

Company Name: _____

Affiliated Company Name: _____

Policy No.: ^1 _____

(Life)(人壽) _____

公司名稱

關聯公司名稱

保單號碼

(Medical)(醫療) _____

(A) Addition of Employee (s) 參加員工

Benefits Class ^2 福利級別 ^2	Identity Document Type ^3 身份證明文件類別 ^3	Identity Document Number ^4 身份證明文件號碼 ^4	Staff Number* 員工號碼*	English Name of Proposed Insured (As shown in Bank Account) 準受保人英文姓名 (請依照銀行戶口姓名填寫)	Gender 性別	Nationality ^6 國籍 ^6	Date of Birth 出生日期			Date of Employment* 入職日期*			Effective Date 生效日期			Basic Monthly Salary* 每月基本薪金*	Employee's Bank Account No.* 僱員之銀行戶口號碼*		
							MM 月	DD 日	YY 年	MM 月	DD 日	YY 年	MM 月	DD 日	YY 年		Bank 銀行	Branch 分行	Account 戶口號碼
	☐ I ☐ N ☐ P																		
Country of Residence***原居地:			Residential Address*** 居住地址:				Email *# 電郵:									Mobile Phone Number*# 手提電話號碼:			
	☐ I ☐ N ☐ P																		
Country of Residence***原居地:			Residential Address*** 居住地址:				Email *# 電郵:									Mobile Phone Number*# 手提電話號碼:			
	☐ I ☐ N ☐ P																		
Country of Residence***原居地:			Residential Address*** 居住地址:				Email *# 電郵:									Mobile Phone Number*# 手提電話號碼:			
	☐ I ☐ N ☐ P																		
Country of Residence***原居地:			Residential Address*** 居住地址:				Email *# 電郵:									Mobile Phone Number*# 手提電話號碼:			
	☐ I ☐ N ☐ P																		
Country of Residence***原居地:			Residential Address*** 居住地址:				Email *# 電郵:									Mobile Phone Number*# 手提電話號碼:			
	☐ I ☐ N ☐ P																		
Country of Residence***原居地:			Residential Address*** 居住地址:				Email *# 電郵:									Mobile Phone Number*# 手提電話號碼:			

(B) Addition of Dependant (s) 參加家屬

Name of Employee** 僱員姓名**	English Name of Proposed Insured 準受保人英文姓名	Relationship with Employee**^5 準受保人與僱員之關係**^5	Gender 性別	Nationality ^6 國籍 ^6	Identity Document Type ^3 身份證明文件類別 ^3	Identity Document Number ^4 身份證明文件號碼 ^4	Date of Birth 出生日期			Date of Marriage 結婚日期			Effective Date 生效日期			Benefits Class ^2 福利級別 ^2
							MM 月	DD 日	YY 年	MM 月	DD 日	YY 年	MM 月	DD 日	YY 年	
		☐ S ☐ C			☐ I ☐ N ☐ P											
		☐ S ☐ C			☐ I ☐ N ☐ P											
		☐ S ☐ C			☐ I ☐ N ☐ P											

Declaration 聲明:

The Company/Affiliated Company confirms that all eligible employees and their dependents have been informed and have agreed that their personal information will be released to YF Life Insurance International Ltd. and vice versa from YF Life Insurance International Ltd. to the Company/Affiliated Company. It is agreed that the information provided may be transferred to any related company or any other company carrying on insurance or reinsurance related business or an intermediary for a claim or investigation or other service providers providing services relevant to insurance business or any association or federation of insurance companies that exists or is formed from time to time. The Company/Affiliated Company has verified the identification documents of all its employees and dependents enrolled or to be enrolled whether under this form or otherwise, it undertakes to keep such information up to date and shall inform YF Life Insurance International Ltd. of any changes to such information and provided documentary proofs to the satisfaction of YF Life Insurance International Ltd. forthwith upon its request.

