

ManuPlan Application Form
專業僱員保障計劃申請表格

Notes

- Please complete this form in BLOCK LETTERS and check the boxes where appropriate. Please certify with authorized signature and company chop for any amendments.
- Applications received by fax will not be accepted by Manulife.
- Proposal with authorized signature and any required documents should be submitted together with this form.

注意事項

- 請用正楷填寫本表格，並於適當空格內加✓號。如有任何修改，請貴公司加蓋並蓋上公司印章作實。
- 宏利將不接受以傳真遞交之申請。
- 請一併交回已獲授權人士簽署的建議書及任何需要文件。

A. EMPLOYER / APPLICANT INFORMATION 僱主 / 投保人資料

1 * Full Name of Employer (Company)/Applicant 僱主(公司)/投保人英文名稱 _____
Address 英文地址 _____

2 * Affiliated Companies 附屬公司

(a) Full Name 英文名稱 _____
Address 英文地址 _____

(b) Full Name 英文名稱 _____
Address 英文地址 _____

3 Nature of Business 業務性質

<input type="checkbox"/> c10-Construction 建築業	<input type="checkbox"/> c11-Manufacturing 製造業	<input type="checkbox"/> c12-Wholesale/Retail/Imports & Exports 批發 / 零售 / 出入口
<input type="checkbox"/> c13-Restaurants/Hotels 飲食 / 酒店業	<input type="checkbox"/> c14-Telecommunications 電訊業	<input type="checkbox"/> c15-Transport Services 運輸業
<input type="checkbox"/> c16-Banking/Finance 銀行 / 金融業	<input type="checkbox"/> c17-Insurance/Real Estate 保險 / 地產業	<input type="checkbox"/> c18-Business Services 商業服務
<input type="checkbox"/> c19-Community/Social Services 社會服務	<input type="checkbox"/> c99-Others 其他 (Please specify 請註明 _____)	

4 Does your company have any existing Group Employee Benefits Plan, either Pension or Group Life & Health including Long Term Disability, with Manulife? 貴公司現時是否有由宏利管理的團體僱員福利計劃，即公積金計劃或包括長期傷殘保障的團體人壽與醫療保險計劃?

Yes 是 Group Life & Health 團體人壽與醫療保險計劃 (Policy No. 保單編號 _____)

ORSO/MPF 公積金計劃 / 強積金計劃 (Group/Sub-Scheme No. 保單 / 附屬計劃編號 _____)

