僱員福利保險新增僱員、更改資料及離職表格
Employee Addition, Changes and Termination Form for Employee Benefits Insurance

FWD 富衛

備註 Note :

1 請以英文正楷填寫及於更改生效日期後 31 天內交回本公司。
Please complete this form in BLOCK LETTERS and return to us within 31 days after the effective date of such changes.

2 適用於團體醫療保險: 如於保單生效日或續保日公司僱員人數少於 4 人，新增加之僱員須填寫健康申報表及須連同此表格一併交回本公司以作核保之用。
For Group Medical Insurance: For companies with less than 4 employees on the policy effective date or renewal date, the new employee is required to complete the Health Declaration Form and return it to us together with this form for underwriting purposes.

3 適用於團體人壽保險: 如新增加之僱員之投保額超過自動受保額，新增加之僱員須填寫健康申報表及須連同此表格一併交回本公司以作核保之用。
For Group Life Insurance: If the sum assured of the new employee exceeds the Automatic Acceptance Limit, the new employee is required to complete the Health Declaration Form and return it to us together with this form for underwriting purposes.

電郵 E-mail : **employeebenefits@fwd.com**

傳真 Fax : **2850 3003**

保單持有人 Policyholder : _____

團體醫療保單號碼 Group Medical Policy No.: _____

附屬公司 Affiliated Company : _____

團體人壽保單號碼 Group Life Policy No.: _____

新增僱員或家屬 Addition of Employee/Dependant :

僱員編號 Employee Code (如適用 If applicable)	僱員姓名 Employee's Name	家屬姓名 Dependant's Name (如適用 If applicable)	關係 Rel.*	婚姻狀況 Marital Status #	性別 Sex	出生日期 Date of Birth (DD/MM/YYYY)	身份證/護照號碼 ID Card/Passport No.	僱員類別 Employee Type	受僱日期 Employment Date (DD/MM/YYYY)	月薪 Monthly Salary** / 職位 Position	僱員之銀行戶口號碼 (僱員必須提供此項資料用作醫療賠償用途) Employee's Bank Account No. (This information must be provided and will be used for medical benefit reimbursement) / 電郵地址 E-mail Address ##	生效日期 Effective Date (DD/MM/YYYY)

* EE – 僱員 Employee, SP – 配偶 Spouse, CH – 子女 Child

\# S – 未婚 Single, M – 已婚 Married, D – 離婚 Divorced, W – 寡居 Widowed

只適用於有家屬保障的員工填寫 Applicable for employee with dependent coverage only

** 月薪 Monthly Salary - 只適用於人壽保險 For Life coverage only

如有提供電郵地址，醫療索償理賠表將以電郵送遞 Claim Adjustment Statement will be sent by email if email address is provided

終止僱員及家屬之保障 Termination of Employees & Dependants

僱員編號 Employee Code (如適用 If applicable)	身份證/護照號碼 ID Card/Passport No.	僱員姓名 Employee's Name	家屬姓名 Dependant's Name	離職日期 (最後工作日) Termination Date (last working date) (DD/MM/YYYY)	備註 Remarks

更改薪金/僱員類別 Change of Salary/Employee Type

僱員編號 Employee Code (如適用 If applicable)	身份證/護照號碼 ID Card/Passport No.	僱員姓名 Employee's Name	由 From	至 To	新職位/更改原因 New Position/Reason of Change (如適用 If applicable)	生效日期 Effective Date (DD/MM/YYYY)

其他更改 Other Changes

僱員編號 Employee Code (如適用 If applicable)	身份證/護照號碼 ID Card/Passport No.	僱員姓名 Employee's Name	僱員之銀行戶口號碼 (用於醫療賠償用途) Employee's Bank Account Number (for medical benefit reimbursement)	電郵地址 E-mail Address ##	其他 Other	生效日期 Effective Date (DD/MM/YYYY)

如有提供電郵地址，醫療索償理賠表將以電郵送遞 Claim Adjustment Statement will be sent by email if email address is provided

保單持有人明白及同意 :
The Policyholder understands and agrees that :

保單持有人承諾於遞交所需之個人資料予富衛保險有限公司及/或富衛人壽保險 (百慕達) 有限公司（統稱「富衛」）前，須通知有關僱員及其家屬(如適用) 有關本保單及富衛之收集個人資料聲明(不論是否載於此或由其他途徑取得)。富衛將不會就有關僱員及其家屬(如適用) 未被通知的情況而承擔任何責任。

The Policyholder undertakes that it will inform /has informed the relevant employees and their dependents (if applicable) about this Policy and the Personal Information Collection Statement of FWD General Insurance Company Limited and /or FWD Life Insurance Company (Bermuda) Limited (collectively, "FWD") (whether contained herein or otherwise obtained) before transferring their personal information to FWD. FWD shall not accept any liability for employees and their dependents (if applicable) not been informed.

富衛保險有限公司 / 富衛人壽保險 (百慕達) 有限公司
香港中環德輔道中 308 號富衛金融中心 7 樓
FWD General Insurance Company Limited / FWD Life Insurance Company (Bermuda) Limited
7/F., FWD Financial Centre, 308 Des Voeux Road Central, Hong Kong

授權人簽署及公司蓋章 Authorised Signature with Company Chop　　日期 Date