

Joining Bupa International  
Your application - Lifeline  
Hong Kong



## IMPORTANT INFORMATION

**This product is insured by Bupa (Asia) Limited.**

Please write clearly in black ink and BLOCK CAPITALS. Mail or fax us your completed application.  
Our fax number is: +44 (0) 1 273 866 585. If you fax us your application, please do not mail us the original as well.  
Our postal address is Bupa International, Russell House, Russell Mews, Brighton, BN1 2NR, United Kingdom.

**If you have any questions when completing this form, please call us on +44 (0) 1 273 208 181**

### Checklist - please make sure:

- you have read, signed and dated the declaration in section 13
- the information you have given in sections 1-12 is correct and complete
- for payments by Direct Debit or Credit Card, you have completed the Direct Debit Instruction or the Credit Card Authority

**We will not be able to process your application if this form is incomplete.**

**Please be sure to check the entire form.**



## 1 Main member: your personal details



The date you want your cover to start: 

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| D | D | M | M | Y | Y |
|---|---|---|---|---|---|

 Your cover cannot start before the date we receive your completed application form.

|  |   |             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |               |   |              |   |   |   |   |  |  |  |  |  |  |  |  |  |  |  |  |
|--|---|-------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------|---|--------------|---|---|---|---|--|--|--|--|--|--|--|--|--|--|--|--|
| Title  |   | First name  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |               |   |              |   |   |   |   |  |  |  |  |  |  |  |  |  |  |  |  |
| Other initials   |   | Family name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |               |   |              |   |   |   |   |  |  |  |  |  |  |  |  |  |  |  |  |
| Male / Female  | <input type="checkbox"/> <input type="checkbox"/> | Nationality |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |               |   | 1st Language |   |   |   |   |  |  |  |  |  |  |  |  |  |  |  |  |
| Occupation   |   |             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Date of birth | D | D            | M | M | Y | Y |  |  |  |  |  |  |  |  |  |  |  |  |
| Do you have current medical cover with any other insurer, including Bupa? Yes <input type="radio"/> No <input type="radio"/> |   |             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |               |   |              |   |   |   |   |  |  |  |  |  |  |  |  |  |  |  |  |
| If Yes, please give details:   |   |             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |               |   |              |   |   |   |   |  |  |  |  |  |  |  |  |  |  |  |  |

|                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Name of other health insurer |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

|                        |                   |
|------------------------|-------------------|
| Name of scheme / cover | Membership number |
|------------------------|-------------------|

If you are joining the **ECIS** plan and you or your employer hold current **ECIS** membership, please send us proof of membership with this form.

## 2 Main member: your address details *(please let us know straightaway about any change of address)*



| Residency address <i>(your permanent or usual address in the country where you are resident. This should be the country in which you are living on the first day of your current membership year.)</i> | Correspondence address <i>(where membership documents cannot easily be sent to you at your residency address, please supply an alternative address to which they may be sent)</i> |
|--|---|
| Building name / number   | Building name / number  |
| Street   | Street  |
| Town/City  | Town/City   |
| Postal / zip / area code   | Postal / zip / area code  |
| Region   | Region  |
| Country  | Country   |

Do you have a residence in the USA? Yes  No



## 3 Main member: your other contact details



| Main contact <i>(home)</i> |              |           |        | Secondary contact <i>(work)</i> |              |           |        |
|----------------------------|--------------|-----------|--------|---------------------------------|--------------|-----------|--------|
|                            | Country code | Area code | Number |                                 | Country code | Area code | Number |
| Telephone                  |              |           |        | Telephone                       |              |           |        |
| Fax                        |              |           |        | Fax                             |              |           |        |
| Mobile                     |              |           |        | Mobile                          |              |           |        |
| Email                      |              |           |        | Email                           |              |           |        |



## 1st additional person: personal details

1st

|                      |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
|----------------------|---|---|-------------|-------------|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|---------------|---|---|---|---|---|---|
| Title                |   |   |             | First name  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
| Other initials       |   |   |             | Family name |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
| Male / Female        |  |  | Nationality |             |  |  |  |  |  |  |  |  |  | 1st Language |  |  |  |  |               |   |   |   |   |   |   |
| Occupation           |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  | Date of birth | D | D | M | M | Y | Y |
| Relationship to you: |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |



