed Member for any reason, to give full particulars thereof including prior medical history to Bupa. A copy of this authorisation 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 has discretion to appoint Registered Medical Practitioners, Hospitals, Qualified Nurses, cancer centres, day-case centres, diabetic centres, wellness centres and other service providers to provide health and care services, credit facilities for eligible medical expenses and to do all things and acts incidental to such appointment for the Member. 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 any such service provider appointed by Bupa by the Member.

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 / 吾等申請成為「保柏悅康健」醫療保障計劃（「計劃」）之會員及本人 / 吾等確認根據申請之計劃規定，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（亞洲）有限公司（「保柏」）接納。

本人 / 吾等聲明，就本人 / 吾等所知所信以及根據準會員合法監護人提供的資料（如適用），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及於本申請表內所列之準會員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 / 準會員觀察或治療的醫生、醫院、診所，或持有本人及 / 或會員健康或任何資料之保險公司或機構將本人及 / 或準會員之全部資料（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 / 吾等確認保柏可酌情委任註冊西醫、醫院、合資格護士、癌症中心、日症中心、糖尿病中心、保健中心及其他服務供應商以提供醫療服務、合資格醫療費用之墊支服務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。就會員向有關保柏所委任的服務供應商所作出之申索，保柏一概不會負責。

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。

Applicable to Application through authorised insurance broker 適用於透過獲授權保險經紀進行之申請

I understand, acknowledge and agree that, as a result of me purchasing and taking up the policy to be issued by Bupa, Bupa will pay the authorised insurance broker commission during the continuance of the policy including renewals, for arranging the said policy.

I further understand that the above agreement is necessary for Bupa to proceed with the Application.

本人明白、確知及同意，保柏會就本人購買及接受其簽發的保單，於保單有效期內（包括續保期）向負責安排有關保單的獲授權保險經紀支付佣金。

本人亦明白保柏必須取得本人以上的同意，才可以處理其保險申請。

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 X _____ (Full Name 姓名))	Signed in Hong Kong on 於香港簽署之日期 _____ DD 日 MM 月 YY 年	Member's / Proposed Member's Signature (Aged 18 or above) 年滿18歲或以上之會員 / 準會員簽署 X _____ (Full Name 姓名))	Signed in Hong Kong on 於香港簽署之日期 _____ DD 日 MM 月 YY 年
Member's / Proposed Member's Signature (Aged 18 or above) 年滿18歲或以上之會員 / 準會員簽署 X _____ (Full Name 姓名))	Signed in Hong Kong on 於香港簽署之日期 _____ DD 日 MM 月 YY 年	Member's / Proposed Member's Signature (Aged 18 or above) 年滿18歲或以上之會員 / 準會員簽署 X _____ (Full Name 姓名))	Signed in Hong Kong on 於香港簽署之日期 _____ DD 日 MM 月 YY 年
Member's / Proposed Member's Signature (Aged 18 or above) 年滿18歲或以上之會員 / 準會員簽署 X _____ (Full Name 姓名))	Signed in Hong Kong on 於香港簽署之日期 _____ DD 日 MM 月 YY 年	Agent's / Broker's / Telesales' Name (if applicable and must be completed by the Subscriber) 代理人 / 經紀 / 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 / 經紀 / 營業代表編號 Agent's / Broker's / Telesales' Contact Tel. No. 代理人 / 經紀 / 營業代表聯絡電話號碼	

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 other members covered under your policy (each a "Member"), to supply the Company with certain personal information (including where relevant, credit information and claims history) relating to you, or the Member, 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 in relation to yourself or the Member.
- The Company may collect, use or disclose personal information relating to you, or the Member, 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, analysing, investigating, detecting and preventing fraud (whether or not relating to the policy issued in respect of any application or claim) processing, assessing, determining, settling 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 (or with you on behalf of 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 transfer 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 adjusters, agents and brokers;
 - any re-insurance companies authorised by the Company;
 - employers (for members of corporate policy only);
 - healthcare professionals and hospitals;
 - 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; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisations or other persons named in this paragraph); organisations that consolidate claims and underwriting information for the insurance industry; the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information; 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; and
 - 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 recognised 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 personal information collected from time to time, including name, contact details, gender, health and family status, to provide you with marketing communications (including by email, SMS or instant messenger) relating to the following products and services:
 - insurance, medical, healthcare, wellness, personal development, beauty, lifestyle, entertainment, financial, and related services and products;
 - rewards, benefits, discounts, member activities, loyalty or privileges programmes 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, to third parties for them to use for their own direct marketing purposes without your consent. For the avoidance of doubt, whether or not you consent to receive marketing communications of the type described in this paragraph 6, the Company may still communicate with you regarding the administration, features and renewal of your insurance policy.
- 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:

- 在閣下或受保於閣下保單的其他會員(每位「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閣下或會員的個人資料(包括信用資料和以往申索紀錄,如適用)。
- 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,例如當閣下為本人或代會員向本公司提出保險索償時。
- 本公司可能會收集、使用或披露閣下或會員的個人資料作下列用途:
 - 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、偵測及防止欺詐行為(無論是否與就此申請而簽發之保單及相關的任何申請或索償)、處理、評估、決定、解決或回應該等索償;
 - 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(或與代表會員的閣下)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轉移該等個人資料作第(4)及第(6)段列出的用途:
 - 本公司的集團公司(「集團公司」);
 - 任何由本公司授權的保險理算人、代理及經紀;
 - 任何由本公司授權的再保險公司;
 - 僱主(只適用於團體保單之會員);
 - 醫護專業人員及醫院;
 - 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、理財顧問、律師、會計師、理賠調查員、防欺詐組織、其他保險公司(無論是直接地,或是通過防欺詐組織或本段中指名的其他人士)、為保險業界整合申索及承保資料之組織、警察、供保險業界用作分析及核對所提供的資料與既有資料的資料庫及登記冊(及其運營者)、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;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,使用閣下的個人資料如姓名、聯絡方法、性別、健康及家庭狀況,向閣下提供有關以下產品和服務的市場推廣資訊(包括以電郵、手機短訊或即時通訊):
 - 保險、醫療、康健、健康、個人發展、美容、生活消閒、娛樂、財務及其相關的服務及產品;
 - 獎賞、權益、折扣、會員活動、會員忠誠或優惠計劃及其相關的服務及產品;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的個人資料向第三方透露,用作他們的市場推廣用途。為避免有疑慮,不論閣下是否同意接收以上第六點所述的市場推廣資訊類別,本公司仍然可能就閣下保單相關的行政、保障及續保事宜與閣下聯絡。
- 根據有關條例中的條款,閣下有權:
 - 查核本公司是否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:
香港鰂魚涌華蘭路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。