中銀集團保險有限公司
BANK OF CHINA GROUP INSURANCE COMPANY LIMITED

公司專用 For office use
經手人 Input By

香港中環德輔道中 71 號永安集團大廈九樓 9/F., Wing On House, 71 Des Voeux Road Central, Hong Kong. 客戶服務熱線 Customer Service Hotline：3187 5100 傳真 Fax：3906 9906

中銀醫療綜合保障計劃(系列一)批改申請書
BOC Medical Comprehensive Protection Plan (Series 1) Endorsement Application Form

致 To：中銀集團保險有限公司 Bank of China Group Insurance Company Limited

保單號碼 Policy No (此資料必須由客戶提供或確認 This information must be provided or confirmed by client)	投保人名稱 Name of Policyholder	投保人身份證號碼 Insured's HKID Card No. (只需填寫英文字頭及首3位數目字 Fill in the first letter & first 3 digits only)

第一部份 Part 1　更改保單持有人*/受保人個人資料 Change of Policyholder's*/Insured's personal information

(先生 Mr / 小姐 Miss / 太太 Mrs./ 女士 Ms.) 英文姓名 Name in English* (請先填寫姓氏 Surname first)	中文姓名 Name in Chinese
<<請提供改名契副本 Please provide a copy of deed poll>>	
聯絡人姓名 Name of contact person	職業 Occupation
聯絡電話(住宅 / 手提) Contact no. (Home / Mobile)	香港身份證 / 護照號碼 HKID card / Passport No.
電郵地址 E-mail address	其他個人資料更改 Other changes on personal particulars
*如更改保單持有人，請列明更改原因 * Please state the reason if change of Policy Holder	

第二部份 Part 2　更改通訊地址 Change of correspondence address

生效日期 Effective Date:_____/ _____ / _____
日 dd / 月 mm / 年 yy

新通訊地址 New correspondence address (請用英文正楷填寫 In block letters):

室 Room/Flat	層數 Floor	座數 Block /Tower	大廈/屋苑名稱 Name of Building/Estate

街道號數及名稱 Name/Number of street/road	地區 District	城市/國家 City/Country

第三部份 Part 3　取消保單/保障/受保人 Cancellation of Policy/Insured Benefits/Deletion of Insured Person(s)

注意 Important Notes:

(1) 如要取消整張保單，必須連同原保單、醫療咭(如有)一起退回 In order to cancel the entire Policy, please return the original Policy, Medical Card (if any) together with Endorsement Application Form.

(2) 如屬住院及手術計劃 4 於指定情況下或因受保人身故，於保障生效期間中途取消保單/保障，請提供相關文件以茲證明 Please provide relevant documents in the event that Insured Person of Hospital & Surgical Plan 4 terminates the Policy / Insured Benefit during Period of Insurance under designated occasions or Insured Person deceases.

終止保障日期 Deletion Date _____/ _____ / _____ 日 dd / 月 mm / 年 yy	保障生效期間中途取消保單/保障/受保人，將**以下年度續保日為取消生效日並不會退還本年度已繳保費**(屬住院及手術計劃 4 除外) Full annual premium will be collected and paid premiums shall not be refunded in the event of termination of Policy / Insured Benefits during Period of Insurance and the termination will be effective from next renewal date, except insured under Hospital & Surgical Plan 4.

☐ **i.) 取消整張保單**
Cancel the entire Policy

☐ **ii.) 取消部份的受保人及/或保障 Insured Persons and/or Benefits to be deleted**
(請填寫以下部份 Please complete the following part)

受保人姓名 Name of Insured Person	**香港身分證/護照號碼 HKID Card/Passport No.**	**與投保人關係 Relationship with Policyholder**	**終止保障日期 Deletion Date** (日/月/年 dd/mm/yy)	**擬終止之保障 Benefit to be deleted**
		☐ 配偶 Spouse ☐ 子女 Child		
		☐ 配偶 Spouse ☐ 子女 Child		
		☐ 配偶 Spouse ☐ 子女 Child		
		☐ 配偶 Spouse ☐ 子女 Child		

第四部份 Part 4　增加受保人 Addition of Insured Person(s)

如增加受保人，請一併填妥表格第五部份及第七部份(健康聲明)

If addition of Insured Person, please complete Part 5 and Part 7 (Health Declaration)

擬生效日期　Effective Date : _____ **(日 DD) /** _____ **(月 MM) /** _____ **(年 YY)**

註：增加受保人，若申請成功批核，該受保人之保障將會於保險公司接納後的下一個保單年度起保日生效，請在續保日前 30 天遞交。

If the application for addition of Insured person is approved, insurance of such family members will become effective and commence on the effective date of the next policy year. Please submit the application 30 days before the renewal date .

