Galaxy Entertainment Group

Voluntary Employee Benefits Program

VEB-08//2018

Personal Accident Cover

Accidental Death and Disablement Benefit:
Compensates the Insured benefit up to a maximum of HK$1,000,000 against accidental death, total disability and dismemberment within 12 months of an accident.

Accidental Medical Expenses Benefit:
Reimburses the Insured for injury sustained through an accident. Provides cover for outpatient, specialist, hospitalization expenses, surgical expenses, Chinese bonesetters and acupuncturists expenses. The expenses paid to Chinese bonesetters and acupuncturists can be reimbursed up to HK$1,500 per disability and HK$3,000 per policy year subject to the maximum amount of the selected Accidental Medical Expenses Benefit.

Coverage (MOP)			Monthly Premium (MOP)			
Unit	**Accidental Death & Disablement Benefit**	**Accidental Medical Expenses per Disability**	**Staff**	**Staff +Spouse**	**Family**	**Staff + Child(ren)**
1	**200,000**	**3,000**	$ 30	$ 60	$ 60	$ 30
2	**400,000**	**6,000**	$ 50	$ 100	$ 100	$ 50
3	**600,000**	**9,000**	$ 69	$ 138	$ 138	$ 69
4	**800,000**	**12,000**	$ 89	$ 178	$ 178	$ 89
5	**1,000,000**	**15,000**	$ 108	$ 216	$ 216	$ 108

- The sum insured of staff and spouse are the same.
- Each dependent child's Accidental Death and Disablement and Accidental Medical Expenses coverage is 15% of the Principal Insured's benefit subject to the maximum of the Accidental Medical Expenses benefit.

Coverage of Accidental Death & Disability Benefit

COVERAGES	COMPENSATION
1. Death	100%
2. Permanent Total Disablement	100%
3. Permanent and Incurable Paralysis of all Limbs	100%
4. Permanent Total Loss of Sight of both Eyes	100%
5. Permanent Total Loss of Sight of one Eye	100%
6. Loss of or the Permanent Total Loss of use of two Limbs	100%
7. Loss of or the Permanent Total Loss of use of one Limb	100%
8. Loss of Speech and Hearing	100%
9. Permanent and Incurable Insanity	100%
10. Permanent Total Loss of Hearing in	
(a) both Ears	75%
(b) one Ear	15%
11. Loss of Speech	50%
12. Permanent Total Loss of the Lens of one Eye	50%
13. Loss of or the Permanent Total Loss of use of four Fingers and Thumb of	
(a) Right Hand	70%
(b) Left Hand	50%
14. Loss of or the Permanent Total Loss of use of four Fingers of	
(a) Right Hand	40%
(b) Left Hand	30%
15. Loss of or the Permanent Total Loss of use of one Thumb	
(a) both Right Joints	30%
(b) one Right Joint	15%
(c) both Left Joints	20%
(d) one Left Joint	10%
16.Loss of or the Permanent Total Loss of use of Fingers	
(a) three Right Joints	10%
(b) two Right Joints	7.5%
(c) one Right Joint	5%
(d) three Left Joints	7.5%
(e) two Left Joints	5%
(f) one Left Joint	2%
17.Loss of or the Permanent Total Loss of use of Toes	
(a) all - one Foot	15%
(b) great - both Joints	5%
(c) great – Joint	3%
18.Fractured Leg or Patella with established non-union	10%
19.Shortening of Leg by at least 5cm	7.5%
20.Permanent Disability not otherwise provided for under Events 10 to 19 inclusive. Such percentage of the Principal Sum Insured as the Company shall in its absolute discretion determine and being in its opinion not inconsistent with the Compensation provided under Events 10 to 19 inclusive.	

Note: The Right/ Left benefits shown above will be reserved in the case of a left-handed insured person.

Daily Hospital Home Benefit

Daily Hospital Cash Benefit:
Reimburses the Insured a daily hospital cash benefit up to 365 days when hospitalized.

Intensive Care Unit Benefit:
Daily hospital cash will be doubled up to 30 days if the Insured is confined to an intensive care unit.

Long Term Hospitalization Benefit:
Reimburses the Insured an extra long-term hospitalization benefit up to 30 days from the 31st day of hospitalization.

Cover Summary (MOP)			
Unit	***Daily Hospital Cash Benefit / day***	***Intensive Care Unit Benefit / day***	***Long Term Hospitalization Benefit / day***
1	**250**	**Extra 250**	**Extra 250**
2	**500**	**Extra 500**	**Extra 500**
3	**750**	**Extra 750**	**Extra 750**
4	**1,000**	**Extra 1,000**	**Extra 1,000**
5	**1,250**	**Extra 1,250**	**Extra 1,250**

Entry Age	**Monthly Premium (MOP)**			
	Staff	***Staff + Spouse***	***Family Coverage***	***Staff + Child(ren)***
18 – 25	$ 24	$ 47	$ 59	$ 35
26 – 30	$ 27	$ 54	$ 68	$ 41
31 – 35	$ 29	$ 59	$ 74	$ 44
36 – 40	$ 31	$ 62	$ 78	$ 47
41 – 45	$ 36	$ 71	$ 89	$ 54
46 – 50	$ 43	$ 86	$ 107	$ 64
51 – 55	$ 53	$ 105	$ 132	$ 79
56 – 60	$ 59	$ 119	$ 149	$ 89
61 – 65	$ 77	$ 154	$ 192	$ 115
Renewable up to 66 – 69	$ 103	$ 205	$ 256	$ 154

- The sum insured of staff, spouse and child (ren) are the same.
- Premium will be based on the entry age of the staff and remains unchanged unless sub-sequential increase in benefits. New premium will be based on the attained age for the entire amount.

Critical Illness Cover

A lump sum will be paid to the Insured in the event of diagnosis of any of the specified critical illnesses.

