

Bupa MyBasic VHIS Plan Application Form

保柏自願醫保計劃申請表



To ensure your cover can take effect on the first day of the following month, please send us the completed application form at least 5 working days prior to the end of the month. Applications are subject to underwriting.
如欲合約在下月一號生效，請將填妥的申請表於月底前最少5個工作天寄回保柏。所有申請必須通過核保始能生效。

If there is insufficient space provided for your answer or information given in this Application form, please continue on a separate sheet of paper, specifying the section to which your answer relates, and add your signature with date.
如本申請表未能提供足夠空間填寫，請另加紙張提供說明所涉部份並附加簽署與日期。

Please complete this form in **ENGLISH and BLOCK LETTERS**. Please tick as appropriate.
請以**英文正楷**填妥本申請表，並於適用地方加「✓」號。

For Bupa
use only
保柏專用

Reference No. :
參考編號

Policy Effective
Date 生效日期:

DD 日 MM 月 YYYY 年

All Ages described in this form refer to the Age as at the Policy Effective Date.
本申請表內所有歲數以保單生效日之歲數計算。

Personal Details of Policy Holder 保單持有人資料 (Policy Holder's Age must be 18 years or above 保單持有人年齡必須為18歲或以上)

Title 稱謂 Name of Policy Holder (same as HKID Card) 保單持有人姓名 (與香港身份證相同)

Mr 先生 Surname 姓
 Mrs 太太
 Ms 女士 Given Name
 Miss 小姐 名

HKID Card No. / Passport No. 香港身份證號碼 / 護照號碼 Sex 性別 M 男 F 女 Date of Birth 出生日期 DD 日 MM 月 YYYY 年

Contact Details of Policy Holder 保單持有人聯絡資料

Correspondence Address* 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

Email Address# 電郵地址#
Contact No. 聯絡電話 Fax No. 傳真號碼 Mobile No. 流動電話號碼

Successive Policy Holder (Optional) 繼任的保單持有人 (可選擇填寫)

Please state the successive Policy Holder in case you pass away 請列明在您身故的情況下繼任的保單持有人

Surname 姓
Given Name 名

HKID Card No. / Passport No. 香港身份證號碼 / 護照號碼 Relationship with Proposed Insured Person[^] 與準受保人關係[^]

* 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。

You can access our e-Services through **myBupa**, our online and mobile platform, to view and download some of your policy-related documents. To access these e-documents**, you are required to register for a **myBupa** account and provide an email address where you will receive email notifications when a document is ready for you to access from your **myBupa** account. You will no longer receive hard copy of these documents by post.

If you wish to receive a hard copy of all documents by post, please tick the box below. If you do not tick the box, we will consider that you have agreed to register for and use **myBupa** to access these e-documents.

I request to receive hard copy of all documents by post.

** 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.

[^] Applicable to spouse/child/parents/parents-in-law/siblings/spouse's siblings/grandparents/grandparents-in-law/grandchild/domestic partner/domestic partner's child/domestic partner's parents

您可透過 **myBupa** 網上及手機的電子服務查閱及下載與您保單相關的部分文件。要查閱這些電子文件**，您須登記 **myBupa** 帳戶，並提供電郵地址。當文件已上載於您的 **myBupa** 帳戶後，您便會收到電郵通知。您將不會以郵寄方式收到這些保單文件的印刷本。

如您想以郵寄方式收取所有文件的印刷本，請於以下方格內加上剔號。如您沒有剔選以下方格，我們將認為您已同意登記及使用 **myBupa** 以瀏覽這些電子文件。

我要求以郵寄方式收取所有文件的印刷本。

** 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。

[^] 適用於配偶/子女/父母/配偶的父母/兄弟姊妹/配偶的兄弟姊妹/祖父母/配偶的祖父母/孫子女/同居伴侶/同居伴侶的子女/同居伴侶的父母



Details of Proposed Insured Person 準受保人資料 (Age must be between 15 days - 80 years inclusive 年齡必須為15日至80歲(包括首尾歲數))

Myself 本人

(Details as page 1 資料如同第一頁)

Place of Residence¹

居住地¹

Or

Proposed Insured Person 準受保人

Proposed Insured Person's Name (same as HKID Card/Passport/Birth Certificate) 準受保人姓名 (與香港身份證/護照/出生證明書相同)

Surname

姓

Given Name

名

HKID Card No./Passport No./Birth Certificate No.

