

**ManuShield Application Form**  
**宏安保申請表格**
**Notes**

- Please complete this form in BLOCK LETTERS and check the boxes where appropriate. Please initial any corrections you make on this form.
- "Dependent" in this Application shall mean spouse and/or children of the Applicant.
- "Parent" in this Application shall mean parent and/or parent-in-law of the Applicant.
- Coverage will be effective on the first 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 will be subject to the terms and conditions of the Policy and at Manulife's approval.
- Applications received by fax will not be accepted by Manulife.
- Before the premium payment is received by the bank, 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✓號。如須作出任何更改，請於刪改之位置旁簽署。
- 本申請表內之"家屬"指申請人配偶及/或子女。
- 本申請表內之"父母"指申請人父母及/或僱員配偶父母。
- 保障將於以下日期後之首個月的一號生效 i) 投保申請獲宏利人壽保險(國際)有限公司("宏利") 審批後及 ii) 收到保費當日，以較後者為準。
- 保障將根據保單條款釐定及須獲公司批核。
- 宏利將不接受以傳真遞交之申請。
- 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，申請人或建議受保人必須在銀行接納所繳付保費前立即以書面通知宏利。否則，宏利將保留權利，拒絕該保單的任何索償。

**A. APPLICANT INFORMATION 申請人資料**

(As shown on HKID Card 必須與身份證相同)

 Applicant's Full Name (Surname first) \_\_\_\_\_ (in English) \_\_\_\_\_ (in Chinese)  
 申請人姓名(以姓氏先排) \_\_\_\_\_ 英文 \_\_\_\_\_ 中文

Date of Birth 出生日期 DD 日 / MM 月 / YY 年	Sex 性別	Nationality 國籍	Country of Residence 居住地 (Please complete if not in HK 若居住在香港，請無須填寫)	HKID Card No. 香港身份證號碼
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Contact Information 聯絡資料 Residential Address 住宅地址	Email Address 電郵地址
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Room/Flat/Floor/Block/Name of Building/Estate 室/樓/座/大廈/屋苑名稱	Mobile No. 手提電話
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Street No./Street Name 街道號碼/街道名稱	Office Tel No. 公司電話
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District 區域 <input type="checkbox"/> Hong Kong 香港 <input type="checkbox"/> Kowloon 九龍 <input type="checkbox"/> New Territories 新界 <input type="checkbox"/> Others 其他 _____	Home Tel No. 住宅電話
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The contact information applies to all of your existing products/services in Hong Kong and Macau provided by all companies within the Manulife group of companies and also companies which provide trustee/custodian services. If you are a member of any provident fund scheme(s) administered by Manulife, any information provided here will (unless otherwise stated below) be treated as an instruction to register above address as the registered residential address under the scheme(s). Any residential address(es) previously registered under the scheme(s) will be superseded accordingly.

閣下所提供的聯絡資料，適用於閣下現時持有並由宏利集團旗下公司，以及為本公司提供信託/託管服務的公司在香港及澳門所提供的產品/服務上。如閣下是宏利管理的公積金計劃成員，於此部份填寫的資料(除以下作出其他指示外)將視為給予本公司的指示，要求把以上地址作為閣下於宏利公積金計劃內的登記住宅地址，並取代以往於計劃內的所有登記住宅地址。

To apply above address to this certificate only, please "✓" this box. 如以上地址只適用於此證書，請在方格內填上「✓」號。

Occupation / Job Duties <sup>^</sup> (Please specify % of time spent on manual work) 職業/工作職務 <sup>^</sup> (請說明體力勞動工作佔工作職務時間的百分比) ( % )	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單編號 (如適用)
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<sup>^</sup> If you do not provide any information for the occupation / job duties here, it is deemed that you are a clerical worker with no time spent on manual work. If the space provided is insufficient, you can provide further descriptions on separate sheet. 如閣下沒有在此欄提供職業/工作職務資料，則視作閣下從事文職工作，當中沒有任何體力勞動工作的成分。閣下可自行以附頁提供更多有關閣下的職業/工作職務的資料。

