PRUChoice MediExtra Medical Insurance – Variation Form
保誠精選「健康寶」僱員醫療保障計劃 — 更改保單申請表

PRUDENTIAL 保誠保險

Please complete Section 1 and 2 as required and return the completed form to: 請依指示填寫第一及第二部份，及將填妥之申請表寄回：

Prudential General Insurance Hong Kong Limited
Part of Prudential plc (United Kingdom)
P.O. Box No. 28162, Gloucester Road Post Office, Hong Kong
Telephone : 3656 8362 Facsimile: 2164 8445

保誠財險有限公司
保誠集團成員
香港告士打道郵政局郵政信箱28162號
電話：3656 8362 傳真：2164 8445

Name of the Insured 保單持有人姓名	Telephone No. 電話號碼
Policy No. 保單號碼	Facsimile No. 圖文傳真號碼

Section 1 - Types of Changes 第一部份 - 更改項目

(Please tick the change(s) requested and fill in details as required.)
(請用 "√" 號選擇所需更改，並填妥有關資料。)

☐ A. Deletion of Insured Person(s) 減除受保人

(Application is only allowed at renewal. Please make sure that this form is received by us 1 month before the renewal date.)
(只可於續保時申請。請於續保到期前一個月將申請表寄抵本公司。)

Name 姓名

☐ B. Change of Level of Cover 更改投保等級

(Application is only allowed at renewal. Please complete Section 2 as well and make sure that this form is received by us 1 month before the renewal date.)
(只可於續保時申請。並請同時填寫第二部份及於續保到期前一個月將申請表寄抵本公司。)

☐ For Insured Person 受保人 (Name 姓名 _____)

Please write down the appropriate deductible option on the space provided. 請於橫線上填寫適當的墊底費選擇。

☐ Private Room 私家病房 _____ ☐ Semi-Private Room 半私家病房 _____ ☐ Ward Bed 大房病床 _____

☐ C. Change of Bank Account for Claim Reimbursement 更改作賠償入賬的銀行戶口號碼

(The holder of the bank account must be the Insured.)
(銀行戶口持有人必須為保單持有人。)

Bank Name 銀行名稱	Account Holder 戶口持有人姓名
Account No. 戶口號碼	

For changing of direct debit, please fill in the Payment Details Amendment Form.
如欲更改以自動轉賬繳付保費的銀行戶口號碼，請另填更改付款資料申請表。

☐ D. Change of Correspondence Address / Telephone Number 更改通訊地址 / 電話號碼

New Address 新地址	Telephone No. 電話號碼

☐ E. Termination of Policy 終止保單

Note : Premium paid is not refundable.
注意 ：已繳保費，一概不發還。

(Application is only allowed at renewal. Please make sure that this form is received by us 10 working days before the renewal date.)
(只可於續保時申請。請於續保到期前十個工作天將申請表寄抵本公司。)

☐ F. Cancellation of Basic Top Up Medical Plan 取消基本住院附加醫療保障計劃

(Application is only allowed at renewal. Please make sure that this form is received by us 10 working days before the renewal date.)
(只可於續保時申請。請於續保到期前十個工作天將申請表寄抵本公司。)

Basic Top Up Medical Plan 基本住院附加醫療保障計劃

☐ I would like to cancel the Basic Top Up Medical Plan* but keep the Optional Hospital & Surgical Plan effective.
本人欲取消基本住院附加醫療保障計劃*，但保留生效中的自選住院及手術保障計劃。

*Once cancelled, reapplication on this Plan shall not be accepted. 保障一旦被取消，您便不能再次提出申請。

☐ G. Addition of Optional Hospital and Surgical Plan 參加自選住院及手術保障計劃

Application of Optional Hospital and Surgical Plan is allowed to the Insured Person(s) who has/have successfully Insured with Basic Top Up Medical Plan at renewal or resignation of current employment only. Should the application is submitted at renewal, please make sure that this form is received by us 1 month before the renewal date. Should the application is submitted at resignation of current employment, the Insured Person(s) must submit this application together with a reference letter issued by the employer within 45 days after the resignation. (Not applicable to cancellation)
只提供予已成功投保基本住院附加醫療保障計劃的受保人於續保或離職時申請自選住院及手術保障計劃。如在續保時提出申請，請於續保到期前一個月將申請表寄抵本公司。如在離職時提出申請，受保人必須在離職45日內連同一封離職時由僱主發出的轉介信一併遞交。(取消除外)

