

For Office Use Only 公司專用

Agent Name & Code/Branch 代理人姓名及編號/分行: _____

Policy Number 保單編號: _____

Certificate Number 證書編號: _____

Effective Date of Coverage 保障生效日期: _____

ManuChoice⁺ Medical Plan Application
自選醫療保障計劃申請書

Notes

- Please complete this form in BLOCK LETTERS and check the boxes where appropriate. Please initial next to any corrections you make on this form.
- "Dependent" in this Application shall mean spouse and/or unmarried child(ren) of the Applicant who is/are resident(s) in Hong Kong.
- Coverage will be effective on the 1st 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 is subject to the terms and conditions of the Benefit Schedule and the Policy Provisions.
- Applications received by Manulife by fax will not be accepted.
- Before the bank receives premium payment, 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，並於適當空格內加上✓號。如須作出任何更改，請於刪改之處另加簽作實。
- 本投保申請書內所載「家屬」一詞是指申請人居港配偶及/或未婚子女。
- 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。
- 保障範圍須受賠償表的條款及條件以及保單條文所規限。
- 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)
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 No. 香港身份證號碼 ()

Contact Information 聯絡資料 Residential Address 住宅地址 E-mail Address 電郵地址 @

Room/Flat/Floor/Block/Name of Building/Estate 室/樓/座/大廈/屋苑名稱 Mobile No. 手提電話

Street No./Street Name 街道號碼/街道名稱 Office Tel No. 公司電話

District 區域 Home Tel No. 住宅電話

Hong Kong 香港 Kowloon 九龍 New Territories 新界 Others 其他

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。

Applicant's Bank Account (For medical claim reimbursement purpose) 申請人銀行賬戶 (用以存入醫療索償金額)

Bank Name 銀行名稱 Bank Account Number 銀行賬戶號碼

Has your Employer endorsed this plan? 閣下的僱主是否已核准這個計劃?

Yes, please provide your Employer name.

是，請提供貴公司的名稱。

No

否

Are you actively at work? 現時是否在职人士?

Yes 是

No 否

Occupation / Job Duties^A (Please specify % of time spent on manual work)

職業/工作職務^A (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)

^A 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 applying for coverage 請填寫擬申請投保之所有家屬

Proposed Insured * 建議受保人*	Name of Proposed Insured (Surname first) 建議受保人姓名 (以姓氏先排)	Country of Residence 居住地# (Please complete if not in HK 若居住在香港, 請無須填寫)	HKID 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										

* 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. 請確保閣下備存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。

* An eligible Applicant must be actively at work, hold a HKID card and at least 18 but not yet 65 years of age. Dependent coverage is available to the Applicant's spouse who is 18 to 64 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，年滿十八歲但未足六十五歲並且持有香港身份證。計劃亦為申請人的家屬提供保障，惟投保配偶的年齡須介乎十八至六十四歲，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。



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Please affix the policy no. here

請在此貼上保單編號

C. PLAN CHOICES 投保計劃 請圈出投保計劃的保障類別及其保障級別。家屬申請之保障類別及其保障級別必須與申請人相同。

Please circle the benefit type and level of coverage applied for. Dependents applying for coverage must apply for the same benefit type and level of coverage as the Applicant.

Proposed Insured 建議受保人	Hospital and Surgical Benefits* 住院及手術保障*	Clinical Benefits 門診保障	Dental Benefits** 牙科保障**	Premium (HK\$) 每期保費 (港幣) (Please put a "✓" in the applicable box 請在適當位置寫上"✓"號) <input type="checkbox"/> Annual Mode 年繳形式 OR 或 <input type="checkbox"/> Monthly Mode 月繳形式 Note: For monthly mode, please complete the attached Direct Debit Authorisation Form 注意: 若選擇月繳保費形式, 請填寫附上的直 接付款授權書。	Health Screening (Optional) 健康測試(自行選擇) Please circle the applicable premium (HK\$) 請圈出適用金額(港幣)	
					Basic 基本	Comprehensive 綜合
1 Applicant 申請人	B / I / C***	B / I / C***	Yes 是 / No 否	\$	\$760	\$1060
2 Spouse 配偶				\$	\$760	\$1060
3 Child 子女				\$	\$760	\$1060
4 Child 子女				\$	\$760	\$1060
5 Child 子女				\$	\$760	\$1060
Subtotal MONTHLY OR YEARLY Premium 每月或每年保費				\$ (A)		
				Subtotal Health Screening Premium (if any) 健康測試總費用 (如適用)		\$ (B)
INITIAL PAYMENT: Yearly Initial Payment = (A) + (B) (if any) OR Monthly Initial Payment = ((A) x 3) + (B) (if any) 首期保費: 年繳首期保費 = (A) + (B) (如適用) 或 月繳首期保費 = ((A) x 3) + (B) (如適用)						\$