與投保人關係 Relationship with Policyholder	受保人姓名 Name of Insured person	香港身分證 / 護照號碼 HKID / Passport No.	性別 Sex	出生日期 Date of Birth (日/月/年 dd/mm/yy)	職業及職位 Occupation & Position	高度 Height ☐ 厘米 cm ☐ 呎 Ft	體重 Weight ☐ 千克 kg ☐ 磅 lbs
☐ 配偶 Spouse							
☐ 子女 Child (1)							
☐ 子女 Child (2)							

第五部份 Part 5　更改保障類別 / 增加自選保障 Change of Benefit Plan Category / Addition of Benefit(s)

請一併填妥此表格第七部份之健康聲明　Please also complete the Health Declaration under Part 7 of this form

擬生效日期　Effective Date* : _____ **(日 DD) /** _____ **(月 MM) /** _____ **(年 YYYY)**

受保人[1] / 保障計劃[2] Insured Person[1] / Benefit Plan[2]	I. 基本保障 Basic Benefit (各受保人可 3 選 1 任擇下列其中一項綑綁保障及在所選保障下選擇其中一個計劃 each insured person can select 1 out of 3 from any one package benefit listed below and to select one insured Plan under your selected benefit)			II. 自選保障 Optional Benefit (各受保人可任擇下列保障及在所選保障下任擇其中一個計劃 each insured person can select any benefit listed below and to select one insured Plan under your selected benefit)			
	(A + B 保障) 住院及手術及附加重症住院 Hospital & Surgical and Supplementary Major Medical	(A + C 保障) 住院及手術及住院現金[3] Hospital & Surgical and Hospital Cash[3]	(A + B + C 保障) 住院及手術、附加重症住院及住院現金[3] Hospital & Surgical， Supplementary Major Medical and Hospital Cash[3]	D.門診 Out-patient	E.牙科 Dental	F.產科 Maternity	G.危疾 Critical Illness
1. ☐ 投保人 Insured	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3a ☐ 計劃 Plan 3b	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3 ☐ 計劃 Plan 4	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3a ☐ 計劃 Plan 3b	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3	☐ 計劃 Plan 1 ☐ 計劃 Plan 2	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3 ☐ 吸煙者 smoker (如是者請 if yes please "✓")
2. ☐ 配偶 Spouse	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3a ☐ 計劃 Plan 3b	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3 ☐ 計劃 Plan 4	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3a ☐ 計劃 Plan 3b	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3	☐ 計劃 Plan 1 ☐ 計劃 Plan 2	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3 ☐ 吸煙者 smoker (如是者請 if yes please "✓")
3. ☐ 子女[4] Child	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3a ☐ 計劃 Plan 3b	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3 ☐ 計劃 Plan 4	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3a ☐ 計劃 Plan 3b	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3	☐ 計劃 Plan 1 ☐ 計劃 Plan 2	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3 ☐ 吸煙者 smoker (如是者請 if yes please "✓")
4. ☐ 子女[4] Child	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3a ☐ 計劃 Plan 3b	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3 ☐ 計劃 Plan 4	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3a ☐ 計劃 Plan 3b	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3	☐ 計劃 Plan 1 ☐ 計劃 Plan 2	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3	☐ 計劃 Plan 1 ☐ 計劃 Plan 2 ☐ 計劃 Plan 3 ☐ 吸煙者 smoker (如是者請 if yes please "✓")

註 Remarks：

1. 投保年齡：成人受保人於住院及手術、附加重症住院、門診及牙科保障最高投保年齡為 65 歲，住院現金可至 60 歲，而產科及危疾保障的投保年齡為 18 歲至 50 歲。Insured age: Adult Insured Person's maximum entry age is 65 for Hospital & Surgical, Supplementary Major Medical, Out-patient and Dental Benefit, 60 for Hospital Cash, also, the insured age for Maternity & Critical Illness Benefits is from 18 to 50.
2. 保障計劃：不同受保人於同一保單可選擇不同基本保障、計劃及自選保障項目。Benefit Plan: Insured Person(s) under the same policy can apply for different Basic Benefit, Plan and Optional Benefit.
3. 住院現金保障：無論選擇任何一款基本保障及計劃，若受保子女年齡為 18 歲或以下，住院現金保障保額將按「計劃 1」受保。Hospital Cash Benefit: Regardless of any Basic Benefit and Plan selected, the sum insured of Hospital Cash Benefit will be covered under "Plan 1" only for the insured child(ren) aged 18 or below.
4. 子女：指投保人的合法子女，包括繼子女、領養子女或監護兒童。Child: refer(s) to the legal child of the Proposed Insured, including step child, adopted child, or guardian child.