Unit	1	2	3	4	5
Sum Insured (MOP$)	100,000	200,000	300,000	400,000	500,000

Monthly Premium Table (per unit)：

Entry Age	*Monthly Premium (MOP)*				
	Staff		*Staff + Child(ren)*		*Family / Staff + Spouse*
	Female	*Male*	*Female*	*Male*	
18 – 25	$ 24	$ 32	$ 30	$ 40	$ 48
26 – 30	$ 35	$ 50	$ 44	$ 63	$ 73
31 – 35	$ 47	$ 71	$ 59	$ 89	$ 100
36 – 40	$ 62	$ 98	$ 78	$ 123	$ 135
41 – 45	$ 84	$ 138	$ 105	$ 173	$ 188
46 – 50	$ 103	$ 178	$ 129	$ 223	$ 238
51 – 55	$ 125	$ 229	$ 156	$ 286	$ 301
56 – 60	$ 139	$ 261	$ 174	$ 326	$ 340
61 – 65	$ 239	$ 326	$ 299	$ 408	$ 433
Renewable up to 66 – 69	$ 347	$ 473	$ 433	$ 590	$ 628

- The sum insured of spouse and child(ren) is 100% and 15% of the insured staff respectively.
- Premium will be based on the entry age of the staff and remains unchanged unless sub-sequential increase in benefits. New premium will be based on the attained age for the entire amount.

The covered 47 critical illnesses include:

1. Stroke
2. Major Cancer
3. Heart Attack
4. Other Serious Coronary Artery Disease
5. Coronary Artery By-pass Surgery
6. Heart Valve Surgery
7. Fulminant Hepatitis
8. End Stage Liver Failure
9. Primary Pulmonary Hypertension
10. End-stage Lung Disease
11. Kidney Failure
12. Surgery to Aorta
13. Aplastic Anaemia
14. Major Organ / Bone Marrow Transplantation
15. Blindness (Loss of Sight)
16. Deafness (Loss of Hearing)
17. Loss of Speech
18. Coma
19. Major Burns
20. Multiple Sclerosis
21. Paralysis (Loss of use of Limbs)
22. Poliomyelitis
23. Muscular Dystrophy
24. Alzheimer's Disease / Severe Dementia
25. Motor Neurone Disease
26. Parkinson's Disease
27. Encephalitis
28. Benign Brain Tumour
29. Major Head Trauma
30. Bacterial Meningitis
31. Apallic Syndrome
32. Systemic Lupus Erythematosus (SLE) caused with Lupus Nephritis
33. Chrohn's Disease
34. Acute Necrotizing Pancreatitis
35. Terminal Illness
36. Loss of Independent Existence
37. Elephantiasis
38. AIDS due to Blood Transfusion
39. Occupational Acquired HIV
40. Severe Rheumatoid Arthritis
41. Medillary Cyctic Disease
42. Cardiomyopathy
43. Ebola
44. Creutzfeld-Jacob Disease
45. Angioplasty and Other Invasive Treatments for Coronary Artery*
46. Severe Acute Respiratory Syndrome (SARS)**
47. Cerebral Aneurysm Requiring Surgery***

* *Only 10% of the sum assured will be paid subject to the amount selected. This Critical Illness will be terminated upon such payment and the amount of subsequent Critical Illness Benefit will then be reduced.*

** *Only 10% of the sum assured or maximum HK$20,000 will be paid subject to whichever is lower. This Critical Illness will be terminated upon such payment and the amount of subsequent Critical Illness Benefit will then be reduced.*

*** *Only 40% of the sum assured will be paid subject to the amount selected. This Critical Illness will be terminated upon such payment and the amount of subsequent Critical Illness Benefit will then be reduced.*

Optional Senior Care Protection Plan

(Staff should choose one of above basic coverage first before applying the plan for their parent(s) and / or parent(s)-in-law)

Cover Summary	Plan A	Plan B
1. Accidental Death and Disablement Benefit	150,000	300,000
2. Accidental Medical Expenses Benefit	Maximum 2,000 per disability and maximum 10,000 per policy year.	Maximum 3,000 per disability and maximum 20,000 per policy year.
a) Medical Expenses	This benefit reimburses the Insured Person for accident surgical expenses, general medical expenses, including expenses of in / out patient	This benefit reimburses the Insured Person for accident surgical expenses, general medical expenses, including expenses of in / out patient.
b) Chinese Bonesetters and Acupuncturists	Chinese Bonesetters and Acupuncturists with 180 / visit / day reimbursement, maximum 2,000 per disability and maximum 4,000 per policy year.	Chinese Bonesetters and Acupuncturists with 180 / visit / day reimbursement, maximum 2,000 per disability and maximum 4,000 per policy year.
3. Daily Hospital Income Benefit	200/day	300/day
4. Care Assistant Benefit	2,500/month, maximum 60 months	5,000/month, maximum 60 months
5. Broken Bones Benefit	75,000	150,000

Premium Table

	Monthly Premium
Plan A	MOP 112
Plan B	MOP 204

- The entry age is 45-75 and renew up to 85. Benefit will be reduced by 50% for any age over 80.
- Daily Hospital Income Benefit per each hospital confinement is subject to 3 days waiting period and maximum payment period of 30 days.

Coverage of Broken Bones

Events	Percentage of Sum Insured
Fracture of Bones	
Hip or Pelvis	100%
Thigh or Heel	50%
Skull, Collarbone, Lower Leg, Ankle, Arm, Elbow, Wrist	40%
Lower Jaw	30%
Vertebrae, Shoulder Blade, Knee Cap, Sternum, Hand, Foot	20%
Upper Jaw, Cheek Bone, Nose, Ribs, Coccyx, Toes, Fingers	15%

Important Notice

All full-time staff, spouse age between 18-65 and renew until age 69; parents or parent-in-law aged between 45-75 are eligible to join Senior Plan and renew until age of 85.