* Hospital and Surgical Benefits are only available to existing Manulife Employee Benefits customers or Applicants whose Employer has endorsed the plan. 住院及手術保障只為現有的宏利僱員福利客戶或僱主核准計劃之申請人提供。

** Dental Benefits are only available to Applicants whose Employer has endorsed the plan and as a rider to the Hospital or Clinical Benefits. 牙科保障只適用於僱主核准計劃之申請人作為住院或門診保障之附加保障。

*** B = Basic Plan 基本計劃, I = Intermediate Plan 精選計劃, C = Comprehensive Plan 綜合計劃

PAYMENT INSTRUCTIONS 付款方法

- The Initial Payment can be paid by making a cheque payable to "Manulife (International) Limited" or by credit card. For monthly payment mode, the Initial Payment includes the first 2 monthly premium payments, 1 monthly premium for deposit purposes and the Health Screening Premium (if applicable). For annual payment mode, the Initial Payment includes the first year premium payment and the Health Screening Premium (if any). 請以支票或信用卡繳付首期保費, 支票抬頭請寫「宏利人壽保險(國際)有限公司」。選擇月繳形式, 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)。選擇年繳形式, 首期保費包括第一年保費及健康測試費用(如適用)。
- For monthly payment mode, any subsequent premium will be collected by Manulife directly through the authorised person's bank account. Please complete and return the duly signed Direct Debit Authorisation form together with this Application. For annual payment mode, Manulife will bill any subsequent premium by sending a renewal invitation 40 days prior to the anniversary date. The policyowner must settle the renewal premium by cheque. 如選擇月繳形式, 宏利將直接於指定人士的銀行賬戶收取往後的保費。請填妥及簽署隨申請書附上的直接付款授權書。如選擇年繳形式, 宏利將於保單週年日前四十天前寄發出續保邀請書收取續保保費, 保單持有人必須以支票繳費。

D. HEALTH STATEMENT 健康狀況聲明

"You" or "Your" is defined as the Applicant and his/her spouse and child(ren) if applying for coverage. 「閣下」是指申請人及其配偶及子女(如配偶及子女同時投保本計劃)

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"/> Ulcer of any kind 任何類型的潰瘍症 <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"/> Asthma or respiratory diseases 哮喘病或呼吸系統疾病 <input type="checkbox"/> Depression or any other mental illness 抑鬱及其他精神病	<input type="checkbox"/> Any disorder of the liver, gall bladder, bowel or stomach 任何肝、膽疾病或腸胃疾病? <input type="checkbox"/> Arthritis of any kind 關節炎 <input type="checkbox"/> Systemic Lupus Erythematosus 紅斑狼瘡症 <input type="checkbox"/> Diabetes 糖尿病 <input type="checkbox"/> Hypertension 高血壓 <input type="checkbox"/> Thyroid or glandular disease 甲狀腺病或內分泌疾病	<input type="checkbox"/> Spinal or muscular skeletal conditions/diseases 脊椎或肌肉或骨骼疾病 <input type="checkbox"/> Epilepsy, stroke or paralysis 癲癇, 中風或癱瘓 <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"/> 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"/> Infection by Human Immunodeficiency Virus(HIV), AIDS or sexually transmitted disease 感染人類免疫力缺乏症病毒或愛滋病或 其他性病 <input type="checkbox"/> Hepatitis B, C or carrier status 乙型或丙型肝炎病毒或其帶菌者 <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	Applicant 申請人 Yes 是 No 否	Spouse 配偶 Yes 是 No 否	Children 子女 Yes 是 No 否
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: _____				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
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. 閣下曾否被拒投保任何人生或醫療保險? 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。				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
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、心电图、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?				<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.

