Blue Cross 藍十字
An AIA Company 友邦保險成員公司

收集個人資料聲明
Personal Information Collection Statement

聯絡我們
Contact Us

更改保單內容申請書（個人醫療保險）
Policy Alteration Request Form (Individual Medical Insurance)

注意: 1. 請以英文正楷填寫此份申請書，並連同相關文件（如適用）寄回**藍十字（亞太）保險有限公司**（「本公司」）。
2. 於下列第二及第三部分內填寫的生效日期必須為此申請書的簽署日期或其後的日子。簽妥的申請書請於生效日期7日內寄回本公司。

Note: 1. Please complete this form in BLOCK letters and if applicable, return it together with relevant documents to **Blue Cross (Asia-Pacific) Insurance Limited** ("the Company").
2. The effective date of the changes with respect to part (II) and part (III) below must be on or after the date of signing this form. Please return the signed form to the Company within 7 days from the effective date.

保單持有人姓名 Name of Policyholder	電郵地址 Email Address
保單號碼 Policy No.	保單計劃名稱 Name of Plan

(I) 更改個人資料 Change of Personal Particulars （請在適當的地方加上剔號 Please tick where appropriate）

☐ 保單持有人Policyholder ☐ 受保人Insured （姓名Name／受保人號碼 Insured No.）

通訊地址Correspondence Address

室 Flat ____ 樓 Floor ____ 座 Block ____ 大廈 Building ____

屋苑 Estate ____ 期 Phase ____

街道號數 Street No. ____ 街道名稱／地段 Street Name/Lot ____

地區 District ____ ☐ 香港 HK ☐ 九龍 KLN ☐ 新界／離島 NT/Outlying Islands

☐ 聯絡電話 Contact Tel No.

手提電話 Mobile Phone _____ 住宅電話 Home Tel. _____ 辦公室電話 Office Tel. _____

☐ 其他Others（請詳細列明Please specify in details）

銀行戶口號碼* Bank Account No.* 銀行編號 Bank Code / 分行編號 Branch Code / 戶口號碼 Account No.	銀行戶口持有人姓名 Name of Bank Account Holder	銀行名稱 Bank Name	分行名稱 Branch Name

* 有關所有受保人的合資格醫療賠償將會存入此指定銀行戶口；只接受15位數字或以下之銀行戶口。
Eligible medical claims payment relevant to all Insured(s) will be credited to this designated bank account; Only bank account with 15 digits or below is acceptable.

(II) 增加受保人 Addition of Insured(s) （不適用於自願醫保計劃 Not applicable to VHIS plan）

請填寫第八部分的健康聲明並連同劃線支票抬頭「藍十字（亞太）保險有限公司」寄回本公司
Please complete the Health Statement in part (VIII) and return it together with your crossed cheque payable to Blue Cross (Asia-Pacific) Insurance Limited

準受保人姓名 Name of Proposed Insured	與保單持有人關係 Relationship with the Policyholder	保障計劃 Benefits Plan	保障代碼 Benefits Code	生效日期 Effective Date
1.		☐ 基本住院及手術保障 Basic Hospital & Surgical Benefits		
		☐ 附加額外醫療保障 Optional Supplementary Medical Benefits		
		☐ 附加門診保障 Optional Outpatient Benefits		
		☐ 其他 Others		
2.		☐ 基本住院及手術保障 Basic Hospital & Surgical Benefits		
		☐ 附加額外醫療保障 Optional Supplementary Medical Benefits		
		☐ 附加門診保障 Optional Outpatient Benefits		
		☐ 其他 Others		
3.		☐ 基本住院及手術保障 Basic Hospital & Surgical Benefits		
		☐ 附加額外醫療保障 Optional Supplementary Medical Benefits		
		☐ 附加門診保障 Optional Outpatient Benefits		
		☐ 其他 Others		

(III) 刪除受保人 Deletion of Insured(s)

（請在生效日期前退回所有醫療卡予本公司。All medical cards must be returned to the Company before the specified effective date.）)

受保人號碼 Insured No.	受保人姓名 Name of Insured	生效日期 Effective Date

(IV) 更改保障利益 Change of Benefit

（有關變更將於下次保單續保日期生效。Changes shall become effective upon next policy renewal date.）

受保人姓名 Name of Insured	增加*／更改*保障內容 （請填寫第八部分的健康聲明並連同保費寄回本公司） Benefit(s) to be added*/changed* (Please complete the Health Statement in part (VIII) and return it together with the premium payment to the Company)	刪除保障內容 Benefit(s) to be cancelled
1.		
2.		
3.		
4.		