- "Family Coverage" includes staff, spouse, and all unmarried dependent children aged from 6 months to 21, or up to 25 for full-time student. Staff must opt the same categories.
- The Insured must enroll first and then his/her family members including parent(s) and parent(s)-in-law are eligible to apply.
- The premium is on a monthly basis and would be directly debited from the staff's assigned credit card payment.

Termination

Upon resignation or retirement, you and your family can still enjoy this privileged coverage with fixed premium up to 69 years of age provided that you have sent written notification to Chartis prior to your change of occupation. (This does not apply if you are going into an occupation with higher risk nature.)

General Exclusion

War; civil war; engaging in the Armed or Disciplinary Forces; flying as a pilot or crew member in any aircraft; intentional self injury or suicide; pre-existing conditions*; childbirth, pregnancy and miscarriage; drug addiction; alcoholism and its related conditions, or any psychiatric condition; professional sports and AIDS**.

Additional Exclusion applicable to Accidental Death and Disablement, Accidental Medical Expenses, and Broken Bones Benefit

- Sickness

Additional Exclusions applicable to Daily Hospital Income Benefit

- Rest cure and any medical check-up, congenital abnormalities and their related conditions, all dental care and plastic surgery except as a result of accident.
- Any signs or symptoms which first occurred prior to or within 15 days following the effective date of this insurance.

Additional Exclusions for Critical Illness Plan

- Any congenital defect and pre-existing condition***.
- Any critical illness of which the signs or symptoms first occurred prior to or within ninety (90) days following the effective date of this insurance.
- Any critical illness where the Insured Person does not survive for a period of fourteen (14) days after the first Diagnosis.
- Any SARS/Atypical Pneumonia of which the signs or symptoms first occurred prior to or within fifteen (15) days following the effective date of this insurance.

*Pre-existing Condition**

Condition for which the Insured Person received or were recommended by a Registered Medical Practitioner for any medical treatment, diagnosis, consultation or prescribed drugs, or the existence of any symptoms (known or unknown to the Insured Person(s), leading to a claim under this Policy, within three (3) years preceding the Policy's effective date, last reinstatement date or date of any increase of benefit coverage (to the extent of such increase only), whichever is later. Such condition shall be covered provided the Insured Person(s) have been insured under this Policy for three (3) consecutive years from the Policy's effective date, last reinstatement date or date of any increase of benefit coverage (to the extent of such increase only), whichever is later.

*General Exclusions for "AIDS"***

Not applicable to item 38 and 39 under Critical Illness Cover.

*Critical Illness Pre-existing Condition****

Condition shall mean any Illness, disease or other condition of the Insured Person within a five (5) years period prior to the Effective Date of this Policy, last reinstatement date or date of any increase of benefit coverage (to the extent of such increase only), whichever is later for any: (a) first manifested itself, worsened, became acute or exhibited symptoms which would have caused an ordinarily prudent person to seek diagnosis, care or treatment; (b) required the Insured Person taking prescribed drugs or medicine; or (c) was treated by a Registered Medical Practitioner or a Qualified Medical Practitioner or treatment had been recommended by a Registered Medical Practitioner or a Qualified Medical Practitioner. Pre-existing Condition shall also mean the existence of symptoms of any Critical Illness or a condition likely to cause a Critical Illness, which would cause an ordinarily prudent person to seek diagnosis, care or test.

This Exclusion List only serves descriptive purpose. Details should refer to actual policy wordings.

Enrollment Method

For enrolment, please complete the application and send together with the payment forms to AIG Insurance Hong Kong Limited (Macau Branch), Unit 506,5 th Floor, AIA Tower No.251A_301, Avenida Comercial de Macau. The coverage will become effective from the first day of the following month upon the receipt and acceptance of your application.

For any queries, please contact AIG Insurance Hong Kong Limited (Macau Branch)
Unit 506,5/F,AIA Tower, No. 251A-301 Avenida Comercial de Macau.
Tel: (853) 2835 5602 Fax:(853) 2835 5299 (Free Service Hotline: 0800227
Monday to Friday (except public holiday), 8:45 am to 1:00 pm and 2:00 pm to 5:15 pm.

- This brochure outlines in general terms only the type and nature of the cover provided which is subject to the terms and conditions of the policy. It is not a substitute for the policy itself. You should read the policy document for a precise description of the actual terms and conditions of the coverage available under the policy.
- AIG reserves the right to underwrite and/or accept your application and/or change and/or amend the policy details at any time

AIG 美亞保險

銀河娛樂集團
Galaxy Entertainment Group
僱員自購保障計劃申請表
("VEB" Application Form)

For office Use Only	
CN No	
Source	
Effective Date	
Bill Date	
Handler	

VEB-08/2018

A. Staff (Insured) Personal Particulars **僱員(投保人)個人資料** ***(Please use the capital letter)*** *（請以英文正楷填寫）*
Please tick the appropriate box 請於適用之方格內加☑

英文姓名 性別 男 女 出生日期 慣用左手
English Name :_____ **Sex : M** ❑ **F** ❑ **Date of Birth :** ____**M**月____**D**日_____**YR**年 **Left Handed** ❑
中文姓名 身份證號碼 員工 編號
Chinese Name: _____ **I.D. No. :**_____ **Staff No. :**_____
住址電話 辦公室電話 傳呼/手提電話號碼
Tel (Home) :_____ **Tel (Office) :** _____ **Pager/Mobile No. :**_____
地址 職位
Address :_____ **Position :** _____
電郵地址
_____ **E-mail Address:** _____

