Bupa Together Health Insurance Scheme Application Form
保柏互通保額醫療保障計劃申請表

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。

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

Effective Date : 生效日期 DD 日 MM 月 YYYY 年

Personal Details of Applicant 申請人資料 (Applicant must be aged 18 years or above 申請人年齡必須為18歲或以上)

Title 稱謂 Name of Applicant (same as HKID Card) 申請人姓名 (與香港身份證相同)

☐ Mr先生
☐ Mrs太太
☐ Ms女士
☐ Miss小姐

Surname 姓

Given Name 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

Height 身高 m米 cm厘米/ ft尺 in吋

Weight 體重 kg公斤/ lb磅

Smoker 吸煙者 ☐ Yes是 ☐ No否

Contact Details of Applicant 申請人聯絡資料

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

Country of Residence 居住國家^
(If not in Hong Kong 如非香港)

* 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.

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。

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PAAPP

MP170/11/1120/2.5K

Details of Proposed Member(s) and Choice of Cover 準會員資料及投保項目

☐ Myself 本人 (Details as page 1 資料如同第一頁)

Core Benefit 主要保障 ☑ Hospital and Surgical Benefit 住院及手術保障 | Benefit Level 保障級別 ☑ Ward 大房 | Optional Benefit 自選額外保障 ☐ Supplementary Major Medical Benefit 附加醫療保障[1] ☐ Clinical 門診 ☐ Maternity 產科[2] ☐ Dental (Plan A) 牙科 (計劃A) ☐ Dental (Plan B) 牙科 (計劃B)

☐ Spouse 配偶 (must be aged 16 years or above. 年齡必須介乎16歲或以上。)

Spouse's Name (same as HKID Card) 配偶姓名 (與香港身份證相同)

Surname 姓

Given Name 名

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

Height** 身高 m米 cm厘米/ ft尺 in吋 | Weight** 體重 kg公斤/ lb磅 | Smoker** 吸煙者 ☐ Yes是 ☐ No否

Country of Residence 居住國家^ (If not in Hong Kong 如非香港)

Core Benefit 主要保障 ☑ Hospital and Surgical Benefit 住院及手術保障 | Benefit Level 保障級別 ☑ Ward 大房 | Optional Benefit 自選額外保障 ☐ Supplementary Major Medical Benefit 附加醫療保障[1] ☐ Clinical 門診 ☐ Maternity 產科[2] ☐ Dental (Plan A) 牙科 (計劃A) ☐ Dental (Plan B) 牙科 (計劃B)

☐ Child 子女 1 (Child Members must be aged 15 days or above. 子女年齡必須為15日或以上。)

Child's Name (same as HKID Card/Birth Certificate) 子女姓名 (與香港身份證/出生證明書相同)

Surname 姓

Given Name 名

HKID Card No. / Birth Certificate No. 香港身份證號碼 / 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

Height** 身高 m米 cm厘米/ ft尺 in吋 | Weight** 體重 kg公斤/ lb磅 | Smoker** 吸煙者 ☐ Yes是 ☐ No否

Country of Residence 居住國家^ (If not in Hong Kong 如非香港)

Core Benefit 主要保障 ☑ Hospital and Surgical Benefit 住院及手術保障 | Benefit Level 保障級別 ☑ Ward 大房 | Optional Benefit 自選額外保障 ☐ Supplementary Major Medical Benefit 附加醫療保障[1] ☐ Clinical 門診 ☐ Maternity 產科[2] ☐ Dental (Plan A) 牙科 (計劃A) ☐ Dental (Plan B) 牙科 (計劃B)

☐ Child 子女 2 (Child Members must be aged 15 days or above. 子女年齡必須為15日或以上。)

Child's Name (same as HKID Card/Birth Certificate) 子女姓名 (與香港身份證/出生證明書相同)

Surname 姓

Given Name 名

HKID Card No. / Birth Certificate No. 香港身份證號碼 / 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

