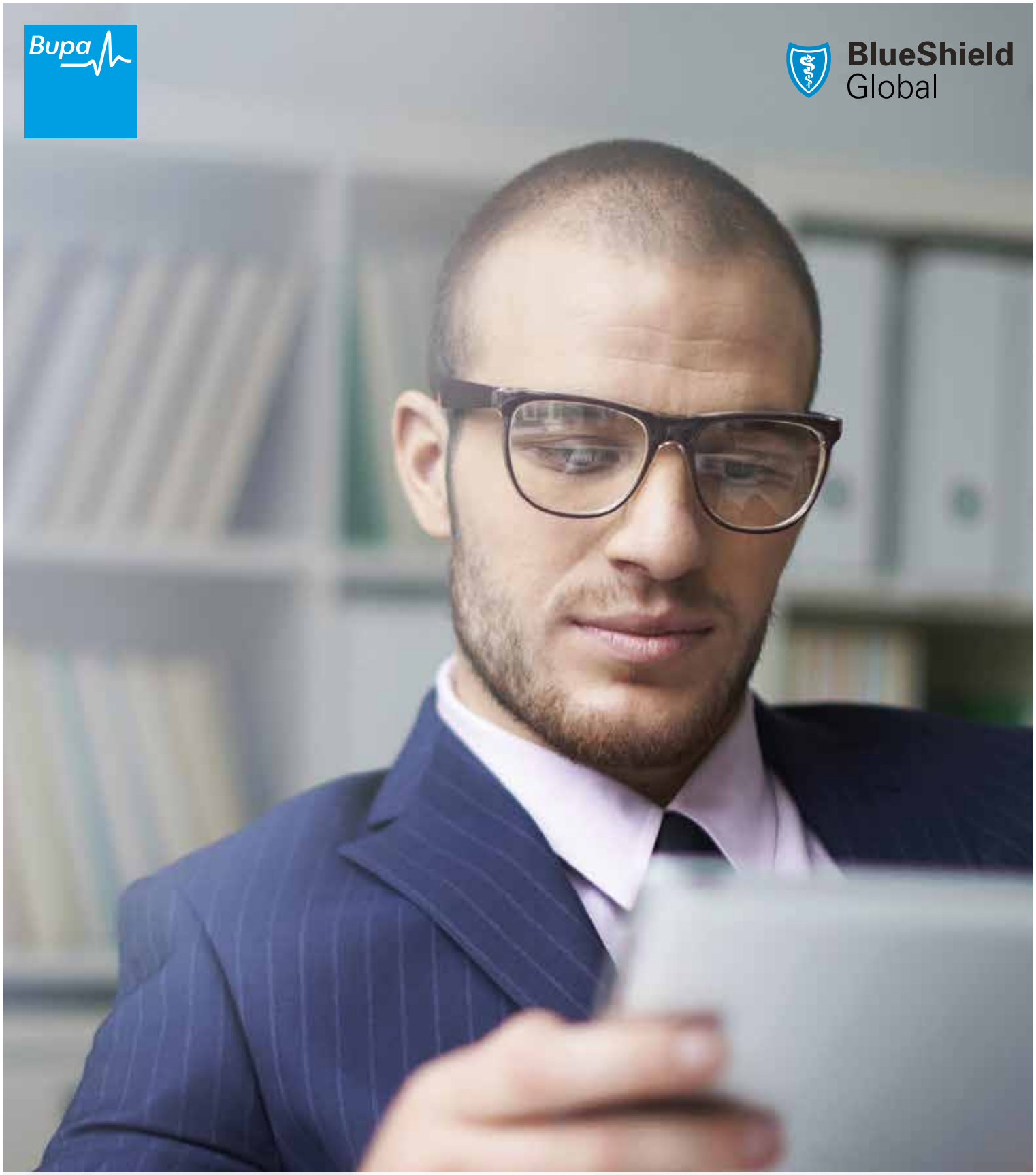

BUSINESS HEALTH PLANS EMPLOYEE APPLICATION FORM

A COLLABORATION BETWEEN TWO OF THE MOST RESPECTED NAMES IN GLOBAL HEALTHCARE

BUPA GLOBAL BUSINESS HEALTH PLANS

This application form is for employees and eligible dependants who are applying to join Bupa Global or to amend an existing membership.