* 保障變更須經核保審批 Acceptance of benefit shall be subject to underwriting decision

(V) 更改繳款方法／方式 Change of Payment Method/Mode

（有關變更將於下次保單續保日期生效。Changes shall become effective upon next policy renewal date.）

請填寫第十部分之直接付款授權書／信用卡付款指示及授權書或連同劃線支票寄回本公司。

Please complete the Direct Debit Authorisation/Credit Card Payment Instruction & Authorisation in part (X) or return it together with a crossed cheque to the Company where applicable.

繳款方式
Payment Mode

☐ 年繳
Annual

☐ 半年繳
Semi-Annual

☐ 季繳（只適用於銀行戶口自動轉賬／信用卡）
Quarterly (applicable to bank account auto-transfer/credit card only)

☐ 月繳（只適用於銀行戶口自動轉賬／信用卡）
Monthly (applicable to bank account auto-transfer/credit card only)

繳款方法
Payment Method

☐ 現金
Cash

☐ 支票
Cheque

☐ 銀行戶口自動轉賬
Bank Account Auto-transfer

☐ 信用卡
Credit Card

(VI) 指定受益人 Designation of Beneficiary（只適用於"人身意外保障"For "Personal Accident Benefit" only）

受益人姓名 Name of Beneficiary	香港身份證／護照號碼 HKID Card/Passport No.	與受保人之關係 Relationship with Insured

(VII) 其他 Others（請詳細列明 Please specify in details）

(VIII) 健康聲明 Health Statement

保單持有人姓名 Name of Policyholder			保單號碼 Policy No.
受保人／準受保人姓名 Name of Insured/Proposed Insured	性別 Sex	出生日期（日／月／年） Date of Birth (DD/MM/YY)	香港身份證／護照號碼 HKID Card/Passport No.

請問受保人／準受保人是否從事高風險職業包括 (i) 於建築地盤內從事體力勞動工作； (ii) 於離地面或樓面10米以上工作； (iii) 職業拳手； (iv) 騎師 或 (v) 特技人? ☐ 是Yes ☐ 否No
Does the Insured/Proposed Insured engage in high-risk occupation including (i)manual works at construction site; (ii) work at a height (exceeding 10 meters above ground or floor level); (iii) professional boxer; (iv) jockey or (v) stunt

受保人／準受保人居住地方
Place of Residence of the Insured/Proposed Insured

☐ 香港 HK
☐ 其他 Others _____

受保人／準受保人每年平均居港時間 _____ 月 Average stay of the Insured/Proposed Insured in HK per year _____ month

每位新增／提高保障的受保人必須回答下列問題:
Please complete the following section for addition of Insured(s)/benefits upgrade. Every Insured newly added to the policy/upgraded benefit must answer the following questions :

資料收集聲明

(i) 此問卷收集與健康相關的資料僅作為核保之用途，而核保是本公司評估申請人之健康風險及決定申請結果的程序。本公司採用的核保程序應為公平合理，並會因應客戶要求解釋申請結果。

(ii) 作為申請人，閣下需要盡其所知所信，按本問卷中要求向本公司提供完整及準確的資料。本公司根據閣下提供的資料，可能會提出跟進問題或查詢而需要閣下進一步提供資料以作核保之用。

(iii) 若閣下在提交本申請表後至閣下收到保單前的期間就本問卷中提供的資料有任何改變或更新，閣下需要及早通知本公司。

(iv) 即使已成功投保並獲簽發保單，若閣下未按（ii）所述盡其所知所信向本公司提供完整及準確的資料，或未按（iii）所述就資料的任何改變或更新而及早通知本公司，閣下的保險保障可能會受到影響，本公司亦可能因此終止、作廢或撤銷有關保單，或拒絕賠償。

Statement for Collection of Information

(i) This questionnaire collects health-related information solely for the purpose of underwriting which is a process for the Company to evaluate the health risk of the applicants and decide the application results. The underwriting process that the Company adopts should be fair and reasonable, and the Company should explain the application results if requested by the customers.

(ii) As the applicant, you are required to provide the Company with complete and accurate information requested in this questionnaire to the best of your knowledge and belief. Based on the information provided, the Company may have follow-up questions or enquiries that require you to provide further information for underwriting purpose.

