

(Please initial for any amendments) 如有任何資料更改，請加以簽署作實

**PART 1 EMPLOYER INFORMATION 投保人資料**

Employer Name: 僱主名稱: \_\_\_\_\_

Policy No. - A/C No.: 保單號碼: **GI** \_\_\_\_\_ - \_\_\_\_\_  
Policy No. 保單號碼: \_\_\_\_\_ A/C No.: \_\_\_\_\_

**PART 2 EMPLOYEE PARTICULARS 僱員資料**

Full Name (Surname first): 僱員英文姓名 (以姓先填) \_\_\_\_\_  
(Same as that appearing in the HKID Card/Passport) 請按照身份證/護照之姓名填寫

Cert. No.: 證書號碼: \_\_\_\_\_  
(Ignore if assigned by Manulife) 若由宏利編定，不須填寫

Date of Birth: 出生日期: \_\_\_\_\_  
DD 日日 / MM 月月 / YY 年年

Residential Address 住宅地址: \_\_\_\_\_  
Room / Flat / Floor / Block / Name of Building / Estate 室 / 樓 / 座 / 大廈 / 屋苑名稱: \_\_\_\_\_  
Street No. / Street Name 街道號碼 / 街道名稱: \_\_\_\_\_  
District 區域: \_\_\_\_\_  
 Hong Kong 香港  Kowloon 九龍  New Territories 新界  Others 其他 \_\_\_\_\_

Country of Residence: 居住國家: \_\_\_\_\_

Sex: 性別: \_\_\_\_\_  
HKID/Passport No.: 香港身份證/護照號碼: \_\_\_\_\_

Marital Status: 婚姻狀況: \_\_\_\_\_  
 Single 單身  Married 已婚  
 Widowed 孀居  Divorced 離婚

Office Tel No. 公司電話: \_\_\_\_\_ Home Tel No. 住宅電話: \_\_\_\_\_ Pager/Mobile No. 傳呼機/手提電話號碼: \_\_\_\_\_  
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.  
閣下所提供的聯絡資料，將應用於宏利轄下於香港的公司以及為該等公司提供信託/保管服務的公司，其所提供予閣下的所有產品/服務上。  
 No, this address only applies to this certificate. 不，所提供的地址只應用於此證書。

Division: 所屬分行: \_\_\_\_\_

Occupation: 職業: \_\_\_\_\_

Salary 薪金:  Basic Monthly Salary 基本月薪  Annual 年薪  
\$ \_\_\_\_\_

(All specified amount must be in the CURRENCY OF THE GROUP. For LTD product, Basic Monthly Salary will be used in the determination of future benefits if a disability should occur)  
(所有指定金額必須為團體保險所定之貨幣。至於長期殘疾保障產品，如日後出現殘疾保障，金額將以基本月薪釐定)

Date of Employment: 受僱日期: \_\_\_\_\_  
DD 日日 / MM 月月 / YY 年年

Plan: 計劃: \_\_\_\_\_

Effective Date of Coverage: 保單生效日期: \_\_\_\_\_  
DD 日日 / MM 月月 / YY 年年

(Ignore if not applicable) 若不適用，不須填寫  
(Please refer to Eligibility stated in the Contract.) 請參閱合約的符合資格

Employee's Bank Account: (For medical claim paid by AUTOPAY only) 填寫醫療賠償以自動轉帳方式支付  
僱員戶口號碼: \_\_\_\_\_

Bank Name: 銀行名稱: \_\_\_\_\_

Bank A/C No: 戶口號碼: \_\_\_\_\_  
Bank Code: \_\_\_\_\_ Branch Code: \_\_\_\_\_ Account No.: \_\_\_\_\_

If the Country of Residence of the dependent is not same as the employee, please specify it separately. 如家屬之居住國家與僱員不同，請加以另行申報。  
Please fill in, if dependent coverage is provided. 如有家屬被保，請提供以下資料

Dependent Name (Surname first): 家屬姓名 (以姓先填)	Spouse 配偶	Son 子	Daughter 女	Date of Birth 出生日期 D 日 M 月 Y 年	HKID/Passport/Birth Cert. No. 香港身份證/護照/出生證明書號碼
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Unless the employees have proof of coverage, dependent alone is not allowed to join Voluntary Plan. In case that both the employee and his/her spouse are already covered, child alone is also accepted.  
除非僱員能夠提供受保證明，否則其家屬不能獨立購買「靈活保」計劃。除非僱員及其配偶能證明受保證明，否則其子女不可獨立購買「靈活保」計劃。