Question No. 問題編號	Applicant/Dependent Name 申請人/家屬姓名	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 AUTHORISATION 聲明與授權

<p>It is understood and agreed that</p> <p>1 I have obtained the necessary authorisation 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.</p> <p>2 Information provided herein together with any subsequent alterations or supplements of it ("data") are collected to enable Manulife to carry on insurance/financial business and may be:</p> <p>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</p> <p>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.</p> <p>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 shown below.</p> <p>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 the ManuChoice+ Medical Plan benefits, for which I am, or may become eligible, I authorise Manulife to debit my account or authorised account as directed in the Direct Debit Authorisation form.</p> <p>5 I authorise 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 authorisation shall be as valid as the original.</p> <p>6 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.</p> <p>7 I undertake that if there is any change in the information provided, I shall notify your Company as soon as reasonably practicable.</p> <p>8 I confirm that I am not acting on behalf of another person/entity in making this application.</p>	<p>本人明白並同意下列各項</p> <p>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。</p> <p>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或金融業務得以順利運作,而該等資料可供</p> <p>i) 宏利作以下用途:(a)批核及管理本保單,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/金融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保險或金融產品資料;及/或</p> <p>ii) 轉交予(a)任何有關連公司;其他從事與保險或再保險有關業務之公司;或保險業中介人、提供理賠、調查或其他保險業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。</p> <p>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。</p> <p>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為真確無誤。如本人就自選醫療保障計劃的投保申請獲接納,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。</p> <p>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。</p> <p>6 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。</p> <p>7 本人承諾假使所提供的資料有任何更改,本人將於合理的切實可行範圍內盡快通知貴公司有關之改動。</p> <p>8 本人確認並非代表其他人士/實體而作出此申請。</p>
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F. CANCELLATION RIGHTS AND REFUND OF PREMIUM(S) 取消保單權益及發還保費

<p>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.</p>	<p>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。</p>
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G. OTHER SUPPLEMENTARY DOCUMENTS 其他附加文件

<p>The following documents are enclosed with this application 申請附有文件:</p>	
<p><input type="checkbox"/> Applicant's copy of Hong Kong Identity Card 申請人的香港身份證副本</p>	
<p><input type="checkbox"/> Proof of residential address 住址證明副本 (Copy of mobile phone bill, utility bill, bank statement or recognized financial institution statement of recent 3 months 在最近三個月內發出的流動電話結單,公用事業帳單,銀行結單或認可之金融機構結單)</p>	

Date Signed 簽署日期

Signature of Applicant 申請人簽署

Signature of Applicant's Spouse 申請人配偶簽署

Your completed Application may be returned to your Manulife Agent or directly to Manulife (International) Limited, P.O. Box 70302, Kowloon Central Post Office.

請把填妥的表格直接交予您的保險代理人或把表格寄交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。

If you have any questions regarding this application, you may also contact our customer service hotline at 2108 1222. 如就此申請有任何查詢,歡迎致電本公司客戶服務熱線 2108 1222。

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。

Note: The Direct Debit Authorisation is applicable for monthly payment mode only.
注意: 直接付款授權只適用於按月供款

