



**Group Insurance Application Form (Medical / Life)**  
**團體保險申請表 (醫療/人壽)**

**Part A: Company Details 第一部份：公司資料**

Company Name (The Policyholder) 公司名稱(投保公司): \_\_\_\_\_

Address 地址: \_\_\_\_\_

Contact Person 負責人姓名: \_\_\_\_\_ Position 職位: \_\_\_\_\_

Designated E-mail Address 指定電郵地址: \_\_\_\_\_ Fax 傳真號碼: \_\_\_\_\_ 電話: \_\_\_\_\_

Subsidiary Company Name 附屬公司名稱: \_\_\_\_\_

Address 地址: \_\_\_\_\_

Nature of Business 業務性質: \_\_\_\_\_ Business Registration No.<sup>^</sup> 商業登記編號<sup>^</sup>: \_\_\_\_\_

<sup>^</sup>(Please attach copy of Business Registration. 請附上商業登記證副本)

**Part B: Policy and Scheme Details 第二部份：保單及計劃資料**

**Accepted Quotation No. 已接受的報價編號：** \_\_\_\_\_

Policy Commencement Date: 保單生效日期: \_\_\_\_\_ (MM 月) / \_\_\_\_\_ (DD 日) / \_\_\_\_\_ (YYYY 年)

\*Medical Card Facility \*醫療卡:  No 不需要  \*Yes \*需要

※(tick as appropriate 請在適當空格內)

Outpatient 門診  Inpatient (Annualized Premium over 300K) 住院(只適用於全年保費 30 萬或以上)  Both 門診及住院

Eligibility for Employees Joining the Scheme 新受僱員可生效之日期:

Immediate Cover 即時生效  First Day Following \_\_\_\_\_ Months' Probation  
----- 個月試用期滿後之翌日

Medical Claims Reimbursement Method 醫療賠償付款方法:  Autopay 自動轉賬

The policy will be issued on a  Non-Contributory basis  Contributory basis (\_\_\_\_\_%)  
保單將會簽發由 僱主繳付 僱員繳付 (\_\_\_\_\_%)

Has your Company provided any medical insurance cover for your employees within the last 12 months from the Policy Commencement Date? 貴公司曾否在本保單生效日期前 12 個月內為僱員提供其他醫療保險計劃?

Yes (Please attach the benefit schedule, employee member list and claims experience report)  No 否  
是 (請附上福利計劃表、僱員資料表及醫療賠償記錄。)

\* Please refer to Policy for employer's indemnity on medical shortfall credit risks 有關僱主所提供的醫療信貸責任補償，詳情請參閱保單

**Part C: Benefit Details 第三部份：投保項目**

(Tick ✓ as appropriate) 請在適當空格內 ✓

Plan No. 計劃編號	Benefit Types 福利類別							
	Hospital 住院	SMM / EMB 附加重症/額外醫療	Outpatient 醫生門診	Dental 牙科	Maternity 分娩	Life 人壽	ADD 意外傷殘或傷亡	TPD 永久完全傷殘
	<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"/>

**Part D: Classification of Insured Members 第四部份：受僱員定義**

(Please define the Insured Member Classes. 請界定僱員類別。)

Dependent Cover 家屬保障

Plan No. 1 \_\_\_\_\_  Yes 有  No 沒有  
計劃 1  
Plan No. 2 \_\_\_\_\_  Yes 有  No 沒有  
計劃 2  
Plan No. 3 \_\_\_\_\_  Yes 有  No 沒有  
計劃 3  
Plan No. 4 \_\_\_\_\_  Yes 有  No 沒有  
計劃 4

