

Member Application Form 僱員申請表

Part A - Insurance Scheme Details (To be completed by Employer) 甲部 - 保單資料 (由僱主填寫)

Name of Policyholder and Policy No. must be filled. Employer could either complete and sign this part or furnish the information by separate Group Insurance Enrollment Form/ENDOEX Form. 若僱主選擇以團體僱員投保表格/ENDOEX表格申報所需資料，此部份只需填寫保單持有人名稱及保單編號。

Name of Policyholder 保單持有人名稱		Policy No. 保單編號	
Full name of Employee 僱員姓名	Marital Status 婚姻狀況	Date of Employment 僱用日期 (M/D/Y 月/日/年)	Monthly Salary 月薪 (For Life Insurance 壽險適用)
Selected Plan 參加計劃	Plan Effective Date 計劃生效日期 (M/D/Y 月/日/年)	Occupation 職業	Employee Bank A/C No. 僱員銀行戶口號碼

Application should be submitted within 31 days from date of eligibility and no back date of more than 31 days from our received date would be allowed.
有關申請需於僱員計劃生效日期31天內呈交至保險公司，而有關計劃生效日期應以保險公司收訖日前31日為限。

Policyholder / Authorized Signature
保單持有人 / 授權人簽署

Date _____
日期 Month 月 Day 日 Year 年

Part B - Employee & Dependent Information (To be completed by Employee and for each covered dependent if applicable) 乙部 - 個人及家屬資料 (由僱員填寫，如家屬在計劃保障內，亦由僱員代為填寫)

Name (Employee/Dependent) 姓名 (僱員 / 家屬)	Relationship 關係	Sex 性別	HKID / Passport No. 香港身份證號碼	Nationality 國籍	Date of Birth (M/D/Y) 出生日期 (月/日/年)	Height 身高	Weight 體重
	Self 僱員本人					cm 厘米	kgs 公斤
						cm 厘米	kgs 公斤
						cm 厘米	kgs 公斤
						cm 厘米	kgs 公斤
Employee Email Address 僱員電郵地址		Name, Address and Telephone of Family Physician 家庭醫生姓名、地址及電話號碼					

Part C - Health Declaration (To be completed by Employee and for each covered dependent if applicable) 丙部 - 健康聲明 (由僱員填寫，如家屬在計劃保障內，亦由僱員代為填寫)

	YES 是	No 否
1. Have your weight changed more than (+/-) 4.5 kgs in the past year? If yes, pls. state the reasons. 過去一年體重曾否有4.5公斤以上之增減？如“是”，請詳述體重改變原因。	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you smoked any cigarette, cigar or pipe within the past 12 months? If yes, pls. state the average number of sticks per day. 在過往十二個月閣下曾否吸用香煙，雪茄或煙斗？如“是”，請說明每日平均吸煙的支數。	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you consume alcohol on a regular basis? If yes, please state type of alcohol and the average consumption per week. 閣下是否經常飲酒？如“是”，請說明酒的種類及每星期平均飲酒量。	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you participate in, or do you intend to participate in any private flying, any hazardous sports, or races? 閣下曾否參與或意圖參與私人性質飛行或危險性運動、競技？	<input type="checkbox"/>	<input type="checkbox"/>
5. Have any of your parents or family ever had cardiovascular diseases, diabetes, stroke, cancer, hereditary diseases or mental disorder? If so, please state family member, disease, onset age or cause of death. 閣下雙親或家庭中曾否患有心臟病、糖尿病、中風、癌症、遺傳病或精神疾病？如“是”，請詳述之。	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had, or been told you had or been treated for:- 閣下曾否接受過下列疾病之治療或被告知患上下列疾病：		
a. Asthma, emphysema, tuberculosis or other lung diseases? 哮喘，氣腫，結核病或其他肺病？	<input type="checkbox"/>	<input type="checkbox"/>
b. Diseases of heart and blood vessels such as high blood pressure, chest pain? 心臟病，血管問題如高血壓或胸部不適？	<input type="checkbox"/>	<input type="checkbox"/>
c. Hepatitis or hepatitis carrier, ulcer or bowel, liver or gall bladder disease? 肝炎或肝炎帶菌者，腸胃潰瘍，肝或膽囊疾病？	<input type="checkbox"/>	<input type="checkbox"/>
d. Renal stone or any disorder of the genito-urinary disorders? 腎石或其他生殖泌尿系統不正常？	<input type="checkbox"/>	<input type="checkbox"/>
e. Epilepsy, stroke, mental or nervous disorders? 癲癇，中風，精神不正常或神經疾患？	<input type="checkbox"/>	<input type="checkbox"/>

