


How to Fill in the “ManuChoice+ Medical Plan Application”

《自選醫療保障計劃申請書》填表指引



Manulife
EMPLOYEE BENEFITS
宏利僱員福利

For Office Use Only 公司專用

Agent Name & Code/Branch 代理人姓名及編號/分行: _____

Policy Number 保單編號: _____

Certificate Number 證書編號: _____

Effective Date of Coverage 保單生效日期: _____

ManuChoice+ Medical Plan Application
自選醫療保障計劃申請書

Notes

- Please complete this form in BLOCK LETTERS and check the boxes where appropriate. Please initial next to any corrections you make on this form.
- "Dependent" in this Application shall mean spouse and/or unmarried child(ren) of the Applicant who (are) resident(s) in Hong Kong.
- Coverage will be effective on the 1st of the month immediately following the later of: (i) the date the Application is approved by Manulife (International) Limited (Manulife); and (ii) the date the required premium is received.
- Coverage is subject to the terms and conditions of the Benefit Schedule and the Policy Provisions.
- Applications received by Manulife by fax will not be accepted.
- Before the bank receives premium payment, the Applicant or proposed insured(s) must give immediate written notice to Manulife of any alteration of material fact that may affect the risks covered by the Policy. Otherwise, Manulife reserves the right to reject any claims under the Policy.

注意事項

- 請用正楷填寫本表格，並於適當空格內加上✓號。如填作出任何更改，請於刪改之處旁加蓋作實。
- 本投保申請書內所載「家屬」一詞是指申請人居住在香港或未婚子女。
- 保單將於以下日期後之首個月的第一號生效 (i) 投保申請獲准日期 (ii) 保費收到日期。以較後者為準。
- 各轉職或受僱僱主的條款及條件以及保單條文所規限。
- 宏利不接納以傳真遞交之申請。
- 如發生任何重大轉變而導致保單所承保的風險可能受到影響，申請人必須即時通知宏利。否則，宏利保留權利，拒絕保單的任何索償。

A. APPLICANT INFORMATION 申請人資料

(As shown on HKID Card 必須與身份證相同)

(in English) (in Chinese)

姓名(以姓氏先填) _____ 英文 _____ 中文 _____

Date of Birth 出生日期: DD 月 / MM 月 / YY 年 Sex 性別: _____ Country of Residence 居住國家/地區: _____ HKID No. 香港身份證號碼: _____

Contact Information 聯絡資料

Residential Address 住宅地址: _____ E-mail Address 電郵地址: _____

Room/Floor/Block/Name of Building/Estate 室/樓/座/大廈/僱員名稱: _____ Mobile No. 手提電話: _____

Street No./Street Name 街道號碼/街道名稱: _____ Office Tel No. 公司電話: _____

District 區/處: _____ Home Tel No. 住宅電話: _____

Hong Kong 香港 Kowloon 九龍 New Territories 新界 Others 其他

The contact information applies to all of your products/services provided by all companies within the Manulife group of companies in Hong Kong and also companies which provide trustee/custodian services. 閣下所填的聯絡資料，將適用於以下公司為閣下提供的所有產品/服務上。適用於香港的公司以及為該等公司提供託管/信託服務的公司的。
 No, this address only applies to this Application. 否，所填的地址只適用於此申請。

Applicant's Bank Account (For medical claim reimbursement purpose) 申請人銀行戶口 (用以存入醫療索償金額)

BANK NAME 銀行名稱: _____ BANK ACCOUNT NUMBER 銀行戶口號碼: _____

Has your Employer endorsed this plan? 閣下的僱主是否已批准這個計劃?
 Yes, please provide your Employer name. 是，請提供貴公司的名稱。
 No 否

Are you actively at work? 現時是否仍在職人士?
 Yes 是 No 否

Occupation 職業: _____ Job Duties (Please specify % of time spent on manual labour) 工作職務 (請註明/填上%時間從事體力勞動): _____

Current Manulife MPF Sub-scheme No. or Group Insurance Policy No. (if applicable) 現有宏利強積金附屬計劃編號或團體保險編號 (如適用): _____