B. Insured Family Member(s) Information **投保人家庭成員資料** ***(Please use the capital letter)*** *（請以英文正楷填寫）*

	Name 姓名	Left Handed 慣用左手	I.D. No. /Cert. of Birth No 身份證/出生証明書號碼	Occupation 職業	Sex 性別	Date of Birth 出生日期
配偶 Spouse	_____	❑	_____	_____	M 男 ❑ F 女 ❑	__ M 月 __ D 日 ___Yr 年
子女 Child	_____	❑	_____	_____	M 男 ❑ F 女 ❑	__ M 月 __ D 日 ___Yr 年
	_____	❑	_____	_____	M 男 ❑ F 女 ❑	__ M 月 __ D 日 ___Yr 年

C. Monthly Premium Table 每月保費表
Please tick the appropriate box for cover(s)/ Protection required 請於所需保障前之方格加☑
The category for different coverage chosen should be the same (please refer to the example as below)
(各保障所選擇的組合必須相同) (請參閱以下例子)
Example: If the "Family Coverage" category is chosen in "Personal Accident Cover", the category for the rest of cover should be "Family Coverage".
例子: 如 "個人意外保障" 之組合選擇為 "家庭"，其他的保障項目的組合必須同為"家庭"

Personal Accident Cover 個人意外保障					
Unit	**Staff**	**Staff + Spouse**	**Family Coverage**	**Staff + Child(ren)**	**Monthly Premium**
單位	**員工**	**員工+配偶**	**家庭**	**員工+子女**	**每月保費**
1	☐ **$ 30**	☐ **$ 60**	☐ **$ 60**	☐ **$ 30**	
2	☐ **$ 50**	☐ **$ 100**	☐ **$ 100**	☐ **$ 50**	
3	☐ **$ 69**	☐ **$ 138**	☐ **$ 138**	☐**$ 69**	
4	☐ **$ 89**	☐ **$ 178**	☐ **$ 178**	☐ **$ 89**	
5	☐ **$ 108**	☐ **$ 216**	☐ **$ 216**	☐ **$ 108**	

Daily Hospital Income Benefit (per coverage unit) 每日住院現金保障 (每一單位）						
Age	**Staff**	**Staff + Spouse**	**Family Coverage**	**Staff + Child(ren)**	**Unit**	**Monthly Premium**
年齡	**員工**	**員工+配偶**	**家庭**	**員工+子女**	**單位**	**每月保費**
18–25	☐**$ 24**	☐ **$ 47**	☐ **$ 59**	☐**$ 35**	**X**	
26–30	☐ **$ 27**	☐ **$ 54**	☐ **$ 68**	☐ **$ 41**	**X**	
31–35	☐ **$ 29**	☐ **$ 59**	☐ **$ 74**	☐ **$ 44**	**X**	
36–40	☐ **$ 31**	☐ **$ 62**	☐ **$ 78**	☐ **$ 47**	**X**	
41–45	☐ **$ 36**	☐ **$ 71**	☐ **$ 89**	☐ **$ 54**	**X**	
46–50	☐ **$ 43**	☐ **$ 86**	☐ **$ 107**	☐ **$ 64**	**X**	
51–55	☐ **$ 53**	☐ **$ 105**	☐ **$ 132**	☐ **$ 79**	**X**	
56–60	☐ **$ 59**	☐ **$ 119**	☐ **$ 149**	☐ **$ 89**	**X**	
61–65	☐ **$ 77**	☐ **$ 154**	☐ **$ 192**	☐ **$ 115**	**X**	
Renewable up to **66-69**	☐ **$ 103**	☐ **$ 205**	☐ **$ 256**	☐ **$ 154**	**X**	

Critical Illness Cover (per coverage unit) 危疾保障（每一單位）								
Age	Female	Male	Staff + Spouse	Staff + Child(ren) 員工＋子女		Family Coverage	Unit	Monthly Premium
年齡	女性	男性	員工＋配偶	Female 女性	Male 男性	家庭	單位	每月保費
18-25	☐$ 24	☐$ 32	☐$ 48	☐$ 30	☐$ 40	☐$ 48	X	
26-30	☐ $ 35	☐ $ 50	☐ $ 73	☐ $ 44	☐ $ 63	☐ $ 73	X	
31-35	☐ $ 47	☐ $ 71	☐ $ 100	☐ $ 59	☐ $ 89	☐ $ 100	X	
36-40	☐ $ 62	☐ $ 98	☐ $ 135	☐ $ 78	☐ $ 123	☐ $ 135	X	
41-45	☐ $ 84	☐ $ 138	☐ $ 188	☐ $ 105	☐ $ 173	☐ $ 188	X	
46-50	☐ $ 103	☐ $ 178	☐ $ 238	☐ $ 129	☐ $ 223	☐ $ 238	X	
51-55	☐ $ 125	☐ $ 229	☐ $ 301	☐ $ 156	☐ $ 286	☐ $ 301	X	
56-60	☐ $ 139	☐ $ 261	☐ $ 340	☐ $ 174	☐ $ 326	☐ $ 340	X	
61-65	☐ $ 239	☐ $ 326	☐ $ 433	☐ $ 299	☐ $ 408	☐ $ 433	X	
Renewable up to 66-69	☐ $ 347	☐ $ 473	☐ $ 628	☐ $ 433	☐ $ 590	☐ $ 628	X	

Total Monthly Premium 每月總保費 ： **MOP$**

- Staff (Insured) must enroll first before their immediate family members enroll the plan.
- 僱員(投保人)須先行投保，其配偶、子女方可參與此計劃。
- Family includes staff(Insured), spouse, and all their age 6 months to 21 dependent children or renew up to age 25 for a full-time student.
- 家庭保障包括僱員(投保人)、配偶及所有 6 個月至 21 歲未婚及未在職之子女，全日制學生可續保至 25 歲。
- Premium remains unchanged unless subsequent benefit upgrade, premium for the whole "Daily Hospital Income Benefit" and/or "Critical Illness Cover" will then be calculated on the attained age of the insured at the time of benefit upgrade.
- 保費維持不變。其後增加保額，整項 "每日住院現金保障" 及/或 "危疾保障"之保費將按投保人增加保額時的年齡再作計算。