## 2nd additional person: personal details

2nd

|                      |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
|----------------------|---|---|-------------|-------------|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|---------------|---|---|---|---|---|---|
| Title                |   |   |             | First name  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
| Other initials       |   |   |             | Family name |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
| Male / Female        |  |  | Nationality |             |  |  |  |  |  |  |  |  |  | 1st Language |  |  |  |  |               |   |   |   |   |   |   |
| Occupation           |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  | Date of birth | D | D | M | M | Y | Y |
| Relationship to you: |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |



## 3rd additional person: personal details

3rd

|                      |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
|----------------------|---|---|-------------|-------------|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|---------------|---|---|---|---|---|---|
| Title                |   |   |             | First name  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
| Other initials       |   |   |             | Family name |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
| Male / Female        |  |  | Nationality |             |  |  |  |  |  |  |  |  |  | 1st Language |  |  |  |  |               |   |   |   |   |   |   |
| Occupation           |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  | Date of birth | D | D | M | M | Y | Y |
| Relationship to you: |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |

## 4th additional person: personal details

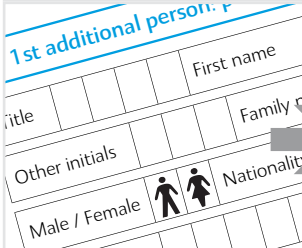
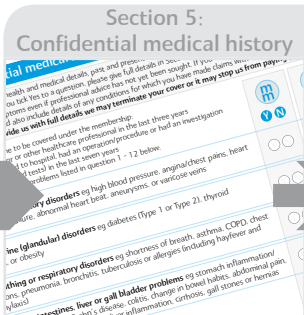
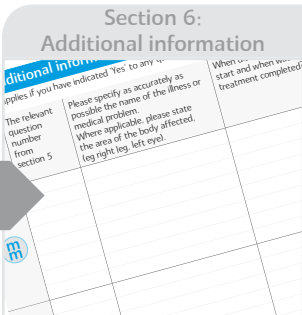





4th

|                      |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
|----------------------|---|---|-------------|-------------|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|---------------|---|---|---|---|---|---|
| Title                |   |   |             | First name  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
| Other initials       |   |   |             | Family name |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |
| Male / Female        |  |  | Nationality |             |  |  |  |  |  |  |  |  |  | 1st Language |  |  |  |  |               |   |   |   |   |   |   |
| Occupation           |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  | Date of birth | D | D | M | M | Y | Y |
| Relationship to you: |   |   |             |             |  |  |  |  |  |  |  |  |  |              |  |  |  |  |               |   |   |   |   |   |   |

If any of these additional persons have different home or correspondence addresses to yours, please write their name and addresses on a separate sheet and confirm you have done so by ticking here:

## IMPORTANT INFORMATION

It is important that the information you give in sections 5 and 6 matches the correct persons from sections 1 and 4.

|   |  |   |   |
|---|--|---|---|
| <p>Sections 1 and 4:<br/>Personal details</p> <p>1st additional person:</p>  | <p>Section 5:<br/>Confidential medical history</p>  | <p>Section 6:<br/>Additional information</p>  | <p>Follow these icons when referring to yourself and additional persons</p> <ul style="list-style-type: none"> <li> = Main member</li> <li> = First additional person</li> <li> = Second additional person</li> <li> = Third additional person</li> <li> = Fourth additional person</li> </ul> |
|---|--|---|---|




This section asks for health and medical details, past and present about yourself and each person named in Section 4. Please tick Yes or No to every question for every person. If you tick Yes to a question, please give full details in Section 6 on the next page. Please ensure you tell us about any known or suspected conditions and symptoms even if professional advice has not yet been sought. If you are applying to increase cover and you are already a Bupa International member, you should also include details of any conditions for which you have made claims within the last four years.