香港身份證號碼/護照號碼/出生證明書號碼

Sex

性別

M 男

F 女

Date of Birth

出生日期

DD 日

MM 月

YYYY 年

Relationship with Policy Holder[^]

與保單持有人關係[^]

Place of Residence¹

居住地¹

[^] Applicable to spouse/child/parents/parents-in-law/siblings/spouse's siblings/grandparents/grandparents-in-law/grandchild/domestic partner/domestic partner's child/domestic partner's parents

¹ The above Place of Residence will be used to determine the validity and coverage of the Policy. Please inform Bupa immediately in writing if the proposed Insured Person has changed the Place of Residence.

[^] 適用於配偶/子女/父母/配偶的父母/兄弟姊妹/配偶的兄弟姊妹/祖父母/配偶的祖父母/孫子女/同居伴侶/同居伴侶的子女/同居伴侶的父母

¹ 上述居住地將用於確定保單的有效性和保障範圍。如任何準受保人已更改居住地，請立即以書面通知保柏。

Choice of Cover 投保項目

Bupa MyBasic VHIS Plan 保柏自願醫保計劃

VHIS Certification Number 自願醫保認可產品編號：

S00020-01-000-01

For Bupa use only 保柏專用

Standard Premium
標準保費

Discount amount,
if any
折扣總額 (如有)

Levy
保費徵費

Total premium and
levy paid (HKD)
保費及保費徵費
總額 (港元)

Verified by
核實：

-	
+	
=	

Please tick this box if you would like to receive coverage for Pre-existing Conditions with Premium Loading.³

請剔取此項，如您需要以附加保費獲得投保前已有病症的保障。³

³ 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 Premium Loading. If you choose this option, we may contact you to collect additional information for assessment.

³ 我們可能會因您所申報的病歷而將一些病症列為不獲保障項目。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。如您選擇此項，我們或會聯絡您以索取額外資料以作審核。

Premium Payment Method 繳付保費方法

Payment Frequency 繳付保費形式	Payment Method 繳付保費方法	Remarks 備註
<input type="checkbox"/> Yearly 年繳	<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"/> Autopay from Bank 銀行自動轉賬 (From renewal payment only 續保繳費起適用)	Please attach a cheque made payable to "Bupa (Asia) Limited" for the 1st year's premium and levy with a completed Direct Debit Authorisation Form 請填妥 直接付款授權書 ，連同首年保費及保費徵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="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」
<input type="checkbox"/> Monthly 月繳	<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"/> Autopay from Bank 銀行自動轉賬	Please attach a cheque made payable to "Bupa (Asia) Limited" for the first 2 months' premium and levy with a completed Direct Debit Authorisation Form 請填妥 直接付款授權書 ，連同首兩個月保費及保費徵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 Policy Holder/Insured Person*, please fill in the following information. 若支票發出人並非保單持有人/受保人*，請填寫以下資料。
 Relationship with the Policy Holder/Insured Person* 與保單持有人/受保人*關係 (Applicable to spouse, parents or children only 只適用於配偶、父母或子女) Reason for paying premium and levy on behalf of the Policy Holder/Insured Person* 代保單持有人/受保人*支付保費及保費徵費的原因

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 (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 (HKD only) 個人香港儲蓄 / 往來銀行戶口號碼 (只限港元)

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 Policy Holder/Insured Person*, please fill in the following information. 若上述之戶口持有人並非保單持有人/受保人*，請填寫以下資料。
 Relationship with the Policy Holder/Insured Person* 與保單持有人/受保人*關係 (Applicable to spouse, parents or children only 只適用於配偶、父母或子女) Reason for receiving claims payment on behalf of the Policy Holder/Insured Person* 代保單持有人/受保人*收取賠款的原因

*Please delete if inappropriate 請刪除不適用者

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」中間題回答「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 Insured Person 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。女性準受保人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。

If there is any change or update on the proposed Insured Person's health conditions at any time after the submission of this Application and before the Policy Effective Date, you are required to notify Bupa immediately. 如在提交本申請後和保單生效日之前的任何時間，準受保人的健康狀況有任何改變或更新，您需要立即通知保柏。