Height** 身高 m米 cm厘米/ ft尺 in吋 | Weight** 體重 kg公斤/ lb磅 | Smoker** 吸煙者 ☐ Yes是 ☐ No否

Country of Residence 居住國家^ (If not in Hong Kong 如非香港)

Core Benefit 主要保障 ☑ Hospital and Surgical Benefit 住院及手術保障 | Benefit Level 保障級別 ☑ Ward 大房 | Optional Benefit 自選額外保障 ☐ Supplementary Major Medical Benefit 附加醫療保障[1] ☐ Clinical 門診 ☐ Maternity 產科[2] ☐ Dental (Plan A) 牙科 (計劃A) ☐ Dental (Plan B) 牙科 (計劃B)

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

1 Applicable to proposed Member(s) under 60 years old. 適用於60歲以下之準會員。

2 Applicable to female proposed Member(s) aged 18-49. 適用於18-49歲之女性準會員。

Details of Proposed Member(s) and Choice of Cover (Cont.) 準會員資料及投保項目 (續)

☐ Applicant's parents / Applicant's parents-in-law 申請人或申請人配偶之父母

Relationship with the applicant 與申請人關係 ☐ Applicant's father 申請人之父親 ☐ Applicant's mother 申請人之母親 ☐ Applicant's father-in-law 申請人配偶之父親 ☐ Applicant's mother-in-law 申請人配偶之母親

Applicant's parents' / Applicant's parents-in-law's Name (same as HKID Card) 申請人或申請人配偶之父母姓名 (與香港身份證相同)

Surname 姓

Given Name 名

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

Height** 身高 m米 cm厘米/ ft尺 in吋 | Weight** 體重 kg公斤/ lb磅 | Smoker** 吸煙者 ☐ Yes是 ☐ No否

Country of Residence 居住國家^ (If not in Hong Kong 如非香港)

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☐ Applicant's parents / Applicant's parents-in-law 申請人或申請人配偶之父母

Relationship with the applicant 與申請人關係 ☐ Applicant's father 申請人之父親 ☐ Applicant's mother 申請人之母親 ☐ Applicant's father-in-law 申請人配偶之父親 ☐ Applicant's mother-in-law 申請人配偶之母親

Applicant's parents' / Applicant's parents-in-law's Name (same as HKID Card) 申請人或申請人配偶之父母姓名 (與香港身份證相同)

Surname 姓

Given Name 名

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

Height** 身高 m米 cm厘米/ ft尺 in吋 | Weight** 體重 kg公斤/ lb磅 | Smoker** 吸煙者 ☐ Yes是 ☐ No否

Country of Residence 居住國家^ (If not in Hong Kong 如非香港)

Core Benefit 主要保障 ☑ Hospital and Surgical Benefit 住院及手術保障 | Benefit Level 保障級別 ☑ Ward 大房 | Optional Benefit 自選額外保障 ☐ Supplementary Major Medical Benefit 附加醫療保障1 ☐ Clinical 門診 ☐ Maternity 產科2 ☐ Dental (Plan A) 牙科 (計劃A) ☐ Dental (Plan B) 牙科 (計劃B)

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2 Applicable to female proposed Member(s) aged 18-49. 適用於18-49歲之女性準會員。

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
☐ Yearly 年繳	☐ 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
	☐ 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 subscription 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」
	☐ 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」
☐ Monthly 月繳	☐ 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
	☐ Autopay from Bank 銀行自動轉賬	Please attach a cheque made payable to "Bupa (Asia) Limited" for the first 2 months' subscription 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 applicant or proposed Member*, please fill in the following information. 若支票發出人並非申請人或準會員*，請填寫以下資料。

Relationship with the applicant or proposed Member* 與申請人或準會員*關係 (Applicable to spouse, parents or children only 只適用於配偶、父母或子女)

Reason for paying subscription and levy on behalf of the applicant or proposed Member* 代申請人或準會員*支付保費及保費徵費的原因

* Please delete if inappropriate 請刪除不適用者

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 (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 applicant, please fill in the following information. 若上述之戶口持有人並非申請人，請填寫以下資料。