**B. FAMILY INFORMATION 家庭成員資料** (Please list all Dependents / Parents applying for coverage. 請填寫擬申請投保之所有家屬 / 父母。)

Proposed Insured <sup>+</sup> 建議受保人 <sup>+</sup>	Name of Proposed Insured (Surname first) 建議受保人姓名 (以姓氏先排)	Occupation 職業	Country of Residence 居住地 <sup>▲</sup> (Please complete if not in HK 若居住在香港，請無須填寫)	HKID Card 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， 請列出每日的 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		
										Gain (kg) 上升 (公斤)	Loss (kg) 下降 (公斤)	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												
6 Parent 父母												
7 Parent 父母												

<sup>+</sup> Please make sure that your Country of Residence is up-to-date in Manulife's Employee Benefits' Group policy record as that will determine the destination of any emergency evacuation or repatriation services under the policy.

請確保閣下於宏利僱員福利團體保障計劃內受保人的居住地資料為正確無誤。如遇上緊急事故，宏利將以此資料作為有關之撤離或遣返安排之目的地。

<sup>▲</sup> An eligible Applicant must be actively at work, hold a HKID card and at least 18 but not yet 60 years of age. Coverage is available to the Applicant's spouse and parent who is 18 to 60 and any unmarried child(ren) provided they are at least 15 days to 18 years old, or age 19 to 22 if attending school or university on a full-time basis. 申請人必須是在職人士，年滿十八歲但未足六十歲且持有香港身份證。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，如屬全日制學生，則須介乎十九至二十二歲。

**C. PLAN CHOICE 投保計劃** (Please circle the coverage unit of benefit applied for. 請圈出投保計劃的保障單位。)

Proposed Insured 建議受保人	#Personal Accident 個人意外保障 HK\$ 250,000 per unit (單位)				#Critical Illness 危疾保障 HK\$ 100,000 per unit (單位)				#Term Life 定期人壽 HK\$ 100,000 per unit (單位)				Monthly Premium 每月保費	Health Screening (Optional) 健康測試 (自行選擇) Please circle the applicable premium 請圈出適當金額	
	1	2	3	4	1	2	3	4	1	2	3	4		Basic 基本	Comprehensive 綜合
1 Applicant 申請人	1	2	3	4	1	2	3	4	1	2	3	4	\$	\$760	\$1060
2 Spouse 配偶	same as Applicant's coverage 相等於申請人的保障												\$	\$760	\$1060
3 Child 子女	equal to 20% of Applicant's coverage 相等於申請人保障的20%												\$	\$760	\$1060
4 Child 子女	equal to 20% of Applicant's coverage 相等於申請人保障的20%												\$	\$760	\$1060
5 Child 子女	equal to 20% of Applicant's coverage 相等於申請人保障的20%												\$	\$760	\$1060
6 Parent 父母	same as Applicant's coverage 相等於申請人的保障												\$	\$760	\$1060
7 Parent 父母	same as Applicant's coverage 相等於申請人的保障												\$	\$760	\$1060

<sup>#</sup>No. of unit purchased on Critical Illness or Term Life should not be more than that of Personal Accident benefit. Expect for Child coverage (which will be equal to 20% of the Applicant's coverage), coverage for all proposed insured must be the same as that for the Applicant, subject to underwriting condition that applies.

危疾保障或定期人壽的購買單位不可超過個人意外保障的購買單位數目。除子女保障相等於僱員保障的20%外，其他建議受保人之保障應與僱員相同，惟因指定核保情況除外。

Subtotal Monthly Premium 每月總保費 (A) \$ (B)

Subtotal Health Screening Premium (if any) 健康測試總費用(如適用)  
INITIAL PAYMENT 首期保費 = ((A) x 3) + (B) (if any)(如適用) \$



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

**PAYMENT INSTRUCTIONS 付款方法**

- Please provide a cheque made payable to "Manulife (International) Limited" for the Initial Payment, which includes the first 2 monthly premium payments, 1 monthly premium for deposit purposes and the Health Screening Premium (if applicable). 首期保費，包括兩個月保費、一個月按金及健康測試費用(如適用)，請以支票付款，抬頭請寫「宏利人壽保險(國際)有限公司」。
- 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. 宏利將直接於指定人士的銀行賬戶收取往後的保費。請填妥及簽署直接付款授權書，然後一併交回。

