Blue Cross 藍十字
An AIA Company 友邦保險成員公司

收集個人資料聲明
Personal Information Collection Statement

聯絡我們
Contact Us

個人健康記錄 - 僱員醫療保障計劃 Personal Health Record Form - Employee Medical Care Plan

每位申請加入醫療保險單內的受保人必須用英文正楷填寫此表格（父母可替子女填寫）。若未填妥交回，藍十字（亞太）保險有限公司（「藍十字」）概不處理索償。請在該受保人的保障生效日期起30天內交回藍十字。如受保僱員人數達5人或以上，則無須提交此「個人健康記錄」表格。

To be filled in **BLOCK letters** by each person included in the policy. (Parents may fill in this form on behalf of children.) No claims will be processed unless the form is duly completed and returned. Please return to Blue Cross (Asia-Pacific) Insurance Limited within 30 days from the effective date of the coverage of such insured. Submission of this Personal Health Record Form is not required if the number of insured employees is 5 or above.

(I) 個人資料 Personal Information

保單持有人／僱主名稱 Name of Policyholder/Employer			保單號碼 Policy No.
受保人（僱員／家屬）姓名（以銀行戶口姓名為準） Name of Insured (Employee/Dependant) (as shown on bank account)	出生日期（日/月/年） Date of Birth (dd/mm/yy)	性別 Sex	香港身份證／護照號碼 HKID Card/Passport No.
職業／工作性質 Occupation/Job Nature	電郵地址[1] Email Address[1]		
銀行名稱 Bank Name	銀行戶口號碼[2] Bank Account No.[2]		
僱員姓名（倘受保人是僱員家屬） Name of Employee (If Insured is a Dependant of Employee)	受保人與保單持有人／僱員之關係[3] Relationship of Insured with Policyholder/Employee[3]		
受僱日期（日／月／年） Date Joined Company (dd/mm/yy)	生效日期（日／月／年） Effective Date (dd/mm/yy)		類別 Category

1. 只接受40位或以下字母。 Maximum of 40 characters is acceptable 2. 所有受保家屬必須以同一戶口作為賠償過數之用。只接受15位數字或以下之僱員銀行戶口。 The autopay A/C No. shall apply to all dependants. Only bank account of employee with 15 digits or below is acceptable. 3. 關係 Relationship Code : E - 僱員 Employee S - 配偶 Spouse C - 子女[4] Child[4] 4. 申請公司需根據保單條款及細則中兒童的釋義，核實其參加資格。The applicant needs to verify the eligibility for enrollment in accordance with the definition of Child as stated in the Policy Terms and Conditions.

(II) 健康狀況 Health Details

1. 在過去5年內，您是否曾感染下列疾病或接受有關治療？若「是」，請於下列適當空格內劃上「✓」號。
During the last 5 years, have you suffered from or been treated for any of the following disorders/diseases?
If "Yes", please tick the appropriate items below. ☐ 是 Yes ☐ 否 No

- ☐ 腎石或腎病 Stone or kidney diseases
- ☐ 各類型潰瘍症 Ulcer of any kind
- ☐ 各類型癌症或腫瘤 Cancer or tumours of any kind
- ☐ 氣喘病或呼吸疾病 Asthma or respiratory diseases
- ☐ 精神病 Mental disorder or psychiatric problems/diseases
- ☐ 性病 Venereal diseases
- ☐ 關節炎 Arthritis
- ☐ 瘧疾 Malaria
- ☐ 痔瘡 Hemorrhoids
- ☐ 靜脈曲張 Varicose Veins
- ☐ 疝氣 Hernia
- ☐ 鼻中隔或鼻甲骨偏側 Deviated nasal septum (or turbinates)
- ☐ 姆趾外翻 Hallux Valgus
- ☐ 糖尿病 Diabetes
- ☐ 高血壓 Hypertension
- ☐ 心臟血管或循環系統疾病 Cardio Vascular or circulatory diseases
- ☐ 甲狀腺病 Thyroid Diseases
- ☐ 脊椎或肌肉及骨骼病 Spinal or muscular skeletal conditions/diseases
- ☐ 風濕熱 Rheumatic Fever
- ☐ 腦癇症 Epilepsy
- ☐ 後天免疫力缺乏症病毒感染 Infection by Human Immunodeficiency Virus (HIV)
- ☐ 痛風 Gout
- ☐ 肛瘻 Anal Fistulae
- ☐ 酗酒或藥癮 Alcoholism or drug addiction
- ☐ 乙型肝炎 Hepatitis B
- ☐ 其他 Others