## The Policyholder

## 投保公司

1. agrees to furnish all information regarding all employees as required by Liberty for the purpose of premiums and/or benefits calculation.  
同意於需要時，提供全體僱員之資料，以便保險公司核算保險費用及福利。
2. agrees to request individual employees (if necessary) to take part in all underwriting requirements by Liberty.  
同意要求個別僱員(如必須)參與保險公司所要求之驗身以便作核保之用。
3. agrees to pay all the required premium to Liberty.  
同意支付全數之保費予保險公司。
4. declares that all eligible employees are actively at work on the Policy Commencement Date.  
聲明在本保單生效當日，所有符合參加資格之僱員皆為正常在職之僱員。
5. declares that all statements made in this Application Form and Employees' Enrolment Form are complete and true. The Policyholder understands that this information shall form part of the Policy between the Policyholder and Liberty, and shall be the basis of Liberty's acceptance.  
聲明在此投保申請表及僱員登記表內陳述之資料均為完整及真確。投保公司並明白此資料可作為投保公司與保險公司所定保單的一部份，亦會被視為保險公司核保之憑證。
6. authorizes Liberty to disclose the employee's data to the related assistance company and medical practices in carrying out emergency assistance and medical services.  
授權保險公司將僱員資料給予有關之緊急救援及醫療服務公司，以便提供相關服務。
7. understands all the information affecting the assessment of the risk has been disclosed, and is true to the best of my/our knowledge and belief  
明白任何足以影響風險估值的資料，均基於誠信原則據實呈報。
8. agrees to fully reimburse the difference or shortfall for any ineligible treatment or untitled benefits under the Policy and agrees to pay a HK\$30 replacement fee in the event of loss or theft of a Liberty Medical Card.  
同意全數支付由非保單包括之治療及保障所產生的差額。若利寶醫療卡遭遺失或偷竊，投保公司同意支付港幣 30 元以作每張新卡之補發費用。
9. agrees and authorizes Liberty International Insurance Ltd. to appoint Medical Doctor Network for providing medical and related services to each insured member under the Group Policy as notified by the Policyholder from time to time  
受保僱主同意和授權於利寶國際保險有限公司選用指定之醫療網絡醫生，隨時為僱員提供有關之醫療團體服務。
10. understands this application shall be the basis of the insurance contract between me/us and Liberty. I/We further agree to accept Liberty's Policy terms and conditions, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto.  
明白本投保申請書將會作為我(們)與利寶國際保險有限公司訂立保險契約之依據。我(們)同意接受利寶保單的條款及所附之除外責任和背書。
11. agrees to be bound by all the terms and conditions as set forth in the ENDOEX Form provided by Liberty to be used for submission of endorsements of information regarding our employees and/or dependents (e.g. enrollments, benefit changes and/or termination). Liberty is authorized to rely on the completed ENDOEX Form sent via email from the Contact Person and Designated Email Address as indicated to process the endorsements even though it may not bear any signature, company chops or other identification from our company.  
同意受利寶所提供用以提交有關本公司僱員及/或家屬的附帶批單資料(如參與僱員投保登記、福利變動及/或保障終止等)的 ENDOEX 表格所載的所有條款及條件約束。即使 ENDOEX 表格並無任何簽名或加蓋公司圖章，或並無本公司的其他標識，利寶仍有權倚賴由聯絡人透過所示的指定電郵地址以電郵發送並經填妥 ENDOEX 表格以處理附帶批單。
12. agrees that we will notify Liberty if there are any changes to the Designated Email Address or Contact Person in writing as soon as the changes take effect. Liberty shall not be held responsible or liable for any harm that our company, our employees and their dependents may suffer in connection with the failure to notify Liberty of such changes.  
同意盡快以書面通知利寶，有關指定電郵地址或聯絡人的任何變動。利寶概不就本公司、本公司僱員及彼等家屬因未有通知利寶有關變動而可能蒙受的任何損害承擔或負上責任。
13. agrees to provide enrollment related information of our employees and our company has authorized Liberty to use email for the purpose of distributing various types of reports (Claims Summary reports, Payment/Shortfall Advice, Hospital Analysis Sheet, etc.) indicated or offering insurance services to our Company and our employees.  
同意提供本公司僱員參與保險計劃的相關資料，而本公司已授權利寶以電郵方式向本公司及/或本公司僱員發送各類報告(如索償概要報告、付款/差額通知書、住院分析表等)及/或提供保險服務。
14. acknowledges that email services over the internet is not a secure medium where privacy can be ensured and that complete security and confidentiality over the internet is not possible at this time. Liberty shall not be held responsible or liable for any harm that our company, our employees and their dependents may suffer in connection with any such breach of confidentiality or security.  
承認互聯網的電郵服務並非可確保私隱的安全媒介，而現時為止互聯網服務或未能達致完全安全及保密的程度。利寶概不就本公司、本公司僱員及彼等家屬因任何有關違反保密或安全事宜而可能蒙受的任何損害承擔或負上責任。
15. understands that (1) it is duly authorized to release the information of its being the Insured and their Insured Dependents Member and will fully indemnify Liberty for any losses, damages, or claims that might result from the release of such information; (3) Liberty may not process this application if it fails to obtain any information requested in this Application; and (2) it has the right to obtain access to and to request amendments of any personal information held by Liberty concerning the Insured Members and to inform all Members regarding this contract before submitting their personal information to Liberty. Liberty shall not accept any liability for uninformed Members. You may contact Liberty's personal data privacy officer at the address below for any request to access and/or correct any information supplied to us. Moreover, Liberty is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance Industry.  
明白(1)本公司獲得正式授權，可以提供其僱員及其家屬的資料予利寶，並全面保障利寶免因提供該資料而遭受任何損失、損害或索償；(2)倘若申請人未能提供本申請所需的資料，利寶可能未能處理本申請；及(3)申請人有權查閱及要求更正利寶持有有關投保人的所有個人資料及在遞交所需之個人資料予利寶前，須就有關合約通知所有投保人。利寶不會就投保人未獲通知而負上任何責任。閣下可聯絡本公司個人資料私隱主任，地址如下，要求查閱/更改任何交予本公司閣下的個人資料。此外，在此授權利寶國際保險有限公司由「聯會」從保險業內收集的資料中查閱及/或核對閣下的任何資料。

(MM 月) / (DD 日) / (YYYY 年)

Authorized Signature with Company Chop  
簽署/連同公司蓋章Date  
日期Title  
職位Witness by Broker/Agent:  
由保險顧問公司/代理人見證Broker/Agent Company Chop:  
保險顧問/代理人公司印章