Part C Continue 丙部 續

YES 是 No 否

6. f. Diabetes, venereal disease, cancer, tumour, or any blood diseases?
糖尿病, 性病, 癌症, 腫瘤或其他血液疾病?
- g. Severe injury, gout, back pain, or other musculoskeletal disorders?
嚴重損傷, 痛風, 背痛或其他肌骨問題?
7. In the past five years, have you had any or you are planning to undergo:
在過往五年, 閣下曾否接受或籌劃任何治療:
a. diagnostic tests such as X-ray, electro-cardiogram, urinalysis or blood study?
診斷測驗如X光, 心電圖, 尿分析或驗血?
Test Findings : Normal / Abnormal * Delete as appropriate **測試結果: 正常 / 不正常** *請刪去不適用者
For abnormal test findings, please provide medical report copy. 如有測試結果不正常, 請遞交測試報告副本
b. illness, operation, medical advice, hospital treatment not mentioned above?
曾患病, 做手術, 醫療指導, 臨床治療, 而在上述問題並沒有提出過的?
8. Are you currently being treated or taking medication for any reason?
閣下現在是否因為任何原因正接受醫療或服用藥物?
9. Have you ever had an application for any form of insurance declined, postponed, modified or rated up?
閣下曾否投保申請任何保險計劃時被要求增加保費、被拒、被延遲或需要更改保險條款?
10. Female only
若是女性, 請答下列問題:
a. Are you pregnant now?
閣下是否現正懷孕?
- b. Any abnormal findings in prenatal check up? If yes, please state the details:
閣下是否在產前檢查中有不正常現象? 如“是”, 請詳細說明。
- c. Have you ever had any disorder of the breast or reproductive organs including abnormal pap smear and abnormal haemorrhage?
閣下曾否有乳房或婦科病症或不正常柏氏塗片測試或出血現象?

If any of the answers from question 1 to 10 is "yes", please give full details below, noting the question(s) and name of respective insured i.e. Employee or dependent(s). If more space is required, please use a separate sheet for declaration and endorsed with signature and date.

如問題一至十填上「是」的話, 請列明題目及有關投保人(僱員或家屬)名稱, 並提供詳細資料。如有需要, 請自行附加白紙, 並加以簽署及申報日期。

No. 題號	Name of Related Insured 有關投保姓名	Details (Date, Reasons or Cause, Results/Reports, Current Conditions, Physician's name & Address / Hospital etc.) 詳情 (有關日期、原因或起因、結果/報告、近況及診治醫生及診所地址 / 醫院等)

Part D - Personal Data Collection Statement 丁部 - 個人資料須知聲明

The information you provide to us is collected to enable us to administer any insurance product or service applied for, or any alternations, variations, cancellation or renewal of such product or service; any claim or investigation or analysis of such claim; and exercising right of subrogation. The said information may be transferred to (1) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claim or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes and our direct marketing. (2) 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 members of the Federation, and (3) any members of the Federation by the Federation for any of the above or related purposes.

You may contact Liberty's personal data privacy officer for any request to access and/or correct any information supplied to us. Moreover, Liberty International Insurance Ltd is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance industry.

閣下所提供的資料, 為本公司提供保險產品/服務之行政業務所需, 或該類產品或服務的任何更改、變更、取消、或續期、任何索償及有關之調查或分析; 行使任何代位權。以上資料, 可轉移於(1)任何有關的公司, 或任何其它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它服務提供者, 以達到任何上述或有關目的或用作直銷; (2)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」執行其監管功能, 或其它基於保險業或任何「聯會」會員的利益而不時在合理要求下賦予「聯會」的職能; (3)或透過「聯會」轉移與任何「聯會」的會員, 以達到任何上述或有關目的, 閣下可聯絡本公司個人資料私隱主任, 要求查閱/更改任何交予本公司閣下的個人資料。此外, 在此授權利寶國際保險有限公司由「聯會」從保險業內收集的資料中查閱及/或核對閣下的任何資料。

Part E - Declaration and Authorization 戊部 - 聲明及授權書

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, institution or person, that has any records, or knowledge of me or my health to give any such information as Liberty International Insurance Ltd may require. A photographic copy of this authorization shall be as valid as the original.

本人藉此授權任何執業醫生, 醫務從業員, 醫院, 診所, 保險公司或其他持有本人健康狀況紀錄之組織或人仕提供有關本人健康或個人資料予利寶國際保險有限公司。此項授權書複印本將與正本同樣有效。

I hereby declare and agree that all answers given to all questions are, to the best of my knowledge and belief, complete and true and that I have not withheld any material facts. 本人茲聲明, 上述各欄之填報, 均屬完全及真實無訛及本人並沒有保留任何重要資料。

Date

日期 Month 月 Day 日 Year 年

Employee's Name in Block Letter
僱員姓名 (請用正楷填寫)Signature of Employee
僱員簽署