只適用於女性 For Female Only：

- ☐ 婦科疾病 Gynecological conditions
- ☐ 與妊娠有關之疾病或其併發症 Diseases/complications or conditions associated with pregnancy

任何以上未提及之其他疾病，請附上詳細資料。

Please attach complete details for any other disorders/diseases not listed here.

2. 在過去5年內，您是否曾在醫院或療養院內接受手術、診察或治療？
Have you ever been in a hospital or sanitorium for surgery, observation or treatment within the last 5 years? ☐ 是 Yes ☐ 否 No

3. 您是否現正接受診察、治療或服用藥物？ Are you currently under observation or taking any treatment or medication? ☐ 是 Yes ☐ 否 No

4. 您是否曾在投保醫療、住院、意外或人壽保險時被拒絕，或有關保單曾被取消、增加保費或附加限制？如答案為「是」者，請說明原因。
Have you ever had any medical, hospitalisation, accident or life insurance application rejected or policy cancelled, rated or restricted?
If "Yes", please provide the reason(s). ☐ 是 Yes ☐ 否 No

若上述1至4項問題的答案為「是」者，請詳述於以下空格內。（若空位不足，請另頁詳加說明）
If you answered "Yes" to any of the above questions 1 to 4, please give details in the following table. (If the space provided is insufficient, please use a separate sheet.)

問題 Question	過往之健康狀況／發生日期 Medical History/Date of Occurrence	病症名稱 Diagnosis	所接受之護理及治療 Care & Treatment Received	現在的情況 Present Conditions	最近一次求診日期 Date of Last Consultation

(III) 聲明及授權 Declaration and Authorisation

本人謹此聲明並同意：

1. 上述所有問題的答案包括所有資料及細節均是準確無誤，真實及為事實之全部，並且是盡本人所知及所信而作答的。本人並沒有隱瞞任何重要資料。
2. 本人並同意所有由藍十字（亞太）保險有限公司（「貴公司」）給予受保人之賠償款項將會存入本申請書所指定之戶口內或於該戶口不存在時以支票支付，並完全解除貴公司就該些索償之一切承保責任。
3. 本人已獲受保人授權提供本申請所需之一切資料。本人並確認受保人已獲明確通知及同意，其個人資料將會轉介予貴公司作辦理本申請之用，亦已獲通知其在個人資料（私隱）條例下所享有的權利。
4. 本人確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。本人亦明白，如貴公司擬使用本人／受保人的個人資料作直接促銷，本人／受保人需要另外給予同意。

I HEREBY DECLARE AND AGREE THAT:

1. The answers to all the above questions including all information and particulars given herein are accurate, true and complete and are given to the best of my knowledge and belief. I have not withheld any material information.
2. I further agree that payment of any benefits hereunder to the Insured by Blue Cross (Asia-Pacific) Insurance Limited ("the Company") in relation to all medical claims shall be credited to the bank account as specified in this application or made by cheque in the absence of such an account, which shall constitute a full discharge on the part of the Company in relation to such claims.
3. I have obtained the authorisation from the Insured to provide the information requested in this application. I further acknowledge that the Insured has been explicitly informed and agrees that his/her personal data will be transferred to the Company for the purpose of this application and has been informed of his/her rights under the Personal Data (Privacy) Ordinance.
4. I confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form. I further understand that my/the Insured's consent will be separately obtained if the Company intends to use my/the Insured's personal data for direct marketing.

日期（日／月／年） Date (dd/mm/yy)	受保人簽署 Signature of Insured

獲授權人姓名及職位 Name & Title of Authorised Person	獲授權人簽署及公司蓋章 Signature of Authorised Person with Company Chop	日期（日／月／年） Date (dd/mm/yy)

*本個人健康記錄的中英文版本如有差異，以英文版本為準。 Should there be any discrepancy between the English and the Chinese versions of this Personal Health Record Form, the English version shall apply and prevail.