

Policyholder Name 保單持有人名稱 _____

Policy No. 單編號 _____
Account No. 分組編號 _____

PART 1 TERMINATION OF COVERAGE 終止保障		
Employee Cert. No. 僱員證書編號	Employee Name 僱員姓名	Last Date of Employment 最後受僱日期 D日/M月/Y年

PART 2 PLAN CHANGE/SALARY CHANGE 更改計劃/薪金						
Employee Cert. No. 僱員證書編號	Employee Name 僱員姓名	Email Address 電子郵址	Revised Salary 經調整後薪金		New Plan 新計劃	Effective Date 生效日期 D日/M月/Y年
			A/M	Amount 金額		

* A - Annual, M - Monthly (All specified Salary must be in Group Currency.) * A - 年薪, M - 月薪 (團體保單所採用的貨幣單位計算)

PART 3 DEPENDENTS ADDITION 家屬新增保障						
Employee Cert. No. 僱員證書編號	Employee Name 僱員姓名	Dependent Name 家屬姓名	Relationship 關係 (SP/S/D)	Dependent's HKID/Passport/Birth Cert No. 家屬香港身份證/護照/出生證明書號碼	Date of Birth 出生日期 D日/M月/Y年	Date of Marriage 結婚日期 D日/M月/Y年

Relationship: SP - Spouse, S - Son, D - Daughter 關係: SP - 配偶, S - 兒子, D - 女兒
Evidence of Insurability is required if application is made more than 31 days after the dependent becomes eligible. 若僱員於其家屬合資格參加計劃後三十一天後才提出申請, 便需提供受保資格證明。

PART 4 DEPENDENTS TERMINATION 家屬終止保障			
Employee Cert. No. 僱員證書編號	Employee Name 僱員姓名	Dependent Name 家屬姓名	Date of Termination 終止日期 D日/M月/Y年

PART 5 OTHER CHANGES 其他更改	
Company Name Change 更改公司名稱	
With effect from 由 _____ (DD/MM/YY), the new company name is 新公司名稱是: _____	
*Please attach a copy of Business Registration Certificate. 請附上商業登記証副本	
Plan Administrator Change 更改計劃管理人	
With effect from 由 _____ (DD/MM/YY), the new plan administrator is 新計劃管理人是 _____	
*Please give the correct recipient name and title if correspondence recipient is other than the new plan administrator 如新計劃管理人並非通訊收件人, 請填寫正確收件人姓名及職銜	
Recipient Name 收件人姓名: _____	Title 職銜: _____ Email Address 電子郵址: _____
Authorized Signature Change 更改授權簽署	
With effect from 由 _____ (DD/MM/YY), the new authorized signature is 新授權簽署是: _____	
Other Changes 其他更改 (e.g. Change Company address 例如更改公司地址) *Please attach a copy of Business Registration Certificate. 請附上商業登記証副本。	
Please specify 請註明: _____	

It is confirmed and agreed that I have obtained all necessary consents from my employees to supply the above information of them and their dependents to your company. They all agree that these data can be treated by your company in the same manner as in the Employee Enrolment Form. I shall indemnify your company for any loss or expenses incurred by your company by reason of any misstatement in the above confirmation by me and/or any claim for breach of Personal Data (Privacy) Ordinance by my employee.
本人確認已取得所有僱員同意, 可向貴公司提供上述有關其與家屬之資料。他們均同意讓貴公司將該等資料與僱員福利計劃參加表格所載資料作同樣處理。本人將就任何因上述聲明出現錯誤及/或本人之僱員就違反個人資料(私隱)條例事宜提出索償而招致之費用或損失, 向貴公司作出賠償。

Date Signed 簽名日期 _____

Authorized Signature 獲授權簽署 _____

FOR OFFICE USE ONLY 只供本公司內部填寫

TXN Code: _____	Entered by: _____ / _____	Checked by: _____ / _____	Corrections/Remarks: _____
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PART 6 FOR EMPLOYEE WHO WANT TO CHANGE MANUCHOICE COVERAGE 更改「靈康保」資料