第六部份 Part 6　保單復效 Reinstatement

請一併填妥此表格第七部份之健康聲明　Please also complete the Health Declaration under Part 7 of this form

擬復效之生效日期 Proposed Reinstatement Effective Date*：	_____ **(日 DD) /** _____ **(月 MM) /** _____ **(年 YY)**

注意事項 Important Notes:

保單復效須於保單失效日期起計 90 天內提出。超過 90 天者，請填妥投保書重新投保。 Reinstatement must be submitted within 90 days from the Policy Termination Date. Please complete BOC Medical Comprehensive Protection Plan (Series 1) Proposal form for request raised beyond 90 days.

***以公司批核為準　Subject to the Company's approval**

第七部份 Part 7　健康聲明 Health Declaration

(只適用於第四、第五及第六部份的更改情況 Only applicable for changes of Part 4, Part 5 & Part 6)

請詳閱及回答下列所有問題。Please read the following questions and answer in full.	**是 YES**	**否 NO**
1. 您及/或受保人是從事非文職或任何附帶特殊風險之職業，如高空工作，空中或航海工作人員；紀律部隊；體力勞動；拖頭及/或中港貨車司機；職業運動員。如答案為「是」者，請詳加說明。You and/or Insured Person(s) is employed as non clerical worker or any occupation with special risk, such as work at height, air or ship crews; disciplinary services; manual worker; tractor driver and/or lorry driver transporting goods to and from HKSAR and China; professional sportsman? If you have ticked "YES", please give full details. _____	☐	☐
2. 您及/或受保人是香港境外就讀的留學生。如答案為「是」者，請提供受保人姓名、就讀學府的詳細資料(包括就讀學府名稱及地址)及海外住址。You and/or Insured Person(s) is a student studying outside HKSAR. If you have ticked "YES", please provide the name of Insured Person, full details of the attended Educational Institution (including name and address of the attended Educational Institution) and overseas residential address. _____	☐	☐
3. 您及/或受保人的「身體質量指數」是不符合標準。You and/or Insured Person(s)'s "Body Mass Index" falls outside standard level.	☐	☐
4. 在過去 5 年您及/或受保人曾否　During the last 5 years, have you and/or Insured Person(s) been: i) 住院或因嚴重疾病/創傷需要向專科醫生尋求醫療諮詢、斷症性之檢查、治療或做手術，或接受或被建議接受 X 光、心電圖、磁力共振顯影、電腦掃瞄、性病或肝炎或愛滋病之測試、或其他化驗/檢查？ hospitalized or have consulted a specialist for medical advice, diagnostic tests, treatment or operation for a serious illness or injury, or ever had or been advised to have any X-ray, ECG, MRI, CT Scan, or tests/counseling in connection with sexually transmitted disease or hepatitis or HIV, or other laboratory tests/ investigations? ii) 因任何病徵、疾病、缺陷或身體狀況例如但不限於肝炎帶菌者、糖尿病、腎病、高血壓、關節炎、心臟血管疾病、各類型癌症或腫瘤導致現在或將來急需做手術或接受長期治療？any symptoms, illness, defects or conditions such as, but not limited to hepatitis carrier status, diabetes, kidney disease, high blood pressure, arthritis, cardio vascular diseases, any type of cancer or tumor, that may require impending operation, continuous treatment now or in the future?	☐ ☐	☐ ☐
5. 在過去 5 年您及/或受保人曾否因住院向保險公司索償或在投保壽險或醫療保險時被拒絕、或有關保單被取消、增加保費或附加限制？ In the past 5 years, have you and/or Insured Person(s) ever filed a claim for hospitalization with an insurance company or had any life or medical insurance application rejected or policy cancelled, rated or restricted?	☐	☐
只適用於危疾保障　Applicable for Critical Illness Benefit only		
6. 過去 5 年，您及/或受保人曾否患上中風、膽囊毛病、身體虛脫、貧血/血友病/其他血液毛病、肢體殘缺、精神病、黃疸/肝炎/其他肝臟毛病、聽覺/視力受損(遠視/近視除外)、肌肉及骨骼系統問題如背痛/關節或肌肉痛症、或任何其他類別的疾病(不包括小毛病如傷風、感冒、腸胃炎等)或傷殘？During the last 5 years, have you and/or Insured Person(s) ever suffer from stroke, gall bladder disorder, debility or other disorder, anaemia/hemophilia/other disorder of blood, loss of use limb, mental illness, jaundice/hepatitis/other liver disorder, impaired hearing/vision (except hyperopia or myopia), musculo-skeletal problem such as backache/joint or muscle pains, or any other illness (other than minor sickness such as upper respiratory tract infection, flu, gastroenteritis, etc.) / disability?	☐	☐
7. 您及/或受保人的雙親、兄弟或姊妹當中是否曾於 60 歲前患上或死於中風、心臟病、糖尿病、腎病、多發性硬化、癌病或遺傳病？ Have you and/or Insured Person(s) parents, brothers or sisters had or died from Stroke, Heart Disease, Diabetes, Kidney Disease, Mutiple Sclerosis, Cancer or Inherited Disease before the ages of 60?	☐	☐
8. 您及/或受保人是否有吸食煙草或毒品或飲酒之習慣或被醫生建議減少或停止吸食煙草產品/飲酒？如答案為「是」者，請列明每週之數量？ Have you and/or Insured Person(s) use tobacco products or narcotics or drink alcohol regularly or ever been advised by doctor to reduce or discontinue consumption of tobacco or alcohol? If you have ticked "YES", please state amount typically consumed per week. _____	☐	☐

