

# Bupa Together Health Insurance Scheme Registration Variation Form

## 保柏互通保額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。

Subscriber's Name 投保人姓名	Tel No. 電話號碼
Membership No. (16 digits) 會員編號 (16位數字)	Fax No. 傳真號碼
	Email Address 電郵地址

**Types of Changes 更改項目** (Please tick the change(s) and fill in the details as required 請選擇更改部份並填妥所需資料)

### I. Change of Benefit 更改保障 (Health Declaration Part I must be completed for benefit addition (marked with "\*"). The new benefit will be effective on the date of renewal, if approved. 如選擇增加保障 (註有 "\*" 號)，必須填寫健康聲明第一部份，一經批核，新保障將於續保日生效。)

Applicable to existing Member. 適用於現有會員。		Optional Benefit 自選額外保障					
Member's Name 會員姓名		Supplementary Major Medical Benefit <sup>1</sup> 附加醫療保障 <sup>1</sup>		Clinical Benefit 門診保障		Maternity Benefit <sup>2</sup> 產科保障 <sup>2</sup>	
Surname 姓	Given Name 名	*Add 增加	Cancel 取消	*Add 增加	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"/>

\* If the Benefit after the change is higher than the Benefit the Member is entitled to before the change, all eligible medical expenses for the medical conditions that occurred before such change will be reimbursed according to your previous Benefits. 若會員的新保障額較前保障額為大，所有在更改前已患病之合資格醫療費用將根據舊有保障賠償。

<sup>1</sup> Applicable to Member(s) under 60 years old. 適用於60歲以下之會員。

<sup>2</sup> Applicable to female Member(s) aged 18-49. 適用於18-49歲之女性會員。

### II. Payment Method 繳付保費方法

<input type="checkbox"/> Cheque 支票 Bank Name 銀行名稱 Cheque No. 支票號碼	Please attach a cheque <sup>#</sup> made payable to "Bupa (Asia) Limited" 請將支票 <sup>#</sup> 交回本公司，支票抬頭人為「保柏（亞洲）有限公司」
<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

<sup>#</sup> 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 Reason for paying subscription and levy on behalf of the Subscriber  
與投保人關係 代投保人支付保費及徵費的原因

### 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 戶口持有人姓名	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 on **myBupa**, an online and mobile platform, to view and download some of my policy-related documents. To access these e-documents\*, I am required to register for a **myBupa** account and provide an email address in Section 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 Address** 新地址	Flat / Room 單位 / 室	Floor 層數	Block 座	Bldg. / Mansion / House 大廈 / 樓
	Court / Estate / Street 閣 / 屋苑 / 街道		District 地區	Kln / HK / NT 九龍 / 香港 / 新界
New Telephone No. 新電話號碼	Home / Office 住宅 / 公司		Mobile Phone 手提電話	Fax No. (Home / Office) 傳真號碼 (住宅 / 公司)
New Email Address 新電郵地址				

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

For any Member who becomes a US Permanent Resident<sup>1</sup>, please complete Section 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<sup>1</sup>，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 Member(s) Details 更改會員資料

\*\*\* 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 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 名	Membership No. 會員編號	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	Country of Residence# (if not in HK) 居住國家# (如非香港)	US Permanent Resident <sup>1</sup> 美國永久居民 <sup>1</sup>
<input type="checkbox"/> Subscriber 投保人								<input type="checkbox"/> Yes是 <input type="checkbox"/> No否
<input type="checkbox"/> Spouse 配偶								<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。

**■ VII. Addition of Member(s) 增加會員** (Health Declaration Part I must be completed 必須填寫健康聲明第一部份)

Please note 請注意：

- Subscriber's spouse, parents, parents-in-law must be aged 16 years or above.  
投保人之配偶、父母、配偶之父母必須為16歲或以上。
- Subscriber is required to complete Health Declaration Part II and signed endorsement by all existing Members is required.  
投保人必須填寫健康聲明第二部份及所有會員簽署核實。

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或護照副本。
- enclosed a copy of the birth certificate for each proposed Member aged below 18.  
連同每位18歲以下之準會員的出生證明書副本。
- 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。