(iii) If there are any changes to or updates of the information provided in this questionnaire after the time of submission of this application and before you receive the Policy, you are required to notify the Company in a timely manner.

(iv) Even after an insurance policy has been issued upon successful application, the insurance coverage for you may be affected or the policy may be terminated, voided or rescinded, or claims may be repudiated by the Company, if you have not provided the Company with complete and accurate information to the best of your knowledge and belief according to (ii), or if you have not notified the Company on any changes to or updates of the information in time according to (iii).

甲部 Part A – 基本資料 General Information

1. 身高 Height	厘米 centimetres (cm)		或OR		呎／吋 feet/inches
2. 體重 Weight	公斤 kilogrammes (kg)		或OR		磅 pounds (lbs)

乙部 Part B – 健康資料 Health Information

申請人須知：無需於乙部問題披露以下健康狀況或治療。
Note for applicant(s): Questions of Part B do not require the applicant(s) to disclose information regarding the medical conditions or treatments below.

傷風／感冒／喉嚨痛、腸胃炎／食物中毒（已痊癒）、消化不良（無需檢查）、痤瘡、肌肉扭傷（已痊癒）、鵝口瘡、常規產前掃描／血液檢驗（檢驗結果正常）、常規子宮頸細胞塗片檢驗（檢驗結果正常）、常規健康檢查（檢查結果正常）、預防疫苗、荷爾蒙補充治療（更年期）、不育治療或胎兒生長情況正常的懷孕、近視／遠視／散光／老花。
Cold / flu / sore throat, gastroenteritis / food poisoning (fully recovered), indigestions (no investigations required), acne, muscle sprained (fully recovered), thrush, routine scan / blood test for pregnancy (normal result), routine cervical smear (normal result), routine health check (normal result), preventive vaccination, Hormonal Replacement Therapy (menopause), infertility treatment or uncomplicated pregnancy, myopia / hyperopia / astigmatism / presbyopia.

若以下第1至8項任何一項問題之答案為「是」者，請於丙部回答相關的跟進問題。
If your answer to any of the questions 1 - 8 below is "Yes", please proceed to answer the relevant follow-up questions in Part C.

請在適當方格上填上「✓」。 Please tick "✓" the appropriate boxes.	是 Yes	否 No
1. 您是否曾被確診下列疾病或健康狀況？ Have you ever been diagnosed with any of the following diseases or medical conditions?		
(a) 癌症或原位癌 Cancer or carcinoma in situ	☐	☐
(b) 腦部腫瘤 Brain tumor	☐	☐
(c) 心臟疾病 Heart disease	☐	☐
(d) 中風（包括短暫性腦缺血，俗稱「小中風」） Stroke (including transient ischemic attack (TIA))	☐	☐
(e) 高血壓 Hypertension	☐	☐
(f) 糖尿病或葡萄糖耐量異常 Diabetes mellitus or impaired glucose tolerance	☐	☐
(g) 腎病 Kidney disease	☐	☐
(h) 椎間盤突出或脊椎退化性疾病 Prolapsed intervertebral disc or degenerative spine conditions	☐	☐