如在上述問題 1-8 答案的任何一題選擇「是」，請詳述於以下空格內及附上有關醫療報告。如需另頁詳加說明，請在右格內加"✓"並連同附頁一併遞交，而附頁需由有關受保人簽署確認。If any answer to the above question no. 1-8 is "YES", please provide full details in the following table and enclose related medical reports. If you need to provide details on separate sheet, please tick the box at the right hand side and attached the sheet(s). The sheet(s) should be duly signed by the related Insured Person(s).

另有附頁 with attachment ☐

受保人姓名 Name of Insured Person (s)	問題號碼 Question No.	健康狀況如疾病性質、症狀 Health Condition such as Nature or Symptoms of Disease, Diagnosis	所接受之護理及治療 Care and Treatment Received	發病日期 Onset Date	上一次求診日期 Last Consultation Date	結果 Result

第八部份 Part 8　更改繳付保費方法 Change of Payment Method

更改項目 Change Items	更改至 Change To
繳費模式 Payment Mode	☐ 年繳 Annual**(只適用於現有以月繳模式繳費之客戶 Applicable to existing monthly payment mode clients only)**
繳費方法 Payment Method	☐ 支票 Cheque **(只限年繳 Annual Payment Only)**
	☐ 銀行戶口轉帳 Autopay by Bank Account 請填妥第 7 頁的**「直接付款授權書」**，連同年繳保費**(適用於年繳模式)**或首三個月保費**(只適用於現有以月繳模式繳費之客戶)**之劃線支票抬頭寫「中銀集團保險有限公司」交回。 Please attach a crossed cheque for the annual premium **(applicable to annual mode)** or first three months premium **(applicable to existing monthly payment mode clients only)** made payable to "Bank of China Group Insurance Company Limited" with a completed **Direct Debit Authorization Form** as in Page 7.
	☐ 信用卡戶口轉帳 Autopay by Credit Card 請填妥第 6 頁的**「信用卡付款授權書」**交回。 Please attach a completed **Credit Card Authorization Form** in page 6.