**PART 3 FOR EMPLOYEE WHO PURCHASE HEALTH SCREENING 如選擇購買健康測試請填寫以下資料**

Health Screening 健康測試  
 Basic 基本  
 Comprehensive 綜合

Annual Premium 每年保費: \_\_\_\_\_

EE 僱員	SP 配偶	Total 總額
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PART 4 FOR EMPLOYEE WHO PURCHASE MANUCHOICE 如選擇購買「靈活保」請填寫以下資料**

HOSPITAL 住院 <input type="checkbox"/> Basic 基本 <input type="checkbox"/> Comprehensive 綜合	CLINICAL 門診 <input type="checkbox"/> Basic 基本 <input type="checkbox"/> Comprehensive 綜合	DENTAL # 牙齒 _____	Employer Contribution (Y/N) 僱主資助	
			Method of contribution (50% for dependent should be the same as the employee) 僱員家屬之供款方式 (50% 必需與僱員相同)	
Annual Premium (Table 2) 每年保費 (表2): _____	Annual Premium 每年保費: _____	Annual Premium 每年保費: _____	To Employee 僱員: _____	\$ _____ or _____ %
EE 僱員	_____	_____	To Employee 僱員: _____	\$ _____ or _____ %
SP 配偶	_____	_____	To Employee 僱員: _____	\$ _____ or _____ %
CH 子女	_____	_____	To Employee 僱員: _____	\$ _____ or _____ %
CH 子女	_____	_____	To Employee 僱員: _____	\$ _____ or _____ %
CH 子女	_____	_____	To Employee 僱員: _____	\$ _____ or _____ %
CH 子女	_____	_____	To Employee 僱員: _____	\$ _____ or _____ %
Sub-Total 小計: _____	_____	_____	Grand Total 總額: _____	_____

Monthly premium 每月保費 = Grand Total 總額 x 0.09 Factor 員供比率 = \_\_\_\_\_

To select monthly premium mode, total premium must be at least HK\$2,000 on family level and complete Direct Debit Authorization form. 如選擇月供形式，每家應繳保費必須不少於港幣二千元及填妥直接扣款授權書。  
If Covered more / less than 1 year, please use Total Sum / 12 X Covered month(s) = 如保期多 / 少於一年，請用 (總金額 / 12) X 保期月份 = \_\_\_\_\_

The first payment for the individual employee and family is on pro-rata basis for the covered months from his/her individual effective date of cover to the latest ManuChoice anniversary date subject to a minimum 6 months premium payment. Otherwise, the first payment has to be paid up to the 2nd ManuChoice anniversary date. 個別僱員及其家屬的第一期款項以其個人投保生效日期起至下一次靈活保周年日為止按月份比例計算，為期至少六個月。否則，第一期款項需計算至第二個靈活保周年日一併繳交。  
Remarks: 備註: \_\_\_\_\_

The whole family must join the same plan. 僱員及其家屬之福利保障必須相同。  
# Default coverage will be purchased with ManuChoice Clinical or Hospital coverage, unless EE has Clinical or Hospital coverage in Manulife. # 除非僱員已將資料購買門診或住院保障，否則其家屬保障必須連同「靈活保」的門診或住院保障一起購買。  
@ Health Screening Coverage must be purchased with ManuChoice Clinical or Hospital Coverage. @ 健康測試服務必需連同「靈活保」的門診或住院保障一起購買。

Date Signed 簽名日期: \_\_\_\_\_

Plan Administrator Signature 計劃行政主管簽名: \_\_\_\_\_

**PART 5 EMPLOYEE HEALTH STATEMENT**

(Employee must complete on behalf of spouse and children if dependants are covered)

Most complete the following question

**僱員健康狀況聲明**

如有家屬投保必須由僱員代為填報

以下問題必須填寫

1. Insured employee Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight change during past 12 months \_\_\_\_\_  
 投保之僱員 體高 \_\_\_\_\_ CM 體重 \_\_\_\_\_ KG 過去12個月內體重之變異 \_\_\_\_\_ KG