The start date will generally be the date on which your completed application form is received and accepted by Bupa (Asia) Limited. If you require a different start date in the future please complete the start date box in section 1.

You can type directly into this form, alternatively please write clearly in block capitals using black ink. Please return this form to your company's Group Administrator.

If you do not take reasonable care to provide us with full, complete, and accurate information about yourself or any other person covered under the policy, we will have the right to treat your policy as if it had not existed, or to refuse to pay all or part of a claim.

You must tell us immediately if you or any additional person to be covered under the policy experience any symptoms between the time you complete this application form and the date the policy starts. Failure to do so may mean we are unable to pay your claims.

Please note that 

is for the employee and 1,2,3,4 is for dependants.

We will not be able to process your application if this form is incomplete. Please be sure to check the entire form.

IF YOU HAVE ANY QUESTIONS WHEN COMPLETING THIS FORM, PLEASE CALL US ON +852 2531 8503

CHECKLIST - PLEASE MAKE SURE:

IF THIS IS A NEW GROUP APPLICATION OR A NEW JOINER TO AN EXISTING GROUP PLAN	
Your Group Secretary has completed section 1	◯
The information you have given in section 2-9 is correct and complete	◯
You have read, signed and dated the declaration in section 11	◯
IF YOU WANT TO AMEND YOUR EXISTING MEMBERSHIP	
Your Group Secretary has completed section 1	◯
You have completed the relevant sections to reflect the amendments required (for U.S. upgrades this is section 10)	◯
You have read, signed and dated the declaration in section 11	◯

BRAILLE, LARGE PRINT OR AUDIO

We want to make sure that members with special needs are not excluded in any way. We also offer a choice of Braille, large print or audio for our forms, letters and literature. Please let us know which you would prefer.

1 TO BE COMPLETED BY THE GROUP SECRETARY

Group name																														

Group number																					Cover start date*	D	D	M	M	Y	Y	Y	Y

*Cover cannot start between 28th and 31st inclusive

PLAN INFORMATION

Please select the plan and any co-insurance, optional modules or U.S. cover which will apply to this application.
Note that assistance cover: Evacuation and Repatriation are included in all plans.

Choose Plan	Choose Co-insurance (Applies to out-patient care only)	Choose Dental & Optical	Choose U.S. cover	Choose Maternity cover
◯ Business Health Select Plan	Not available	◯ Dental choice 1 ◯ Dental & Optical choice 2 ◯ Dental & Optical choice 3	◯ Yes ◯ No	◯ Yes ◯ No
◯ Business Health Premier Plan	◯ 0% ◯ 15% ◯ 25%	◯ Dental choice 1 ◯ Dental & Optical choice 2 ◯ Dental & Optical choice 3	◯ Yes ◯ No	◯ Yes ◯ No
◯ Business Health Elite Plan	◯ 0% ◯ 15% ◯ 25%	◯ Dental choice 1 ◯ Dental & Optical choice 2 ◯ Dental & Optical choice 3	◯ Yes ◯ No	◯ Yes ◯ No
◯ Business Health Ultimate Plan	Not available	✓ Included	✓ Included	✓ Included

UNDERWRITING TERMS

Please tick the underwriting terms to be applied to this application. If you are unsure of the underwriting terms agreed for this group plan please contact us.

Full Medical Underwriting: Unless a pre-existing condition or related condition is fully disclosed on our application form and we have not expressly excluded it, benefit will not be payable. Any specific exclusion(s) will be detailed on the insurance certificate issued in our member welcome pack Please complete the medical questions and history in section 7	◯
Continued Personal Medical Exclusions: This is where underwriting terms from your previous insurer are carried over to your Bupa Global Plan. Please complete the medical questions and history in section 8	◯

GROUP SECRETARY DECLARATION

I confirm that I am authorised to sign on behalf of the company and that all applicants named in this application are eligible to join the plan and do not contribute to the cost, which is borne by the employer.