第九部份 Part 9　其他更改 Other Amendments

生效日期 Effective Date:_____ (日 DD) / _____ (月 MM) / _____ (年 YY)

聲明 Declaration

1. 本人接納根據中銀醫療綜合保障計劃(系列一)規定，凡在保單起保日前因已患之疾病、損傷或其他病況而引致之醫療需要，一律不予賠償，除非本人及/或受保人已在投保書內已詳細列明並獲中銀集團保險接納。I acknowledge that benefits are not payable under the BOC Medical Comprehensive Protection Plan (Series 1) for any costs of treatment arising from any existing illnesses, injuries or other conditions unless complete details are fully disclosed by me and/or the Insured Person(s) in the Proposal Form and accepted by BOCG Insurance.
2. 本人謹此聲明本人及/或受保人於申請這份保險時為年齡介乎 15 日至 65 歲居於香港特別行政區的合法居民。I declare that myself and/or the Insured Person(s) are ordinarily residing and legal resident of HKSAR aged between 15 days and 65 years old when applying for this insurance.
3. 本人謹此聲明，本人已向上述家屬(如有)取得授權，於本投保書之陳述乃真確無訛，可作為簽發保單之根據。本人亦明白如資料錯誤或不詳盡，本人及/或受保人之保障有失效之虞。I declare that I have obtained the necessary authorization from the above mentioned family member (if any), the information stated in this Proposal Form is true and complete and will form the basis of this insurance. I also understand that if any information stated is untrue or incomplete, the cover for myself and/or for the Insured Person(s) may be invalided.
4. 本人謹此聲明，**本投保書是在香港特別行政區內簽署**，如有任何訛騙或資料失實，本人及/或受保人之保障有失效之虞。I declare that **this Proposal Form is applied and signed at HKSAR,** in case of fraud or factual misrepresentation, the cover for myself and/or for the Insured Person(s) may be invalidated.
5. 本人在此授權任何醫生、醫院、診所、保險公司及其他人士，均可向中銀集團保險提供本人及/或上述家屬(如有)健康情況及病歷詳細資料。此授權書之影印本與正本有同等效力。I hereby authorize any doctor, hospital, clinic, insurance company or any other person to provide either myself and/or the above mentioned family members' (if any) health condition or detail medical history to BOCG Insurance. Copy of this authorization form will have same effect as of the original copy.
6. 本人同意中銀集團保險保留一切有關投保書接納與否之權利。I agree BOCG Insurance reserves the right to accept or decline my this application.
7. 本人明白必須繳付保費與生效後，中銀集團保險對本人及/或受保人之保險責任始行生效。I understand that BOCG Insurance insurance's liability for myself and/or for the Insured Person(s) will only take effect provided that premium has been paid and the policy was put in-force.
8. 本人明白此投保申請一經批核，在每個保單年度期滿前，若未有接獲中銀集團保險有關修改任何條款的續保通知，本人只須繳交下個保單年度所須的保費，此保單便會每年自動續保。I agree that once this application for insurance is accepted, if no notice of amendment of renewal terms is sent to me from BOCG Insurance prior to the expiration of each policy year, the policy will be automatically renewed simply by my/our settling the required premium for the upcoming policy year.

收集個人資料聲明 Personal Information Collection Statement

本人明白本人提供的資料為中銀集團保險提供保險業務所需，並可能使用於下列目的：I understand that the information provided by me to BOCG Insurance is collected to enable BOCG Insurance to carry on insurance business and may be used for the purpose of:

(1) 處理及審批本人的保險申請或本人將來提交的保險申請 processing and evaluating my insurance application and any future insurance application I may make；
(2) 執行本人保單的行政工作及提供與本人保單相關的服務 administering my insurance policy and providing services in relation to my insurance policy;
(3) 分析或調查、處理及支付本人保單有關的索償 analysis or investigating, processing and paying claims made under my insurance policy;
(4) 發出繳交保費通知及向本人收取保費及欠款 invoicing and collecting premiums and outstanding amounts from me;
(5) 任何與保險有關的產品或服務的任何更改、變更、取消或續期 any alterations, variations, cancellation or renewal of any insurance related product or service;
(6) 就以上用途聯絡本人 contacting me for any of the above purposes;
(7) 中銀集團保險行使任何代位權 exercising any right of subrogation by BOCG Insurance;
(8) 其它與上述用途有直接關係的附帶用途 other ancillary purposes which are directly related to the above purposes;及 and
(9) 遵循適用法律，條例及業內守則及指引 complying with applicable laws, regulations or any industry codes or guidelines.

