Bupa CarePro Health Insurance Scheme
保柏卓康健醫療保障計劃

PAAPP

Application Form 申請表

Please ensure your completed application form is received by Bupa at least **5 working days prior to the end of month** so as to effect the cover on the 1st day of the following month. Please also make sure you have **enclosed your full Subscription and a copy of HKID Card / passport**. All Applications are subject to underwriting.
如欲合約在下月一號生效，請將填妥的申請表連同**正確的保費及香港身份證 / 護照副本**於月底前**最少五個工作天**寄回保柏。
所有申請表必須經過保柏核保始能生效。
Any amendments to this form should be endorsed. A copy of the application form will be sent to you together with membership pack for your record.
本申請表上如有任何更改，請於更正資料旁邊的空白位置簽署作實。本申請表副本將會連同會員證書等資料一併寄出供閣下保留。

For Bupa use only 保柏專用

Contract No. 合約編號 : _____

Effective Date 生效日期 : _____

Please complete both sides of the form IN ENGLISH AND BLOCK LETTERS and return it to Bupa.
請以英文正楷填妥本申請表之正頁及背頁，並寄回保柏。

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

Surname 姓	Given Name (same as HKID Card) 名 (與香港身份證相同)	Sex 性別	HKID Card No./Passport No. 香港身份證號碼/護照號碼	Date of Birth 出生日期 DD 日 / MM 月 / YY 年	Height (cm/ft) 身高 (公分/尺)	Weight (kg/lb) 體重 (公斤/磅)	Marital Status 婚姻狀況	Smoker 吸煙者
							○ Single 單身 ○ Married 已婚 ○ With children 有子女	○ Yes 是 ○ No 否

Home Address 住宅地址	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	

Correspondence Address 通訊地址 (if different from Home Address 如與住宅地址不同)	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	

Country of Residence 居住國家 # (if not Hong Kong 如非香港)	Mobile Phone No. 手提電話號碼	Home Phone No. 住宅電話號碼	Home Fax No. 住宅傳真號碼	Home E-mail Address 住宅電郵地址
Business Nature 業務性質	Job Position 職位	Office Phone No. 公司電話號碼	Office Fax No. 公司傳真號碼	Office E-mail Address 公司電郵地址

Please give details if your spouse is a proposed/existing member of Bupa CarePro and/or your child(ren) is a proposed/existing member of Bupa Care Kid
如您的配偶為「保柏卓康健」的準會員/現時會員，及/或您的子女為「保柏童康健」的準會員/現時會員，請提供以下資料：

Spouse's Name 配偶姓名	Date of Birth 出生日期	HKID No. 香港身份證號碼
Children's Name 子女姓名	Date of Birth 出生日期	HKID No 香港身份證號碼

Unless otherwise specified by applicant in writing, Inter Partner Assistance (IPA) will consider Hong Kong as the Country of Residence and repatriate the applicant to Hong Kong when Medically Necessary.
除非申請人特別以書面通知，國際救援（亞洲）公司將設定香港為申請人之居住國家，於有醫療需要時送返申請人回香港。

Claims Reimbursement Details 賠償申請資料

Claims payment will be reimbursed by autopay only. 賠償款項只以自動轉賬方式進行。
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

Bank Name 銀行名稱	Bank No. 銀行編號	Branch No. 分行編號	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 與申請人關係 _____
Reason for receiving claims payment on behalf of the applicant 代申請人收取賠款的原因 _____

Application for e-Statement Service 申請電子結算表服務

○ I hereby agree to receive an e-Statement notification to access my electronic claims statement / shortfall invoice. I understand that no printed copy of claims statement / shortfall invoice will be issued thereafter.
本人現同意收取電子結算表通知以取得本人之電子賠償單 / 差額通知書。本人明白其後將不會再獲發書面形式之賠償單 / 差額通知書。
e-Statement notification sent to (choose one) 以此電郵地址收取電子結算表通知（任選其一） ○ Office E-mail address 公司電郵地址 ○ Home E-mail address 住宅電郵地址

Choice of Cover 投保項目 (Please tick as appropriate 請選擇並加「✔」號)

