

富邦銀行「醫智選」 醫療保險計劃投保表格

Fubon MediChoice Medical Insurance Plan Enrolment Form



Fubon Bank
富邦銀行



ZURICH
蘇黎世

請用英文正楷填寫。Please ensure it is properly and fully completed in BLOCK LETTERS.

請√適用方格及*請刪去不適用者。Please tick the appropriate box and * delete wherever is inappropriate.

^若投保人為受保人，請提供有關資料。^Please fill in if the proposer is the insured person.

I. 投保人資料 Proposer's information

英文姓名 (先生/太太/女士)*
Name in English (Mr./Mrs./Ms.) * _____

中文姓名
Name in Chinese _____

香港身份證號碼
HKID card no. _____ ()

出生日期 (日/月/年)
Date of birth (dd/mm/yy) _____

身高 (厘米)^
Height (cm)^ _____

體重 (公斤)^
Weight (kg)^ _____

職業及職位^
Occupation & position^ _____

電郵地址
E-mail address _____

手提電話
Mobile tel. no. _____

住宅電話
Home tel. no. _____

公司電話
Company tel. no. _____

傳真號碼
Fax no. _____

通訊地址
Correspondence address _____

室/單位*
Flat/ Rm.* _____

樓
Floor _____

座
Block _____

大廈
Building _____

屋苑名稱/ 街名及門牌/ 地段*
Estate name/ street no. & name/ lot no.* _____

地區
District _____

香港/九龍/新界*
HK/ KLN/ NT*

保險生效日期 (日/月/年)
Effective date of insurance (dd/mm/yy) _____

II. 受保人資料 Insured person's information

姓名 Name	與投保人關係 Relationship with Proposer	性別 Sex	香港身份證號碼 HKID card no.	出生日期 (日/月/年) Date of Birth (dd/mm/yy)	身高 (厘米) Height (cm)	體重 (公斤) Weight (kg)	職業 Occupation
受保人 Insured person (如受保人非投保人請填寫有關資料 Please fill in the details if the insured person is not the proposer)							

III. 一般資料 General information

下列問題須詳細回答。All questions must be answered in full and apply to the insured person.

	是 Yes	否 No
1. 閣下是否正在或曾於過去五年內入住醫院或療養院接受手術、觀察及治療或服用藥物治療? Are you currently or have you ever been in the past 5 years in a hospital or sanitarium for surgery, observation and treatment or receiving medication?		
2. 閣下是否患有先天性缺陷及/或疾病、慢性疾病或遺傳病? Have you ever suffered from any congenital abnormalities and/or disease, chronic disease or hereditary disease?		
3. 閣下是否曾於投保或續保人壽或任何醫療保障保險時被拒或附加特別條款才被接納? Have you ever been refused enrolment or renewal of life insurance or medical benefit insurance or such enrolment or renewal has only been accepted subject to special terms and conditions?		

如以上任何一項或所有答案為「是」者，請一併填寫「健康狀況問卷」。If any or all of the above answers is / are "Yes", please also fill in the "Health Questionnaire".

IV. 投保計劃與保費 Plan selection & premium

選擇計劃 Selection of plan				保費 (港幣/元) Premium (HK\$)
計劃級別 Plan level	<input type="checkbox"/> 標準 Standard	<input type="checkbox"/> 優越 Premier	<input type="checkbox"/> 特級 Deluxe	(A)
計劃類別 Types of cover	<input type="checkbox"/> 綜合計劃 Package cover	<input type="checkbox"/> 第一節獨立保障 Section 1 only	<input type="checkbox"/> 第二節獨立保障 Section 2 only	
自選附加項目 Optional plan (只能選擇附加項目 A 或 B Only either optional plan A or B can be selected)				
<input type="checkbox"/> A. 附加額外住院補助 Supplementary major medical benefit	<input type="checkbox"/> 標準 Standard	<input type="checkbox"/> 優越 Premier	<input type="checkbox"/> 特級 Deluxe	(B)

<input type="checkbox"/> B. 自願性自負額 Voluntary deductible	<input type="checkbox"/> HK\$10,000 (8折) HK\$10,000 (20% off)	<input type="checkbox"/> HK\$20,000 (75折) HK\$20,000 (25% off)	<input type="checkbox"/> HK\$30,000 (72.5折) HK\$30,000 (27.5% off)	N/A
扣除自願性自負額折扣 Less voluntary deductible discount [(A+B) 保費 x 自願性自負額折扣 Premium of (A+B) x voluntary deductible discount]				(C)
附加費 (由核保部決定) Premium loading (to be advised by underwriter if any) [(A+B-C) 保費 x 附加費% Premium of (A+B-C) x Premium loading %]				(D)
扣除保單折扣 8 折 Less policy discount of 20% [(A+B-C+D) 保費 x 0.2 Premium of (A+B-C+D) x 0.2]				(E)
總保費(港幣) Total premium (HK\$) (A+B-C+D-E)				

備註 Remarks:

1. 自選附加項目不適用於只選擇第一節獨立保障/第二節獨立保障之客戶。Optional plan is not available to customer who opts for either Section 1 or Section 2 only.
2. 附加額外住院補助計劃所選擇之級別須與綜合保障級別相同。The plan level of supplementary major medical benefit selected must be the same as that of the package cover.
3. 附加額外住院補助或自願性自負額只能任選其一。Only either supplementary major medical benefit or voluntary deductible can be selected.