中銀集團保險亦可因應上述用途將本人及/或受保人的個人資料移轉予下列各方(不論在香港特別行政區境內或境外)BOCG Insurance may disclose my and/or the Insured Person(s)'s personal data for the above purposes to the following classes of transferees (whether within or outside the Hong Kong Special Administrative Region):

a. 就上述用途，向中銀集團保險提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問 (包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist BOCG Insurance to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors);
b. 處理索賠個案的理賠師、理賠調查員及醫療顧問 in the event of a claim, loss adjudicators, claims investigators and medical advisors;
c. 追討欠款的收數公司或索償代理 in the event of default, debt collectors and recovery agents;
d. 保險資料服務公司及信貸資料服務公司 insurance reference bureaus or credit reference bureaus;
e. 再保公司及再保經紀 reinsurers and reinsurance brokers;
f. 本人的保險經紀（若有）my insurance broker (if I have one);
g. 中銀集團保險的法律及專業業務顧問 BOCG Insurance's legal and professional advisors;
h. 中銀集團保險的關連公司(以《公司條例》內的定義為準) BOCG Insurance's related companies (as that term is defined in the Companies Ordinance);
i. 現存或不時成立的任何保險公司協會或聯會或類同組織(「聯會」)及其會員，以達到任何上述或有關目的，或以便「聯會」執行其監管職能，或其他基於保險業或任何「聯會」會員的利益而不時在合理要求下賦予「聯會」的職能 any association, federation or similar organization of insurance companies ("Federation") and its members that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation;
j. 透過「聯會」移轉予任何「聯會」的會員，以達到任何上述或有關目的 any member(s) of the "Federation" by the "Federation" for any of the above or related purposes;
k. 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的 any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
l. 任何負責處理保險相關投訴及/或爭議之行業或監管機構 any industry or regulatory bodies responsible for handling insurance related complaints and/or disputes;及 and
m. 法例要求或許可的政府機關 government agencies and authorities as required or permitted by law.

本人在此授權中銀集團保險可向「聯會」從保險業內收集的資料中查閱及/或核對本人及/或受保人任何資料 BOCG Insurance is hereby authorized to obtain access to and/or to verify any of my and/or the Insured Person(s)'s data with the information collected by the Federation from the insurance industry.
此外，經本人同意，中銀集團保險可能會以其它方式使用及披露本人及/或受保人的個人資料 Moreover, BOCG Insurance may also use and disclose my and/or the Insured Person(s)'s personal data otherwise with my consent.
本人有權查閱及要求更正由中銀集團保險持有有關本人及/或受保人的個人資料。如有需要，可向中銀集團保險法律與合規部提出 (地址: 香港中環德輔道中 71 號永安集團大廈 9 樓) I have the right to obtain access to and to request correction of any personal information concerning myself and/or the Insured Person(s) held by BOCG Insurance. Requests for such access can be made to BOCG Insurance's Legal and Compliance Department (Address: 9/F., Wing On House, 71 Des Voeux Road Central, Hong Kong).

接收推廣訊息指示 Receive Direct Marketing Materials Instruction

本人**不欲**中銀集團保險使用本人的個人資料經以下渠道作直銷推廣 (請以"✓"選擇渠道) I **do not wish** BOCG Insurance to use my personal data in direct marketing via the following channel(s) (please use "✓" to select the channel(s)):

☐ 電子推廣郵件 Promotion Email ☐ 電話短訊 SMS ☐ 直銷郵件 Direct Mailing ☐ 電話直銷 Telephone Call

如您遞交此投保書而沒有在以上任何方格內以"✓"號顯示您的選擇，即代表您並不拒絕中銀集團保險任何形式的直銷推廣。If you return this Proposal Form without ticking any of the above boxes, it means that you do not wish to opt-out from any form of direct marketing of BOCG Insurance.

以上代表您現在對是否接收直銷推廣資料的選擇，亦取代任何您之前已告知中銀集團保險的選擇。請注意，您以上的選擇適用於根據中銀集團保險的「資料政策通告」上所載的產品，服務及/或標的。請您參考該通告上有關中銀集團保險擬用於直銷推廣的個人資料種類。The above represents your present choice whether or not to receive direct marketing materials and replaces any choice communicated by you to BOCG Insurance prior to this application. Please note that your above choice applies to the direct marketing of the classes of products, services and/or subjects as set out in the Data Policy Notice of BOCG Insurance. Please also refer to the said Notice on the kinds of personal data which may be used in direct marketing.