**D. HEALTH STATEMENT 健康狀況聲明**

The following questions must be completed by the Applicant and his / her spouse and parents if applying for coverage. Applicant should complete the questions and sign on behalf of his / her children if they are covered. 以下問題必須由申請人及其配偶及父母填寫(如配偶及父母同時投保本計劃)。如申請家屬保障，申請人須代其子女填寫。  
 "You" and "Your" is defined as the Applicant and his / her dependents and parents if applying for coverage.  
 「閣下」是指申請人及其家屬及父母(如家屬及父母同時投保本計劃)。

1 So far as You know, have You ever had or been treated for any of the following disorders/diseases? If "Yes", please check the appropriate box below and provide the proposed insured's name and details below. 就閣下所知，閣下曾否患上下列疾病或接受有關治療？如「有」，請於下列適當空格內劃上「✓」號。

<input type="checkbox"/> Disease of kidney or urinary tract 腎臟及泌尿系統疾病	<input type="checkbox"/> Any disorder of the liver, gall bladder, bowel or stomach 任何肝、膽或腸胃疾病	<input type="checkbox"/> Spinal or muscular skeletal conditions/diseases 脊椎或肌肉或骨骼疾病	<input type="checkbox"/> Infection by Human Immunodeficiency Virus(HIV), AIDS or sexually transmitted disease 人類免疫力缺乏症病毒感染或愛滋病或其他性病
<input type="checkbox"/> Ulcer of any kind 任何類型的潰瘍症	<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"/> Hepatitis B, C or carrier status 乙型或丙型肝炎或其帶菌者
<input type="checkbox"/> Cancer, tumour or growth of any kind 任何類型的癌症、腫瘤或組織增生	<input type="checkbox"/> Systemic Lupus Erythematosus 紅斑狼瘡症	<input type="checkbox"/> Leukemia or other blood disorders 壞血病或其他與血液有關的疾病	<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
<input type="checkbox"/> Asthma or respiratory diseases 哮喘病或呼吸系統疾病	<input type="checkbox"/> Diabetes 糖尿病	<input type="checkbox"/> Breast disease or gynaecological conditions including abnormal pap smear test(s) and irregular menses 乳房疾病或婦科疾病,包括柏氏塗片檢查異常及月經失調	
<input type="checkbox"/> Depression or any other mental illness 抑鬱及其他精神病	<input type="checkbox"/> Hypertension 高血壓		
	<input type="checkbox"/> Thyroid or glandular disease 甲狀腺或內分泌疾病		

2 Have You ever been covered by medical insurance plan? 閣下曾否購買任何醫療保險計劃？  
 If "Yes", please provide the insurance company name and policy number below.  
 如有，請列出保險公司的名稱及保單的編號：

3 Have You ever been declined for life or any medical insurance application or policy rated or restricted? If answered "Yes", please provide the proposed insured name and the reason below.  
 閣下曾否被拒絕投保任何人壽或醫療保險？又或曾否被調高保費或修訂保單？如有，請列出建議受保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:  
 閣下過去五年曾否或現正或計劃因下述事宜到醫院、診所或向醫生求診：  
 i) any diagnostic tests such as X-ray, ultrasonogram, blood test(s), CT scan, biopsy, ECG, urine or other investigation other than for routine medical check purpose?  
 接受X光檢查、超聲波、血液測試、電腦掃描、活組織檢驗、心電圖、尿液或其他不屬於例行身體檢查的檢驗？  
 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、醫療意見及治療？

Applicant 申請人		Spouse 配偶		Children 子女		Parent 父母	
Yes 是	No 否	Yes 是	No 否	Yes 是	No 否	Yes 是	No 否
<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"/>	<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"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If You answered "Yes" to any of the questions above, please provide details below. If You require additional space, please use a separate page. 如以上有任何答案為「是」，請於以下空格提供詳細資料。如有需要，請另加紙張。

Question No. 問題編號	Applicant/Dependent/Parent Name 申請人/家屬/父母姓名	Nature of Disorder 疾病性質	Duration and Date (From - To) 持續日期	Result (Degree of Recovery) 診治結果(康復程度)	Name and Address of Attending Doctor and Hospital 應診醫生及醫院名稱及地址