Height 身高**	m 米	cm 厘米/	ft 尺	in 吋	Weight 體重**	kg 公斤/	lb 磅	Smoker 吸煙者**	<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否
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** Not required for proposed Insured Person(s) below 18 years old. 18歲以下之準受保人無需填寫。

Health Declaration – Section A 健康聲明 — 甲部

1. In the last 3 years, have you (or the proposed Insured Person) had: 在過去三年內，您(或準受保人)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？	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
2. In the last 5 years, have you (or the proposed Insured Person) 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(或準受保人)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？	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
3. In the last 7 years, have you (or the proposed Insured Person) been admitted to hospital, had an operation or a procedure? 在過去七年內，您(或準受保人)是否曾住院，接受手術或治療程序？	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
4. In the last 6 months, have you (or the proposed Insured Person) had any <u>undiagnosed</u> symptoms, or currently undergoing medical investigations or awaiting results for the said symptoms? 在過去六個月內，您(或準受保人)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？	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
5. Have you (or the proposed Insured Person) 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(或準受保人)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)？	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
Applicable to proposed Insured Person Aged 24 months or below only. 此問題只適用於年齡為24個月或以下的準受保人：	
6. Was the proposed Insured Person born before 37 weeks or after 42 weeks of pregnancy? 準受保人是否於懷孕37周前或42周後出生？	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否

^{##} For proposed Insured Persons Aged 17 and below, this includes abnormalities in growth development (e.g. height and weight) 於十七歲或以下準受保人，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
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 (or the proposed Insured Person) have? Please include dates, type of investigations (e.g. MRI, blood test) and their results. 您(或準受保人)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 (or the proposed Insured Person) have? Please include treatment period, type of treatment and their details (e.g. name of medication, name of procedure or surgery) 您(或準受保人)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 (or the proposed Insured Person) made a full recovery? (Yes/No) 您(或準受保人)是否已完全康復?(是/否)			

If you (or the proposed Insured Person) have any medical reports or reports of investigations, please enclose them and put a tick in the box.
如您(或準受保人)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

The Policy Holder and the proposed Insured Person hereby declare that:

I apply for the health insurance plan (the "Plan") stated in this application form (the "Application"). If I am making an Application for a proposed Insured Person under the Age of 18, I have been duly authorised by the guardian of the proposed Insured Person to make this Application.

I confirm that I have selected this insurance plan of my own free will. I further confirm that the product features of the Plan were able to fulfil my/ proposed Insured Person's current medical protection needs, financial situation and premium affordability.

保單持有人和準受保人謹此聲明：

本人提出此申請表（「此申請」）中列明之醫療保障計劃（「計劃」）之申請。如準受保人年齡未滿18歲，本人已獲準受保人的監護人正式授權為準受保人提出此申請。

本人確認本人所選之保險計劃乃按照本人之獨立意願而決定。本人並確認計劃的產品內容符合本人/準受保人現時的醫療保障需求、財務狀況及保費承擔能力。

Coverage and Pre-existing Conditions 保障及已有病症

I declare that, to the best of my knowledge and belief the information provided in this Application or in support of this Application (including to any Bupa appointed Medical Examiner) ("Information") is true, accurate and complete. I understand that (1) all Information forms the basis and becomes a part of the Policy; (2) failure to provide Bupa with full, complete and accurate Information may result in Bupa having the right to treat the Policy as if it had not existed, or refusing to pay all or part of a claim; and (3) failure to provide full, complete and accurate Information in respect of the Insured Person may affect the cover for that Insured Person.

If I am making this Application on behalf of the proposed Insured Person under the Age of 18, all Information disclosed on behalf of the proposed Insured Person has been verified by me as true and correct. I acknowledge that the knowledge of proposed Insured Person is imputed to my knowledge.

I acknowledge that benefit is not payable under the Plan for any costs of treatment arising from any existing illnesses, injuries or other conditions which has been treated or diagnosed or manifested with signs and symptoms that should be reasonably aware before the Policy Effective Date of the Plan (or, if applicable, the date as referred in the Endorsement Letter if switching from an existing Bupa Health Insurance Scheme) unless complete details are fully disclosed in this Application and accepted by Bupa. I understand that I am required to notify Bupa immediately if the health condition of the proposed Insured Person has changed at any time after the submission of this Application and before the Policy Effective Date of the Plan.