B. FAMILY INFORMATION 家庭成員資料 Please list all Dependents applying for coverage 請填寫申請投保之所有家屬

Proposed Insured* 建議投保人*	Name of Proposed Insured (Surname first) 建議投保人姓名 (以姓氏先填)	Country of Residence 居住國家/地區	HKID No. 香港身份證號碼	Sex 性別	Date of Birth (dd/mm/yy) 出生日期 (日/月/年)	For smokers, number of cigarettes smoked daily 如屬吸煙人士，請填出每日的吸煙數量	Height (cm) 身高 (厘米)	Weight (kg) 體重 (公斤)	Weight change in the last year 過去一年的體重變化	Reason 原因
1 Applicant 申請人	Applicant (As above) 申請人 (同上)									
2 Spouse 配偶										
3 Child 子女										
4 Child 子女										
5 Child 子女										

* An eligible Applicant must be actively at work, hold a HKID card and at least 18 but not yet 65 years of age. Dependent coverage is available to the Applicant's spouse who is 18 to 64 and any unmarried child(ren) provided they are at least 15 days to 18 years old, or ages 19 to 22 if attending school or university on a full-time basis. 申請人必須是職人士，年滿十八歲但未定六十五歲並且持有香港身份證。計劃亦為申請人的家屬提供保障。惟投保人配偶的年齡須介乎十八至六十四歲。而未婚子女的年齡須介乎出生後十五日至十八歲。如屬全日學生，則須介乎十九至二十二歲。

(For office use only 公司專用)

Please affix the policy no. here 請在此貼上保單編號

Please provide residential address in ENGLISH.
住宅地址必須以英文填寫。

Please state your "Occupation" and "Job Duties" for our underwriting consideration.
請註明閣下的「職業」及「工作職務」，以便作為本公司核保時的考慮因素。

Applicant must ALSO fill in this part.
投保人必須同時填寫此部份。

Please note that height and weight are measured in the units of "centimetre" (cm) and "kilogram" (kg).
請注意，身高及體重的量度單位分別為「厘米」及「公斤」。

- 1 foot is equivalent to 30.48 cm
1英尺相等於30.48厘米
- 1 kg is equivalent to 2.2 pounds
1公斤相等於2.2磅

Please put a "✓" in the appropriate box for the selected payment mode.
請於適當位置寫上"✓"號，以選擇繳付保費形式。

Please circle your selected benefit type and level.
請圈出閣下所選擇的保障類別及其保障級別。

C. Please circle the benefit type and level you wish to select. Dependents applying for coverage must apply for the same level of coverage as the Applicant.
請圈出閣下所選擇的保障類別及保障級別。家屬申請保費者必須與申請人選擇同一保障級別。

Beneficiary	Benefit Type	Benefit Level	Annual Mode	Monthly Mode	Basic Plan	Comprehensive Plan
1 Applicant 申請人	Health and Surgical Benefits 住院及手術保障	Level 1 第一級	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$500	\$600
2 Spouse 配偶	Health and Surgical Benefits 住院及手術保障	Level 1 第一級	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$500	\$600
3 Child 子女	Health and Surgical Benefits 住院及手術保障	Level 1 第一級	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$500	\$600
4 Child 子女	Health and Surgical Benefits 住院及手術保障	Level 1 第一級	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$500	\$600
5 Child 子女	Health and Surgical Benefits 住院及手術保障	Level 1 第一級	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$500	\$600
Subtotal MONTHLY OR YEARLY Premium 每月或每年保費					\$	\$
Subtotal Health Screening Premium (if any) 健康測科總費(如適用)					\$	\$

INITIAL PAYMENT: Yearly Initial Payment = (A) + (B) (if any) OR Monthly Initial Payment = (A) x (C) + (B) (if any)
首次付款：一年度首次保費 = (A) + (B) (如適用) 或 每月首次保費 = (A) x (C) + (B) (如適用)

1. Hospital and Surgical Benefits are only available to existing Manulife Employee Benefits outcomers or Applicants whose Employer has endorsed the plan. 住院及手術保障只為現任及前僱主之 Manulife 員工及獲僱主之 Manulife 員工之申請人提供。
2. Dental Benefits are only available to Applicants whose Employer has endorsed the plan and as a rider to the Hospital and Surgical Benefits. 牙科保障只適用於獲僱主之 Manulife 員工及獲僱主之 Manulife 員工之申請人。
3. Basic Plan 基本計劃; H+ Intermediate Plan 中級計劃; C+ Comprehensive Plan 高級計劃