**E. DECLARATION AND AUTHORIZATION 聲明與授權**

It is understood and agreed that  
 1 I have obtained the necessary authorization 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.  
 2 Information provided herein together with any subsequent alterations or supplements of it ("data") are collected to enable Manulife to carry on its insurance/financial business and may be:  
 (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/promoting the insurance or financial related products or services to me through insurance intermediaries or direct marketing; and/or  
 (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/organization to fulfill any of the above purposes and/or for the purpose of data verification by way of matching procedures or otherwise.  
 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 if I wish to discontinue such use I may write to Manulife at the address below.  
 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 ManuShield benefits, for which I am, or may become eligible, I authorize Manulife to debit my account or authorized account as directed in the Direct Debit Authorization Form.  
 5 I authorize 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.  
 6 It is for the benefit and use of any parent insured that any benefit payable under the policy applied for by reason of the death of the insured parent will be paid to the Applicant and the insured parent's coverage is being applied for.  
 7 Upon acceptance of this [application/enrolment], commission or other remuneration may be payable by Manulife to any insurance/MPF Intermediaries involved in this transaction and they are permitted to receive the same on account of their services.

本人明白並同意下列各項  
 1 本人已向所有受保家屬取得授權(如適用)，可向宏利提供其個人資料。本人亦明白申請表內提供的資料是讓宏利作處理本人投保申請之用。  
 2 本人於本表格內提供之資料及日後作出之任何修訂或補充(「資料」)，旨在確保宏利的保險業務得以順利運作，而該等資料可供：  
 (i) 宏利作以下用途：(a) 批核及管理本型單，或其後進行任何修訂、取消保單或續保事宜；(b) 核保、分析及處理賠償申請；(c) 供宏利、聯營公司或保險業作統計或精算研究用途；(d) 透過保險中介人或直接推廣方式向本人提供/推廣宏利或聯營公司之產品資料；及/或  
 (ii) 轉交予(a)任何有關連公司；其他從事保險或再保險有關業務之公司；或保險業中介人、提供理賠、調查或其他保險相關服務之供應商或現時已存在或日後組成之保險公司聯會或組織；(b)任何人士/機構以作上述用途及/或以配對或其他方法核實資料。  
 3 本人有權以書面通知宏利的僱員福利部，要求索閱及更改個人資料(如需要)。本人亦可致函要求宏利不要向本人寄發宣傳推廣資料。  
 4 本人謹此證明，本人於投保申請書所提供的一切資料為本人所知的全部及真確無誤。如本人就宏安保的投保申請獲接納，本人授權宏利在本人的賬戶或直接付款授權書所示的指定賬戶內扣除保費。  
 5 本人授權任何醫生、醫學界執業人士、醫院、診所或其他與醫療有關的機構、保險公司或其他組織、機關或人士，將其所有關於本人及家屬的記錄或健康狀況資料，提供予宏利。此項授權書的影印本與正本同樣有效。  
 6 受保父母之保障申請是為受保父母之使用而申請，有關利益包括將受保父母之身故賠償金額付予申請人。  
 7 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/強積金中介人佣金或其他待遇，他們現獲得許可就提供的服務接受有關的得益。

**F. CANCELLATION RIGHTS AND REFUND OF PREMIUM(S) 取消保單權益及發還保費**

I understand that I have the right to cancel and obtain a refund of any premium(s) paid by giving written notice. Such notice must be signed by me and received directly by Manulife (International) Limited, Employee Benefits, P.O. Box 70302, Kowloon Central Post Office within 21 days after the delivery of the policy or issue of a notice to the policyholder or the policyholder's representative, whichever is the earlier.  
 本人明白本人有權以書面通知要求取消保單及取回所有已繳保費；但是本人必須簽署該通知，並確保宏利(地址：九龍中央郵政局郵政信箱70302號「宏利人壽保險(國際)有限公司僱員福利行政部」)於以下時段內直接收到該通知：保單交予本人或本人的代表後或《通知書》發予本人或本人的代表後，起計的21天，以較先者為準。

Date Signed 簽署日期	Signature of Applicant 申請人簽署	Signature of Insured Spouse 配偶受保人簽署
Date Signed 簽署日期	Name & Signature of Insured Parent 父母受保人簽署	Name & Signature of Insured Parent 父母受保人簽署

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。