


# Application Form A



(Please use block letters)

## For Administration Use

Ref. _____	Policy Number _____	# _____	 <b>SWISS-SURE COMPANY LIMITED</b> 11/F Lam Che Bldg., 18 Wing Lok St., Central, Hong Kong Tel: 2543 9429 Fax: 2541 8147 E-mail: info@swiss-sure.com.hk www.swiss-sure.com <small>CIB Member of "The Hong Kong Confederation of Insurance Brokers"</small>
Date _____	_____		

## Commencement date

I / we request that the policy commences from 01 day \_\_\_\_\_ month \_\_\_\_\_ year

## Policyholder

First name(s) _____	Date of birth (day/month/year) _____
Family name(s) _____	Sex (M/F) <input type="checkbox"/>
Address _____	
Address _____	Postal Code _____
City _____	Telephone _____
Country _____	Fax _____
E-mail _____	

## Online customer sign up

I hereby sign up as an online customer. As an online customer, I will receive all documents and correspondence from ihi Bupa via my personal site myPage on www.ihicom.com.

## Intermediary's access to documents

In the event that I am represented by an intermediary, I hereby accept that my intermediary will get access to my documents online on his/her personal and secure ihi Bupa website.

## Reimbursement via bank transfer

If you would like us to transfer future reimbursements to your bank account, please state:

Account holder's name(s) \_\_\_\_\_

Name of bank \_\_\_\_\_

Bank address \_\_\_\_\_

Postal Code \_\_\_\_\_ City \_\_\_\_\_ Country \_\_\_\_\_

IBAN No. \_\_\_\_\_

SWIFT No. \_\_\_\_\_

## Dependants

First name(s) _____	Date of birth (day/month/year) _____
Family name(s) _____	Sex (M/F) <input type="checkbox"/>
First name(s) _____	Date of birth (day/month/year) _____
Family name(s) _____	Sex (M/F) <input type="checkbox"/>
First name(s) _____	Date of birth (day/month/year) _____
Family name(s) _____	Sex (M/F) <input type="checkbox"/>

**Cover** - please choose cover, currency and deductible by ticking the relevant boxes

Main insurance						Supplementary insurance	
<input type="radio"/> Complete Plan, deductible			<input type="radio"/> Hospital Plan, deductible			<input type="radio"/> Dental & Optical	
<b>CHF</b>	<b>EUR</b>	<b>USD</b>	<b>CHF</b>	<b>EUR</b>	<b>USD</b>	<input type="radio"/> Medical Evacuation & Repatriation	
<input type="radio"/> Nil	<input type="radio"/> Nil	<input type="radio"/> Nil	<input type="radio"/> Nil	<input type="radio"/> Nil	<input type="radio"/> Nil		
<input type="radio"/> 300	<input type="radio"/> 200	<input type="radio"/> 200	<input type="radio"/> 600	<input type="radio"/> 400	<input type="radio"/> 400		
<input type="radio"/> 600	<input type="radio"/> 400	<input type="radio"/> 400	<input type="radio"/> 2,000	<input type="radio"/> 1,350	<input type="radio"/> 1,350		
<input type="radio"/> 2,000	<input type="radio"/> 1,350	<input type="radio"/> 1,350	<input type="radio"/> 4,000	<input type="radio"/> 2,700	<input type="radio"/> 2,700		
<input type="radio"/> 4,000	<input type="radio"/> 2,700	<input type="radio"/> 2,700					

**Please note that the chosen currency is binding.**

**Premium payment**

Annual                       Semi-annual

**Request for payment from a bank or another address** (if different from residential address)

Name(s)			
Address		Account No. (if bank)	
Address		Postal Code	
City		Country	

**Request for payment by International Credit Card**

I / we wish to pay the premium via credit card. Bupa Denmark, filial af Bupa Insurance Limited, England will charge the credit card company directly.

American Express                       VISA                       Eurocard / MasterCard

JCB     Diners

Card no.    Expiry date (m/y)                      CVC code\*

\* CVC code: The last three/four digits after the card number on the back of the card or the last three digits in the signature field.

Cardholder's data if cardholder and policyholder are not the same person:

Name(s)			
Address			
Address		Postal Code	
City		Country	

I also authorise Bupa Denmark, filial af Bupa Insurance Limited, England, until further notice in writing, to charge my credit card account with unspecified amounts in respect of my premium payments as and when these become due. The Company will inform me in advance of any premium adjustments.

**Please note that the Company will need the original, signed form to be able to charge the credit card.**

Cardholder's signature \_\_\_\_\_ Date \_\_\_\_\_