PAYMENT INSTRUCTIONS 付款方法

1. The Initial Payment can be paid by making a cheque payable to "Manulife (International) Limited" or by credit card. For monthly payment mode, the Initial Payment includes the first 2 monthly premium payments, 1 monthly premium for dental purposes and the Health Screening Premium (if any). For annual payment mode, the Initial Payment includes the first year premium payment and the Health Screening Premium (if any). 首次保費可透過支票或信用卡支付。若選擇每月繳付保費，首次保費包括首兩個月的保費、牙科保費及健康測科保費(如適用)。若選擇每年繳付保費，首次保費包括首年保費及健康測科保費(如適用)。

2. For monthly payment mode, any subsequent premium will be collected by Manulife directly through the authorized person's bank account. Please complete and return the duly signed Direct Debit Authorization Form together with this Application. For annual payment mode, Manulife will bill any subsequent premium by sending a renewal invoice 48 days prior to the anniversary date. The policyowner must settle the renewal premium by cheque. 若選擇每月繳付保費，任何後續保費將由 Manulife 直接透過獲授權人士的銀行戶口扣收保費。請填妥及交回已簽署的直付授權書。若選擇每年繳付保費，Manulife 將於保費周年前 48 天寄發續保通知單及續保保費。保單持有人必須以支票繳付保費。

D. HEALTH STATEMENT 健康狀況聲明
You, as "You" as defined in the Application and herein (you and your children if applying for coverage) 閣下，是指申請人及其配偶及子女(如閣下為子女申請投保計劃)

1. Go for as "Yes", "No" or "Not Sure" (or "Not Answered") for any of the following disorders/diseases? If "Yes", please check the appropriate box below and provide the proposed medical notes and details below. 閣下請在表格上對下列疾病或病症填上「是」、「否」或「不確定」。若填上「是」，請於下列適當表格內填上「✓」號。

<input type="checkbox"/> Diseases of kidney or urinary tract 腎臟或泌尿系統疾病	<input type="checkbox"/> Any disorder of the liver, gall bladder, bowel or stomach 任何肝、膽、腸胃或胃病	<input type="checkbox"/> Spiral or muscular skeletal conditions/diseases 骨質增生或骨質疏鬆症	<input type="checkbox"/> Infection by Human Immunodeficiency Virus (HIV), AIDS or sexually transmitted disease 感染人類免疫缺陷病毒、愛滋病或性傳染病
<input type="checkbox"/> Ulcer of any kind or recurrent ulcers 任何類型的潰瘍或復發性潰瘍	<input type="checkbox"/> Arthritis of any kind 關節炎	<input type="checkbox"/> Epilepsy, stroke or paralysis 癲癇、中風或癱瘓	<input type="checkbox"/> Other chronic infectious diseases 其他慢性傳染病
<input type="checkbox"/> Cancer, tumour or growth of any kind 任何類型的癌症、腫瘤或生長物	<input type="checkbox"/> Diabetes, Leukaemia, Erythraemia 糖尿病、白血病、紅血球增多症	<input type="checkbox"/> Leukemia or other blood disorders 白血病或其他血液病	<input type="checkbox"/> Hepatitis B, C or chronic status 乙型肝炎 B 型、C 型或慢性狀態
<input type="checkbox"/> Asthma or respiratory diseases 哮喘或呼吸系統疾病	<input type="checkbox"/> Thyroid or glandular diseases 任何類型的甲狀腺病	<input type="checkbox"/> Breast disease or gynaecological conditions including abnormal pap smear test and irregular menses 乳房疾病或婦科病症，包括異常的抹片檢查結果及月經不調	<input type="checkbox"/> Chest pain, high cholesterol or any heart or blood vessel disease 胸痛、高膽固醇，或任何心臟或血管疾病

2. Have You ever been covered by medical insurance plan? 閣下是否曾購買任何醫療保險計劃?
If "YES", please provide the insurance company name and policy number below:
如有，請列明保險公司及保單號碼。