Relationship with the applicant or proposed Member* 與申請人或準會員*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 applicant or proposed Member*
代申請人或準會員*收取賠款的原因

* Please delete if inappropriate 請刪除不適用者

Health Declaration 健康聲明

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. 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。

During the insurance application process, it's important that you act with utmost good faith and disclose all material facts to Bupa. If you are uncertain as to whether a fact is material, then it should be disclosed. If you fail to disclose or misrepresent a material fact and this causes Bupa to accept the risk, this will raise questions about your entitlement to insurance benefits. Consequences may include termination of your policy or reduction of entitlement to claims payments in all or part. 在保險申請過程中，務必以至高誠信向保柏披露所有重要事實。如果您不確定某個事實是否重要，則應將其披露。如您未能披露或錯誤陳述重要事實，而導致保柏承擔有關風險，這將影響你您享有的保障。其結果可能包括終止您的保單；或減少全部或部分您所獲得的賠償。

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. 您無須告知我們傷風、感冒、上呼吸道感染的病史。女性準會員也不用告知我們有關分娩的紀錄。

If there is any change or update on the proposed Member's health conditions at any time after the submission of this Application and before the Coverage Commencement Date, you are required to notify Bupa immediately. 如在提交本申請後和保障開始日之前的任何時間，準會員的健康狀況有任何改變或更新，您需要立即通知保柏。

Health Declaration – Section A
健康聲明 — 甲部

	Full Name of applicant 申請人全名	Full Name of proposed Member 準會員全名	Full Name of proposed Member 準會員全名	Full Name of proposed Member 準會員全名
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 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐
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 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐
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 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐
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 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐
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 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐
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 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐
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 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐	Yes 是 ☐ No 否 ☐

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 (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
Full Name of applicant / proposed Member 申請人 / 準會員全名			
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，請説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 Together Health Insurance Scheme ("Scheme"). I / We confirm that I / we have selected this insurance plan of my / our own free will. I/We further confirm that the product features of the Scheme were able to fulfil my / our medical protection needs, financial situation and premium affordability. 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 agree to be bound by the terms and conditions of the Contract of this Scheme, which I / we understand are available on request and will be provided to me / us if this application is approved. 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 understand that I have the right to cancel this Contract within 21 days from the Coverage Commencement Date and that if I do not cancel the Contract within that period, all information in this Application is deemed to be final.
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.
本人/吾等申請成為「保柏互通保額」醫療保障計劃（「計劃」）之會員。本人/吾等確認本人/吾等所選之保險計劃乃按照本人/吾等之獨立意願而決定。本人/吾等並確認計劃的產品內容符合本人/吾等現時的醫療保障需求、財務狀況及保費承擔能力。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出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/吾等同意遵守此計劃合約之各條款及細則，並明白可在要求下索取，此外保柏亦會於此申請獲批後提供該些條款及細則予本人/吾等。本人/吾等同意本申請表內之健康聲明及回答將作為本人/吾等與保柏之間所訂合約之根據。本人明白本人有權於合約生效日後21日內取消此合約。如本人沒有於此期間取消合約，此申請內的所有內容將被視為最終資料。
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。

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。

Personal Information Collection Statement 個人資料收集聲明

(i) I / We have read and understood the Personal Information Collection Statement included in this application form.
本人/吾等已細閱並明白本申請表所述的「個人資料收集聲明」；及

(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 **subscription discounts**), wellness, rewards, loyalty or privileges programmes and related products and services. 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 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 discounts** 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。

Declaration of residency 居民身份聲明

☐ By ticking this box, I solemnly declare myself (the "Applicant") and other proposed Member(s) listed in this Application are **NOT** US permanent resident*. I further 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 USA 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. Equivalently, I understand that I am obliged to immediately notify Bupa in writing if any of the Members become a permanent resident of USA during the Contract Year.
本人確認剔取此項即代表本人聲明本人(投保人)及列於此申請表的其他準會員**並非**美國永久居民*。本人明白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。本人明白如本人如於合約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。