(Please complete Part 6 to Part 8 and please note changes would only be submitted 30 days before the anniversary date)
請填寫第六部份至第八部份資料，更改資料，必需在保單周年日前三十日交回。

Employee Name 僱員姓名: _____ Certificate No. 僱員編號: _____

COVERAGE CHANGE AT RENEWAL ONLY 更改保險福利只能在保單周年日

TERM LIFE 定期人壽 <input type="checkbox"/> Basic 基本 <input type="checkbox"/> Comprehensive 綜合 * For employee only	HOSPITAL 住院 <input type="checkbox"/> Basic 基本 <input type="checkbox"/> Comprehensive 綜合	SM* 附加醫療保障 <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	Health Screening @ 健康測試	DENTAL # 牙醫 #	Employer Contribution (V/N) 僱主資助
EE 僱員						To Employee 僱員:
SP 配偶	N/A					S or %
CH 子女	N/A					To Spouse 配偶:
CH 子女	N/A					S or %
CH 子女	N/A					To Each Child 每個小孩:
CH 子女	N/A					S or %
Sub-Total 小計						Grand Total 總額

Monthly Premium 每月保費 = Grand Total 總額 x 0.09 Factor 因子 = _____

Beneficiary nominated 受益人 (For Term Life Coverage only).
Name 英文姓名: _____ HK LD No. 香港身份證號碼: _____

Covered months must be in a period of 12 consecutive months. 保障期必需連續十二個月。

Remarks 備註:
To select monthly premium mode, total premium must be at least HK\$2000 on family level and complete Direct Debit Authorization form. 如選擇月保形式，每家家庭保費必須不少於港幣二千元正並請直接付款授權書。
The whole family must join the same plan. 僱員及其家屬必需選擇保障相同。
Unless the employees have proof of coverage, dependent also is not allowed to join ManuChoice Plan. In case that both the employee and his/her spouse are already covered, child also is not accepted.
僱員須備有保險保障證明，否則其家屬不能獨立購買「靈康保」計劃。除非僱員及其配偶能證明，否則其子女不能獨立購買「靈康保」計劃。
* Only those who have ManuChoice CLM Hospital plan are allowed to buy ManuChoice SM* Top-Up (RRR benefit must be \$350.00 or above). *只有選擇團體保險醫療保障計劃之成員（住家總額需達 \$350 或以上），方可參加「靈康保」之附加醫療保障計劃。
* It is not allowed to join ManuChoice Hospital Plan and ManuChoice SM* Top-Up at the same time. *不可同時參加「靈康保」的附加及醫療保障計劃。
* Dental coverage must be purchased with ManuChoice Clinical or Hospital coverage, unless EE has Clinical or Hospital coverage in Manulife. # 除非僱員已有宏利醫療門診或住院保障，否則其醫療保障必須連同「靈康保」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「靈康保」的門診或住院保障一起購買。

PART 7 HEALTH STATEMENT 健康聲明 (Employee must complete on behalf of spouse and children if dependents are covered) 如家屬均為受保人，僱員必須為配偶及子女填妥下表