Declaration & Authorization 聲明及授權

Applicant's Declaration:

1. I/We agree that AIG Insurance Hong Kong Limited (Macau Branch) (hereinafter called "the Company"), reserves its right to accept or reject my/our application for an insurance. If my/our application is accepted and approved by the Company, the policy/policies will become effective.
2. I/We agree that this Application Form shall be the basis of the insurance contract(s) between myself/ourselves and the Company. I/We declare that the information provided in this application is true, correct and complete to the best of my/our knowledge and belief.
3. I/We agree that the statements in the Application Form shall form part of this application, and shall be the basis for the underwriting thereof. I/We understand that if there is any change of the information provided herein by me/us, I/weshall inform the Company of the same immediately. Any failure of disclosure of the change may affect the acceptance and assessment of or invalidate the insurance you require.
4. I/We agree that if there is any inaccurate or misleading information provided in this application, the Company has the right to reject all claims and treat any insurance issued void from inception.
5. In the event of differences between the English and Chinese version of this Application Form, the English version shall prevail. It is also understood that the insurance policy/policies relevant to this Application Form is/are issued in English only and will be binding upon this application being accepted and approved by the Company.
6. I/We DECLARE and AGREE that any personal data and other information relating to me/us or my/our policy(ies) contained in this application or collected, obtained, complied or held by the Company by any means from time to time may be used, maintained, processed, stored, transferred, disclosed and/or shared by the Company for the purposes of processing, administering, implementing and effecting the requests or transactions contemplated in this application or any other applications made by me/us from time to time, promoting or providing subsequent or other services or products to me/us, direct marketing, data matching and/or communicating with me/us. I/We further DECLARE and AGREE that the Company may transfer, disclose, grant access of or share such personal data and other information to or with individuals, entities and/or organizations associated with the Company and/or to or with third parties (including, without limitation, reinsurance companies, claims investigation companies, industry associations or federations, fund management companies, financial institutions, or service providers) selected by the Company, in each case whether within or outside of Macau, for any of the aforesaid purposes and/or for the purposes of providing administrative, data processing, data maintenance or storage, telecommunications, computer, payment or other services to the Company in connection with the operation of its business. I/We understand that I/we have the right to obtain access to and to request correction of my/our personal data held or controlled by the Company. Such request can be made to Data Privacy Officer at Unit 506, 5/F, AIA Tower, No. 251A-301, Avenida Comercial de Macau. If I/We do not wish to receive marketing information or materials, I/We will send an opt-out notice to the Company, in which case my/our personal data and other information would be included in a centralized customer opt-out list that may be shared amongst the Company's associated partners for reference.

投保人聲明

1. 本人 / 本公司同意美亞保險香港有限公司(澳門分行)(以下簡稱為“貴公司”)，保留一切接納申請與否之權利，並明白申請一經接納及批核，保障立即生效。
2. 本人 / 本公司同意此投保表格為本人 / 本公司與貴公司訂立保險契約之根據。本人 / 本公司特此聲明此投保表格內所填報之資料，據本人 / 本公司所知並確定全部正確無訛、完整及足夠。
3. 本人 / 本公司同意此投保表格內填寫的內容，均視為本投保申請之一部份，亦為貴公司核保之根據。本人 / 本公司明白若於此投保表格內提供的資料有任何更改，本人 / 本公司須立即通知貴公司。若未有如實披露有關更改，均可能引致貴公司拒絕接受有關投保申請或影響貴公司評估本人 / 本公司的有關申請，甚至取消合約。
4. 本人 / 本公司同意在填寫此投保表格及其他有關資料時，若有任何陳述或資料為不實或有誤導之處，貴公司則有權拒絕作出賠償，而該保單亦由受保日期起無效。
5. 本人 / 本公司同意如本文之中文譯本於意義上遇到任何爭議，一概以英文版本為準；有關此投保表格的保單，只會以英文發出；而保單將於此投保申請為貴公司接納及核實之時生效。
6. 本人 / 本公司現聲明並同意貴公司可使用、保留、處理、儲存、轉交、透露及 / 或共用貴公司所收集、索取、整理或保留在此申請表所載或從其他途徑取得之任何有關本人 / 本公司的個人資料或其他有關本人 / 本公司的保單的資料，用作處理、管理、落實及實行在此申請表所載或本人 / 本公司從任何其他申請表所提出之要求，及介紹或提供其稍後或其他的服務或產品予本人 / 本公司、直接促銷、資料核對及 / 或聯絡本人 / 本公司之用途。本人 / 本公司再聲明並同意貴公司可向與貴公司有關的澳門或海外人士、團體及/或機構及 / 或任何被選的第三機構（包括並不限於再保險及賠償調查公司，及有關的行業協會 / 聯會、基金管理公司、金融機構或提供有關服務之公司）轉交、透露、授權取得或共用本人 / 本公司之個人或其他資料，用作以上列明之用途及 / 或貴公司業務運作之用，包括行政、資料處理、資料保存或儲存、通訊、電腦、付款或其他服務。本人/本公司明白到本人 / 本公司有權向貴公司查閱及申請更改貴公司儲存或管理與本人 / 本公司有關的個人資料。有關的申請可致函澳門商業大馬路251A至301號友邦廣場5樓506室個人資料管理員辦理。若本人 / 本公司不想收到貴公司的銷售資料或刊物，本人 / 本公司會發出信函通知貴公司，而本人 / 本公司的個人或其他資料會存於貴公司之中央資料檔內的非聯絡客戶名單，並會供貴公司及有關人士 / 機構作參考。