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

Optional Benefit 自選額外保障
- ○ Clinical Benefit 門診保障
- ○ Hospital Cash Benefit 住院現金保障
- ○ Supplementary Major Medical Benefit 附加醫療保障 *(age must be below 60 年齡必須為60歲以下)*

Benefit Level 保障等級 (choose one 任選其一)
- ○ Plan 計劃 1 Private 私家房
- ○ Plan 計劃 2 Semi-private 半私家房
- ○ Plan 計劃 3 Ward 大房

Total Subscription paid with Application 連同申請表繳付之保費 HK$ 港幣 _____

Method of Payment 繳付保費方法 (Please tick as appropriate 請選擇並加「✔」號)

Payment Mode 繳付保費形式	Payment Method 繳付保費方法	Remarks 備註
○ Yearly 年繳	○ Autopay 自動轉賬	Please attach a cheque made payable to 'Bupa (Asia) Limited' for 1st year Subscription with a completed Direct Debit Authorisation Form (請填妥直接付款授權書，連同首年保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」)
	○ 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)
○ Monthly 月繳	○ Autopay 自動轉賬	Please attach a cheque made payable to 'Bupa (Asia) Limited' for first 2 months' Subscription 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, please fill in the following information. 若支票發出人並非申請人，請填寫以下資料。
Relationship with the applicant 與申請人關係 _____
Reason for paying Subscription on behalf of the applicant 代申請人支付保費的原因 _____

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Bupa CarePro Health Insurance Scheme
保柏卓康健醫療保障計劃

Application Form 申請表

Health Declaration 健康聲明

Please ensure you have completed all the details in the Members Information section before signing this Health Declaration. Please note that Members will not be eligible for claims resulting from the non-disclosure of health information.
注意：簽署本健康聲明前，請填妥會員資料部分。請注意，任何因未經填報之健康狀況而引致之索償申請，將不獲接納。

At any time during the past seven years from the time of this Application, has / have the Member(s): 由申請計劃前的過去七年內，會員是否：	Yes 是	No 否
1. had any chronic or recurrent diseases? 曾患有任何慢性或復發性疾病？	○	○
2. had exhibited any of the following symptoms in a repeated / persistent way? 曾反覆 / 持續出現以下病徵？ Fever, headache, dizziness, chest pain or discomfort, shortness of breath, blood spitting, hoarseness or cough, night sweating,loss of consciousness, seizure, indigestion, vomiting, abdominal pain, diarrhea, jaundice, blood in the stool or urine, abnormal vaginal bleeding, dysuria, incontinence, allergy, back and/or leg pain, joint pain / swelling, etc.? 發熱、頭痛、頭暈、胸痛或胸部不適、氣促、血痰(吐血)、聲嘶或咳嗽、夜間出汗、失去知覺、抽搐、消化不良、嘔吐、腹痛、肚瀉、黃疸、血尿或血便、異常陰道出血、排尿困難、失禁、敏感、腰腿痛、關節痛/腫脹等？	○	○
3. received any in-patient treatment / operation / physiotherapy? 曾接受任何入院診治/手術/物理治療？	○	○
4. had any medical investigations / examinations? 曾接受任何醫療檢查 / 檢驗？	○	○
5. taken any regular medications? 曾定期服用藥物？	○	○
If your answer is YES to any of the above questions, please give details of the medical condition in the space provided below, and provide a copy of the relevant medical report(s): 如果您就以上任何問題的回答為「是」，請列出有關詳情，並提供相關的醫療報告副本。	with attachment 另有附頁 ○	

Symptom / Diagnosis 病徵 / 診斷	Treatment / Operation / Medication 治療 / 手術 / 藥物	Date of Onset / Recovery 病發日期 / 痊癒日期		Degree of Recovery 痊癒程度	Name, Address and Tel. No. of Doctor 醫生姓名、地址及電話號碼

I enrol as a Member of the Bupa CarePro Health Insurance Scheme ('Scheme') and acknowledge that Benefit is not payable under this Scheme for any costs of treatment arising from any existing illnesses, injuries or other conditions presented before the Coverage Commencement Date unless complete current details are fully disclosed by me in this Application and accepted by Bupa. I declare that, to the best of my knowledge and belief, the statements contained in this Application are true and complete. Bupa reserves the right to ask for submission of more details of health status or medical reports of me at my own cost. I have read and agreed to be bound by the terms and conditions of the Contract of this Scheme and I agree that this Health Declaration and the answers given in this Application shall be the basis of the Contract between me and Bupa.