AUTHORISED SIGNATORY	DATE
	D D M M Y Y Y Y

Print name																														

2 MAIN APPLICANT: MEMBERSHIP DETAILS

M

Membership number																														

Alternatively, if you have previously had a policy with Bupa, please tick here and provide the membership number above ◯

3 MAIN APPLICANT: YOUR PERSONAL DETAILS

M

Title		Male ◯	Female ◯	1st language	
First name					
Middle name					
Last name					
Date of birth	D D M M Y Y Y Y			Country of nationality	
Occupation					

4 MAIN APPLICANT: YOUR ADDRESS DETAILS

M

Residency address

(your permanent or usual address in the country where you are resident, on the day you would like the policy to start)

Address line 1	
Address line 2	
Town/City	
State/Emirate	
Country	
Postal/Zip/Area code	

Are you or any additional persons to be covered with you a U.S. resident?	Ⓨ Ⓝ
If yes, will you be resident outside of the U.S. for six month or more in any one year?	Ⓨ Ⓝ

Correspondence address

(where membership documents cannot easily be sent to you at your residency address, please supply an alternative address to which they may be sent)

Address line 1	
Address line 2	
Town/City	
State/Emirate	
Country	
Postal/Zip/Area code	

5 MAIN APPLICANT: YOUR OTHER CONTACT DETAILS

M

(Please include country code, area code and number)

Phone / Mobile	
Email	

6 ADDITIONAL PERSONS TO BE COVERED WITH YOU

If any of these additional persons have different residency or correspondence addresses to yours, please write their name and addresses on the "Notes" section at the end of this form and indicate you have done so by ticking here ◯

1

Title | Male ◯ | Female ◯ | 1st language

First name | Middle name

Family name

Date of birth (D D M M Y Y Y Y) | Country of nationality

Country of residency | Relationship to you

Email

Have you had a previous policy with Bupa? (Y) (N) | If yes, provide your membership number

2

Title | Male ◯ | Female ◯ | 1st language

First name | Middle name

Family name

Date of birth (D D M M Y Y Y Y) | Country of nationality

Country of residency | Relationship to you

Email

Have you had a previous policy with Bupa? (Y) (N) | If yes, provide your membership number

3

Title | Male ◯ | Female ◯ | 1st language

First name | Middle name

Family name

Date of birth (D D M M Y Y Y Y) | Country of nationality

Country of residency | Relationship to you

Email

Have you had a previous policy with Bupa? (Y) (N) | If yes, provide your membership number

4

Title | Male ◯ | Female ◯ | 1st language

First name | Middle name

Family name

Date of birth (D D M M Y Y Y Y) | Country of nationality

Country of residency | Relationship to you

Email

Have you had a previous policy with Bupa? (Y) (N) | If yes, provide your membership number

7 MEDICAL QUESTIONS AND HISTORY – FULL MEDICAL UNDERWRITING

Complete this section if Full Medical Underwriting has been selected in section 1 of this form.

This section asks for health and medical details, past and present about yourself and each person named in section 6.

Please tick Yes or No to every question for every person. If you tick Yes to a question, please give full details in section 9.

If you do not provide us with full details, we may terminate your cover, or it may stop us from paying your claims and/or cause us to review the terms and conditions of your policy.