In respect of the Eligible Expenses arising from unknown pre-existing illness, injuries or other conditions that the proposed Insured Person was not aware and would not reasonably have been aware before the Policy Effective Date of the Plan (or, if applicable, the date as referred in the Endorsement Letter if switching from an existing Bupa Health Insurance Scheme), I acknowledge that the benefits (if payable) under this Plan will be subject to the waiting period and reimbursement percentage as stated in the Policy. In the event the pre-existing medical conditions have been disclosed in the Application and accepted by Bupa, Bupa may apply a Premium Loading to cover that specific condition(s) and the percentage of Premium Loading shall be notified to me in writing. Bupa may apply Case-based Exclusion(s) due to a pre-existing condition or any other factor that may affect the insurability of the proposed Insured Person.

I acknowledge that Bupa may terminate the cover for the proposed Insured Person with immediate effect if the law of the country in which the proposed Insured Person is located, or the proposed Insured Person's Place of Residence or nationality, including but not limited to USA and Japan, or any other law which applies to Bupa or the Policy, prohibits the provision of healthcare cover by Bupa to local nationals, residents or citizens. I further declare that the proposed Insured Person is not US permanent residents. I understand that I am obliged to immediately notify Bupa in writing if the proposed Insured Person becomes a permanent resident of USA during the Policy Year. For the above purpose, '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.

本人聲明，就本人所知所信，本申請表上（包括向任何保柏委託的醫護人士）提供或予以支持有關申請的一切資料（「資料」），均屬真實、準確及完整。本人明白(1)所有資料將成為簽發保單的基礎並成為保單一部分；(2)如未有向保柏提供真實、準確及完整的資料，保柏有權將本人的保單視為不存在或拒絕支付全部或部分的索償；及(3)如未有為準受保人提供真實、準確及完整的資料，將會影響該準受保人之保障。

如本人代表年齡未滿18歲的準受保人提出此申請，所有代表準受保人透露的所有資料已經本人核實為真實及正確。本人確認準受保人所知之事被視為本人所知之事。

本人確認凡在保單生效日（或從現有保柏醫療保障計劃轉換至本計劃的批注信件中列明之日期，如適用）前因已接受治療或被確診或已察覺或理應察覺病徵或症狀的已有病症、損傷或其他病況而引致之醫療費用，除非本人在本申請表內已詳細列出並獲得保柏接納，有關費用一律不予賠償。本人明白如在提交本申請後和本計劃保單生效日之前的任何時間，準受保人的健康狀況有任何改變，本人需要立即通知保柏。

關於準受保人在保單生效日（或從現有保柏醫療保障計劃轉換至本計劃的批注信件中列明之日期，如適用）之前未能察覺及理應不察覺的已有病症、損傷或其他病況而引致之合資格費用，本人確認此計劃下的保障將受限於保單列明的等候期及賠償百分比。

如已有病症已於申請表內披露並獲保柏接納承保，保柏會徵收附加保費以保障有關個別病況，將徵收的附加保費率將會以書面通知本人。保柏亦可按已有病症或任何其他影響準受保人可保性的因素而加設的個別不保項目。

本人確認如準受保人的所在國家或其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保單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，保柏可終止相關準受保人的保障並立即生效。本人此外聲明準受保人並非美國永久居民。本人明白如準受保人如於保單年度期間成為美國永久居民，本人有責任立即以書面通知保柏。「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。

Personal Data and Information Disclosure 個人資料及資訊披露

I consent to Bupa using and disclosing the personal data provided in this Application and other personal data it collects about me, for the purposes set out in and in accordance with the Personal Information Collection Statement on the last page of this Application.

The Policy Holder further confirms to have obtained consent from the proposed Insured Person (or the guardian, if applicable) for me to provide Bupa, and for Bupa to provide me, with health and medical information and other personal data regarding the proposed Insured Person for the purposes of this Application, and the continuance of the Policy, including renewal.

I acknowledge that Bupa reserves the right to ask for submission of more details of health status or medical reports of the proposed Insured Person at my own cost. I also authorise any medical practitioner, hospital, clinic, by whom or where the proposed Insured Person has been observed or treated or any insurance company or organisation that has any records or health information concerning the proposed Insured Person 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 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 Expenses and to do all things and acts incidental to such appointment for the proposed Insured Person. I 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 by me against any such service provider appointed by Bupa.