**If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.**

Have you or anyone to be covered under the membership:

- seen a doctor or other healthcare professional in the last three years
- been admitted to hospital, had an operation/procedure or had an investigation (eg a scan/blood tests) in the last seven years

for any of the medical problems listed in question 1 - 12 below. Please note that we have given examples of conditions here, but not all conditions can be listed.

|  | <br>Y N | <br>Y N | <br>Y N | <br>Y N | <br>Y N |
|--|--|--|--|--|--|
| <b>1. Heart or circulatory disorders</b> eg high blood pressure, angina/chest pains, heart attack, heart failure, abnormal heart beat, aneurysms, or varicose veins  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>2. Endocrine (glandular) disorders</b> eg diabetes (Type 1 or Type 2), thyroid problems, or obesity   | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>3. Breathing or respiratory disorders</b> eg shortness of breath, asthma, COPD, chest infections, pneumonia, bronchitis, tuberculosis or allergies (including hayfever and anaphylaxis)   | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>4. Stomach, intestines, liver or gall bladder problems</b> eg stomach inflammation/ulcers, irritable bowel, Crohn's disease, colitis, change in bowel habits, abdominal pain, haemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, gall stones or hernias   | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>5. Cancer, tumours or growths</b> eg polyps, benign growths, any cancers or pre-cancerous condition   | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>6. Skin problems</b> eg eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed, or allergic conditions  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>7. Brain or nervous system disorders</b> eg stroke, dementia, migraine, repeated headaches, multiple sclerosis, epilepsy/fits, nerve pain (including sciatica and shingles) or meningitis   | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>8. Muscle or skeletal problems</b> eg arthritis, back pain, neck/shoulder problems, cartilage and ligament problems, joint replacements, fractures, osteoporosis, gout or inflammatory conditions.  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>9. Urinary or reproductive system problems</b> eg kidney or bladder problems (including kidney failure), recurrent urinary infections, incontinence: pregnancy/childbirth problems (including caesarean sections), heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, polycystic ovaries, testicular or prostate disorders. | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>10. Blood/infective/immune disorders</b> eg abnormal blood tests, high cholesterol, anaemia; hepatitis, HIV, malaria; or any autoimmune disorder.   | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>11. Eye, ear, nose, throat and dental problems</b> eg cataracts, glaucoma, visual impairment; deafness, ear infections, tonsillitis; dental infections, wisdom teeth problems or gingivitis.  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>12. Psychiatric/ psychological disorders</b> eg schizophrenia, compulsive or eating disorders; depression, stress, anxiety or drug/alcohol dependency.  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>Please also answer the following questions:</b>   |  |  |  |  |  |
| 13. Is anyone to be covered taking any medication, prescribed or otherwise?  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| 14. Is anyone to be covered receiving any treatment of any kind, or require or expect to require any review, investigations or treatment for any current or past medical problem not already mentioned in this application?  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| 15. Has anyone to be covered experienced any signs or symptoms of any medical problem in the last six months, regardless of whether a healthcare professional has been consulted?  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |
| <b>Further details (for over 16s only):</b>  |  |  |  |  |  |
| How tall are you?                      feet/inches <input type="radio"/> metres/centimetres <input type="radio"/>  | <input type="text"/>   | <input type="text"/>   | <input type="text"/>   | <input type="text"/>   | <input type="text"/>   |
| How much do you weigh?              stones/pounds <input type="radio"/> kilogrammes <input type="radio"/>  | <input type="text"/>   | <input type="text"/>   | <input type="text"/>   | <input type="text"/>   | <input type="text"/>   |
| Have you used tobacco products within the last seven years?  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  | <input type="radio"/> <input type="radio"/>  |