乙部 Part B – 健康資料 Health Information

請在適當方格上填上「✓」。 Please tick "✓" the appropriate boxes.	是 Yes	否 No
(i) 需要植入醫療儀器或義肢的疾病或健康狀況 Diseases or medical conditions requiring a medical device or prosthesis to be implanted within the body	☐	☐
(j) 人體免疫力缺乏病毒（愛滋病病毒）感染 Human immunodeficiency virus ("HIV") infection	☐	☐
(k) 先天性疾病（指於出生時或之前已存在的醫學、生理或精神上的異常） Congenital conditions (medical, physical or mental abnormalities that existed at the time of or before birth)	☐	☐
(l) 身體缺陷、不健全、畸形，及／或影響活動能力、視力、說話能力或聽力的狀況 Physical defects, impairments, deformities, and / or conditions affecting mobility, sight, speech or hearing	☐	☐
(m) 精神健康狀況（例如抑鬱、焦慮、精神分裂、飲食失調或躁狂抑鬱症） Mental health conditions (such as depression, anxiety, schizophrenia, eating disorders, or bipolar disorders)	☐	☐
(n) 高膽固醇症或高血脂症 Hypercholesterolemia or Hyperlipidemia	☐	☐
(o) 肝臟疾病（例如乙型或丙型肝炎（包括測試呈陽性反應）、脂肪肝或肝硬化） Liver disorder (such as hepatitis B or hepatitis C (including tested positive), fatty liver or cirrhosis of liver)	☐	☐
(p) 多發性硬化症 Multiple sclerosis	☐	☐
2. 您目前是否患有下列疾病或健康狀況？ Do you currently have any of the following diseases or medical conditions?		
(a) 疝氣（俗稱「小腸氣」） Hernia	☐	☐
(b) 乳房病變（腫瘤／硬塊／腫塊／囊腫／結節／增生） Breast lesion (tumour / mass / lump / cyst / nodule / growth)	☐	☐
(c) 子宮或卵巢病變（腫瘤／硬塊／腫塊／囊腫／瘜肉／結節／增生） Uterine or ovarian lesion (tumour / mass / lump / cyst / polyp / nodule / growth)	☐	☐
(d) 良性前列腺肥大 Benign prostatic hypertrophy	☐	☐
(e) 膽結石或泌尿道結石（腎結石、輸尿管結石或膀胱結石） Gall bladder stone or urinary stone (renal stone, ureteric stones or urinary bladder stone)	☐	☐
(f) 白內障、青光眼或視網膜病變 Cataract, glaucoma or retinopathy	☐	☐
(g) 關節炎或其他關節疾病 Arthritis or other joint disorder	☐	☐
3. 在過去五年內，您是否曾經或被建議定期或持續（例如每月、每兩個月、每半年、每年）為任何疾病或健康狀況接受專業醫護人員（例如專科醫生、物理治療師、精神科醫生）的跟進診治或醫療護理？ In the last 5 years, have you ever had or been advised to have any regular or ongoing (such as monthly, every 2 months, half-yearly, annually) follow-up consultations or medical care with a healthcare professional (such as specialist doctor, physiotherapist, psychiatrist) for any disease or medical condition?	☐	☐
4. 在過去五年內，您是否曾被醫生建議定期（例如按醫生指示每日／每週一次／有需要時）服用為期超過一個月的處方藥物？ In the last 5 years, have you been advised by your doctor to take any medications (such as to be taken daily / once per week / as needed as directed by doctor) for a continuous period of more than one (1) month?	☐	☐
5. 在過去五年內，您是否曾入住醫院？ In the last 5 years, have you been admitted into a hospital?	☐	☐
6. 在過去五年內，您是否曾在非住院情況下接受外科程序（包括內窺鏡檢查或活組織化驗）？ In the last 5 years, have you undergone a surgical procedure (including endoscopy or biopsy) without being admitted into a hospital?	☐	☐
7. 在過去五年內，您是否曾接受或曾被建議接受檢查（例如驗血、驗尿、心電圖、X光、超聲波、電腦掃描、磁力共振、正電子掃描、愛滋病測試、乙型肝炎測試、丙型肝炎測試）？ In the last 5 years, have you ever had or been advised to undergo investigations (such as blood or urine test, ECG, X-ray, ultrasound, CT scan, MRI, PET scan, HIV test, Hepatitis B test, Hepatitis C test)?	☐	☐
如果答案屬「是」，您的檢查結果是否包括下列情況？ If the answer is "Yes", do your investigation result(s) include the followings?		
(a) 檢驗結果正常 Normal test result is advised	☐	☐
(b) 檢驗結果異常 Abnormal test result is advised	☐	☐
(c) 您正等候檢驗或檢驗結果 You are still awaiting test / test result	☐	☐
(d) 檢驗結果為無定論或不確定（需要重新或進一步檢驗） Test result is inconclusive or uncertain (retesting or follow up test is required)	☐	☐
(e) 就檢驗結果已尋求醫療意見或需要接受治療（例如一些未必需要即時治療的情況如肝囊腫／腦囊腫／關節退化或鈣化／於成像檢測中發現肺部或乳房或甲狀腺出現鈣化） Medical advice has been sought or treatment is required for the test result (such as liver cyst / brain cyst / joint degeneration or calcification / lung or breast or thyroid calcification discovered on imaging test, that may not require immediate treatment)	☐	☐
8. 除了您在第1至7項問題中已披露的資料外，您是否有下列情況? Apart from anything you have already disclosed in Questions 1 - 7, do you have any of the following conditions?		
(a) 在過去一年內，體重無故地減少了5公斤（11磅）以上 Unintentional weight loss by more than 5 kg (11 lbs) over past 1 year	☐	☐
(b) 不正常出血（例如陰道出血、便血、流鼻血或咳血）至少一個月 Abnormal bleeding (such as vaginal bleeding, rectal bleeding, nose bleeding or coughing up of blood) for at least one month	☐	☐
(c) 在過去一年內，您有任何健康狀況或病徵及症狀曾經接受或需要接受專業醫護人員（例如專科醫生、物理治療師、精神科醫生）的跟進診治 In the last 1 year, you had or have been required to have follow-up consultation with a healthcare professional (such as specialist doctor, physiotherapist, psychiatrist) for any medical condition or sign and symptom	☐	☐
(d) 其他健康狀況或病徵及症狀（例如腫塊、頭痛、持續咳嗽、胸痛或上腹痛）而正在或打算尋求醫療意見 Other medical conditions or sign and symptom (such as lump, headache, persistent coughing, chest pain or epigastric pain) that you are seeking or intend to seek medical advice	☐	☐