本人同意保柏可以使用並披露此申請表內或其他途徑所收集關於本人的個人資料，用作根據本申請表最後一頁的「個人資料收集聲明」內所陳述的用途。

保單持有人此外確認，本人已向準受保人（或其監護人，如適用）取得同意，本人可向保柏以及保柏可向本人於申請及延續（包括續保）此保單時提供有關準受保人的健康醫療資訊及其他個人資料。

本人確認保柏有權要求提供更多有關準受保人之健康狀況及醫療報告，一切費用由本人支付。本人並且授權任何為準受保人觀察或治療的醫生、醫院、診所，或持有準受保人健康或任何資料之保險公司或機構將準受保人之全部資料（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準受保人。本人確認並同意有關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。就準受保人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。

Policy and Eligibility for Tax Deduction 保單及稅務扣減的資格

I agree to be bound by the terms and conditions of the Policy of this Plan, which will be provided to me if this Application is approved.

I acknowledge that the premium paid under this Plan shall not be automatically entitled to tax deduction even this Application is approved by Bupa. I understand that I am required to fulfil the conditions and assessment criteria imposed by the Inland Revenue Department and any applicable laws (which may amend from time to time), which include but not limited to allowable relationship for dependant, age/disability/full-time education requirement, date and amount of qualifying premium paid, in order to enjoy any tax deduction.

Policies purchased for grandchild, domestic partner (i.e. civil partner, or the person with whom the Policy Holder lives in a continuous, committed, exclusive relationship during which period neither the Policy Holder or that person were or are married to or partnered with any other person) and domestic partner's child/parents are not eligible for tax deductions.

本人同意遵守計劃保單之各條款及細則，該保單將會於此申請獲批後提供予本人。

本人明白即使此申請已獲保柏接納，本計劃下已繳付的保費並不會自動享有稅務扣減。本人明白本人須符合稅務局及任何適用的法律（可不時修改）所規定的條件及評估標準方可享有稅務扣減，包括但不限於認可的受供養人、年齡/殘疾/全日制學生資格，以及支付合資格保費的金額及日期。

本人為孫子女、同居伴侶（同居伴侶指民事結合的伴侶或與保單持有人共同生活，並保持持續、忠誠以及唯一的關係的人士，而期間保單持有人或該人士並沒有和其他人士結婚或結合）和同居伴侶的子女/父母所購買的保單並不符合稅務扣減的資格。

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。

(P.T.O.)

Declaration and Authorisation (Cont.) 聲明及授權 (續)

Personal Information Collection Statement 個人資料收集聲明

(i) I have read and understood the Personal Information Collection Statement included in this application form. I have also brought the Personal Information Collection Statement to the attention of the proposed Insured Person (or the guardian if applicable) and confirmed the understanding and agreement to it.
本人已細閱並明白本申請表所述的「個人資料收集聲明」。本人亦已促使準受保人（或其監護人，如適用）留意「個人資料收集聲明」並確認明白及同意有關內容。

(ii) I consent to Bupa using my personal data, including my name, contact details, gender, health and family status, to send me marketing communications (including by email, SMS or instant messenger) as described in the Personal Information Collection Statement, including in relation to insurance (such as premium discounts), wellness, rewards, loyalty or privileges programmes and related product and services. I understand that I have the right to request Bupa to cease using my personal data for direct marketing purposes by emailing customer-care@bupa.com.hk or calling the Bupa Customer Care helpdesk on 2517 5333.
本人同意保柏使用本人之個人資料，包括本人的姓名、聯絡方法、性別、健康及家庭狀況，向本人傳送根據「個人資料收集聲明」所述包括保險（例如保費折扣）、健康、獎賞、會員忠誠或優惠計劃及其相關的產品及服務的市場推廣資訊（包括以電郵、手機短訊或即時通訊），並明白本人有權透過聯絡保柏的客戶服務專線（電郵至customer-care@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。

本人同意保柏使用本人之個人資料，包括本人的姓名、聯絡方法、性別、健康及家庭狀況，向本人傳送根據「個人資料收集聲明」所述包括保險（例如保費折扣）、健康、獎賞、會員忠誠或優惠計劃及其相關的產品及服務的市場推廣資訊（包括以電郵、手機短訊或即時通訊），並明白本人有權透過聯絡保柏的客戶服務專線（電郵至customer-care@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 premium 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。

Cancellation Rights and Refund of Premium(s) 取消保單權益及發還保費

I understand that I have the right to cancel and obtain a refund of any premium(s) and levy paid by giving written notice. Such notice must be signed by me and received directly by Bupa (Asia) Limited at 18/F, Berkshire House, 25 Westlands Road, Quarry Bay, Hong Kong within 21 days after the delivery of the Policy.

