醫院管理局
HOSPITAL AUTHORITY

CONFIDENTIAL

Annex 6

APPLICATION FORM FOR WAIVING OF MEDICAL CHARGES

減費申請重誠信 如實申報要做到
Medical Fee Assistance Demands Your Honesty

Attention:

- Please provide accurate information and read the Application Guide and this form, in particularly Section 4, carefully before signing
- Please complete the form clearly with black or dark blue pen.
  Please cross out any incorrect entries and sign against all amendments.
  Do not use correction fluid.
- The amount of value ($) to be stated as the integer without decimal places.

* Delete whichever is inappropriate
❍ Please tick (✓) as appropriate
☐ Please tick (✓) as appropriate
✦ Please fill in or circle the appropriate date

Section 1. Patient Particulars (Patient Gum Label, if applicable)

Name: _____ HKID /HKBC: _____

(for non-HKID/HKBC holder)
Identity document & document number submitted in this application: _____

Sex: ☐ M ☐ F

Date of Birth: _____ (D/M/Y)

Residential Address: ☐ Self-owned ☐ Rented ☐ Others

_____

_____

Tel. No.: _____

Housing Type: ☐ Public housing ☐ Private housing ☐ Institution
☐ Subsidised home ownership housing [Note 1] (e.g. Home Ownership Scheme)
☐ Others: (Please specify _____)

For Official Use

Checked ID Doc

☐ Yes

☐ Not applicable

If the patient is not the applicant, please complete the following fields (and complete the authorization letter if applicable):

Name of Applicant:	* HKID / Travel Document No.:
Relationship with patient:	Tel. No.:
Address:	

Section 2. Financial Condition of Patient's Household

The definition of "household": firstly to determine whether the patient is a dependent member of the household or not. A dependent is defined as a person who is unmarried AND either (i) under 18 years old; or (ii) 18-25 years old receiving full-time education. A patient who does not fulfil the above requirements is classified as a non-dependent patient. The definitions of household and core family member are listed as below:

Patient Type	Household and core family member definitions
Dependent patient	The patient, his/her parents [Note 2]/legal guardians, and dependent [Note 3] siblings living under the same roof
Non-dependent patient	If married [Note 4] – the patient, his/her spouse, and dependent [Note 3] children [Note 2] (but not parents/legal guardians or siblings) living under the same roof If unmarried – the patient would be treated as a single person household (irrespective of whether parents/legal guardians or siblings are living under the same roof)

When there are other family members living with the patient's household and their basic necessity for living is maintained by patient's household [Note 5], patient / applicant can include these dependent family members into the means test by providing their income, asset and expenditures information, and they will be taken into account in the calculation of allowable deductions and deductible allowance.

EWS - MSSWAP - 1

Note 1: Subsidized home ownership housing includes flats built under the Home Ownership Scheme, Middle Income Housing Scheme, Private Sector Participation Scheme, Buy or Rent Option Scheme and Mortgage Subsidy Scheme, flats built under the Flat for Sale Scheme, Sandwich Class Housing Scheme and Subsidised Sale Flats Projects of the Hong Kong Housing Society; and flats in Urban Renewal Authority Subsidised Sale Flats Scheme. As from Q1 2002, subsidised sale flats that can be traded in open market are excluded.

Note 2: Legally recognised adoptive parents/children or illegitimate children with proof of parentage are also included.

Note 3: A dependent is defined as a person who is unmarried AND either (i) under 18 years old; or (ii) 18-25 years old receiving full-time education.

Note 4: Including patient who is separated, divorced, undergoing legal proceedings to divorce or widowed.

Note 5: For example, the family member is an elderly who is dependent on patient's household, or adult with no / low income and unable to sustain independent living; or individual unable to take care of oneself by reason of mental or physical condition, etc.

Part A. Monthly Income of Patient and Household Members

1. Please state the situation of the patient and household members for the most recent 6 months before the submission of the application form

Number of core family members (including the patient) total:

	Situation (if the patient is employed, please state information – e.g. industry, post/ name & contact tel. no. of the employer)	**Average Monthly Income (HK$)**	**For Official Use** Submitted Documentary proof
The Patient (Same as above: Section 1 Patient Particulars)	☐Full-time:_____ ☐Part-time:_____ ☐Unemployed, from_____Month_____Year ➢ to_____Month_____Year ／Present ☐Retired * with / without Pensions ☐Full-time Housewife (no income) ☐Infant / Student ☐Others (Please specify): _____		☐Bankbook (BB) ☐Bank Statement (BS) ☐Income Certificate issued by employer (IC) ☐Others (O) _____