3. Have You ever been declined for life or any medical insurance application or policy, stated or restricted? If answered "Yes", please provide the proposed insured name and the reason below.
閣下是否曾被拒絕任何人士或曾被拒絕任何文憑或活期保險申請或保單？如有，請列明被保險人的姓名及有關原因。

4. Do You plan to attend, or are you currently attending or have attended in the last 5 years any hospital, clinic or doctor due to:
閣下是否計劃前往或目前正在前往或過去五年內曾前往任何醫院、診所或醫生處，原因如下：
(i) any diagnostic tests such as X-ray, ultrasonogram, blood tests, CT scan, biopsy, ECG, urine or other investigation other than for routine medical check ups only?
接受 X 光檢查、超聲波、血液測試、電腦掃描、心臟電、尿檢或其他不屬於例行的身體檢查的檢驗？
(ii) illness, operations or other medical advice or treatment not stated under any previous questions?
以上任何問題未有提及的疾病、手術、醫療意見或治療？

Please provide details if you answer "Yes" in part D.
如閣下於 D 部份填寫「是」，請提供詳細資料。

If You answered "Yes" to any of the questions above, please provide details below. If You require additional space, please use a separate page.
若以上有任何問題填上「是」，請於以下表格提供詳細資料。如有需要，請另加紙張。

Question No. 問題編號	Applicant/Dependent Name 申請人/家屬姓名	Name of Doctor 高級科名	Duration and Date (From - To) 持續日期	Result (Degree of Recovery) 治療結果(康復程度)	Name and Address of Attending Doctor and Hospital 應診醫生及醫院名稱及地址

