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

個人醫療保險批改申請書
Individual Medical Insurance Endorsement Application Form

致 To：中銀集團保險有限公司 Bank of China Group Insurance Co. Ltd.

第一部份 Part 1 個人資料 Personal Data

保單號碼 (此資料必須由客戶提供或確認) Policy No (This information must be provided or confirmed by client):	代理及經辦單位編號 Agent Code & Unit No
保戶名稱 Name of Policyholder:	香港身分證號碼 (只需填寫英文字頭及首 3 位數目字) HKID No. (Fill in the first letter & first 3 digits only)

第二部份 Part 2 更改保戶通訊地址 Change of correspondence address

生效日期 Effective Date ____/____/____

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 更改受益人姓名 Change of beneficiary

生效日期 Effective Date ____/____/____

新受益人姓名 Name of beneficiary (請用正楷 in block letter)	與受保人關係 Relationship

第四部份 Part 4 取消保單/受保人 Cancellation of Policy/deletion of insured person(s)

*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.

取消保單日期 Date of Cancellation	原因 Resaon(s)

受保人姓名 Name of Insured person	香港身分證號碼 HKID	與投保人關係 Relationship	終止保障日期 Deletion Date (日/月/年 dd/mm/yy)
		☐ 配偶 Spouse ☐ 子女 Child	
		☐ 配偶 Spouse ☐ 子女 Child	
		☐ 配偶 Spouse ☐ 子女 Child	

第五部份 Part 5 增加受保人/更改保障項目 Addition of Insured person(s)/Change of plan

個人資料 Information

新增項目生效日期 Effective Date: ____/____/____

受保人姓名 Name of Insured person	香港身分證號碼 HKID	性別 Sex	出生日期 DOB (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	保障計劃 Name of Plan
投保人 The Insured	與投保時資料相同 Same as application						
☐ 配偶 Spouse							
☐ 子女 Child							
☐ 子女 Child							
☐ 子女 Child							

註一：更改保障項目，須於保單到期日前三十天申請；若申請成功批核，有關更改將於下一個保單年度生效。If the insured give written notice 30 days before the policy expiry date, and such application is approved by the Company, the new Plan will be effective on the first day of the earliest coming renewal policy year.

註二：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翌月一日起生效。If the application for addition of Insured person is approved, insurance of such family members will become effective and commence on the first day of the nearest month.

第六部份 Part 6 其他更改 Other amendment(s)

生效日期 Effective Date: ____/_____/____

健康聲明 HEALTH DECLARATION (只適用於增加受保人/更改保障項目 Only applicable for addition of Insured person(s)/change of plan)

請詳閱及回答下列所有問題。Please read the following questions and answer the in full.	**是 YES**	**否 NO**
1. 在過去 5 年閣下/受保人曾否住院或因嚴重疾病/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？ In the past 5 years, have you/Insured Persons been hospitalized or have consulted a specialist for medical advice, diagnostic tests, treatment or operation for a serious illness or injury?	☐	☐
2. 閣下/受保人曾否因任何病徵、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？ Do you/Insured Person(s) have 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?	☐	☐
3. 在過去 5 年閣下/受保人是否曾在醫院或療養院內接受手術、診察或治療或現正接受診察、治療或服用藥物？ In the past 5 years, have you/Insured person(s) ever been in a hospital or sanatorium for surgery, observation or treatment, or currently under observation or taking any treatment or medication?	☐	☐
4. 在過去 5 年閣下/受保人曾否因住院向保險公司索償？ In the past 5 years, have you/Insured person(s) ever filed a claim for hospitalization with an insurance company?	☐	☐
5. 閣下/受保人曾否在投保醫療、住院、意外、或人壽保險時被拒絕、或有關保單被取消、增加保費或附加限制？ Have you/Insured person(s) ever had any medical, hospitalization, accident or life insurance application rejected or policy cancelled, rated or restricted?	☐	☐

如在上述問題答案選擇「是」，請另紙詳述該受保人姓名及健康狀況如疾病性質，症狀，所接受之護理及治療，上一次求診日期以及有關醫療報告，由有關受保人簽署後，連同投保書一併交回本公司核辦。 If any answer to the above question is "Yes", please provide full details in separate sheet which should be duly signed describing Insured Person's name and health condition such as nature or symptoms of disease, diagnosis, care and treatment received, date of last consultation and related medical report and return together with the proposal form to our Company's attention.

聲明 DECLARATION

1. 本人謹此聲明，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，本人或受保人之保障有失效之虞。
2. 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，本人或受保人之保障有失效之虞。
3. 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「中銀集團保險有限公司」提供本人及/或上述家屬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。
4. 本人同意**「中銀集團保險有限公司」**保留一切有關投保書接納與否之權利。
5. 本人明白必須繳付保費後，「中銀集團保險有限公司」對本人及/或家屬之保險責任始行生效。同時，在保障生效日後首 15 天內發生之疾病，均不在保障範圍內。
6. 本人明白本人提供的資料，為**中銀集團保險有限公司**提供保險業務所需，並可能使用於下列目的：
   - 任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期；
   - 任何索償，或該等索償的調查或分析；
   - 行使任何代位權；及

   可能移轉予：
   - 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；
   - 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』），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；及
   - 或透過『聯會』移轉予任何『聯會』的會員，以達到任何上述或有關目的。

   此外，本人在此授權**中銀集團保險有限公司**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。

   本人明白本人有權查閱及要求更正由**中銀集團保險有限公司**持有有關本人及/或受保人的個人資料。如有需要，可向**中銀集團保險有限公司**法律與合規部提出（電話：2867 0888，傳真：3906 9939）。

1. I declare that 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 me and for the Insured Person(s) may be invalided.
2. I declare that this Proposal Form is applied and signed at HKSAR, in case of fraud or factual misrepresentation the cover for me or for the Insured Person(s) may be invalid.
3. I hereby authorize any doctor, hospital, clinic, insurance company or any other person to provide either myself and/or the above mentioned family members' health condition or detail medical history to "**Bank of China Group Insurance Company Ltd.**". Copy of this authorization form will have same effect as of the original copy.
4. I agree "Bank of China Group Insurance Company Ltd." reserves the right to accept or decline my application.
5. I understand that "Bank of China Group Insurance Company Ltd." insurance liability for myself and/or my family members will only take effect provided that premium has been paid. Besides, the sickness occurs within the first fifteen (15) days from the effective date of the insured member will not be covered under this policy.
6. The information provided by me to **Bank of China Group Insurance Co. Ltd.** is collected to enable the Company to carry on insurance business and may be used for the purpose of:
   - any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or services;
   - any claim or investigation or analysis of such claim;
   - exercising any right of subrogation; and

   may be transferred to;
   - 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;
   - any association, federation or similar organization of insurance companies ("Federation") 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 and
   - any members of the "Federation" by the "Federation" for any of the above or related purposes.

   Moreover, **Bank of China Group Insurance Co. Ltd**. is hereby authorized to obtain access to and/or to verify any data provided by me and/or the Insured Person(s) with the information collected by the Federation from the insurance industry.

   I understand that 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 **Bank of China Group Insurance Co. Ltd.** Requests for such access can be made to the Legal and Compliance Department of **Bank of China Group Insurance Co. Ltd.** (Tel:2867 0888 / Fax:3906 9939).

申請人簽章 Signature of Policyholder

日期 Date