Please tick either Yes or No to each of these questions	M	1	2	3	4
1. Within the last 3 years, has any applicant seen a doctor or other healthcare professional for:					
○ any recurrent or persistent medical condition or symptoms? (Persistent meaning for 2 weeks or more)	Y N	Y N	Y N	Y N	Y N
○ any abnormal tests or results?	Y N	Y N	Y N	Y N	Y N
2. In the last 5 years, has any applicant been admitted to hospital, had an operation, procedure or investigation (e.g. a scan/blood tests).	Y N	Y N	Y N	Y N	Y N
3. Is any applicant taking any medication, prescribed or otherwise?	Y N	Y N	Y N	Y N	Y N
4. Does any applicant have any medical devices (e.g. shunts for draining fluids from the brain, pins and plates for broken bones) currently in their body?	Y N	Y N	Y N	Y N	Y N
5. Has any applicant (at any time in the past) had a history of:					
○ **cancer, including benign brain tumours**	Y N	Y N	Y N	Y N	Y N
○ **heart condition**	Y N	Y N	Y N	Y N	Y N
○ **stroke**	Y N	Y N	Y N	Y N	Y N
○ **joint replacements**	Y N	Y N	Y N	Y N	Y N
6. Has any applicant experienced any signs or symptoms of any medical problems, illnesses, or injuries not already disclosed, regardless of whether a doctor or other healthcare professional has been consulted.	Y N	Y N	Y N	Y N	Y N
7. Do you have any planned or pending treatment, investigations or tests?	Y N	Y N	Y N	Y N	Y N

Further details (for over 16s only):

How tall are you?	○ feet/inches	○ metres/centimetres				
How much do you weigh?	○ stones/pounds	○ kilograms				

8 MEDICAL QUESTIONS AND HISTORY – CONTINUED PERSONAL MEDICAL EXCLUSIONS (CPME)

Complete this section if Continued Personal Medical Exclusions has been selected in section 1 of this form.

This section asks for health and medical details, past and present about yourself and each person named in section 6.

Please tick Yes or No to every question for every person. If you tick Yes to a question, please give full details in section 9.

If you do not provide us with full details, we may terminate your cover, or it may stop us from paying your claims and/or cause us to review the terms and conditions of your policy.

Please tick either Yes or No to each of these questions	M	1	2	3	4
1. Have you ever suffered from any form of:					
○ cancer, including benign brain tumours	Y N	Y N	Y N	Y N	Y N
○ heart condition	Y N	Y N	Y N	Y N	Y N
○ stroke	Y N	Y N	Y N	Y N	Y N
○ psychiatric condition	Y N	Y N	Y N	Y N	Y N
2. Have you had a joint replacement or spinal surgery?	Y N	Y N	Y N	Y N	Y N
3. Have you made a claim under your existing insurance in the last 12 months?	Y N	Y N	Y N	Y N	Y N
4. Do you have any long-term conditions which require regular treatment and reviews with a doctor?	Y N	Y N	Y N	Y N	Y N
5. Do you have any planned or pending treatment, investigations or tests?	Y N	Y N	Y N	Y N	Y N

9 MEDICAL QUESTIONS AND HISTORY: ADDITIONAL INFORMATION

This section applies if you have answered 'Yes' to any of the medical questions in sections 7 or 8. If you are unsure whether any details are relevant, you must include them

Please attach medical reports or test results relating to the medical conditions you have declared if these are available.

Is additional medical information included? (Y) (N)

Main Applicant or dependant	The relevant question number from section 7 or 8	Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected (e.g., right leg, left eye).	When were symptoms first experienced and when was treatment completed (if applicable)?	What treatment did you receive and when (please include dates, names and details of medications)?	What was the outcome of the treatment (e.g. ongoing, complete recovery, recurrent or likely to recur)?
M					
1					
2					
3					
4					

If there is insufficient space, please use the "Notes" section at the end of this form and indicate that you have done so by ticking here ☐

10 UPGRADE COVER TO INCLUDE U.S. COVER FOLLOWING COMMENCEMENT OF THE POLICY

If you are filling out this form to upgrade to U.S. cover following the commencement of the policy, you should complete this section in place of section 7 or 8, Medical Questions and History. Medical underwriting will be undertaken at the point of application to upgrade cover to include U.S. Exclusions may be applied to U.S. cover.