Sub-total a ($)

Household Member(s)

Personal particulars	**Situation** (if the person is employed, please state information – e.g. industry, post/ name & contact tel. no. of the employer)	**Average Monthly Income (HK$)**	**For Official Use** Submitted Documentary proof
Name:_____ Gender:_____Age:_____ HKID / Travel Doc No.:_____ Relationship with patient：* ☐Wife / Husband ☐Son / Daughter ☐Father / Mother ☐Brother / Sister, who is dependent ❍ Yes, type i / ii (please refer to the note 3 under the section heading) ❍ No ☐Other (Please specify)：_____	☐Full-time:_____ ☐Part-time:_____ ☐Unemployed, from _____ (M/Y) ➢ to _____ (M/Y) / Present ☐Retired * with / without Pensions ☐Full-time Housewife (no income) ☐Infant / Student ☐Others (Please specify): _____		☐BB ☐BS ☐IC ☐O: _____ ☐N/A: _____
Name:_____ Gender:_____Age:_____ HKID / Travel Doc No.:_____ Relationship with patient：* ☐Wife / Husband ☐Son / Daughter ☐Father / Mother ☐Brother / Sister, who is dependent ❍ Yes, type i / ii (please refer to the note 3 under the section heading) ❍ No ☐Other (Please specify)：_____	☐Full-time:_____ ☐Part-time:_____ ☐Unemployed, from _____ (M/Y) ➢ to _____ (M/Y) / Present ☐Retired * with / without Pensions ☐Full-time Housewife (no income) ☐Infant / Student ☐Others (Please specify): _____		☐BB ☐BS ☐IC ☐O: _____ ☐N/A: _____

Personal particulars	Situation (if the patient is employed, please state information – e.g. industry, post/ name & contact tel. no. of the employer)	Average Monthly Income (HK$)	For Official Use Submitted Documentary proof
Name:_____ Gender:_____ Age:_____ HKID / Travel Doc No.:_____ Relationship with patient：* ☐Wife / Husband ☐Son / Daughter ☐Father / Mother ☐Brother / Sister, who is dependent ❍ Yes, type i / ii (please refer to the note 3 under the section heading) ❍ No ☐Other (Please specify)：_____	☐Full-time:_____ ☐Part-time:_____ ☐Unemployed, from _____ (M/Y) ➢ to _____ (M/Y) / Present ☐Retired * with / without Pensions ☐Full-time Housewife (no income) ☐Infant / Student ☐Others (Please specify): _____		☐BB ☐BS ☐IC ☐O: ☐N/A:
Name:_____ Gender:_____ Age:_____ HKID / Travel Doc No.:_____ Relationship with patient：* ☐Wife / Husband ☐Son / Daughter ☐Father / Mother ☐Brother / Sister, who is dependent ❍ Yes, type i / ii (please refer to the note 3 under the section heading) ❍ No ☐Other (Please specify)：_____	☐Full-time:_____ ☐Part-time:_____ ☐Unemployed, from _____ (M/Y) ➢ to _____ (M/Y) / Present ☐Retired * with / without Pensions ☐Full-time Housewife (no income) ☐Infant / Student ☐Others (Please specify): _____		☐BB ☐BS ☐IC ☐O: ☐N/A:

Sub-total b ($)

2. Have the patient and the above household members received the income from other sources for the most recent 6 months before the submission of the application form?

		Average Monthly Income (HK$)	For Official Use Submitted Documentary proof
i) Received Financial Contributions from other children not living together	☐No ☐Yes		
ii) Received Financial Contributions from other relatives/ friends not living together	☐No ☐Yes		
iii) Rental Income *(If income received from the rental of non-owner occupied property / other asset, please fill in Part B Question 4 / 6)*	☐No ☐Yes		
iv) Other Income *(e.g. Alimony, monthly compensation or compensation received on a regular basis, the payout provided under the annuity scheme, etc.)*	☐No ☐Yes, please specify:		

Sub-total c ($)

[Please do not omit any information. If there is not enough space here to fill in all information, please supplement the information by appending Part A.Annex (1)]

Is there any supplementary information in **Part A. Annex (1)**? ☐ Yes / ☐ No

		For Official Use
Part A. Monthly Income of Patient and Household Members	**a + b + c =**	**$**
	Total amount of Part A. Annex (1) =	**$**
	Total Amount =	**$**

EWS - MSSWAP - 3

Part B. <u>Total Assets of Patient and Household Members</u>

(including all assets of the patient and the above household members in Hong Kong and outside Hong Kong, with all or part of ownership)