丙部 Part C – 健康資料補充 Supplementary Health Information

若乙部第1至8項任何一項問題之答案為「是」者，請在適用的問題提供更多資料。請盡量提供齊全資料（例如在未能回憶確實日期的情況下提供年份及月份）以便作出公平核保決定。
If the answer to any of the questions 1-8 in Part B is "Yes", please provide additional information as applicable. Please provide information as detailed as possible (e.g. provide year and month if exact date could not be recalled) for the sake of fair assessment in underwriting.

題號 Question No. 題號1-8每題適用之跟進問題 Follow-up questions to each of Q1-8 as applicable	疾病／健康狀況／病徵及症狀 Disease / medical condition / sign and symptom	首次出現病徵及症狀的日期 Date of first occurrence of sign and symptom	a) 已進行的治療／檢查／測試／掃描 Treatment / investigations / tests / scans that have been performed b) 有關治療／檢查／測試／掃描日期 Date of such treatment / investigation / tests /scan	現況（例如是否已完全康復、有否跟進／服用跟進藥物／下次覆診日期） Present condition (such as whether fully recovered, follow up action / medication / next follow up date)	最後覆診／治療日期 Date of last follow-up medical consultation / treatment	治療有關疾病／不適／健康狀況／病徵及症狀的醫生姓名※ Name of doctor who treated the disease / sickness / medical condition / sign and symptom※ 醫院名稱（如適用）※ Name of Hospital, where applicable※

※（注意：在保險公司聯絡申請人的醫生及／或醫院以獲取其醫療記錄前，需獲得申請人的書面同意。）
(Note: written consents from applicant are needed before an insurance company may approach the applicant's doctor and/or hospital for access to his/her medical records.)

(IX) 聲明 Declaration

本人／我們現申請辦理上述之更改事項或服務，謹此聲明並同意：

1. 上述所有問題的答案包括所有資料及細節均是準確無誤，真實及為事實之全部，並且是盡本人／我們所知及所信而作答的。本人／我們並沒有隱瞞任何重要資料及同意此申請書之內容及聲明將成為此項保險合約之承保根據。本人／我們在此確認，如未能提供真實及準確無誤之資料或通知藍十字（亞太）保險有限公司（「貴公司」）任何有關此申請之重要資料，將可能導致貴公司不能接受或處理此申請或令本保單失效。
2. 一概保障項目（如適用）必須在本申請獲接納後並已將所需保費繳交予貴公司後始可生效。
3. 保單持有人將有權就一切有關於受保人（等）的索償或按本保單的相關事宜，與貴公司進行交涉，並向其接收或索取與受保人（等）有關之資料。本人／我們並同意所有由貴公司給予保單持有人或受保人（等）之賠償款項將會存入指定之戶口內或於該戶口不存在時以支票支付，並完全解除貴公司就該些索償之一切承保責任。
4. 接受貴公司醫療卡之條款（如適用），並於要求下即時償還任何不在承保範圍內的醫療費用及超出保障之外的醫療費用（賠償差額）。本人／我們茲授權貴公司從本人／我們於承保範圍內的醫療賠償數額中扣除貴公司代本人／我們已支付的承保範圍內的醫療費用。
5. 有關更改事項之申請將由貴公司以書面或附註形式通知被接納後方為有效。
6. 本人／我們同意第八部分的資料收集聲明，和確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。本人／我們亦明白，如貴公司擬使用本人／我們的個人資料作直接促銷，本人／我們需要另外給予同意。