No 否

* As shown on Business Registration Certificate. 公司名稱必須與商業登記證所載相同。

B. POLICY DETAILS 保單內容

1 Effective Date of Policy 保單生效日期 DD 日 / MM 月 / YY 年	Policy Effective Period 保單生效期 <input type="checkbox"/> 1 year 年 <input type="checkbox"/> 2 years 年	Anniversary Date 保單周年日 01 / DD 日 / MM 月
2 Currency to be used for the policy (Applicable only for Life & Disability Benefit. If Medical Benefit is chosen, only HK Dollar policy will be issued.) 保單採用的貨幣單位 (只適用於人壽及傷殘保障。若選擇醫療保障，只有港元保單發出。)		
3 Premium will be paid 保費分期 <input type="checkbox"/> Monthly 每月繳費 <input type="checkbox"/> Quarterly 每季繳費 <input type="checkbox"/> Semi-annually 每半年繳費 <input type="checkbox"/> Annually 每年繳費 <input type="checkbox"/> Once Every Two Years 每兩年繳費		
4 Benefit Eligibility Requirement 參加計劃資格		
(a) Each present full-time employee shall be eligible for benefits 現已聘用的全職僱員合資格參加計劃的日期將落於		
<input type="checkbox"/> upon the effective date of the policy 保單生效日		
<input type="checkbox"/> upon fulfillment of 連續服務滿 _____ months of continuous service 個月當日		
(b) Future full-time employees shall be eligible for benefits 日後新聘的全職僱員合資格參加計劃的日期將落於		
<input type="checkbox"/> upon fulfillment of 連續服務滿 _____ months of continuous service 個月當日		
<input type="checkbox"/> upon completion of the probation period 試用期滿當日		
<input type="checkbox"/> upon the eligible date as specified in the employment letter 聘書內訂明的合資格參加計劃日期		
5 Are dependents covered? 僱員家屬是否包括於計劃內? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 (If yes, please specify the plan no. 請註明計劃編號 _____)		
6 Plan definition 計劃詳情		
Plan 計劃	Definition (In terms of position, seniority, etc; not in benefit amount) 詳情 (請註明僱員職位、年資等，而非保障額)	
_____	_____	
_____	_____	
_____	_____	
7 Benefits Type 保障類別 (Add "✓" to the selected benefit box) 於擬選擇之保障方格內加上 "✓" 號		
(a) Life & Disability Coverage 人壽及傷殘保障		
<input type="checkbox"/> Term Life 定期人壽		
<input type="checkbox"/> Accidental Death & Disablement 意外、身故及傷殘		
<input type="checkbox"/> Total and Permanent Disability 完全及永久傷殘		
<input type="checkbox"/> Total Disability Installments 完全傷殘分期		
<input type="checkbox"/> Long Term Disability 長期傷殘 (Please complete Part C in this form if this benefit is selected. 如選擇此保障，請填妥本表格C部份。)		
<input type="checkbox"/> ManuPro (Packaged Long Term Disability Income) (長期傷殘入息保障)		
(b) Medical Coverage 醫療保障		
<input type="checkbox"/> Hospital & Surgical Benefit 住院及手術保障	<input type="checkbox"/> ManuPlan medical card services 專業僱員保障計劃醫療服務卡 ("Network Providers") 「網絡供應商」	
<input type="checkbox"/> Supplementary Major Medical Benefit 附加醫療保障	<input type="checkbox"/> ManuPlan Out-patient Care 專業僱員保障計劃門診保障	
<input type="checkbox"/> Extended Medical Benefit 額外醫療保障	<input type="checkbox"/> ManuPlan Hospital & Out-patient Care 專業僱員保障計劃住院及門診保障	
<input type="checkbox"/> Maternity Benefit 產科分娩保障		
<input type="checkbox"/> Clinical 門診保障		
<input type="checkbox"/> Dental Benefit 牙科保障		



(For office use only 公司專用)
Please affix the policy no. here
請在此貼上保單編號

8 The Policy will be Non-Contributory 非供款計劃
保單形式 Contributory 供款計劃
All eligible persons must be insured. 所有合資格僱員均獲受保。
 Contributory 供款計劃
Number of employees eligible for enrolment 合資格參加計劃的僱員人數 _____
Contributory participation percentage 參加計劃成員的百分比 _____
 The employer pays _____ percent and the Employee pays _____ percent of the total premium (Note: Employer must contribute at least 50% of the total premium) or;
保費總額的百分之 _____ 由僱主支付，餘下的百分之 _____ 由僱員支付（註：由僱主支付的保費總額百分比下限為50%）或
 The employer pays all premium of the Employee benefits and the Employee pays premium of the Dependent benefits.
僱員保障的保費由僱主全數支付，而僱員家屬保障保費則由僱員支付。

9 Payment of medical claim will be done through autopay, unless otherwise requested by the employee specifically.
除僱主要求作出特別處理外，否則醫療賠償將會以自動轉帳方式支付。

C. LONG TERM DISABILITY 長期傷殘

1 Will Employees contribute towards cost? 僱員需否支付費用? Yes 需要 No 不需要

2 Pre-Disability income are to be averaged by 傷殘前入息供計算平均數 _____ month 個月

3 Benefit Amount 保險金額: _____ % of basic monthly salary not to exceed a maximum monthly benefit of \$ _____ 基本月薪之 _____ %，每月最高賠償以不超過\$ _____ 為限

4 Benefit Duration 最長賠償期：
Sickness 疾病: 2 / 5 / 10 Years 年 / to age 55 / 60 / 65 / 70 歲
Accident 意外: 2 / 5 / 10 Years 年 / to age 55 / 60 / 65 / 70 歲 or Lifetime 或終生