**8 Your details of cover** (Note: the level of cover you choose will apply to all members detailed on this form)

|   |                                  | 1 <sup>st</sup>       | 2 <sup>nd</sup>       | 3 <sup>rd</sup>       | 4 <sup>th</sup>       |
|---|----------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <b>Lifeline Essential:</b><br>This level concentrates on covering you for in-patient hospital stays. You have the security that you'll be covered for treatment you may receive as an in-patient or as a daycare patient.   | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>Lifeline Classic:</b><br>Our Classic level is designed to cover you and your family for any specialist medical treatment or diagnosis. You will be covered for in-patient hospital stays as well as out-patient consultations, treatment such as physiotherapy and a range of preventive health checks.  | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>Lifeline Gold:</b><br>Our top level gives you all the cover you need for both in-patient and out-patient care. In addition, Gold also covers family doctor treatment and any prescription medication you may need, as well as accident related dental treatment. Maternity cover, home nursing and a range of four preventive health checks are also included in this comprehensive plan.  | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>USA cover:</b><br>We understand that many people do not need medical insurance for the USA, so you can choose whether you want to include it. Unfortunately, we cannot offer Bupa International Lifeline to anyone who is normally resident in the USA.<br><br><ul style="list-style-type: none"> <li>This cover will increase your premium.</li> <li>Bupa International will not pay for treatment in the USA if you are travelling there for the purpose of that treatment.</li> </ul> | <input type="radio"/>            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**Choose your Annual Deductible**

If you are paying by Direct Debit or Credit Card, you may choose an annual deductible. This is the amount you would pay towards eligible medical treatment each year.

|      |      |                       |       |                       |       |                       |       |                       |        |                       |        |                       |
|------|------|-----------------------|-------|-----------------------|-------|-----------------------|-------|-----------------------|--------|-----------------------|--------|-----------------------|
| GBP: | None | <input type="radio"/> | £100  | <input type="radio"/> | £250  | <input type="radio"/> | £500  | <input type="radio"/> | £1000  | <input type="radio"/> | £2000  | <input type="radio"/> |
| USD: | None | <input type="radio"/> | \$160 | <input type="radio"/> | \$400 | <input type="radio"/> | \$800 | <input type="radio"/> | \$1600 | <input type="radio"/> | \$3200 | <input type="radio"/> |
| EUR: | None | <input type="radio"/> | €160  | <input type="radio"/> | €400  | <input type="radio"/> | €800  | <input type="radio"/> | €1600  | <input type="radio"/> | €3200  | <input type="radio"/> |

**9 Your assistance cover options**

|  |                       | 1 <sup>st</sup>       | 2 <sup>nd</sup>       | 3 <sup>rd</sup>       | 4 <sup>th</sup>       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <b>Evacuation:</b><br>If you are concerned about the quality of local medical care, this is ideal. If the treatment you need is not available locally, we will arrange for you to be evacuated to the nearest centre of medical excellence, no matter where you are in the world.  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>Repatriation</b> (automatically includes Evacuation cover):<br>Our highest level of Assistance cover also gives you the choice of returning to your home country, to be treated in familiar surroundings, near your friends and relatives (if treatment is not available locally). If this happens, you can choose to have someone to accompany you for your visit back home. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

## 10 Your payment details (Direct debit, credit card or cheque/bankers draft)

Your choice of currency for your cover and subscription payments *(please tick one only)*: GBP(£)  USD(\$) EUR(€)

How will you make your subscription payments *(please tick one only)*: Monthly  Quarterly  Yearly

By Direct Debit through a UK bank. *(This is only an option for GBP(£) payments. Please complete the below Direct Debit Instruction):*

By Credit Card *(please complete the below Card Payment Authority):*

By cheque or bankers draft in the currency you have indicated above:

Who will be paying the subscription?

A valid Direct Debit agreement or Card Authority is required throughout your membership year. Your cover may be suspended or terminated if you do not have such an agreement or authority in place.

## 11 Direct Debit (for GBP (£) payments only - this must come out of a UK bank account)

If you are paying by Direct Debit you must complete this section.

### Instruction to your Bank or Building Society to pay by Direct Debit



Name(s) of account holder(s):

Bank/Building Society account number:

Branch sort code:

-  -

Swift code:

Name and full postal address of your Bank/Building Society:

To: The Manager

Address:

Postcode:

#### Instruction to your Bank or Building Society

Please pay Bupa International Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Bupa International and, if so, details will be passed electronically to my Bank/Building Society.

Cardholder's signature

Date

Reference number (for Bupa International use only)

BI -  -  -

Originator's ID number

9  8  0  9  3  9

Banks and Building Societies may not accept Direct Debit Instructions for some type of accounts.