本人明白本人有權以書面通知要求取消保單及取回所有已繳保費及保費徵費。但是本人必須簽署該通知，並確保保柏（亞洲）有限公司（香港鰂魚涌華蘭路25號柏克大廈18樓）於保單交付本人後起計的21天內收到該通知。

I, as the Policy Holder, understand that I declare and sign on behalf of the proposed Insured Person listed in this Application under this Plan who is under the Age of 18.

本人茲申請為保單持有人，明白本人代表此計劃申請表內列出之18歲以下準受保人作出聲明及簽署。

I understand that no cover will be payable under the Policy unless this Application is approved and premium 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，保柏方按保單支付保障。

<p>Policy Holder's Signature 保單持有人簽署</p> <p>X</p> <p>(Full Name 姓名)</p>	<p>Signed in Hong Kong on 於香港簽署之日期</p> <p>DD 日 MM 月 YYYY 年</p>	<p>Proposed Insured Person's Signature (Age 18 years old or above) 準受保人簽署 (18歲或以上)</p> <p>X</p> <p>(Full Name 姓名)</p>	<p>Signed in Hong Kong on 於香港簽署之日期</p> <p>DD 日 MM 月 YYYY 年</p>
<p>Agent's / Broker's / Telesales' Name (If applicable and must be completed by the Policy Holder) 代理人 / 經紀 / 營業代表姓名 (如適用及必須由保單持有人填寫)</p>	<p>Agent's / Broker's / Telesales' Contact Tel No. 代理人 / 經紀 / 營業代表聯絡電話號碼</p>		
<p>Agent's / Broker's / Telesales' Code 代理人 / 經紀 / 營業代表編號</p>	<p>Agent's / Broker's / Telesales' Email Address 代理人 / 經紀 / 營業代表電郵地址</p>		

Reminder 提醒您

To help us process your Application quickly, please ensure that you have:

- enclosed payment of the correct premium and levy and a copy of your HKID Card or Passport
- initialled any amendments on this application form
- enclosed a copy of the HKID Card, Passport or the birth certificate of the Proposed Insured Person

我們想更快地助您完成申請，因此請您在遞交申請表時謹記：

- 連同正確之保費及保費徵費與您的香港身份證或護照副本
- 於任何更改之處簽署作實
- 連同準受保人的香港身份證、護照或出生證明副本

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,本公司特意通知閣下以下事項:

- 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,就涉及之轉讓、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定的其他人士)、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 柏
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。

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Bupa MyBasic VHIS Plan Credit Card Authorisation Form

保柏自願醫保計劃信用卡付款授權書



Policy Holder's Name 保單持有人姓名

Surname

姓

Given Name

名

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 premium and levy due from my credit card account on an annual / monthly 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/每月支付應繳保費及保費徵費金額，直至另行通知。

If the Cardholder is not the Policy Holder/Insured Person*, please fill in the following information. 若信用卡持有人並非保單持有人/受保人*，請填寫以下資料。

Relationship with the Policy Holder/Insured Person* 與保單持有人/受保人*關係
(Applicable to spouse, parents or children only 只適用於配偶、父母或子女)

Reason for paying premium and levy on behalf of the Policy Holder/Insured Person*
代保單持有人/受保人*支付標準保費及保費徵費的原因

I hereby confirm to pay the premium and levy due of Bupa MyBasic VHIS Plan for the Policy Holder as listed in this form.