I/WE, HEREBY REQUEST THE ABOVE CHANGES OR SERVICES BE EFFECTED AND DECLARE AND AGREE THAT:

1. The answers to all of the above questions including all information and particulars given herein are accurate, true, and complete and are given to the best of my/our knowledge and belief. I/We have not withheld any material information and accept that this request and declaration shall form the basis of the contract between Blue Cross (Asia-Pacific) Insurance Limited ("the Company") and me/us. I/We hereby acknowledge that failure to supply true and accurate answers to this request or inform the Company of all material information about my/our request may render the Company unable to accept or process this request, or the insurance policy void.
2. The insurance coverage applied for, if applicable, shall only take effect when this request has been accepted by and the required premium has been paid to the Company.
3. The Policyholder shall have the authority to deal with, receive, or request for information from the Company concerning the Insured(s) in relation to claims or any matters arising from the policy. I/We further agree that payment of any benefits hereunder to the Policyholder or Insured(s) by the Company in relation to all medical claims shall be credited to the bank account as specified or made by cheque in the absence of such an account, which shall constitute a full discharge on the part of the Company in relation to such claims.
4. Accept the terms and conditions for the usage of the medical card, if applicable, and reimburse the Company for ineligible expenses that are not covered by the policy or expenses exceeding the benefit limit of the policy (claim charge back) immediately upon demand. I/We hereby authorise the Company to offset any ineligible claims paid on behalf of myself/ourselves against eligible claims that will be reimbursed to me/us.
5. The request for change shall be effective only upon confirmation of acceptance by the Company in writing or endorsement.
6. I/We agree Statement for Collection of Information in part (VIII), and confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form. I/We further understand that my/our consent will be separately obtained if the Company intends to use my/our personal data for direct marketing.

保單持有人簽署 Signature of Policyholder	受保人／準受保人簽署 Signature of Insured(s)/Proposed Insured(s)	日期（日／月／年） Date (dd/mm/yy)

(X) 付款方法 Payment Method

請選擇付款方法並且填寫適當部分。Please select a payment method and complete the appropriate section accordingly.

☐ 支票付款（劃線支票抬頭「**藍十字（亞太）保險有限公司**」）（不適用於季繳及月繳）
By cheque (please make your crossed cheque payable to **Blue Cross (Asia-Pacific) Insurance Limited**) (Not applicable to quarterly and monthly payment)

☐ 信用卡付款（請填寫以下(a)部分）By credit card (please complete section (a) below)

☐ 銀行戶口自動轉賬（請填寫以下(b)部分）By bank account auto-transfer (please complete section (b) below)

(a) 信用卡付款指示及授權書 Credit Card Payment Instruction and Authorisation

（建議使用保單持有人之信用卡。只接受港元信用卡戶口。Payment by the Policyholder's credit card is recommended. Accept credit card in HK currency only.）

☐ Visa ☐ Mastercard	信用卡戶口號碼 Credit Card Account No.	
持卡人姓名（姓／名） Name of Cardholder (Surname/First Name)	信用卡到期日（月／年） Expiry Date (mm/yy)	與保單持有人之關係（必須為直屬家庭成員）* Relationship with the Policyholder (must be immediate family member)*

聲明：

（一）本人現授權貴公司從本人所指定之信用卡戶口內扣除保單之任何保費（包括續保保費）、保險業監管局徵費及賠償差額（如適用），直至本人另行發出書面通知為止。

（二）本人明白本人可隨時通知貴公司取消此授權，並同意該取消或更改本授權書通知，須於取消／更改生效日最少一個月之前交予貴公司及／或信用卡中心。

（三）如選擇月繳，於投保時貴公司將預先收取首兩個月保費及保險業監管局徵費。

（四）本人確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。

Declaration:

1. I hereby authorise the Company to effect debit of any premium (including renewal premium), levy to the Insurance Authority and claims charge back (if applicable) from the Credit Card Account specified herewith for the insurance policy, until further written notice is given by me.
2. I understand that I have the right to cancel this authorisation at any time and agree that any notice of cancellation or variation of this authorisation shall be given to the Company and/or Credit Card Centre at least 1 month prior to the effective date of such cancellation/variation.
3. If monthly payment mode is selected, the Company will charge 2-month premium and levy to the Insurance Authority in advance at the time of application.
4. I confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form.

