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

Note 備註:

1 Please complete this form in BLOCK LETTERS and return to us within 31 days after the effective date of such changes. 請以英文正楷填寫及於更改生效日期後三十一天內交回本公司。

2 For Group Medical Insurance: For companies with less than 10 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.
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十人，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。

3 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.
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。

E-mail 電郵 : **employeebenefits@fwd.com**
Fax 傳真 : **2850 3003**

Policyholder 保單持有人 : _____ Group Medical Policy No. 團體醫療保單號碼: _____

Affiliated Company 附屬公司 : _____ Group Life Policy No. 團體人壽保單號碼: _____

Addition of Employee/Dependant 新增僱員或家屬

Employee Code 僱員編號 (If applicable 如適用)	Employee's Name 僱員姓名	Dependant's Name 家屬姓名 (If applicable 如適用)	Rel.* 關係	Marital Status# 婚姻狀況	Sex 性別	Date of Birth 出生日期 (DD/MM/YYYY)	ID Card /Passport No. 身份證/護照號碼	Employee Type 僱員類別	Employment Date 受僱日期 (DD/MM/YYYY)	Monthly** Salary 月薪 / Position 職位	Employee's Bank Account No. (This information must be provided and will be used for medical benefit reimbursement) 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) / E-mail Address 電郵地址##	Effective Date 生效日期 (DD/MM/YYYY)

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

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

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

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

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

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

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

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

Other Changes 其他更改

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

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

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

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.

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。

Employee Benefits Division 僱員福利部

7/F., FWD Financial Centre, 308 Des Voeux Road Central, Hong Kong

香港中環德輔道中 308 號富衛金融中心 7 樓

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