* 'Permanent resident' 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 USA, United States Minor Outlying Islands, Virgin Islands, U.S. and 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。美國為此包括美國本土、美國本土外小島嶼、美屬維京群島及波多黎各自由邦。

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.
本人茲申請為投保人，明白本人代表此計劃申請表內列出之18歲以下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。

Applicant's Signature 申請人簽署	Signed in Hong Kong on 於香港簽署之日期	Proposed Member's Signature (Aged 18 or above) 年滿18歲或以上之準會員簽署	Signed in Hong Kong on 於香港簽署之日期
X (Full Name 姓名)	DD 日 MM 月 YY 年	X (Full Name 姓名)	DD 日 MM 月 YY 年
Proposed Member's Signature (Aged 18 or above) 年滿18歲或以上之準會員簽署	**Signed in Hong Kong on 於香港簽署之日期**	**Proposed Member's Signature (Aged 18 or above) 年滿18歲或以上之準會員簽署**	**Signed in Hong Kong on 於香港簽署之日期**
X (Full Name 姓名)	DD 日 MM 月 YY 年	X (Full Name 姓名)	DD 日 MM 月 YY 年

Agent's / Broker's / Telesales' Name (If applicable and must be completed by the applicant) 代理人 / 經紀 / 營業代表姓名（如適用及必須由申請人填寫）	Agent's / Broker's / Telesales' Contact Tel. No. 代理人 / 經紀 / 營業代表聯絡電話號碼
Agent's / Broker's / Telesales' Code 代理人 / 經紀 / 營業代表編號	Agent's / Broker's / Telesales' Email Address 代理人 / 經紀 / 營業代表電郵地址

Reminder 提提您

To help us process your Application quickly, please ensure that you have:
- ☑ enclosed payment of the correct subscription and levy and a copy of your HKID Card or Passport
- ☑ enclosed a copy of the HKID Card or Passport for each family member aged 18 or above enrolling in the same Contract
- ☑ enclosed a copy of the HKID Card or the birth certificate for each child aged below 18 whom you would like to enrol
- ☑ enclosed a completed Medical Insurance Need Assessment Form
- ☑ initialled any amendments on this application form

Where necessary, we will request you to provide documents to prove family relationship.

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
- ☑ 連同您每位18歲或以上之家庭成員的香港身份證或護照副本 (如家庭成員一同投保)
- ☑ 連同您每位18歲以下之子女的香港身份證或出生證明書副本 (如子女一同投保)
- ☑ 連同已填妥的醫療保障需要分析表
- ☑ 於任何更改之處簽署作實

在有需要的情況下，我們會請您提供家庭成員的關係證明。

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:

1. 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.
2. **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.**
3. 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.
4. **The Company may collect, use or disclose personal information relating to you, or the Member, for the following purposes:**
   a. processing, assessing and determining any Applications for insurance products and services;
   b. 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;
   c. 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;
   d. 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;
   e. provision and design of products and services of the Company;
   f. 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;
   g. 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;
   h. 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
   i. making disclosure to satisfy the requirements of any laws, rules and regulations, codes of practice, guidance notes or guidelines binding on the Company.
5. **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:**
   a. the Company's group companies ("Group Company");
   b. any insurance adjusters, agents and brokers;
   c. any re-insurance companies authorised by the Company;
   d. employers (for members of corporate policy only);
   e. healthcare professionals and hospitals;
   f. 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);
   g. any actual or proposed assignee, transferee, participant or sub-participant of all or a substantial part of the Company's rights or business; and
   h. 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.
6. 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:
   a. Insurance, medical, healthcare, wellness, personal development, beauty, lifestyle, entertainment, financial, and related services and products;
   b. rewards, benefits, discounts, member activities, loyalty or privileges programmes and related services and products; and
   c. 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.
7. **Under and in accordance with the terms of the Ordinance, you have the following rights:**
   a. to check whether the Company holds personal information relating to you or the Member and to access such personal information;
   b. to require the Company to correct any personal information relating to you or the Member which is inaccurate;
   c. 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
   d. 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
8. 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.
9. For any enquiries about this Statement, please do not hesitate to contact our Customer Care helpdesk at 2517 5333.
10. Nothing in this Statement shall limit the rights of customers under the Ordinance.
11. 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：