本人同意及承擔列於此表格上的保單持有人之全數應繳之保柏自願醫保計劃保費及保費徵費金額。

Cardholder's Signature 持卡人簽署

X

Contact Phone No. 聯絡電話號碼

Date 日期

DD 日 MM 月 YY 年

For Bupa use only
保柏專用

Bupa MyBasic VHIS Plan Insured Person Policy No.
保柏自願醫保計劃受保人保單號碼：

Date
日期

DD 日 MM 月 YY 年

Authorised Code :
授權代碼

*Please delete if inappropriate 請刪除不適用者

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Bupa MyBasic VHIS Plan Direct Debit Authorisation Form

保柏自願醫保計劃直接付款授權書



Policy Holder's Name 保單持有人姓名

Surname 姓

姓

Given Name 名

名

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 premium and levy amount.

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及保費徵費金額的支票交回保柏。

Name of party to be credited (The beneficiary)

收款之一方 (受益人)

BUPA (ASIA) LIMITED

Bank No.

銀行編號

0 2 4 7 8 7

Branch No.

分行編號

6 2 1 7 8 8 0 0 1

Account No.

收款戶口號碼

I/We hereby authorise my/our above-named bank (the "Bank") to effect transfer from my/our above-mentioned account to the above-named beneficiary in accordance with such instructions as the Bank may receive from the beneficiary from time to time, provided always that the amount of any one such transfer shall not exceed the limit indicated above (if applicable).

本人(等)現授權上述之銀行(「該銀行」)，根據收款人不時給予該銀行之指示，自本人(等)上述戶口轉賬予收款人。但每次轉賬金額不得超過以上指定之限額(如適用)。

I/We agree that the Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me/us.

本人(等)同意該銀行毋須證實該等轉賬是否已通知本人(等)。

I/We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our above-mentioned account which may arise as a result of any such transfer(s).

如因該等轉賬而令本人(等)之上述戶口出現透支(或令現時之透支增加)，本人(等)會共同及各別承擔全部責任。

I/We confirm that my/our signature(s) on this authorisation is/are the same as filed with the Bank for the operation of my/our above-mentioned account to be debited for the transfer.

本人(等)確證在本授權書內之簽名，與本人(等)上述戶口於該銀行簽署紀錄完全相同。

I/We agree that should there be insufficient funds in my/our above-mentioned account to meet any transfer hereby authorised, the Bank shall be entitled, at its discretion, not to effect such transfer in which event the Bank may make the usual service charge to be paid by me/us.

本人(等)同意如上述戶口並無足夠款項支付有關轉賬，該銀行有權不予辦理且可收取有關之手續費用，該等費用一概由本人(等)支付。

I/We agree that any notice of cancellation or variation of this authorisation which I/we may give to the Bank shall be given at least two working days prior to the date on which such cancellation or variation is to take effect.

本人(等)同意取銷或更改本授權書之任何通知，須於取銷或更改生效日最少兩個工作天之前交予該銀行。

This authorisation shall have effect until further notice or until the above given expiry date (whichever first occurs).

本授權書將繼續生效直至另行通知為止或直至上列到期日為止(以兩者中最早之日期為準)。

My / Our Bank and Branch Name

本人 / 吾等之銀行及分行名稱

Bank No.

銀行編號

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

HKID Card No. / Passport No.

香港身份證號碼 / 護照號碼

My / Our signature(s) 本人 / 吾等之簽署

X

Date of signing 簽署日期

DD 日 MM 月 YY 年

My / Our address as recorded on Statement / Passbook 本人 / 吾等在結單 / 存摺上之地址

Debtor's Name (If other than account holder) 債務人之姓名 (若非戶口持有人)

Insured Person's Policy No. (Debtor's Reference) 受保人保單號碼 (債務人備註)

If the account holder is not the Policy Holder / Insured Person*, please fill in the following information. 若戶口持有人並非保單持有人/受保人*，請填寫以下資料。

Relationship with the Policy Holder/Insured Person* 與保單持有人/受保人*關係

(Applicable to spouse, parents or children only 只適用於配偶、父母或子女)

Reason for paying premium and levy on behalf of the Policy Holder/Insured Person*

代保單持有人/受保人*支付保費及保費徵費的原因

*Please delete if inappropriate 請刪除不適用者

For bank use only

銀行專用

Signature Verified

核實簽署

Notes: 1. The box marked "Insured Person's Policy No." is to be completed by Bupa.
2. The signature on this authorisation form must be the same as the signature of your Bank Account.

附註: 1. 受保人保單號碼一欄由保柏填寫。
2. 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。

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