

Policyowner Name 保單持有人: _____

(Group Name 團體名稱)

MEMBER'S PARTICULARS 成員資料

PLEASE COMPLETE IN BLOCK LETTERS 請以正楷填寫

| | | | |
|--|--------------------------|---|------------------------------|
| English Name : 英文姓名 : | Chinese Name : 中文姓名 : | Sex : 性別 : | ID Card No. : 身份證號碼 : () |
| Nationality 國籍 | Department 部門名稱 | Date of Birth : 出生日期 : _____ / _____ / _____ M 月 D 日 Y 年 | |
| Phone No. : (Home) 電話號碼 : (住宅) | (Office) (辦公室) | (Mobile) (手提電話) | Email Address 電郵地址 : |
| Residential Address : (English) 居住地址 : (英文) | | Permanent Address (If it is different from the Residential Address) : (English) 永久地址 (如跟居住地址不同) : (英文) | |

BENEFIT OPTIONS 保障範圍

| | | |
|---|--|--------------------------|
| Dental Care Plan 牙科保健計劃 | <i>Eligible Age : 6 – 70 years old 合資格投保年齡為 6 至 70 歲</i> | Annual Premium 年費 |
| Option 1 計劃 1 : Scaling and polishing once per year 每年 1 次洗牙 | | HK\$388 |
| Option 2 計劃 2 : Scaling and polishing twice per year 每年 2 次洗牙 | | HK\$498 |

Proposed Insured's Particulars 投保人之個人資料 Please list family members to be covered (if applicable) 請列明同時受保之家庭成員 (如適用)

| English Name of Proposed Insured 投保人英文姓名 | Relationship with the above member 與上述成員的關係 | Date of Birth 出生日期 | | | Sex 性別 | Nationality 國籍 | ID Card No. / Birth Cert. No. 身分證號碼/ 出世紙號碼 | Dental 牙科保健 | | Annual Premium (HK\$) 每年保費 (港元) |
|--|--|-----------------------|--------|--------|-----------|-------------------|---|--------------------------|---|------------------------------------|
| | | M 月 | D 日 | Y 年 | | | | Option1 計劃 1 | Option2 計劃 2 | |
| | Member 成員 | As above 同上 | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| All proposed insured must provide a copy of identity card 所有投保人必須遞交身份證明文件副本 | | | | | | | | | Total Premium (HK\$) 保費總額 (港元) | |

If space is insufficient, please fill in the required information on a separate enrolment form and counter sign. 如空位不足, 請填寫另一份參加表格並在表格上加簽。

Premium Payment Method 繳付保費方法:

- By Cheque 支票** (Please attach a cheque made payable to "MassMutual Asia Ltd". 請連同支票抬頭寫上「美國萬通保險亞洲有限公司」。)
- By Credit Card 信用卡** (Please complete the overleaf "Credit Card Payment Authorization Form" 請填妥背頁之「信用卡付款授權書」。)

Premium Payment Mode 繳付保費方式: Annually 年繳
Declaration & Agreement 聲明及同意:

- I confirm that all of the above information is complete and correct.
本人證實以上資料完全真確無誤。
- I agree that the benefits provided by MassMutual Asia Ltd. ("the Company") are subject to the Limitations & Exclusions, and the terms and conditions as stated in the Policy.
本人同意由美國萬通保險亞洲有限公司(貴公司)所提供的保障是受保單所列明的限制及不保事項及條款限制。
- I understand that this Plan is a non-refundable program and it will be automatically renewed on an annual basis subject to the payment of renewal premium in advance. The Company reserves the right not to renew the benefits upon Policy Anniversary at its sole discretion. I also understand that a full description of network medical services will be provided in the Policy Schedule.
本人明白此計劃已繳付的保費將不予退還, 保障並將按年自動續保, 續保保費須於續保前繳付。本公司亦保留權利於保單週年不予續保。本人同時明白本計劃所提供的網絡醫療服務是根據已列明於本保單的保單計劃表內。
- I agree that the Company shall not be held responsible for any damages incurred through tort, negligence, breach of contract or malpractice by the Appointed Panel of Medical Practitioners, or which result from any defective or dangerous condition in or about the medical facility premises. I also agree that the Company does not undertake any obligation with regard to the Appointed Panel of Medical Practitioner's practice or services except to warrant that the Appointed Panel of Medical Practitioners are currently the General Dental Practitioners for the purposes of rendering dental services in Hong Kong under the laws of Hong Kong.
本人同意貴公司不需承擔因委任網絡醫生之疏忽、失職、違約、侵權行為、使用不符合標準的診療設施或提供不安全之診療場所等而導致任何人有所損失的一切責任; 本人並同意貴公司不會保證委任網絡醫生之專業操守, 但可保證委任網絡醫生確為現時在香港法律下可在香港執業的牙科醫生。
- I understand and agree that all personal data in relation to me and/or my dependents ("Data") may be used and disclosed by the Company for such purposes and to such persons in accordance with the notice made available by the Company to their respective customers from time to time. I also agree that the Company may transfer my/our Data outside Hong Kong, conduct matching procedures (as defined in the Personal Data (Privacy) Ordinance) using the Data, and disclose the Data to any third party for marketing purposes. I understand and agree that the Appointed Panel of General Dental Practitioners may without further notification to me or my dependents verify and disclose to other parties my/our personal information and medical records for the purposes of this plan. I understand that I may request access to and correction of personal information relating to me or my dependents held by the Company by contacting the Manager, Employee Benefits Department at 4/F MassMutual Tower, 38 Gloucester Road, Wanchai, Hong Kong.
本人知悉及同意貴公司可根據客戶通知函件內指明的人士及用途, 使用或披露本人及/或本人已投保之家屬的個人資料。本人亦同意貴公司可將本人及/或本人已投保家屬的個人資料轉移往香港特別行政區以外的地區, 按個人資料(私隱)條例核對本人及/或本人已投保家屬之身份, 使用或披露本人及/或本人已投保之家屬的個人資料予第三者作市場推廣用途。此外, 本人明白及同意本計劃內之委任網絡牙科醫生, 在旨在提供本計劃之牙科服務的情況下, 將可能核對及披露本人及/或本人已投保家屬之個人資料及病歷, 予其他相關人士或機構。本人可向貴公司總辦事處之僱員福利部經理查閱及更改由貴公司持有之本人及已投保家屬的個人資料。
- I understand that I am required to provide valid documentation proofs (such as identity document and address proof) to the satisfaction of the Company for the Company to conduct due diligence on myself, the ultimate beneficial owner of the policy (if any) and my/our authorized signatory(ies) (if applicable) pursuant to the Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance, Cap. 615. If I fail or refuse to do so, the Company shall have the right to disapprove the application.
本人明白本人必須提供符合貴公司要求之有效證明文件(例如身份證明及地址證明)予貴公司, 讓貴公司能按照於「打擊洗錢及恐怖分子資金籌集(金融機構)條例」第 615 章所載, 對本人、保單之最終實益擁有人(如有)及本人之授權簽署人士(如適用)進行客戶盡職審查。如本人未符合此要求, 貴公司有權不批核上述申請。
- I undertake to inform the Company forthwith of any changes to my information provided to it under this application and shall provide documentary proofs of such changes to the satisfaction of the Company forthwith upon its request.
本人保證會立即通知貴公司本人根據這申請所提供的資料之更新, 及於貴公司的要求下, 立刻向貴公司提供與更新有關的及符合貴公司要求之證明文件。