Insured Signature 投保人簽署: _____ Date 日期:_____

銀河娛樂集團
Galaxy Entertainment Group
僱員自購保障計劃
Voluntary Employee Benefit Program
額外保障–頤康樂申請表
Optional Senior Care Protection Plan Application Form

For office Use Only	
CN No	
Source	
Effective Date	
Bill Date	
Handler	

VEB-08/2018

A. ***Staff (Insured) Personal Particulars*** **僱員(投保人)個人資料** *(Please use the capital letter)（請以英文正楷填寫）*

Please tick the appropriate box 請於適用之方格內加(✓)

英文姓名 性別 男 女 出生日期 慣用左手

English Name :_____ **Sex : M** ❑ **F** ❑ **Date of Birth :** ___**M**月___**D**日___**YR**年 **Left Handed** ❑

中文姓名 身份證號碼 員工編號

Chinese Name: _____ **I.D. No. :**_____ **Staff No. :**_____

住址電話 辦公室電話 傳呼/手提電話號碼

Tel (Home) :_____ **Tel (Office) :** _____ **Pager/Mobile No. :**_____

地址 職位

Address : _____ **Position :** _____

電郵地址

_____ **E-mail Address:** _____

B. Insured Family Member(s) Information ***投保人家庭成員資料***

(For parent(s) /parent(s)-in-law) (只供投保父母/配偶父母保障填寫)

	Name 姓名	Left Handed 慣用左手	I.D. No. /Cert. of Birth No 身份證/出生証明書號碼	Occupation 職業	Sex 性別	Date of Birth 出生日期
父母 Parents	_____	❑	_____	_____	M 男 ❑ F 女 ❑	___ M 月 ___ D 日 ___Yr 年
	_____	❑	_____	_____	M 男 ❑ F 女 ❑	___ M 月 ___ D 日 ___Yr 年
配偶父母 Parents-in-law	_____	❑	_____	_____	M 男 ❑ F 女 ❑	___ M 月 ___ D 日 ___Yr 年
	_____	❑	_____	_____	M 男 ❑ F 女 ❑	___ M 月 ___ D 日 ___Yr 年

C. Monthly Premium Table **每月保費表**

Please tick the appropriate box for cover(s) / Protection required 請於所需保障前之方格加(✓)

Monthly Premium (MOP) 每月保費 (澳門幣)			
Plan A 計劃 A	**No. of people 人數**	**Plan B 計劃 B**	**No. of people 人數**
❑ **$ 112**	**X**	❑ **$ 204**	**X**

Total Monthly Premium 每月總保費 : **MOP $**

- *Staff (Insured) must join the "VEB" first before his/her parent(s) and/or parent(s)-in-law to join in.*
  僱員(投保人) 須先行投保「僱員自購保障計劃」，其父母方可參與此計劃。
- The entry age of Senior Care Protection Plan is 45-75 and policy will renew up to age 85. Benefit will be reduced by 50% for any senior aged 81.
  「頤康樂」投保年齡為45 - 75歲，保障直至85歲之止，如受保長者年齡達81歲，其保障額將會減半。
- Premium remains unchanged.
  保費維持不變。

Please read and sign the Declaration & Authorization and Payment Method Form on the page overleaf
請參閱及簽署次頁之聲明及授權和保費支付方法表

Declaration & Authorization *聲明及授權*

Applicant's Declaration:

1. I/We agree that AIG Insurance Hong Kong Limited (Macau Branch) (hereinafter called "the Company"), reserves its right to accept or reject my/our application for an insurance. If my/our application is accepted and approved by the Company, the policy/policies will become effective.
2. I/We agree that this Application Form shall be the basis of the insurance contract(s) between myself/ourselves and the Company. I/We declare that the information provided in this application is true, correct and complete to the best of my/our knowledge and belief.
3. I/We agree that the statements in the Application Form shall form part of this application, and shall be the basis for the underwriting thereof. I/We understand that if there is any change of the information provided herein by me/us, I/we shall inform the Company of the same immediately. Any failure of disclosure of the change may affect the acceptance and assessment of or invalidate the insurance you require.
4. I/We agree that if there is any inaccurate or misleading information provided in this application, the Company has the right to reject all claims and treat any insurance issued void from inception.
5. In the event of differences between the English and Chinese version of this Application Form, the English version shall prevail. It is also understood that the insurance policy/policies relevant to this Application Form is/are issued in English only and will be binding upon this application being accepted and approved by the Company.
6. I/We DECLARE and AGREE that any personal data and other information relating to me/us or my/our policy(ies) contained in this application or collected, obtained, complied or held by the Company by any means from time to time may be used, maintained, processed, stored, transferred, disclosed and/or shared by the Company for the purposes of processing, administering, implementing and effecting the requests or transactions contemplated in this application or any other applications made by me/us from time to time, promoting or providing subsequent or other services or products to me/us, direct marketing, data matching and/or communicating with me/us. I/We further DECLARE and AGREE that the Company may transfer, disclose, grant access of or share such personal data and other information to or with individuals, entities and/or organizations associated with the Company and/or to or with third parties (including, without limitation, reinsurance companies, claims investigation companies, industry associations or federations, fund management companies, financial institutions, or service providers) selected by the Company, in each case whether within or outside of Macau, for any of the aforesaid purposes and/or for the purposes of providing administrative, data processing, data maintenance or storage, telecommunications, computer, payment or other services to the Company in connection with the operation of its business. I/We understand that I/we have the right to obtain access to and to request correction of my/our personal data held or controlled by the Company. Such request can be made to Data Privacy Officer at Unit 506, 5/F, AIA Tower, No. 251A-301, Avenida Comercial de Macau. If I/We do not wish to receive marketing information or materials, I/We will send an opt-out notice to the Company, in which case my/our personal data and other information would be included in a centralized customer opt-out list that may be shared amongst the Company's associated partners for reference.