The Company/Affiliated Company declares that all eligible dependent children enrolling under this Policy are full time students.

本公司／關聯公司確認已知會所有合資格僱員及其家屬，關於其個人資料將會披露予萬通保險國際有限公司之事宜；而僱員亦同意此安排，反之亦然。所提供的資料將可轉交予其他有關公司或任何其他其進行保險或再保業務的公司；或中間人作賠償及調查之用；或其他提供保險服務的提供者；或任何現存及將來成立的保險公司協會或聯會。本公司／關聯公司已核對所有僱員及其家屬之身份證明文件及住址，包括以此或其他表格作出登記或將會登記，並保證會保存最新的資料及通知萬通保險國際有限公司有關那些資料之更新。本公司／關聯公司保證會在萬通保險國際有限公司的要求下，立刻向其提交與該更改有關及令其滿意的文件。

本公司／關聯公司聲明所有加入此保單的合資格家屬子女皆為全日制學生。

Authorized Signature & Company Chop
負責人簽署及公司印章: _____

Date
日期: _____

* To be completed only for Employee enrolment 只適用於加入僱員時填寫

** To be completed only for Dependent enrolment 只適用於加入家屬時填寫

*** To be completed only for Medical Policy 只供醫療保單填寫

Only applicable to a policy which has selected to use E-claims Advice service 只適用於已選用電子賠償通知書服務之保單

^1 Please complete both life & medical policy number if the enrolment is for both products 如需要同時加入人壽及醫療保險計劃，請填寫人壽及醫療保單號碼

^2 Please follow the classification defined in the policy provision 請根據保單上訂立之福利計劃級別填寫

^3 I for HK permanent resident, N for HK non-permanent resident, P for Passport holder 香港永久性居民請用 I，香港非永久性居民請用 N，非香港居民(護照持有人)請用 P

^4 In the case of a HK non-permanent resident, please also provide his passport number 如非香港永久居民，請另外提供其護照號碼

^5 S for Spouse, C for Child 配偶請用 S，子女請用 C

^6 No need to fill in if the proposed insured is a HK permanent resident 如準受保人為香港永久居民，請不用填寫

Company Name: _____ Affiliated Company Name: _____
 公司名稱 關聯公司名稱

Policy No.^1: (Life)(人壽) _____
保單號碼

(Medical)(醫療) _____

Report of Changes 資料更改報告											
Identity Document / Certificate Number 身份證明文件/ 證書號碼	English Name of Insured Member 受保人英文姓名	New Benefits Class ^2 新福利級別 ^2	New Basic Monthly Salary* 新每月基本 薪金*	New Affiliated Company* 新關聯公司*	New Nationality ^3 新國籍 ^3	Employee's New Bank Account No* 僱員之新銀行戶口號碼*			Effective Date 生效日期		
						Bank 銀行	Branch 分行	Account 戶口號碼	MM 月	DD 日	YY 年
New Country of Residence 新原居地:**			New Residential Address 新居住地址:**								
New Mobile Phone Number** 新手提電話號碼:			New Email** 新電郵:								
New Country of Residence 新原居地:**			New Residential Address 新居住地址:**								
New Mobile Phone Number** 新手提電話號碼:			New Email** 新電郵:								
New Country of Residence 新原居地:**			New Residential Address 新居住地址:**								
New Mobile Phone Number** 新手提電話號碼:			New Email** 新電郵:								
New Country of Residence 新原居地:**			New Residential Address 新居住地址:**								
New Mobile Phone Number** 新手提電話號碼:			New Email** 新電郵:								
New Country of Residence 新原居地:**			New Residential Address 新居住地址:**								
New Mobile Phone Number** 新手提電話號碼:			New Email** 新電郵:								

[illegible]

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Authorized Signature &
Company Chop
負責人簽署及公司印章:

Date
日期:

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** To be completed only for Medical Policy 只供醫療保單填寫

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