2. Employee's spouse Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight change during past 12 months \_\_\_\_\_  
 僱員之配偶 體高 \_\_\_\_\_ CM 體重 \_\_\_\_\_ KG 過去12個月內體重之變異 \_\_\_\_\_ KG

\* You are required to be a Full-time Employee and active at your job.  
 \* 閣下必須為全職僱員及處於正常工作。

3. Have you smoked tobacco in the last 12 months?  
 在過去12個月內是否曾吸煙?  Yes  No  
 是 否

4. Have you or any dependent ever been advised to have any diagnostic test, hospital confinement or surgical operation which has not been completed?  
 閣下或貴家屬曾否受到勸告應作斷症之檢查、應往院治療或應地用手術但未照辦?  Yes  No

5. Are you or any dependent currently under observation or taking any treatment or medication?  
 閣下或貴家屬是否正接受健康觀察、治療或服用藥物?  Yes  No

6. Have you or any dependent ever been given a form of life or health insurance or ever had a policy rated, modified or renewal refused, or ever applied for or received benefits, compensation or pension because of sickness or injury?  
 閣下或貴家屬曾否投保人壽或醫療保險而被拒絕、調高保費、修訂保單權益或被拒絕續保；或曾因疾病或受傷而申請或領取保障、賠償或退休金?  Yes  No

7. Have you or any dependent ever been treated for, or diagnosed as having heart disease, high blood pressure, diabetes, lung disease, cancer, ulcer or any other disorder, or being a hepatitis B Carrier?  
 閣下或貴家屬曾否接受治療或通知存有心臟病、高血壓、糖尿病、肺病、癌症、胃潰瘍或其它症狀，或B型肝炎帶菌者?  Yes  No

8. Have you or any dependent had any operation, treatment, hospital care or medical examination in the last 5 years not mentioned above or has any been recommended?  
 閣下或貴家屬在過去五年內，曾否接受或被建議接受上述未有提及之手術、治療、留院護理或體格檢驗?  Yes  No

9. Have you or any dependent had any form of sexually transmitted disease or is there anything about your life style which could expose you to the risk of AIDS?  
 閣下或貴家屬曾否有任何性病或由於閣下的生活方式而導致有愛滋病?  Yes  No

10. Are you or any dependent suffering from AIDS? Have you had test results indicating exposure to the AIDS virus?  
 閣下或貴家屬是否患有愛滋病？或曾經驗血而患有愛滋病菌之檢查報告？  Yes  No

11. Have you ever participated or intended to participate in aviation (in any capacity other than as a passenger), racing, scuba diving, sky diving or other hazardous sports? (If yes, please complete the appropriate questionnaire)  
 閣下曾否參與或準備參與飛行（以乘客身份者除外）賽車、潛水、跳傘或其他危險運動（若“是”，請填寫有關之問卷）  Yes  No

12. Have you ever consulted a physician, even been treated for, or had any known indication of:  
 閣下曾否經醫生診斷或治療下列之症狀：  
 The musculo-skeletal system such as trauma or disorder of the muscles, bones, joints spine? Amputation, paralysis or deformity?  
 肌肉及骨骼系統包括肌肉、骨、關節及骨質曾否有任何創傷失調等毛病？有否曾經手術切除、癱瘓或殘缺？  Yes  No

**For Question 4 to 12, please provide details of each question answered "Yes". 在問題4至12答“是”者請詳細說明下列：**

Question No 問題編號	Name of Person Treated 病人姓名	Details of Ailment 疾病說明	Duration Date 治療日期 From 由 To 至	Degree of Recovery* 康復狀況*	Name and Address of Attending Doctor 診治醫生姓名及地址

\*A. Under treatment 治療中 /B. On and Off 間歇性 /C. Fully recover 完全康復

**PART 6 OPTIONAL INFORMATION (It is voluntary for you to supply the information items under this Part which may be used in conjunction with the data collected under Part 2 for the purpose of enabling our Company/associated companies to supply the information of our/their products/services to you, by the way of direct marketing or otherwise.)**

**其他資料** (閣下可自行決定是否提供本部份資料讓本公司請其與從第二期收集所得資料結合，以便本公司/關聯公司透過直接推銷或其他方式向閣下提供產品/服務資訊。)

1. Education Level:  c1-Primary or Below 小學或以下  c2-Secondary 中學  c6-Multigraded/Post Secondary 預科/專科  
 教育程度  c3-Technical Institute 工業學院  c7-College 專上學院  c4-University or Above 大學或以上