1. 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)。
2. **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。**
3. 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。
4. **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：**
   a. 處理、評估、決定任何保險產品及服務之申請；
   b. 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；
   c. 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；
   d. 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；
   e. 提供及設計本公司的產品及服務；
   f. 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；
   g. 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；
   h. 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
   i. 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。
5. **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：**
   a. 本公司的集團公司(「集團公司」)；
   b. 任何由本公司授權的保險理算人、代理及經紀；
   c. 任何由本公司授權的再保險公司；
   d. 僱主 (只適用於團體保單之會員)；
   e. 醫護專業人員及醫院；
   f. 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)；
   g. 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
   h. 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。
6. 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)：
   a. 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；
   b. 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
   c. 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之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。
7. **根據有關條例中的條款，閣下有權：**
   a. 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；
   b. 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；
   c. 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
   d. 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號栢克大廈18樓
   保柏（亞洲）有限公司
   保障資料主任
8. 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。
9. 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。
10. 本聲明不會限制客戶在條例下所享有之權利。
11. 中英文本如有歧義，概以英文為準。

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Bupa Together Health Insurance Scheme Credit Card Authorisation Form
保柏互通保額醫療保障計劃信用卡付款授權書

Subscriber's Name 投保人姓名
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 subscription 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 applicant or proposed Member*, please fill in the following information. 若信用卡持有人並非申請人或準會員*，請填寫以下資料。

Relationship with the applicant or proposed Member* 與申請人或準會員*關係
(Applicable to spouse, parents or children only 只適用於配偶、父母或子女)

Reason for paying subscription and levy on behalf of the applicant or proposed Member* 代申請人或準會員*支付保費及保費徵費的原因

☐ I hereby confirm to pay the subscription and levy due of Bupa Health Insurance Scheme for the applicant or proposed Member* as listed in this form.
本人同意及承擔列於此表格上的申請人或準會員*之全數應繳之保柏醫療保障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 Together Membership No.
「保柏互通保額」會員編號：

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

Bupa (Asia) Limited 保柏（亞洲）有限公司
Address: 18/F, Berkshire House, 25 Westlands Road, Quarry Bay, Hong Kong
地址: 香港鰂魚涌華蘭路25號栢克大廈18樓
Telephone 電話: (852) 2517 5175 Facsimile 傳真: (852) 2548 1848 Website 網址: www.bupa.com.hk
Bupa Hong Kong

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Bupa Together Health Insurance Scheme Direct Debit Authorisation Form
保柏互通保額醫療保障計劃直接付款授權書

Subscriber's Name 投保人姓名
Surname
姓

Given Name
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 subscription 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）	Bank No. 銀行編號	Branch No. 分行編號	Account No. 收款戶口號碼
BUPA (ASIA) LIMITED	0 2 4	7 8 7	6 2 1 7 8 8 0 0 1

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)	Membership No. (Debtor's Reference) 會員編號 (債務人備註)

If the account holder is not the applicant or proposed Member*, please fill in the following information. 若戶口持有人並非申請人或準會員*，請填寫以下資料。

Relationship with the applicant or proposed Member* 與申請人或準會員*關係
(Applicable to spouse, parents or children only 只適用於配偶、父母或子女)

Reason for paying subscription and levy on behalf of the applicant or proposed Member*
代申請人或準會員*支付保費及保費徵費的原因

For bank use only **銀行專用**	**Signature Verified** **核實簽署**

Notes: 1. The box marked "Membership 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.
* Please delete if inappropriate

附註： 1. 會員編號一欄由保柏填寫。
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。
* 請刪除不適用者

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