I understand that all my personal information collected or held by Bupa is provided and may be held, used, and disclosed by Bupa or individuals / organisations associated with Bupa, appointed agent / broker, if applicable, or any selected third party (within or outside of Hong Kong, including reinsurance and claims investigation companies and industry associations / federations) for the purposes of processing this Application and providing subsequent services and claims analysis for this or providing any other insurance products and services, direct marketing, and data matching, and to communicate with me for such purposes. I shall have the right to access and correct any of my personal information held by Bupa; and request for such access and correction can be made to the Personal Data Privacy Officer of Bupa at 18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong.

本人投保成為保柏卓康健醫療保障計劃（'計劃'）之會員及知道根據此計劃規定，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，除非本人在本申請表內已詳細列出並獲得保柏接納。本人聲明，就本人所知所信，本申請表上填報之一切資料，均屬實完整。保柏有權要求提供更多有關本人之健康狀況及醫療報告，一切費用由本人支付。本人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與保柏之間所訂合約之根據。

本人明白保柏可保留、使用或透露保柏所收集或持有之所有關於本人的個人資料，及給予與保柏有關的人士 / 機構、獲委任之保險代理人 / 經紀（如適用）或任何被揀選的第三者（在香港境內或境外，包括再保險及賠償調查公司，及有關的行業協會或聯會），用作處理本申請及索償分析用途或提供售後服務或任何其他保險產品及服務、直接促銷及資料核對等用途，及因此等用途與本人聯絡。本人將有權索閱及修正保柏所持有任何關於本人的個人資料；有關索閱及修正資料可致函保柏（亞洲）有限公司香港鰂魚涌華蘭路25號大昌行商業中心18樓「個人資料私隱主任」收。

Applicant's Signature 申請人簽署 Date 日期

X

Agent's / Broker's / Telesales' Name (if applicable and must be completed by applicant) 代理人 / 顧問 / 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 / 顧問 / 營業代表編號
	Agent's / Broker's / Telesales' Contact Tel. No. 代理人 / 顧問 / 營業代表聯絡電話號碼

For transfer Contract only 只供轉移合約之用

Previous Bupa Membership No.:
前保柏會員編號：

Subject to Bupa's approval of membership transfer, eligible claims related to any sicknesses or injuries that was covered under the previous contract and commenced before the effective date of coverage under this Contract will be payable up to the Maximum Limit of the contract with the lower Benefit level.
如經本公司批准轉移的會籍，一切於前合約受保及於本合約保障開始日前已患有之疾病或損傷之合資格賠償，將根據前合約或本合約內所載之最高賠償額，以較低者為準，作出賠償。

Applicant's Signature 申請人簽署 Date 日期

X

Bupa (Asia) Limited 保柏 (亞洲) 有限公司
Address 地址: 18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong
香港鰂魚涌華蘭路25號大昌行商業中心18樓
Telephone 電話: (852) 2517 5175 Facsimile 傳真: (852) 2548 1848
Website 網址: www.bupa.com.hk

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Bupa CarePro Health Insurance Scheme
保柏卓康健醫療保障計劃

Direct Debit Authorisation Form 直接付款授權書

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.
若選擇以自動轉賬付款，請填妥此表授權書及簽署於"X"位置並連同支票交回保柏。

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 0 4	4 9 9	2 1 5 0 0 2 0 0 1