8. I, being the ultimate beneficial owner of the Policy, am acting on my behalf to own and control all the rights of the Policy. If this is not the case, I shall put down the relationship and the personal particulars of the ultimate beneficial owner of the Policy in the "Others" of this application and provide valid documentation proofs (such as his/her identity document and address proof) to the satisfaction of the Company.

本人作為按本保單之實益擁有人，是為本人擁有及控制本保單所賦與的所有權益。若非如此，本人會於本申請書「其他個人資料」項目內提供本保單的實益擁有人的個人資料及與本人之關係，並向貴公司提供其有效的身份證明文件、住址和永久地址證明。

Others 其他個人資料

Note : If the duly completed enrolment form and the required premium are received by MassMutual Asia Ltd. on or before 20th of the month, the benefits will come into effect on the first day of the following month, otherwise the benefits will come into effect on the first day of the month after the following month. 若本公司於每月 20 號或之前收到填妥的參加表格及應繳保費，保障將由下月首日生效，否則保障將於隨後第 2 個月的首日生效。

Signature of Member : _____
成員簽署

Date : _____ / _____ / _____
日期 M月 D日 Y年

Credit Card Payment Authorization Form 信用卡付款授權書

I authorize MassMutual Asia Limited to debit the following credit card account for all annual payments payable to MassMutual Asia Limited in relation to the **MassMutual**

Voluntary Group Assurance Plan until further notice. 本人授權美國萬通保險亞洲有限公司在以下信用卡戶口扣除有關**美國萬通自選福利計劃**之年費直至另行通知。

Credit Card Account Details 信用卡戶口資料 (PLEASE COMPLETE IN BLOCK LETTERS 請以正楷填寫)

VISA MasterCard Name of Credit Card Issuing Bank 發卡銀行名稱: _____

Credit Card Number :
信用卡號碼

Credit Card Valid Thru
信用卡有效期至

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

Name of Member 成員姓名 (In English 英文): _____

Credit Cardholder's Name 信用卡持有人姓名 (In English 英文): _____

Credit Cardholder's Relationship with Member 信用卡持有人與成員的關係: _____

(If Cardholder is neither the Member nor Insured 若信用卡持有人並非成員或受保人必須申報)

Hong Kong Identity Card No./ Passport No. 信用卡持有人的香港身份證號碼 / 護照號碼: _____

Contact Telephone Number 聯絡電話: _____

In consideration of MassMutual Asia Limited agreeing to the above, I acknowledge and agree that (notwithstanding any terms to the contrary in the relevant cardholder agreement governing the use of my above Credit Card) in the event of any dispute regarding charges aforesaid, I will raise it within 30 days from the benefit effective date, failing which I hereby waive all my rights against MassMutual Asia Limited or any person in respect of such charges or payments. 有鑑於美國萬通保險亞洲有限公司同意上述安排，本人了解及同意(縱然抵觸「信用卡使用守則」)若本人對上述信用卡賬戶支取費用有任何不滿，本人必須在保障生效後 30 天內提出；否則，本人將放棄向美國萬通保險亞洲有限公司或有關人士追究的權利。

Signature 簽名: _____ Date 日期: _____

Signature of Credit Card Holder 信用卡持有人簽名

M月 / D日 / Y年

(same as Credit Card A/C Signature 與信用卡戶口之簽名相同)