投保人聲明

1. 本人 / 本公司同意美亞保險香港有限公司(澳門分行)(以下簡稱為"貴公司")，保留一切接納申請與否之權利，並明白申請一經接納及批核，保障立即生效。
2. 本人 / 本公司同意此投保表格為本人 / 本公司與貴公司訂立保險契約之根據。本人 / 本公司特此聲明此投保表格內所填報之資料，據本人 / 本公司所知並確定全部正確無訛、完整及足夠。
3. 本人 / 本公司同意此投保表格內填寫的內容，均視為本投保申請之一部份，亦為貴公司核保之根據。本人 / 本公司明白若於此投保表格內提供的資料有任何更改，本人 / 本公司須立即通知貴公司。若未有如實披露有關更改，均可能引致貴公司拒絕接受有關投保申請或影響貴公司評估本人 / 本公司的有關申請，甚至取消合約。
4. 本人 / 本公司同意在填寫此投保表格及其他有關資料時，若有任何陳述或資料為不實或有誤導之處，貴公司則有權拒絕作出賠償，而該保單亦由受保日期起無效。
5. 本人 / 本公司同意如本文之中文譯本於意義上遇到任何爭議，一概以英文版本為準；有關此投保表格的保單，只會以英文發出；而保單將於此投保申請為貴公司接納及核實之時生效。
6. 本人 / 本公司現聲明並同意貴公司可使用、保留、處理、儲存、轉交、透露及 / 或共用貴公司所收集、索取、整理或保留在此申請表所載或從其他途徑取得之任何有關本人 / 本公司的個人資料或其他有關本人 / 本公司的保單的資料，用作處理、管理、落實及實行在此申請表所載或本人 / 本公司從任何其他申請表所提出之要求，及介紹或提供其稍後或其他的服務或產品予本人 / 本公司、直接促銷、資料核對及 / 或聯絡本人 / 本公司之用途。本人 / 本公司再聲明並同意貴公司可向與貴公司有關的澳門或海外人士、團體及/或機構及 / 或任何被選的第三機構（包括並不限於再保險及賠償調查公司，及有關的行業協會 / 聯會、基金管理公司、金融機構或提供有關服務之公司）轉交、透露、授權取得或共用本人 / 本公司之個人或其他資料，用作以上列明之用途及 / 或貴公司業務運作之用，包括行政、資料處理、資料保存或儲存、通訊、電腦、付款或其他服務。本人/本公司明白到本人 / 本公司有權向貴公司查閱及申請更改貴公司儲存或管理與本人 / 本公司有關的個人資料。有關的申請可致函澳門商業大馬路251A至301號友邦廣場5樓506室個人資料管理員辦理。若本人 / 本公司不想收到貴公司的銷售資料或刊物，本人 / 本公司會發出信函通知貴公司，而本人 / 本公司的個人或其他資料會存於貴公司之中央資料檔內的非聯絡客戶名單，並會供貴公司及有關人士 / 機構作參考。

Insured Signature 投保人簽署: _____ Date 日期:_____

PAYMENT METHOD FORM
保費支付方法表

PAYMENT METHOD FORM 保費支付方法

- Please choose the payment method either by Credit Card or by Autopay for monthly payment. (Autopay is only Available to Account Holder of OCBC Wing Hang Bank Limited or Banco Nacional Ultramarino.)
  請選擇以信用咭或銀行自動轉賬支付每月保費。(銀行自動轉賬只適用於永亨銀行或大西洋銀行存戶)

By Credit Card 信用咭付款

Charge my monthly premium to 請在以下的信用咭賬號扣除每月保費 (Tick one box only 請選擇其中一項) :

☐ Visa Card ☐ Master Card

I/We hereby authorize AIG Insurance Hong Kong Limited (Macau Branch) to charge my/our credit card account below for all payment(s) of this policy including that/those related to its renewal(s).

本人/吾等授權美亞保險香港有限公司 (澳門分行)，經由本人/吾等下列的信用咭戶口內，扣除有關本保單的費用，包括其續保之有關費用。

Credit card No. 信用咭號碼 :	
Expiry Date 有效期至 :	MM 月 YY年
Name on Credit card 持咭人姓名 :	
Cardholder's Signature 持咭人簽名 :	

DIRECT DEBIT AUTHORIZATION 直接付款授權書

Please complete and return this form to the party to be credited. 請依次填寫並將此授權書交給收款之一方

Name of party to be credited (The Beneficiary) 收款之一方(受益人) AIG Insurance Hong Kong Limited (Macau Branch)	Bank Name 銀行名稱 OCBC Wing Hang Bank Limited	Account No. to be credited 收款賬戶之號碼 780199-001

Authorization Agreement Form With Creditor 付款授權同意書

I/We hereby authorise my/our below named Bank of effect transfers from my/our account to that of the above named beneficiary in accordance with such instructions as my/our Bank may receive from the beneficiary from time to time.

I/We agree that my/our Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me/us.

I/We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our account which may arise as a result of any such transfer(s).

I/We agree that should there be insufficient funds in my/our bank account to meet any transfer hereby authorised, my/our Bank shall be entitled, in its discretion, not to affect such transfer in which event the bank may the usual charge and that it may cancel this authorization at any time on one week's written notice.

This authorisation shall have effect until further notice.

I/We agree that any notice of cancellation or variation of this authorization which I/We may give to my/our bank shall be given at least seven working days prior to the date on which such cancellation/variation is to take effect.

I/we agree that if this authorization form is not directly sent to my/our bank, I/We agree to take all legal or/and economic responsibilities caused by disclosing the details of the said form to any other third party. Under on circumstances my/our bank shall be responsible.