將個人資料披露給本集團公司作直接促銷指示 Instruction to disclose personal data to the Group companies for direct marketing (只適用於個人投保 Applicable for Individual Enrolment only)

☐ 為改善及提供更全面的服務予中銀集團保險的客戶，中銀集團保險可能會將您的個人資料提供予「本集團」*其他成員及其他人作其包括財務、保險、信用卡、證券、商品、投資、銀行及相關服務和產品及授信的直銷推廣 (請您參考中銀集團保險的「資料政策通告」上有關中銀集團保險擬提供之直銷推廣的個人資料種類，該資料擬提供予甚麼類別的人士，以及該資料擬就甚麼類別的產品，服務及/或標的而使用。) 若您不欲中銀集團保險提供您的個人資料予以上人士作以上用途，請您在這方格上以"✓"號表示。To improve and provide more comprehensive services to our customers, BOCG Insurance may provide your personal data to other members of the Group* and any other persons for their use in direct marketing of financial, insurance, credit card, securities, commodities, investment, banking and related services and products and facilities and so forth. (Please refer to the Data Policy Notice of BOCG Insurance on the kinds of personal data which may be transferred to in direct marketing, the classes of persons to which your personal data may be provided to, and the classes of products, services and/or subjects in relation to which the data is to be used.) Please tick "✓" this box if you do not wish BOCG Insurance to provide your personal data to the above persons for the above purposes.

*「本集團」指中銀集團保險及其控股公司、分行、附屬公司、代表辦事處及附屬成員，不論其所在地。附屬成員包括中銀集團保險的控股公司之分行、附屬公司、代表辦事處及附屬成員，不論其所在地。The "Group" means BOCG Insurance and its holding companies, branches, subsidiaries, representative offices and affiliates, wherever situated. Affiliates include branches, subsidiaries, representative offices and affiliates of BOCG Insurance holding's companies, wherever situated.

本人確認同意本批改申請書內之所有部份，包括但不限於上列之聲明及收集個人資料聲明。 I confirm my agreement to all sections in this Proposal Form, including but not limited to the above Declaration and Personal Information Collection Statement.

保單持有人
Signature of Policyholder

簽署地：香港及日期（日/月/年）
Signed Place：Hong Kong and Date (DD/MM/YY)

本批改申請書在未被同意受保前，中銀集團保險不負任何責任。
The BOCG Insurance has no liability whatsoever before the application for insurance in this Proposal Form is accepted.

信用卡付款授權書 Credit Card Authorization Form

☐ Visa ☐ Master ☐ 中銀銀聯雙幣信用卡(必需由香港發出)
BOC CUP Dual Currency Credit Card (Must be issued in Hong Kong)

持卡人姓名 Cardholder's Name	香港身份證號碼 HKID Card No.	信用卡戶口號碼 Credit Card Account No.	信用卡到期日 (月/年) Credit Card Expiry Date (M/Y)

本人茲授權「中銀集團保險有限公司」從本人的信用卡戶口每月/年支付「中銀醫療綜合保障計劃(系列一)」應繳保費金額，直至另行通知。
I hereby authorize and direct "Bank of China Group Insurance Company Limited" to debit the premium due from my credit card account for "BOC Medical Comprehensive Protection Plan (Series 1)"on a monthly/yearly basis until further notice.

若信用卡持有人並非投保人/受保人，請填寫以下資料。If Cardholder is not the Policyowner/Insured, please fill in the following information.

1. 與投保人/受保人關係 Relationship with the Policyowner/Insured: _____
2. 代投保人/受保人支付保費原因 Reason for paying premium on Policyowner/Insured's behalf _____

☐ 本人同意及承擔下述投保人/受保人之全數應繳之「中銀醫療綜合保障計劃(系列一)」保費金額。
I hereby confirm to pay the premium due of "BOC Medical Comprehensive Protection Plan (Series 1)" for the Policyowner/Insured.

(先生/太太/女士) Mr/Mrs/Ms) _____ 香港身份證號碼 HKID Card No. _____

持卡人簽署 Cardholder's Signature (須與信用卡簽署式樣相同 should be the same as the specimen signature on Credit Card)	X S.V.	聯絡電話號碼 Contact Phone No.	日期 Date (日 DD/月 MM/年 YY)

直接付款授權書 Direct Debit Authorization Form

請依次填寫並將此授權書交給 貴戶之往來銀行 Please complete and return this form to your banker

收款之一方 (受益人) Name of Party to be Credited ("The Beneficiary")	銀行編號 Bank No.	分行編號 Branch No.	收款賬戶號碼 Account No. to be Credited
Bank of China Group Insurance Company Limited	0 3 0	5 5 0	1 0 2 8 2 1 0 8