5 Elimination Period (Waiting Period) 等待期: 30 / 60 / 90 / 120 / 150 / 180 day 日

6 Own Occupation Period 一貫職業保障: 12 / 24 / 36 / 60 months 個月

7 Pre-existing Exclusion 不受保之已存在狀況: 3 / 6 / 12 months 個月 12 / 6 / 24 months 個月 Others 其他 _____

8 Survivor Benefit 死亡賠償保障: 3 months 月 / 1 Year 年 / 2 Years 年

9 Complications of Pregnancy Benefit 懷孕及其併發症保障: Yes 需要 No 不需要

10 Escalation Percent 通脹調整保障: 3 / 4 / 5 / 6 / 7 / 8%

11 Escalation Duration 通脹調整賠償期: 5 / 10 adjustments 調整 / full duration 全期調整

D. PLAN ADMINISTRATOR(S) 計劃管理人

The following authorized person(s)/broker is/are authorized to act on behalf of the applicant in the policy except for the receipt of benefit
下列人士/經紀獲授權代表投保人處理保單事宜，惟收取賠償除外

(a) Name 英文姓名 _____ Tel. No. 電話號碼 _____ Fax No. 傳真號碼 _____ Email Address 電郵地址 _____

(b) Name 英文姓名 _____ Tel. No. 電話號碼 _____ Fax No. 傳真號碼 _____ Email Address 電郵地址 _____

E. DECLARATION AND AUTHORIZATION 聲明及授權

*Paragraph of Part E (4), (5), (6) and (7) shall be applicable to the Applicant / Policyholder for the use of Manuplan medical services cards.
本欄第 (4), (5), (6), (7) 項適用於使用專業僱員福利計劃醫療服務卡的投保人 / 保單持有人。

THE APPLICANT/POLICYHOLDER DECLARES THAT ALL STATEMENTS AND ANSWERS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE AS OF THE DATE THIS APPLICATION IS SIGNED AND IT IS UNDERSTOOD AND AGREED THAT

1 Insurance will take effect once the Application has been accepted and the effective date approved by, and the first payment has been paid to Manulife (International) Limited. Coverage will be subject to terms of the contract.

2 All insureds must be on full-time work on the effective date of their insurance coverage under this contract. If an eligible employee is hospitalized or disabled on the date on or from which he/she would otherwise have been entitled to the Benefits under this contract, he/she shall not be entitled to any Benefits until termination of such hospital confinement or disablement and he/she returns to normal full-time employment in good health for a period of 31 consecutive days.

3 For the purpose of enabling Manulife (International) Limited or any of its associated companies (hereinafter collectively called "Manulife") to provide/promote insurance and financial services to our company and our employees through insurance intermediaries or direct marketing, we may from time to time be required to collect our employees' data and to transfer the same to Manulife. We shall undertake to follow all necessary procedures and to obtain all necessary consent from our employees to allow the said transfer of data in accordance with the Personal Data (Privacy) Ordinance. Should there be any objection/complaint from our employees in respect of the release/transfer of any information/personal data required by Manulife from time to time, Manulife shall have the right to terminate the policy being issued or any part of it and/or reject/terminate any enrolment of the relevant employees and to charge for any insurance coverage or other services provided by Manulife up to the date of termination.

4 We hereby, authorize Manulife to act on our (and the insureds) behalf to (1) arrange and appoint the registered hospitals, medical practitioners and/or other health care provider ("Network Providers") to provide medical care services to the insureds; (2) accept direct billing from Network Providers for health services rendered to the insureds; (3) establish, terminate or suspend relationship with Network Providers as necessary; (4) negotiate all related fees and arrangements with the Network Providers from time to time; and (5) recover from insureds amount for ineligible medical expenses (i.e. those excluded from or exceeded the benefit limit under the Policy) by direct billing.

5 The Applicant/Policyholder shall be fully liable to all shortfalls due to any ineligible expenses incurred by any insureds using Manuplan medical services card(s) and reimburse Manulife in full for such shortfall amounts upon receipt of invoice.

6 In any event of loss of the Manuplan medical services card(s), the Applicant/Policyholder will inform Manulife for full details within 48 hours and will pay the administrative cost for card replacement. Manulife will assume no responsibility and shall not be held liable on account for any further claim, which may arise against the Network Providers.

7 We further understand that the Applicant/Policyholder accepts all the terms and conditions in the contract provision for the use of the Manuplan medical service cards by the insureds under this Policy. In the event of individual membership termination, we shall obtain and return to Manulife all medical service cards issued to the insured member(s) and we are fully liable and agree to reimburse Manulife and the Network Providers any ineligible expenses, which arise from unreturned cards.