☐ For Insured Person 受保人 (Name 姓名 _____)

Optional Hospital & Surgical Plan 自選住院及手術保障計劃

☐ I would like to apply for Optional Hospital & Surgical Plan
本人欲申請自選住院及手術保障計劃
(Please complete Section 2 as well. 請同時填寫第二部份。)

Section 2 - Evidence of Insurability　第二部份 - 可保証明

(For change of Level of Cover only.)
(只供更改投保等級者填寫。)

Please read the following questions carefully and tick as appropriate. Please sign next to the box whenever any correction is done.
請詳閱以下問題，並在適當空格內填上“√”號。如有塗改，請於方格旁簽署作實。

	Yes 是	No 否
1. Has any person to be covered had any symptoms, illness or disorders of the following: 本申請表內所包括之受保人曾否有下列病徵、疾病或問題：		
(a) The musculoskeletal system or skin, e.g. arthritis, rheumatism, gout, sciatica or any disorder of the bones or spine? 與肌肉及骨骼系統或皮膚有關的疾病，如：關節炎、風濕病、痛風、坐骨神經痛、或其他骨骼或脊椎問題？	☐	☐
(b) The nervous system, psychiatric or brain function disorder, or impairment of the eyes or ears, e.g. paralysis, anxiety states, blindness, deafness, giddiness or epilepsy? 與神經系統、精神或與腦有關的疾病，眼或耳有問題，如：癱瘓、精神緊張、失明、失聰、暈眩或癲癇？	☐	☐
(c) The circulatory system, heart or blood, e.g. palpitation, murmur, chest discomfort, abnormal blood pressure, stroke or anaemia? 與循環系統、心臟或血液有關的疾病，如：心跳不正常、心雜音、胸部不適、血壓不正常、中風或貧血？	☐	☐
(d) The respiratory system or endocrine system, e.g. asthma, bronchitis, emphysema, diabetes or goitre? 與呼吸系統或內分泌系統有關的疾病，如：哮喘、支氣管炎、肺氣腫、糖尿病或甲狀腺腫脹？	☐	☐
(e) The digestive system or urinary system, breast or reproductive system, e.g. ulcer, hepatitis (including hepatitis B carrier), mastitis, cervitis, endometriosis, other disorders of the stomach, liver, bowels, kidneys or bladder? 與消化系統或泌尿系統、乳房或生殖器官有關的疾病，如：潰瘍、肝炎（包括乙型肝炎帶菌者）、乳房炎、子宮頸炎、子宮內膜移位或其他胃、肝、腸、腎或膀胱有問題？	☐	☐
(f) Enlarged glands, tumours, cysts, cancer, growth or other malignancy? 腺脹大、腫瘤、水囊、癌或其他惡性病變？	☐	☐
2. Apart from the symptoms, illness or disorders mentioned in question 1, has any person to be covered had any other illness, injury, physical impairment/deformity or condition requiring in-patient treatment, operation, or consultation with a doctor? 除於問題 1 提及之病徵、疾病或問題外，本申請表內所包括之受保人曾否因任何疾病、受傷、身體受損/畸形或其他情況，而需入院接受治療、手術，或向醫生求診？	☐	☐
3. Has any person to be covered taken or been advised to have X-ray, ECG or blood test, biopsies, ultrasound, mammogram or PAP smears, etc? 本申請表內所包括之受保人曾否接受或被建議接受X光，心電圖或抽血檢查、活體檢視、超聲波、乳房X光或子宮頸細胞塗片檢驗等?	☐	☐
4. Has any person to be covered had or been recommended for tests or counseling in connection with HIV, sexually transmitted disease, AIDS, AIDS related complex or any other AIDS related conditions? 本申請表內所包括之受保人曾否被建議接受與人體免疫力缺乏病毒、性病、愛滋病、愛滋衍生疾病及其他因愛滋病而引致之疾病的有關測試或忠告?	☐	☐
5. Has any person to be covered taken or been advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason? 本申請表內所包括之受保人曾否因血友病或其他原因，被禁止捐血、接受輸血或其它血類產品？	☐	☐
6. Does any person to be covered have any foreseeable need for treatment or for consulting any doctor? 本申請表內所包括之受保人是否有可預見之治療或診視需要?	☐	☐
7. Is any person to be covered currently under medical attention or receiving medical treatment or medication? 本申請表內所包括之受保人是否現正接受治療、或有就診需要、或服用藥物?	☐	☐
8. Has any person to be covered ever been insured against Medical Insurance? 本申請表內所包括之受保人曾否購買醫療保險? Please specify the name of Insurance Company: 請列明保險公司名稱：_____	☐	☐
9. Has any person to be covered ever been declined for Medical Insurance or had any special conditions or exclusions imposed? 本申請表內所包括之受保人曾否因醫療保險而被保險公司拒絕受保、或附加特別條款?	☐	☐