I / We hereby authorise my / our below named Bank to effect transfers from my / our account to that of the above named beneficiary in accordance with such instructions as my / our Bank may receive from time to time.	本人 / 吾等現授權本人 / 吾等之下述銀行，（根據受益人不時給予本人 / 吾等銀行之指示）自本人 / 吾等之戶口內轉賬予上述受益人。
I / We agree that my / our Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me / us.	本人 / 吾等同意本人 / 吾等之銀行無須證實該等轉賬通知是否已交予本人 / 吾等。
I / We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my / our account which may arise as a result of any such transfer(s).	如因該等轉賬而令本人 / 吾等之戶口出現透支（或令現時之透支增加），本人 / 吾等願共同及各自承擔全部責任。
I / We agree that should there be insufficient funds in my / our account to meet any transfer hereby authorised, my / our Bank shall be entitled, in its discretion, not to effect such transfer in which event the Bank may make the usual charge and that it may cancel this authorisation at any time on one week's written notice.	本人 / 吾等現同意本人 / 吾等之戶口並無足夠款項支付該等授權轉賬，本人 / 吾等之銀行有權不予轉賬，且銀行可收取慣常之收費，並可隨時以一星期書面通知取消本授權書。
This authorisation shall have effect until further notice.	本授權書將繼續生效直至另行通知為止。
I / We agree that any notice of cancellation or variation of this authorisation which I / we may give to my / our Bank shall be given at least two working days prior to the date on which such cancellation / variation is to take effect.	本人 / 吾等同意，本人 / 吾等取消或更改本授權書之任何通知，須於取消 / 更改生效日最少兩個工作天前交予本人 / 吾等之銀行。

My / Our Bank and Branch Names 本人 / 吾等之銀行及分行名稱	Bank No. 銀行編號	Branch No. 分行編號	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	My / Our Signature(s) 本人 / 吾等之簽署	HKID Card No. / Passport No. 香港身份證號碼 / 護照號碼
	X	

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

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/Subscriber, please fill in the following information. 若戶口持有人並非申請人/投保人，請填寫以下資料。

Relationship with the applicant/Subscriber 與申請人/投保人關係

Reason for paying Subscription on behalf of the applicant / Subscriber 代申請人/投保人支付保費的原因

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

Notes: 1. The box marked 'Membership No.' 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. 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。

Bupa (Asia) Limited 保柏 (亞洲) 有限公司
Address 地址: 18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong
香港鰂魚涌華蘭路25號大昌行商業中心18樓
Telephone 電話: (852) 2517 5175 Facsimile 傳真: (852) 2548 1848
Website 網址: www.bupa.com.hk

Bupa 保柏

Bupa CarePro Health Insurance Scheme
保柏卓康健醫療保障計劃

Credit Card Authorisation Form 信用卡付款授權書

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.
Note: 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，請填妥此表授權書及簽署於"X"位置並交回保柏。若您傳真此表格給我們，請無須寄回此表格。

◯ Visa ◯ MasterCard ◯ Diners Club ◯ American Express

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 / YY 月 / 年)

I hereby authorise and direct Bupa (Asia) Limited to debit the Subscription due from my credit card account on a yearly basis until further notice. 本人茲授權保柏（亞洲）有限公司從本人的信用卡戶口每年支付應繳保費金額，直至另行通知。

Total Annual Subscription 年費總額 (HK$ 港幣)

If Cardholder is not the applicant/Subscriber, please fill in the following information.
若信用卡持有人並非申請人/投保人，請填寫以下資料。

Relationship with the applicant / Subscriber 與申請人/投保人關係 _____

Reason for paying Subscription on behalf of the applicant / Subscriber 代申請人/投保人支付保費的原因 _____

◯ I hereby confirm to pay the Subscription due of Bupa CarePro Health Insurance Scheme for the applicant / Subscriber, 本人同意及承擔以下人士之全數應繳之保柏卓康健醫療保障計劃保費金額 (Mr / Mrs / Ms) （先生 / 太太 / 女士）_____ with HKID Card No. 香港身份證號碼 _____

Cardholder's Signature 持卡人簽署

X

Contact Phone No. 聯絡電話號碼

Date 日期 (DD / MM / YY 日 / 月 / 年)

For Bupa use only 保柏專用
Bupa CarePro Membership No. 保柏卓康健會員編號 :
Subscription 保費 (HK$ 港幣) :
Authorised Code 授權代碼 :
Date 日期 :

Bupa (Asia) Limited 保柏 (亞洲) 有限公司
Address 地址: 18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong
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