Please tick either Yes or No to each of these questions

	M	1	2	3	4
1. Your anticipated length of stay in the U.S.	☐	☐	☐	☐	☐
2. Do you have any ongoing or planned treatment? If yes, please provide details below	(Y) (N)	(Y) (N)	(Y) (N)	(Y) (N)	(Y) (N)
3. FEMALES ONLY: Are you currently pregnant?	(Y) (N)	(Y) (N)	(Y) (N)	(Y) (N)	(Y) (N)

11 YOUR APPLICATION DECLARATION

PRIVACY NOTICE

Bupa (Asia) Limited (the "Company")

Personal Information Collection Statement ("Statement") relating to the Personal Data (Privacy) Ordinance (the "Ordinance")

In compliance with the Ordinance, the Company would like to inform you of the following:

1. From time to time, it is necessary for you, or other members covered under your policy (each a "Member"), to supply the Company with certain personal information (including where relevant, credit information and claims history) relating to you, or the Member, when you apply for insurance or financial products and services from the Company, or when you apply to make changes to your policy, or when you renew a policy.

2. Failure to supply personal information requested by the Company may result in the Company being unable to process your Application and/or provide products, services and other related services to you, or the Member.

3. During the course of your relationship with the Company, further personal information relating to you, or the Member, may also be collected in the ordinary course of our business, for example, when you lodge insurance claims with the Company in relation to yourself or the Member.

4. The Company may collect, use or disclose personal information relating to you, or the Member, for the following purposes:

a. processing, assessing and determining any Applications for insurance products and services;

b. offering and providing products and services to you, or the Member, and processing requests made by you, or the Member, from time to time, including but not limited to requests for addition, alteration, deletion, maintenance, management and operation of insurance benefits or insured Members;

c. any purposes in connection with any claims made by or against or otherwise involving you, or the Member, in respect of any products and/or services provided by the Company including, without limitation, making, defending, analysing, investigating, detecting and preventing fraud (whether or not relating to the policy issued in respect of any application or claim) processing, assessing, determining, settling or responding to such claims;

d. performing any functions and activities related to the products and/or services provided by the Company including, without limitation, audit, reporting, market research, general servicing, maintenance of online and other services, identity verification, data matching, research and statistical analysis, and reinsurance arrangements;

e. provision and design of products and services of the Company;

f. exercising the Company's rights in connection with provision of insurance products and services to you, or the Member, from time to time, for example, to determine any amount of indebtedness from you, and collecting and recovering owing from you or any person who has provided any security or undertaking for your liabilities;

g. communication with you or the Member (or with you on behalf of the Member) in relation to any of the purposes set out in this Statement;

h. enabling an actual or proposed assignee, transferee, participant or sub-participant of all or a substantial part of the Company's rights or business to evaluate the transaction intended to be the subject of the assignment, transfer, participation or sub-participation; and

i. making disclosure to satisfy the requirements of any laws, rules and regulations, codes of practice, guidance notes or guidelines binding on the Company.

5. Personal information collected or held by the Company relating to you, or the Member, will be kept confidential but the Company may transfer such personal information inside or outside the Hong Kong Special Administrative Region, for the purposes specified in paragraph (4) and (6) to the following classes of transferees:

a. the Company's group companies ("Group Company");

b. any insurance adjusters, agents and brokers;

c. any re-insurance companies authorised by the Company;

d. employers (for members of corporate policy only);

e. healthcare professionals and hospitals;

f. any agent, contractor or third party service providers who provide administrative, telecommunications, computer, payment, data processing or storage, printing, research or other services to the Company in connection with the operation of business, (including without limitation insurers; banks; lawyers; accountants; claims investigators; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisations or other persons named in this paragraph); organisations that consolidate claims and underwriting information for the insurance industry; the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information; debt collection agencies; data processing companies; research agencies and professional advisors);

g. any actual or proposed assignee, transferee, participant or sub-participant of all or a substantial part of the Company's rights or business; and

h. any person to whom the Company is under an obligation to make disclosure under the requirements of any law, rules, regulations, codes of practice or guidelines binding on the Company including, without limitation, any applicable regulators, governmental bodies, industry recognised bodies, credit reference agencies, the Courts, and where otherwise required by law.