<p>E. DECLARATION AND AUTHORISATION 聲明與授權</p> <p>I understand and agree that</p> <p>1. I have obtained the necessary authorisation from my Dependent to supply their information to Manulife if my Dependent is to be covered. I also understand that the information requested in the Application is required in order for Manulife to process this Application.</p> <p>2. Information provided herein together with any subsequent additions or supplements of it ("data") are collected to enable Manulife to carry an insurance/financial business and may be:</p> <p>(i) used by Manulife or its associated companies for the purpose of (a) approving and administering the policy or any alterations, cancellation or renewal of it; (b) underwriting and any claims or analysis of it; (c) statistical or actuarial research of Manulife, Manulife's associated companies or the insurance/financial industry; (d) providing/arranging the insurance or financial related products or services to me through insurance intermediaries or direct marketing; and/or</p> <p>(ii) transferred to (a) any related company or other company carrying an insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business or any association or federation of insurance companies that exists or is formed from time to time; (b) any processing organisation to fulfil any of the above purposes and/or for the purpose of data verification by way of matching procedures or otherwise.</p> <p>3. By writing to Manulife - Employee Benefits, I can request access to and correction of my personal data (if appropriate). I also understand that consent to the use of my personal information to offer me products and services is optional and I wish to discontinue such use. I may write to Manulife at the address shown below.</p> <p>4. I certify that all information provided by me in this Application is complete and true to the best of my knowledge and belief in applying for the Manulife (or) Medical Plan benefits, for which I am, or may become eligible. I authorise Manulife to debit my account or authorized account as directed in the Direct Credit Authorisation form.</p> <p>5. I authorise any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my Dependent to provide to Manulife any such information. A photocopy of this authorization shall be as valid as the original.</p>		<p>本人明白並同意下列各事</p> <p>1. 本人已獲得受保家屬同意提供有關資料，可向主附提供其個人資料。本人亦明白申請書內所要求的資料是處理本人投保申請所必需的。</p> <p>2. 本人於本表格內提供的資料及日後作出的任何補訂或增補的「資料」，皆在獲得主附的保險或金融業務而得以應用，而且等資料可被：</p> <p>(i) 應用於以下用途：(a) 批准及管理保單，或其續保、修訂、取消保單或續保事宜；(b) 核保及處理保險申訴；(c) 統計資料、精算分析及保險或金融業務研究；(d) 透過保險代理人或保險經紀人向本人提供或安排有關保險或金融產品或服務；以及/或</p> <p>(ii) 轉交予(a)任何有關保險或再保險業務的保險公司或保險中介人；或(b)任何提供保險或再保險業務或與保險業務有關的服務之公司；或保險經紀人、律師樓、調查或其保險或再保險業務之保險或經紀人；或在此其後組成之保險或再保險組織；(c) 對任何人士轉讓以作上述用途或以配合其他方法等資料。</p> <p>3. 本人若屬以書面通知主附的保險福利部，要求查閱及更改個人資料和服務，本人亦可向該部索取有關向本人提供服務的資料。</p> <p>4. 本人謹此聲明，本人於此項申請書所提供的一切資料均為本人所知的全部及為真確無誤。從本人同意書面通知主附停止使用該項資料，本人授權主附在本人於賬戶或銀行及支票簿中存入或扣除戶內的保險保費。</p> <p>5. 本人授權任何醫生、醫學專家、人士、醫院、診所或其其他與醫療有關的機構、保險公司或其他組織、機關或人士，將其任何關於本人及家屬的記錄或知識的資料，提供予主附。此項授權書的影印本與正本同樣有效。</p>
<p>F. CANCELLATION RIGHTS AND REFUND OF PREMIUM(S) 取消保單權益及發還保費</p> <p>I understand that I have the right to cancel and obtain a refund of any premium paid provided the service has not been used by giving written notice. Such notice must be signed by me and received directly by Manulife (International) Limited, Employee Benefits, P.O. Box 70000, Kowloon Central Post Office within the following time frame: whichever is later: (i) 21 days from the date of this Application; (ii) 16 days from the date of issue of the Policy; or (iii) 30 days from the date of delivery of the Policy. Failure to exercise the above right will be deemed as final acceptance of the policy.</p>		<p>本人明白本人有權註銷保單並發還保費，而在未使用保單任何保費的情況下，可註銷已繳保費。但本人必須書面通知主附發還保費之申請，並直接寄往地址：九龍中環郵政總局信箱70000號「主附人壽保險福利部有限公司員工福利部」。照以下時間表以書面通知主附發還保費：(i) 於此項申請書發出日期起計二十一(21)天內；(ii) 於保單發給日期起計十六(16)天內；(iii) 於保單交付日期起計三十(30)天內。倘未能行使上述權利，則表示本人最終接受此保單。</p>
<p>Date Signed 簽署日期</p>	<p>Signature of Applicant 申請人簽署</p>	<p>Signature of Applicant's Spouse 申請人配偶簽署</p>
<p>Your completed Application may be returned to your Manulife Agent or directly to Manulife (International) Limited, P.O. Box 70000, Kowloon Central Post Office. 請將填妥的申請書交予您的保險代理人或把申請書交予九龍中環郵政總局信箱70000號主附人壽保險福利部。 (國際) 有限公司。 If you have any questions regarding this application, you may also contact our customer service hotline at 2165 1222. 如對此申請有任何查詢，歡迎致電本公司客戶服務熱線 2165 1222。 The Chinese version of this form is for reference only. In the event of discrepancies between the Chinese and English versions, the English version shall prevail. 本表格之中文版本只供參考用途。如有中英文版本衝突，則以英文版本為準。</p>		

Note 注意：

- For MONTHLY MODE, the initial premium payment can be settled either by Cheque or Credit Card ONLY, any subsequent MONTHLY premium payment must be settled by autopay. For ANNUAL MODE, the initial premium payment can be settled either by Cheque or Credit Card. Any subsequent ANNUAL premium payment must be settled by Cheque. 客戶如選擇月繳保費，其首次保費可以支票或信用卡繳付，其後每月保費必須透過自動轉帳繳付。如選擇年繳保費，首次保費同樣可以支票或信用卡繳付，其後的每年保費則須以支票繳付。
- For MONTHLY MODE, you are reminded to complete the “Direct Debit Authorisation” form. Please allow 6 to 8 weeks for DDA set up to be effective. 客戶如選擇月繳保費，請填妥申請表內的《直接付款授權書》，而有關的付款安排約需六至八個星期方才生效。
- Applicant should fill in all parts of this form. Incomplete form may result in delayed processing. 投保人須填寫本表格各部份。未經填妥的表格可能會延誤申請處理過程。