V. 支付保費方法與授權書 Payment instruction & authorization

本人授權蘇黎世保險有限公司從本人下述之信用卡賬戶支取富邦銀行「醫智選」醫療保險計劃之首期及其後各期之保費，直至本人有進一步書面通知。

I hereby authorize Zurich Insurance Company Limited to charge my credit card account below for the Fubon MediChoice Medical Insurance Plan initial instalment and subsequent payments until further written notice from me.

持卡人姓名 _____ 與投保人關係 _____
Name of the cardholder _____ Relationship with proposer _____
持卡人香港身份證號碼 _____
Cardholder's HKID card no. _____ ()
信用卡號碼 _____ 信用卡有效日期至 _____ 月 _____ 年
Credit card no. _____ Credit card expiry date _____ M _____ Y

<input type="checkbox"/> VISA (VISA 卡)	<input type="checkbox"/> MasterCard (萬事達卡)
<input type="checkbox"/> American Express (美國運通信用卡)	<input type="checkbox"/> Diners Club International (大來信用証)

持卡人簽名 _____ 日期 _____
Cardholder's signature _____ Date _____

VI. 聲明 Declaration

1. 本人謹此聲明本投保表格所列全部資料乃就本人/其他受保人所知一切據實填報，並經本人核實正確無誤。本人聲明本人已獲得其他受保人授予全權，簽署此項投保申請，並提供本人/其他受保人的任何個人資料作評核此項投保申請之用。本人明白本投保表格及聲明將構成本人/其他受保人與蘇黎世保險有限公司(「貴公司」)之間的合約依據。
2. 本人授權貴公司有權向本人/其他受保人之醫生索取有關病歷資料，本人亦同意提供任何進一步與保險計劃有關之資料並自付所需費用。
3. 本人明白貴公司收集或持有的個人資料，不論以任何方式獲得，均可供貴公司使用或向在香港境內或境外之任何人或機構披露作以下用途：(1) 評核此項申請，(2) 辦理直接付款授權書或信用卡付款，(3) 提供貴公司及關連機構的推廣資料，(4) 處理保險的索償或有關之分析。
4. 本人明白本人/其他受保人可向貴公司之個人資料私隱主任提出查閱及/或要求更改有關本人/其他受保人的任何個人資料，地址為香港港島東華蘭路18號港島東中心24-27樓。

保險計劃須待貴公司覆核、接納投保申請及保費付訖後才能生效。

1. I declare that to the best of my/ the insured person's knowledge and belief the information given on this enrolment form is true and complete in every respect and all information disclosed have been verified by me as true and correct. I declare that I have full and complete authority from the insured person to sign this application and disclose any personal information in relation to me/ the insured person being requested to assess this application and I agree that this enrolment form and declaration shall form the basis of the contract between me/ the insured person and Zurich Insurance Company Limited ("the Company").
2. I authorize the Company to obtain medical information from my/ the insured person's medical practitioner(s) and I agree to supply additional information relevant to the insurance policy at my own expense.
3. I understand that all the personal information collected or held by the Company, howsoever obtained, may be used by or disclosed to any individual or organization within or outside Hong Kong for the following purposes: (1) to assess and service this application; (2) to process the direct debit authorization or credit card payment; (3) to provide marketing material of the Company or its associated companies and (4) to conduct the insurance claims or analysis.
4. I understand that I / the insured person may contact the Company's Data Privacy Officer at 24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong for any request to access to and/or correct any information about me/ the insured person supplied to the Company.

The insurance will not be in force until this application has been accepted by the Company and the premium has been paid.

日期 Date _____ 簽署 Signature _____

蘇黎世保險有限公司(於瑞士註冊成立之公司)

香港港島東華蘭路18號港島東中心24-27樓

客戶服務熱線：(852) 2903 9470 傳真：(852) 2903 9340 <http://www.zurich.com.hk>

Zurich Insurance Company Limited (a company incorporated in Switzerland)

24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong

Customer Services Hotline: (852) 2903 9470 Fax: (852) 2903 9340 <http://www.zurich.com.hk>

富邦銀行「醫智選」 醫療保險計劃健康狀況問卷 Fubon MediChoice Medical Insurance Plan Health Questionnaire



如在富邦銀行「醫智選」醫療保險計劃投保表格『一般資料』一欄中任何一項或所有答案為「是」者，請詳述如下。

If any or all of your answers to the general information in the Fubon MediChoice Medical Insurance Plan enrolment form is / are "Yes", please give full details below.

受保人姓名 Name of insured person
第一題 Question no. 1 曾於投保或續保任何人壽或醫療保險時被拒或需附加特別條款或增收保費始被接納的原因 Reason(s) for being subject to special terms and conditions or additional premium or being refused upon your enrolment or renewal of life or medical insurance in the past
第二題 Question no. 2 請說明有關殘障、疾病及所接受的治療（包括任何種類藥物治療）Details of physical impairment, diagnosis & treatment received (Including any kind of medication treatment)
第三題 Question no. 3 身體現時狀況 Present health condition
第四題 Question no. 4 治療期間 Period of medical treatment
第五題 Question no. 5 診治醫生姓名及地址 Name & address of attending doctor

本問卷乃以下署名投保人所申報的富邦銀行「醫智選」醫療保險計劃投保書之一部分。

This questionnaire shall form part of the Fubon MediChoice Medical Insurance Plan enrolment form as completed by the undersigned.

投保人姓名 Name of Proposer _____

簽署 Signature _____

日期 Date _____

蘇黎世保險有限公司(於瑞士註冊成立之公司)

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