- 本人/吾等現授權本人/吾等之下述銀行，(根據受益人及/或代理行不時給予本人/吾等銀行之指示)自本人/吾等之賬戶內轉賬至上述賬戶。惟每次轉賬金額不得超過以下指定之限額。I/We hereby authorize my/our below named Bank to effect transfers from my/our account to the above account in accordance with such instructions as my/our Bank may receive from the beneficiary and/or its banker and/or its banker's correspondent from time to time provided always that the amount of any one such transfer shall not exceed the limit indicated below.
- 本人/吾等同意本人/吾等之銀行毋須證實該等轉賬通知是否已交予本人/吾等。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.
- 如因該等轉賬而令本人/吾等之賬戶出現透支(或令現時之透支增加)，本人/吾等願共同及各別承擔全部責任。I/We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our account which may arise as result of any such transfer(s).
- 本人/吾等同意如本人/吾等之賬戶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。I/We agree that should there be insufficient funds in my/our Bank account to meet any transfer hereby authorized, my/our Bank shall be entitled, in it discretion, not to effect such transfer in which event the Bank may make the usual service charge and that it may cancel this authorization at any time on one week's written notice.
- 本授權書將繼續生效直至另行通知為止或直至下列到期日為止 (以兩者中最早之日期為准)。This authorization shall have effect until further notice or until the expiry date written below (whichever shall first occur).
- 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(但不包括星期六)之前交予本人/吾等之銀行。 I/We agree that any notice of cancellation or variation of this authorization which I/we may give to my/our Bank shall be given at least two working days (except Saturdays) prior to the date on which such cancellation/variation is to take effect.

本人/吾等之銀行及分行之名稱 My/Our Bank Name and Branch	銀行編號 Bank No. 分行編號 Branch No.	本人/吾等之賬戶號碼 My/Our Account No.
本人/吾等在結單/存摺上所紀錄之名稱 My/Our Name(s) as record on Statement/Passbook	*每次/月付款之限額 *Limit for Each Payment/Month	到期日 (參閱下列附註各點) Expiry Date (See Notes Below) Day 日 Month 月 年 Year
債務人之姓名 (若非賬戶持有人) Name of Debtor (if other than Account Holder)	債務人參考 (必填之欄 – 請參閱下列附註各點) Debtors' Reference (Compulsory Field-See Notes Below)	
本人/吾等在結單/存摺上所紀錄之地址 My/Our Address as record on Statement / Passbook	聯絡電話 Telephone No.	本人/吾等之簽名 My/Our Signature(s) 日期 Date
以下由銀行填寫 For Bank Use Only	核對印鑑 Signature(s) Verified	

* 請刪去不適用者。Please delete whichever is not appropriate.

\# 請以英文正楷填寫。Please write in block letters.

附註 NOTES：

1. 如 台端付款之數額每次可能不相同，則請將最高者定為每次付款之最高限額。If the amounts of your payments are likely to vary each time, set the Limit for Each Payment at the maximum amount you would expect to pay at any one time.
2. 本直接付款授權書將於「到期日」一欄中所填寫之日期自動撤銷。如 貴戶意欲直接付款授權書無限期有效 (或直至 貴戶予以撤銷為止)，則請將該欄留空。The Direct Debit Authorization will be cancelled automatically on the date included in the box marked "Expiry Date". If you wish the Direct Debit Authorization to have effect indefinitely (or until cancelled by you) please leave box blank.
3. 請保證 貴戶在此授權書內之簽名，與銀行賬戶所簽者完全相同。Please ensure that you sign the form in the usual way that you would sign on your Bank Account.
4. 在債務人之參考欄內，請將 貴戶與受款人一方之關係，略予說明，例如學生編號、抵押合約號碼等。In the box marked "Debtor's Reference" enter the identifying reference between yourself and the party to be credited i.e. Student No., Mortgage Agreement No., Rental Agreement No., etc.
5. 當"每次/月付款之限額"一欄未有填上時，債務銀行可酌權就轉賬金額設下一個限額。The debtors' bank may set an internal limit when the "Limit for Each Payment/Month" is not specified.
6. 如果轉賬金額超過債務銀行所定限額，除預先安排外，債務銀行會保留利不予以轉賬。The debtor's bank reserves the right to reject the payment exceeding the maximum limit specified by the debtor's bank unless prior arrangements have been made.