	Subscriber 投保人	Spouse 配偶	Child 子女 1 <sup>^</sup>	Child 子女 2 <sup>^</sup>	Subscriber's father 投保人之父親	Subscriber's mother 投保人之母親	Subscriber's father-in-law 投保人配偶之父親	Subscriber's mother-in-law 投保人配偶之母親
Surname 姓								
Given Name 名								
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日/MM月/YY年)								
Country of Residence <sup>#</sup> 居住國家 <sup>#</sup> (if not in Hong Kong 如非香港)								
US Permanent Resident <sup>1,2</sup> 美國永久居民 <sup>1,2</sup>	<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	<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

<sup>^</sup> Child Members must be aged 15 days or above. 子女年齡必須為15日或以上。

<sup>#</sup> 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. 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。

**Choice of Cover 投保項目**

Core Benefit : Hospital and Surgical Benefit  
主要保障 : 住院及手術保障

Benefit Level : Ward  
保障級別 : 大房

Please tick the Optional Benefit. 請於自選額外保障項目空格內加上「✓」號。

Supplementary Major Medical Benefit <sup>1</sup> 附加醫療保障 <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical 門診保障	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternity <sup>2</sup> 產科保障 <sup>2</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

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Health Declaration - Part I 健康聲明 - 第一部份

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、上呼吸道感染的病史。女性(準)會員也不用告知我們有關分娩的紀錄。

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

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

Health Declaration - Section A 健康聲明 — 甲部

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

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

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

**Health Declaration - Section B 健康聲明 — 乙部**

	Medical condition 病症	Medical condition 病症	Medical condition 病症
Name of applicant / (proposed) Member 申請人 / (準)會員姓名			
Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected (eg right knee, left eye). 請盡可能準確註明患上何種疾病或病患。如適用，請說明受影響的身體部位 (例如右膝、左眼)。			
When did the symptoms start? 何時開始出現徵狀?			
What investigations did you have? Please include dates, type of investigations (eg MRI, blood test) and their results. 您曾接受何種檢查? 請註明日期、檢查種類 (如磁力共振、驗血) 及其結果。			
What treatment did you have? Please include treatment period, type of treatment and their details (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

**Health Declaration - Part II (Applicable to Addition of Member only) 健康聲明 - 第二部份 (只適用於申請增加會員)**

This is to be answered by Subscriber of the Contract, and signed endorsement by all existing Members is required.  
此問題需由投保人作答，並必須由合約內所有會員簽署核實。

At any time since the Contract Effective Date, has/have any existing Member(s) under the Contract ever been diagnosed with any of the following disease(s): 合約生效日至今，合約內現有的會員曾被診斷患有以下病症： • Cancer 癌症 • Chronic renal disorder 慢性腎症 • Coronary artery disease or cardiomyopathy (disease of heart muscle) 冠心病或心肌病 • Cerebrovascular disease or brain tumor 腦血管病或腦腫瘤	Yes 有    No 沒有  <input type="checkbox"/> <input type="checkbox"/>
--	---

If the answer to above question is YES, please provide all details requested below. 如以上問題答案為「有」，請提供以下資料。

Name of Member(s) 會員姓名	
Diagnosis 診斷	
Date of Diagnosis 診斷日期	

## Declaration and Authorisation 聲明及授權

I / We apply as a Member of Bupa Together 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「保柏互通保額」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。

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

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

本人/吾等已細讀並明白本申請表最後一頁所述的「個人資料收集聲明」。

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

本人同意接收保柏於「個人資料收集聲明」中所述的市場推廣資訊，包括與本人保單相關的保費折扣資訊及其他推廣優惠，並明白本人有權透過聯絡保柏的客戶服務專線(電郵至 [customer-care@bupa.com.hk](mailto: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 subscription discount in relation to my insurance policy and other marketing offers.

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

I, as the Subscriber, understand that I declare and sign on behalf of the dependant(s) listed in this Application under this Scheme who is / are under the age of 18.

本人作為投保人，明白本人代表此計劃申請表內列出之18歲以下受供養人作出聲明及簽署。

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

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

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

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

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

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

保柏(亞洲)有限公司(「本公司」)

有關個人資料(私隱)條例(「條例」)之個人資料收集聲明(「本聲明」)

遵照條例,本公司特通知閣下以下事項:

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

有關要求請致函本公司保障資料主任,地址如下:

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

- 根據有關條例之條款,本公司有權就任何處理個人資料查閱或更改的要求收取合理費用。
- 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。