2. Monthly Personal Income (HK\$):  c10-below \$5,000以下  c15-\$5,000 to \$9,999  c20-\$10,000 to \$14,999  c25-\$15,000 to \$19,999  
 個人月入(港元)  c30-\$20,000 to \$29,999  c35-\$30,000 to \$39,999  c40-\$40,000 to \$49,999  c50-\$50,000 to \$99,999  
 c50-above \$100,000以上

3. Products/Services that you are now holding: 現時擁有之產品或服務：  
 (i) Individual Insurance 個人保險:  c01-Life 人壽保險  c06-Disability Insurance 傷殘保險  c07-Hospital/Medical 住院/醫療保險  
 (ii) Investment Products 投資產品:  c80-Stock Investment 股票投資  c81-Mutual Funds 互惠基金  c82-Fixed Deposits 定期存款

**PART 7 CERTIFICATION AND AUTHORIZATION 保證與授權**

It is understood and agreed that 本人明白並同意下列各項：

- I am obliged to supply the information required under this enrolment form which is a condition precedent for me to enroll in this policy.  
 本人有責任提供本參加表格內指定之資料，作為申請參加有關保險計劃之先決條件。
  - Information provided herein together with any subsequent alterations or supplements of it ("data") are collected to enable your company to carry on insurance business and may be:  
 本人於表格內提供之資料與任何日後作出之修訂或補充（「資料」），目的在於讓保費公司之保險業務得以順利運作，而該等資料可供  
 (i) used by your company 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 your company, your associated companies or the insurance industry; (d) sending me the products' information of your company or your associated companies; and/or  
 貴公司作以下用途：  
 (a) 批核及管理本保單、任何其後作出之修訂、取消保單或續保事宜；(b) 核保、分析及處理賠償申請；(c) 供貴公司、相關公司或保險業統計或精算研究用途；(d) 向本人郵寄貴公司或其他相關公司之產品資料。  
 (ii) transferred to (a) any related company or 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 or any association or federation of insurance companies that exists or is formed from time to time; (b) any person/organisation or my employer to fulfill any of the above purposes and/or for the purpose of data verification within the insurance industry by way of matching procedures or otherwise; and/or reinsurance of the policy  
 轉移予  
 (a) 任何相關公司；其他從事保險或再保險有關業務之公司；或現已存在或日後組成之中介、理賠、調查查或任何其他服務之供應商或由保險公司組成之聯會或組織；(b) 任何人士/機構/僱主上述用途；於保險業內以配對或其他方法核實資料；與及安排再保險。
3. I have the right to request access and correction of the data. Request can be made to your administrative office - Group Insurance Administration Department  
 本人有權向貴公司之團體保險行政辦事處要求取閱及更改有關資料。
4. I confirm that I have obtained all necessary authorizations from my dependants to supply their information to your company if dependants are covered.  
 本人確認已向所有受保家屬取得一切所需授權，可向貴公司提供其個人資料。
- I certify that all information provided by me in this form is completed and true to the best of my knowledge and belief. In applying for the Group Insurance Benefits for which I am, or may become, eligible, I authorize my employer to provide me the necessary deductions (if any) from my pay.  
 本人證明所有資料均屬真實及完全屬實。據本人所知，均完全屬實無誤，並當本人申請團體保險福利被接納時，本人授權僱主在薪冊中扣除應繳行之保費（如有需要）。  
 I authorize any licensed 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 dependants to provide to Manulife any such information. A photocopy of this authorization shall be as valid as the original.  
 本人授權任何註冊醫生、執業醫藥人員、醫院、診所或其他醫療有關之組織、保險公司或其他機構、機關或人士，將其所有關於本人及家屬之紀錄或健康情況資料，提供予富利保險，此項授權書之影印本將與正本同樣有效。

Date Signed 簽署日期 Employee Signature 僱員簽名

Note: (1) Please return the completed form to Manulife, Group Insurance Administration, 29th floor, 169 Electric Road, North Point, Hong Kong.  
 請將表格，請寄回香港北角電器道一六九號，二十九樓，富利保險-團體保險行政部。  
 (2) If there is inconsistency between the English version and the Chinese version of these terms and conditions, the English version shall prevail.  
 若本條款及細則之中/英文本有任何歧異之處，概以英文本為準。