本人 / 吾等現授權本人 / 吾等之以下銀行，(根據受益人不時給予本人 / 吾等之銀行之指示)自本人 / 吾之賬戶內轉賬予上述受益人。

本人 / 吾等同意本人 / 吾等之銀行毋須證實該等轉賬通知是否已交予本人 / 吾等。

如因該等轉賬而令本人 / 吾等之賬戶出現透支(或令現時之透支增加)，本人 / 吾等願共同及各別承擔全部責任。

本人 / 吾等同意如本人 / 吾等之賬戶並無足夠款項支付該等授權轉賬，本人 / 否等之銀行有權不予轉賬，且銀行可收取慣常之收費，並可隨時以一星期書面通之取消本授權書。

本授權書將繼續生效至另行通知為止。

本人 / 吾等同意，本人 / 吾等取消或更改本授權書之任何通知，須於取消 / 更改生效日最少七個工作天之前予本人 / 吾等之銀行。

本人 / 吾等同意如由於本授權書並非直接交予本人 / 吾等之銀行以致本授權書上所載之資料披露予第三者，知悉由此引起之任何法律或其他經濟責任由本人 / 吾等承擔概與本人 / 吾等之銀行無涉。

My / Our Bank Name and Branch 本人/吾等之銀行及分行之名稱 OCBC Wing Hang Bank Limited	My/Our Account No. 本人/吾之等賬戶號碼	
My/Our Name as recorded on Statement/Passbook 本人/吾等在結單/存摺上所紀錄之名稱	My/Our Signature(s) 戶口持有人簽名	
My/Our Address as recorded on Statement / Passbook 本人/吾等在結單/存摺上所紀錄之地址		
Name of Insured 被保人之姓名	Certificate Number 保單號碼	Date 日期
For Bank Use Only 以下由銀行填寫		Signature Verified

Note 附註 :
Please ensure that you sign the form in the usual way that you would sign on your Bank Account.
請保証 貴戶在此授權書內之簽名，與銀行賬戶所簽者完全相同。

PAYMENT METHOD FORM
保費支付方法表

PAYMENT METHOD FORM 保費支付方法

- Please choose the payment method either by Credit Card or by Autopay for monthly payment. (Autopay is only Available to Account Holder of Banco Weng Hang, S.A. or Banco Nacional Ultramarino.)
  請選擇以信用咭或銀行自動轉賬支付每月保費。(銀行自動轉賬只適用於永亨銀行或大西洋銀行存戶)

DIRECT DEBIT AUTHORIZATION 直接付款授權書

Please complete and return this form to the party to be credited. 請依次填寫並將此授權書交給收款之一方

Name of party to be credited (The Beneficiary) 收款之一方(受益人) AIG Insurance Hong Kong Limited (Macau Branch)	Bank Name 銀行名稱 Banco Nacional Ultramarino	Account No. to be credited 收款賬戶之號碼 9008957-312

Authorization Agreement Form With Creditor 付款授權同意書

I/We hereby authorise my/our below named Bank of effect transfers from my/our account to that of the above named beneficiary in accordance with such instructions as my/our Bank may receive from the beneficiary from time to time.

I/We agree that my/our Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me/us.

I/We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our account which may arise as a result of any such transfer(s).

I/We agree that should there be insufficient funds in my/our bank account to meet any transfer hereby authorised, my/our Bank shall be entitled, in its discretion, not to affect such transfer in which event the bank may the usual charge and that it may cancel this authorization at any time on one week's written notice.

This authorisation shall have effect until further notice.

II/We agree that any notice of cancellation or variation of this authorization which I/We may give to my/our bank shall be given at least seven working days prior to the date on which such cancellation/variation is to take effect.

I/we agree that if this authorization form is not directly sent to my/our bank, I/We agree to take all legal or/and economic responsibilities caused by disclosing the details of the said form to any other third party. Under on circumstances my/our bank shall be responsible.

本人 / 吾等現授權本人 / 吾等之以下銀行，(根據受益人不時給予本人 / 吾等之銀行之指示)自本人 / 吾之賬戶內轉賬予上述受益人。

本人 / 吾等同意本人 / 吾等之銀行毋須證實該等轉賬通知是否已交予本人 / 吾等。

如因該等轉賬而令本人 / 吾等之賬戶出現透支(或令現時之透支增加)，本人 / 吾等願共同及各別承擔全部責任。

本人 / 吾等同意如本人 / 吾等之賬戶並無足夠款項支付該等授權轉賬，本人 / 否等之銀行有權不予轉賬，且銀行可收取慣常之收費，並可隨時以一星期書面通之取消本授權書。

本授權書將繼續生效至另行通知為止。

本人 / 吾等同意，本人 / 吾等取消或更改本授權書之任何通知，須於取消 / 更改生效日最少七個工作天之前予本人 / 吾等之銀行。

本人 / 吾等同意如由於本授權書並非直接交予本人 / 吾等之銀行以致本授權書上所載之資料披露予第三者，知悉由此引起之任何法律或其他經濟責任由本人 / 吾等承擔概與本人 / 吾等之銀行無涉。

My / Our Bank Name and Branch 本人/吾等之銀行及分行之名稱 Banco Nacional Ultramarino		My/Our Account No. 本人/吾之等賬戶號碼	
My/Our Name as recorded on Statement/Passbook 本人/吾等在結單/存摺上所紀錄之名稱		My/Our Signature(s) 戶口持有人簽名	
My/Our Address as recorded on Statement / Passbook 本人/吾等在結單/存摺上所紀錄之地址			
Name of Insured 被保人之姓名		Certificate Number 保單號碼	Date 日期
For Bank Use Only 以下由銀行填寫			Signature Verified

Note 附註 :
Please ensure that you sign the form in the usual way that you would sign on your Bank Account.
請保証 貴戶在此授權書內之簽名，與銀行賬戶所簽者完全相同。