6. Only with your consent or with your indication of no objection, the Company may use your personal information collected from time to time, including name, contact details, gender, health and family status, to provide you with marketing communications (including by email, SMS or instant messenger) relating to the following products and services:

a. Insurance, medical, healthcare, wellness, personal development, beauty, lifestyle, entertainment, financial, and related services and products;

b. rewards, benefits, discounts, member activities, loyalty or privileges programmes and related services and products; and

c. donations and contributions for charitable and/or non-profit making purposes.

The Company will not disclose personal information relating to you, to third parties for them to use for their own direct marketing purposes without your consent.

For the avoidance of doubt, whether or not you consent to receive marketing communications of the type described in this paragraph 6, the Company may still communicate with you regarding the administration, features and renewal of your insurance policy.

7. Under and in accordance with the terms of the Ordinance, you have the following rights:

a. to check whether the Company holds personal information relating to you or the Member and to access such personal information;

b. to require the Company to correct any personal information relating to you or the Member which is inaccurate;

c. to ascertain our policies and practices in relation to personal data and to be informed of the kind of personal data held by the Company, and

d. to request the Company to cease using your personal information for direct marketing purposes.

Requests can be made in writing to the Company's Data Protection Officer at the following address:

Data Protection Officer

6/F, Tower 2, The Quayside,

77 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong

8. In accordance with the terms of the Ordinance, the Company has the right to charge a reasonable fee for the processing of any personal information access or correction request.

9. For any enquiries about this Statement, please do not hesitate to contact our Customer Service Team at +852 2531 8503.

10. Nothing in this Statement shall limit the rights of customers under the Ordinance.

11. In case of discrepancies between the English and Chinese versions of this Statement, the English version shall prevail.

11 YOUR APPLICATION DECLARATION (continued)

OUR COMPLAINTS PROCEDURE

If you have a concern or complaint you can call the Bupa Global service team on +852 2531 8503. Alternatively, you can email or write to the team via:

- Email: service.hk@bupaglobal.com
- Post: Bupa (Asia) Limited, 6/F, Tower 2, The Quayside, 77 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong

DECLARATION

To the best of my knowledge and belief the information given in this application form is true, accurate and complete. I understand that benefits may not be payable in full or at all and my policy may be treated as if it had not existed, if I do not take reasonable care when providing any information requested in this application form.

Where I have provided information on behalf of any other person to be covered by the policy, I confirm that I have checked with them that the information is correct before completing this application form and I have their express agreement to submit this application form on their behalf, or I am their legal representative.

I understand that my personal information and that of any other person to be covered by this policy will be processed by Bupa (Asia) Limited for the purposes set out in Bupa (Asia) Limited Personal Information Collection Statement. I confirm that I have brought in Bupa (Asia) Limited Personal Information Collection Statement to the attention of these covered.

I agree to be bound by the policy terms of my health plan (and for cover provided to any other person to be covered by this policy but under a different health plan, the policy terms of that health plan). I agree that Hong Kong law will apply to the policy.

I agree that any cover for the U.S. shall terminate upon informing Bupa Global that I have become a resident of the U.S. (or in the case of an additional person becoming a resident of the U.S., their cover under the policy shall terminate).

◯ Marketing and preferences: I confirm that I want to receive marketing materials and communications from Bupa (Asia) Limited and Bupa Global keeping me updated about Bupa's products and services.

It is essential that you take reasonable care to provide us with full, complete, and accurate information when you complete this application form. Please be sure to check the entire form.

If you do not take reasonable care to provide us with full, complete, and accurate information about yourself or any other person covered under the policy, we will have the right to treat your policy as if it had not existed, or to refuse to pay all or part of a claim.

Fill in your form with complete up-to-date medical history before you sign and date it. If we do not receive this application form within six weeks of this declaration date, or the date of signature expires six weeks before your cover start date we will ask for a declaration of continued good health. Or we may ask you to submit a new form.

We recommend that you keep a record of all the information you supply to us in connection with this application, including letters. If you would like a copy of this application form, please ask us.

MAIN APPLICANT'S SIGNATURE	DATE
	D D M M Y Y Y Y

Print full name

FOR OFFICE USE ONLY	IDENTIFICATION STAMP / BROKER NAME AND ID NUMBER