If you replied "Yes" in any of the above questions, please give name(s), date and full details on a separate sheet. Please also provide the relevant medical report, if any.
如上述任何問題回答「是」，請於另紙列出其姓名、日期及詳細情況。如有醫療報告，請連同此申請表一併遞交。

Declaration and Authorisation 聲明及授權

The statements and particulars given in this application are, to the best of my/ our knowledge and belief, true and complete and that this application shall form the basis of the contract with Prudential General Insurance Hong Kong Limited.

就本人/ 吾等知悉範圍內，此申請表填報的一切資料，均屬確實完整，本人/ 吾等並同意以此申請表作本人/ 吾等與保誠財險有限公司之間所訂合約的根據。

I/ We hereby authorize Prudential General Insurance Hong Kong Limited to access, obtain and utilize all of my/ our information from any person, company, authority, enterprise and/ or legal entity for the Company's reference, and/ or processing of this claim and/ or other claims submitted previously and in the future. A photocopy of this authorisation shall be considered as effective and valid as the original.

本人/ 本公司茲授權保誠財險有限公司向任何人/ 公司/ 機構索取有關本人/ 公司的任何資料以作貴公司參考及/ 或辦理此索償及/ 或以前及將來的索償。此授權書的影印本與正本具有同等效力。

Personal Information Collection Statement ("PICS") 收集個人資料聲明

Prudential General Insurance Hong Kong Limited (referred to as "our" or "we") takes the privacy and protection of your personal information seriously. Our Personal Information Collection Statement ("PICS") outlines how we will collect and use your personal data and with whom we will share it so we can provide the required products and services and send marketing communications. The PICS is available on our website at https://www.prudential.com.hk/en/personal-information-collection-statement/.

By completing and progressing with this form, the policyholder/ insured person confirms that they have understood and agreed to the PICS.

Is the policyowner Currently a customer in mainland China?

☐ Yes

(If "Yes", please tick below box to agree the following statement. If you disagree with this statement, we may not be able to process your request / application.)

☐ By ticking this box, you agree that as an international group company, in order to provide insurance-related products or services, we may need to store and process your personal information outside of mainland China. Please refer to our Privacy Notice (https://www.prudential.com.hk/en/china-personal-information-protection-law/) for more information.

☐ No

保誠財險有限公司（簡稱「我們」）認真對待閣下個人資料的私隱及保護。我們的個人資料收集聲明概述了我們將如何收集和使用您的個人資料，以及我們將與誰共享這些資料，以便我們能夠提供所需的產品和服務並發送市場營銷通信。收集個人資料聲明可在我們的網站上查閱：https://www.prudential.com.hk/tc/personal-information-collection-statement/index.html 。

填妥並繼續提交本表格，即表示受保人/ 投保人確認他們已明白並同意此收集個人資料聲明中的內容。

保單持有人現在是否是個中國內地客户？

☐ 是

（如「是」，請勾選以下選項以同意下列聲明。如您不同意以下聲明，我們可能無法處理您的指示/申請。）

☐ 勾選此項，表示您同意，我們作為國際集團公司，為提供保險相關產品或服務，可能需要在中國內地境外存儲或處理您的個人信息。更多資訊，請參閱我們的隱私聲明（ https://www.prudential.com.hk/tc/china-personal-information-protection-law/ ）。

☐ 否

Signature of Applicant* 申請人簽署* X	Financial Consultant's Name (Please complete in BLOCK LETTERS) 理財顧問名稱（請用正楷填寫） Financial Consultant's Division and Code 理財顧問組別及編號	
Date 日期	Mobile Number 流動電話號碼	Office Location 辦公地點

* The signature of this Application Form is only valid for 30 days from the date of your signature. 此申請表上的簽署只於簽署日期起30日內有效。

For Office Use Only 本公司專用		
Approved by	Date	Effective Date
Restrictions ☐ No ☐ Yes		

註：所有中文簡譯，如與英文有異，一概以英文為準。