Date 日期	dd日 / mm月 / yyyy年

DIRECT DEBIT AUTHORISATION 直接付款授權書

Name of Party to be Credited (<i>The Beneficiary</i>) 收款的一方 (受益人) Manulife (International) Limited 宏利人壽保險 (國際) 有限公司	Bank No. 銀行號碼 0 3 5	Branch No. 分行號碼 8 0 2	Account No. 戶口號碼 8 6 9 3 0 8 0 0 1
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- I/We hereby authorise my/our below named Bank to effect transfer from my/our account to that of the above named beneficiary in accordance with such instructions as my/our Bank may receive from the beneficiary and/or its banker from time to time provided always that the amount of any one such transfer shall not exceed the limit indicated below.
本人/本人等現授權本人/本人等的下述銀行, 根據受益人或其往來銀行不時給予本人/本人等銀行的指示, 自本人/本人等的戶口內轉賬予上述受益人, 惟每次轉賬金額不得超過以下指定的限額。
- I/We agree that my/our Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me/us.
本人/本人等同意本人/本人等的銀行毋須證實該等轉賬通知是否已交予本人/本人等。
- I/We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our account which may arise as a result of any such transfer(s).
如因該等轉賬而令本人/本人等的戶口出現透支(或令現時的透支增加), 本人/本人等願共同及各別承擔全部責任。
- I/We agree that should there be insufficient funds in my/our account to meet any transfer hereby authorized, my/our Bank shall be entitled, in its discretion, not to effect such transfer, in which event the Bank may make the usual charge and that it may cancel this authorisation at any time on one week's written notice.
本人/本人等同意如本人/本人等的戶口並無足夠款項支付該等授權轉賬, 本人/本人等的銀行有權不予轉賬, 且銀行可收取慣常的收費, 並可隨時以一星期書面通知取消本授權書。
- This direct debit authorisation shall have effect until further notice or until the expiry date written below (whichever shall first occur). I/We agree that if no transaction is performed on my/our account under such authorisation for a continuous period of 2 years, my/our Bank reserves the right to cancel the direct debit arrangement without prior notice to me/us, even though the authorisation has not expired or there is no expiry date for the authorisation.
本直接付款授權書將繼續生效直至另行通知為止或直至下列到期日為止(以兩者中最早的日期為準)。本人/本人等同意如本人/本人等已設立的直接付款授權的戶口連續兩年內未有根據本授權而作出過賬的記錄, 本人/本人等的銀行保留權利取消本直接付款安排而毋須另行通知本人/本人等, 即使本授權書並未到期或未有註明授權到期日。
- I/We agree that any notice of cancellation or variation of this authorisation which I/we may give to my/our Bank shall be given at least two working days prior to the date on which such cancellation/variation is to take effect.
本人/本人等同意, 本人/本人等取消或更改本授權書的任何通知, 須於取消/更改生效日最少兩個工作天之前交予本人/本人等的銀行。

For Manulife Admin Use Only 宏利行政部門專用	Debtor's Reference 債務人備註 (Policy Number 保單編號)

My/Our Bank Name and Branch 本人/本人等的銀行及分行的名稱	Bank No. 銀行號碼	Branch No. 分行號碼	My/Our Account No. 本人/本人等的戶口號碼
#My/Our Name(s) as recorded on Statement/Passbook #本人/本人等在結單/存摺上所紀錄的名稱			Contact Telephone No. 聯絡電話號碼
Limit for Each*Payment/Month *每次/月付款的限額	Expiry Date (day/month/year)(Note 1) 到期日(日/月/年)(附註1)	My/Our Signature(s) (Note 2) 本人/本人等的簽署(附註2)	

* Please delete whichever is not appropriate. 請刪去不適用者。
Please write in BLOCK LETTERS. 請以英文正楷填寫。

Notes 附註:

- You are recommended to leave this box blank to have the Direct Debit Authorisation effect indefinitely (or until cancelled by you). This Direct Debit Authorisation will be cancelled automatically on the date included in this box.
我們建議閣下將此欄留空, 使直接付款授權書無限期有效(或直至閣下予以撤銷為止)。本直接付款授權書將按此欄所填寫的日期自動撤銷。
- Please ensure that you sign the form in the usual way that you would sign on your Bank Account.
請保證閣下在此授權書內的簽名與銀行戶口所簽者完全相同。
- Manulife reserves the right to either cancel authorisation if there is insufficient fund in the debtor's account or to request for a premium mode change.
上述賬戶持有人之戶口若無足夠款項時, 宏利將保留取消直接付款授權的權利, 或要求該保戶更改其支付保費之方式。
- If "Limit for Each Payment/Month" is not specified, the debtor's bank will set the limit as "unlimited".
如「每次/月付款的限額」一欄未有填上, 債務銀行會將轉賬限額設定為「不設上限」。

For Bank Use Only 銀行專用	Signature Verified 簽署核實
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For Office Use Only 公司專用
Insurance Advisor's Name 保險顧問姓名 _____ Insurance Advisor's Code 保險顧問編號 _____ Location 地點 _____ The autopay debit will be processed at midnight (0:00am) on the payment date (14 th of each month) or if such date falls on a non-banking day, the following banking day. 自動轉賬將於每月十四日為付款日期之凌晨零時進行。如該日為銀行假期, 則順延至下一個銀行工作天。

Completed form should be sent to Manulife (International) Limited, P.O. Box 70302, Kowloon Central Post Office.
請把填妥的表格寄交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。

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