As Instruction Form

## 12 Credit Card authority

### CARD PAYMENT AUTHORITY

To Bupa International, I authorise you, until further notice in writing, to charge to my card account, subscriptions and other unspecified amounts, as and when payments become due. I will advise you immediately if the card becomes lost, stolen or if I wish to close my card account or cancel the authority.

*(please tick)* MasterCard  Visa  American Express

*Please note that we do not accept Maestro payments. You will be given 14 days notice of other unspecified amounts to be collected.*

Cardholder's name as it appears on the card:

Card number:

-  -  -

Valid from date:

M  M  Y  Y

Expires/end date:

M  M  Y  Y

Cardholder's signature

Date

## The Direct Debit Guarantee

This guarantee should be detached and retained by the payer



- This Guarantee is offered by all banks and building societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change, Bupa International will notify you seven working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Bupa International or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

**In view of the declaration below, it is essential that complete information is supplied.**

Benefits may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this application and, if you are in any doubt as to whether any facts are material, you should disclose them. You are advised to keep a record of all 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.

It is Bupa International's intention to provide a first class service to our members at all times. However, if you do have any cause for dissatisfaction, please write to the Head of Customer Relations at Bupa International's Head Office. The address is, Bupa International, Russell Mews, Brighton BN1 2NR, United Kingdom. If you remain dissatisfied you may appeal to the Complaints Manager, Bupa (Asia) Limited, International Division. Their address details are: 18/F, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong. Unless otherwise agreed by Bupa International in writing, Hong Kong Law shall apply to the agreement between you and Bupa International.

I hereby apply to be enrolled as a Member with the Dependants listed above included in my membership. I declare that to the best of my knowledge and belief the information given in this Application is true and complete. I agree that the Rules of the Bupa International scheme will be binding on me and all eligible Dependants included in my membership. I agree that any cover which I may purchase for the USA shall terminate upon informing Bupa International that I have become a resident of the USA.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, on behalf of myself and any family members specified in this form for Bupa International to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.

|  |
|--|
| Identification stamp / broker name and ID number |
| <b>Pacific Prime International Limited</b>       |
| for office use only                              |
| Insured by Bupa (Asia) limited.                  |

**Bupa International Data Protection Notice**

**Purpose:** Personal data collected on you, and where appropriate, your family, will be used by Bupa International to process your claims, administer your policy and may be used to detect and prevent fraud or improper claims.

**Confidentiality:** The confidentiality of patient and member information is of paramount concern to Bupa International. To this end, Bupa International fully comply with UK Data Protection Legislation and Medical Confidentiality Guidelines. Bupa sometimes uses third parties to process data on its behalf. Such processing, which may be undertaken outside the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

**Medical Information:** Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your General Practitioner/Primary Health Physician, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents. Claims information may be discussed with the Bupa International Agent/Adviser where you have requested the Adviser to assist you.

**Member details:** All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the principal member.

**Telephone calls:** In the interest of continuously improving our service to members, your call will be recorded and may be monitored.

**Research:** Anonymised or aggregated data may be used by Bupa International, or disclosed to others, for research or statistical purposes.

**Fraud:** Information may be disclosed to others with a view to preventing fraudulent or improper claims.

**Names and Addresses:** Bupa International does not make the names and addresses of members or patients available to other organisations.

**Keeping you informed:** Bupa International would, on occasion, like to keep you informed of Bupa International products and services which it considers may be of interest to you.

**Contact Address:** If you do not wish to receive information about Bupa International's products and services, or have any other Data Protection queries please write to the Bupa Group Information Protection Manager, at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA or at [DataProtection@Bupa.com](mailto:DataProtection@Bupa.com).

**IMPORTANT INFORMATION - YOUR MEMBERSHIP DECLARATION**

Please be aware that this form must be received by Bupa International no more than six weeks after the declaration date.

It is advisable that you fill in your form with complete up-to-date medical history before you sign and date this form.

If we receive this form after six weeks from this declaration date, or with incomplete information, we will be unable to register your details and enrol you on the plan.

**Please use the checklist on the front of the form to ensure you have filled everything in completely.**

|           |
|-----------|
| Signature |
|           |

|      |
|------|
| Date |
|      |

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