- Insured employee Height 投保僱員身高 _____ Weight 體重 _____ Weight change during past 12 months 過去12個月內體重變化 _____
Insured spouse Height 投保僱員配偶身高 _____ Weight 體重 _____ Weight change during past 12 months 過去12個月內體重變化 _____
- Have you smoked tobacco in the last 12 months? Yes No
- Are any of the Insured Persons currently on medication, or consulted doctor or medical advisor, or had any operation, hospital care, medical treatment examination during the last five years?
投保人員目前或否正在接受藥物治療，或在過去五年內是否曾接受、進行手術、住院接受藥物治療？ Yes No
- Have any of the Insured Persons ever applied for life or health insurance before and if the application declined, or accepted at rates above normal?
投保人員過去是否曾申請人壽保險？申請是否曾被拒絕或所保核核保費超出正常保費？ Yes No
- Have any of the Insured Persons 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, or suffering from AIDS; or had any test results indicating exposure to AIDS virus?
投保人員過去是否曾有以下疾病或經以下病狀就醫：心臟病、高血壓、糖尿病、肺病、癌症、潰瘍或任何其他病症；或是否曾患愛滋病；或因化驗結果顯示為愛滋病帶菌者？ Yes No
- Have any of the Insured Persons had any form of sexually transmitted disease or is there anything about your life style which could expose you to the risk of AIDS?
投保人員過去是否曾患任何性傳染病？或您的生活習慣有否機會暴露您受愛滋病？ Yes No
- Have any of the Insured Persons ever participated or intended to participate in aviation (other than as a passenger), racing, scuba diving, sky diving or other hazardous sports?
投保人員是否曾參與或有意參與航空工作（不單是乘客）、賽馬、載水浮潛、延繩高空跳傘或其他危險性運動？ Yes No
- Have you ever consulted a physician, ever been treated for, or had any known indication of:
閣下曾與醫生諮詢或治療下列之症狀：
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、關節及骨質等有任何創傷失調等毛病？有否曾接受手術切除、癱瘓或殘廢？ Yes No

For Question 2 to 8, please provide details of each question answered "Yes". 在問題2至8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 至	Degree of Recovery* 康復狀況*	Name and Address of Attending Doctor 診治醫生姓名及地址
If you reply "YES" to any of the above questions, please give the name of the Insured Person and full details including duration of illness, doctor's name and address, date attended and degree of recovery on separate sheet. 如以上問題有答“是”，請另列別張提供病人姓名及患病年期、醫生姓名地址、就診日期及康復情況。					

*A. Under treatment 治療中 /B. On and Off Intermittent /C. Fully recovered 完全康復

PART 8 CERTIFICATION AND AUTHORIZATION 保証及授權

I understand and agree that

- I am obliged to supply the information required under this form which is a condition precedent for me and my dependents to enrol in ManuChoice.
- 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:
 - used by your company for the purpose of (a) approving and administering the policy or any other alteration, 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; and/or
 - transferred to (a) any related company or 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 or any association or federation of insurance companies that exists or is formed from time to time, (b) any person organization 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.
- I have the right to request access and correction of the data. Request can be made to your administrative office - Group Insurance Administration Department.
- I confirm that I have obtained all necessary authorizations from my dependents to supply their information to your company if dependents are covered.
- 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 ManuChoice benefits for which I am, or may become, eligible.
- 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 dependents to provide to Manulife any such information. A photocopy of this authorization shall be as valid as the original.

本人明白及同意

- 本人須就此申請提供一切所需有關本人及家屬之資料。
- 我在此所提供之資料及其他證明文件予貴公司就以下保險事宜所用及：
 - 貴公司用(即)核核或行使保單或其他相關事宜、取消或續保；(ii) 核保及查覆或分析；(iii) 核保公司、附屬公司及保險業作統計及核算研究之用；(iv) 為本人提供貴公司最新產品消息；及/或
 - 轉介及(如)兄弟姊妹保險公司及與保險公司或中合及/或保險及/或保險業相關之組織及工會 (b) 任何人士及/或本人之親屬及/或為達成以上事項及/或為配合在保險業內核對資料所需；和/或重新核保保單。
- 本人有權索取及更改資料，有需要可向貴保險公司行政部門提出。
- 本人授權任何獲牌照醫生、醫療保健服務提供者、醫院、診所或其他醫療相關機構、保險公司或其他組織、機構或人士，可向宏利提供有關資料，本授權書之複印本同樣有效。
- 本人授權所有擁有本人或本人家屬之紀錄及健康情況資料之註冊醫生、執業醫療保健人、醫院、診所或其他醫療保健相關機構、保險公司或其他組織、機構或人士，可向宏利提供有關資料，本授權書之複印本同樣有效。

I now enclose cheque no. _____ in the amount of HK\$ _____ payable to Manulife (International) Ltd. being the renewal payment.
本人附上港幣 \$ _____ 支票，支票號碼 _____ 支票開予宏利保險 (國際) 有限公司作為以上表保之續保款項。