8 Once approved, this Application will form part of the contract between the Policyholder and Manulife (International) Limited.

9 Upon acceptance of this [application/enrolment], commission or other remuneration may be payable by Manulife to any insurance/MFP Intermediaries involved in this transaction and they are permitted to receive the same on account of their services.

投保人/保單持有人謹此聲明本投保申請書內的所有聲明及答覆為本公司於簽署本投保申請書當日所知之全部並屬真實無訛。本公司明白並同意下列各項

1 於本投保申請書被接納；保單生效日期獲批准；及宏利人壽保險(國際)有限公司妥收首期保費後，保單便隨即生效。保障範圍取決於保單合約條款。

2 所有受保人於本合約下的保障生效當日必須全職執行職務。倘任何合資格僱員於原定可享有保障之日正留院接受治療或因傷病而未能執行職務，則須待其出院或康復並於身體健康的狀態下連續執行全職職務滿三十一日後，方可享有保障。

3 本公司可能不時需要收集本公司僱員的資料並轉交予宏利人壽保險(國際)有限公司，供其或任何聯營公司(以下統稱為「宏利」)透過保險中介人或直接推廣方式向本公司或本公司僱員提供/推廣保險及理財服務之用。本公司必須遵循所有必要的程序，並根據個人資料(私隱)條例的規定，就上述資料轉交事宜取得本公司僱員同意。如本公司僱員就本公司不時接獲宏利的要求發放/轉交任何資料/個人資料提出反對/投訴，宏利有權終止已簽署的保單或取消當中任何部份，及/或拒絕終止有關僱員的任何參加計劃申請，並就宏利於保障終止日前提供的任何保障或其他服務收取費用。

4 本公司特此授權宏利代本公司(及受保人)：(一)安排及委任註冊醫院、醫生及/或其他健康護理服務供應商(「網絡供應商」)為受保人提供醫療保健服務；(二)接受網絡供應商就為受保人提供的醫療服務直接開賬；(三)在有需要時，建立、終止或暫停與網絡供應商的關係；(四)不時與網絡供應商商議所有有關收費及安排；及(五)以直接開賬方式向受保人追討不合資格的醫療開支(即不受保或超出保單保障限額之開支)。

5 投保人/保單持有人將就受保人使用專業僱員保障計劃醫療服務卡招致的不合資格醫療開支差額負上全責，並於接獲有關賬單後，向宏利全數退還差額。

6 專業僱員保障計劃醫療服務卡如有遺失，投保人/保單持有人須於四十八小時內通知宏利有關詳情並支付補領該卡的行政費用。宏利不會及毋須就其後對網絡供應商提出的索償承擔任何責任。

7 本公司同時亦明白投保人/保單持有人接納本保單合約內有關使用專業僱員保障計劃醫療服務卡之全部條款及條件。如有個別成員終止投保，本公司必須收回其所獲發之所有醫療服務卡並退回宏利，同時本公司將就任何因未退回醫療服務卡而招致之不合資格醫療開支負上全責，並且同意向宏利及網絡供應商作出賠償。

8 經批准後，本投保申請書將成為保單持有人及宏利人壽保險(國際)有限公司共同訂立的合約的部份。

9 當本[申請書/參加表格]被接納時，宏利有可能給予參與此宗交易的保險/強積金中個人佣金或其他待遇，他們現獲得許可就提供的服務接受有關的得益。

Signature of Witness 見證人簽署 _____ Authorized Signature and Company Chop 獲授權人士簽署及公司印章 _____

Date Signed 簽署日期 _____ Date Signed 簽署日期 _____

Name of Witness (in Block Letters) 見證人姓名 (請用正楷) _____ Name of Authorized Person & Title (in Block Letters) 獲授權人士姓名及職銜 (請用正楷) _____

Please return the completed form to your Manulife Agent. Our Correspondence Address: Employee Benefits, Manulife (International) Limited, P.O. Box 70302, Kowloon Central Post Office.
請把填妥的表格交予你的保險代理人。我們的郵遞地址：九龍中央郵政局郵政信箱70302號宏利人壽保險(國際)有限公司僱員福利部。

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.
本表格之中文譯本只供參考用途，若與英文版本有異，一概以英文版本為準。