持卡人簽署 Signature of Cardholder	日期（日／月／年） Date (dd/mm/yy)

* 直屬家庭成員指保單持有人之配偶、子女、父母、兄弟姊妹、祖父母、孫、法定監護人或配偶之父母。
Immediate Family Member shall mean spouse, children, parents, brothers or sisters, grandparents, grandchildren, legal guardian or parents-in-law of the policyholder.

(b) 直接付款授權書 Direct Debit Authorisation

收款人名稱 Name of Party to be credited	銀行編號 Bank Code	分行編號 Branch Code	貸方戶口號碼 Account No. to be credited
Blue Cross (Asia-Pacific) Insurance Limited	**0 1 5**	**5 2 1**	**4 0 0 5 0 1 2 4**

聲明：

（一）本人／我們現授權下述銀行，由本人／我們之賬戶轉賬保單之任何保費（包括續保保費）及保險業監管局徵費予貴公司（根據貴公司不時給予本人／我們銀行之指示），直至本人／我們另行發出通知為止。

（二）本人／我們同意本人／我們之銀行毋須證實該等轉賬通知是否已交予本人／我們。

（三）如因該等轉賬而令本人／我們之戶口出現透支（或令現時的透支增加），本人／我們願共同及個別承擔全部責任。

（四）本人／我們同意如本人／我們之戶口並無足夠款項支付該等授權轉賬，本人／我們之銀行將有權不予轉賬，且銀行可收取慣常之收費。

（五）本人／我們明白本人／我們可隨時通知貴公司取消此授權，並同意該取消或更改本授權書之通知，須於取消／更改生效日最少7個工作天之前交予貴公司及／或本人／我們之銀行。

（六）本人／我們確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。

Declaration:

1. I/We hereby authorise the below named Bank to effect transfer of any premium (including renewal premium) and levy to the Insurance Authority from my/our account to the Company (in accordance with such instructions as my/our Bank may receive from the Company from time to time) for the policy, until further written notice is given by me/us.
2. 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.
3. 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).
4. 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 and impose usual service charges on me/us.
5. I/We understand that I/we have the right to cancel this authorisation at any time and agree that any notice of cancellation or variation of this authorisation shall be given to the Company and/or my/our Bank at least seven (7) working days prior to the effective date of such cancellation/variation.
6. I/We confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form.

銀行名稱 Bank Name	分行名稱 Branch Name	銀行編號 Bank Code	分行編號 Branch Code	戶口號碼 Account No.
戶口持有人姓名 Name of Account Holder(s)	戶口持有人身份證號碼 HKID Card No. of Account Holder(s)	如戶口持有人並非保單持有人或任何受保人，請說明與保單持有人之關係。 Please describe the relationship to the policyholder if account holder is not the policyholder or any of the Insured(s).		
戶口持有人簽署 Signature of Account Holder(s)	日期（日／月／年） Date (dd/mm/yy)			

請注意

（一） 所有款項均以港元作出扣除。如須貨幣轉換，兌換率將由東亞銀行以該自動轉賬日所釐訂之兌換率為準。

（二） 此授權書內之簽名必須與閣下銀行戶口之簽名式樣完全相同。

（三） 設定直接付款授權指示需時，如選擇年繳、半年繳或季繳，請以劃線支票方式預先繳交全年、半年或一季之保費及保險業監管局徵費。如選擇月繳，請繳交首2個月之保費及保險業監管局徵費。

Please note:

1. All debits will be made in Hong Kong currency. If currency conversion is required, the exchange rate will be determined by The Bank of East Asia, Limited as at the date of processing the direct debit transaction.
2. Please ensure that your signature(s) on this form is/are the same as the specimen signature(s) on your Bank Account.
3. To allow sufficient time for the set-up of the direct debit authorisation, if annual, semi-annual or quarterly payment mode is selected, please arrange for submission of the annual, semi-annual or quarterly premium and levy to the Insurance Authority in advance by crossed cheque. If monthly payment mode is selected, please submit the first 2-month premium and levy to the Insurance Authority.

本公司專用 For Office Use Only

Policy No. _____ Policyholder _____ Agent Code _____

Reason of Submission ☐ New Business ☐ Replacement ☐ Others _____