	Amount (HK$)
1. Cash	**($)**

Part B. <u>Total Assets of Patient and Household Members</u> (con't)

(including all assets individually and jointly held by the patient and the above household members in Hong Kong or outside Hong Kong)

2. Deposits & Savings in Bank／Financial Institutions (including all savings (HKD, foreign currencies), time deposits, current, club deposits, integrated accounts, investment accounts and others)

i) Do **the patient and the above household members** hold any **<u>Personal Bank Accounts</u>**? ☐Yes ☐No

ii) Do **the patient and the above household members** hold any **<u>Joint Bank Accounts</u>**? ☐Yes ☐No

If (i)/(ii) Yes, please specify **<u>All Personal Bank A/Cs & Joint Bank A/Cs</u>** of **the patient and the above household members**.
(# HKSBC = HK & Shanghai Bank Corp; HSB = Hang Seng Bank; BOC = Bank of China; SCB = Standard Chartered Bank; BEA = Bank of East Asia)

Name of Account Holder(s)	Name of Bank *(# Please circle the appropriate Bank)* / Account No. (A/C No.)	Amount (HK$)	**<u>For Official Use</u>** Submitted Documentary proof
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________

3. Stocks / Shares / Warrants / Funds / Bonds / Other Investments ☐Yes (Please fill in the following blanks) ☐No

Name of Owner	**Investments Items Name / Code & Quantity**	**Current Market Value (HK$)**	**<u>For Official Use</u>** Submitted Documentary proof
		As at_____D_____M______Y **Balance($)**	☐Monthly Statement / Funds Statement ☐Stocks / Warrants bills ☐O____________ ☐N/A__________

E W S - M S S W A P - 4

4.Property (Domestic) / Shops / Commercial Buildings / Factories / Carpark / Land / Others (Exclude the first property (owned or rented) occupied by patient and above family members when submitting the application form)

☐Yes (Please fill in the following blanks) ☐No

Name of Owner	Address of Property	Estimated Current Net Value (HK$) [(i.e. estimated current market value **deduct** outstanding loan) x total percentage of shares of ownership of patient & the above household members (%)]	For Official Use Submitted Documentary proof
			☐D/N for Rates / D/N for Government Rent ☐Mortgage Repayment Schedule ☐O_____ ☐N/A_____

(Part B. 1-4) **Sub-total d ($)**

[Please do not omit any information. If there is not enough space here to fill in all information, please supplement the information by appending Part B. Annex (2/3)]

Is there any supplementary information in **Part B. Annex (2/3)**? ☐ Yes / ☐ No

Part B. Total Assets of Patient and Household Members (con't)

(including all assets individually and jointly held by the patient and the above household members in Hong Kong or outside Hong Kong)

5. Annuity scheme / Insurance policies with investment or saving element (e.g.: Investment-linked insurance policies; cash value , dividend and other disposable value provided by life insurance / annuity scheme, but the one-off lump-sum or instalment premium payment placed under annuity scheme would not be counted)

☐Yes (Please fill in the following blanks) ☐No

[Attention: Please check with the respective insurance company or agent if there is any query about the cash value and dividend of the insurance etc. which are required to report.]

Name of Owner	Insurance Co Name. and Policy No.	Current Amount (HK$)	For Official Use Submitted Documentary proof
		As at_____D_____M_____Y **($)**	☐Annual Report / Monthly Report ☐Certificate of Insurance ☐O_____ ☐N/A_____

6. Other realizable assets and valuable possession (excluding tools of trade) (e.g. Vehicle, Gold, Jewellery, Assets held in trust by others , E-wallet and Others etc.)

☐Yes (Please fill in the following blanks) ☐No

Name of Owner	Asset Type	Current Amount (HK$)	For Official Use Submitted Documentary proof
			☐Vehicle Licence ☐O_____ ☐N/A_____

(Part B. 5-6) **Sub-total E ($)**

[Please do not omit any information. If there is not enough space here to fill in all information, please supplement the information by appending Part B. Annex (4)]

Is there any supplementary information in **Part B. Annex (4)**? ☐ Yes / ☐ No

		For Official Use
Part B. Total Assets of patient and the above household members	**d + e =**	**$**
	Total amount of Part B. Annex (2 / 3 / 4) =	**$**
	Total Amount =	**$**

Section 3. Other Condition of Household (if applicable)

1. Special Expenses of Household (e.g.: medical expenses, monthly alimony paid, and financial contribution to family members not living together, etc.)

Special Expenses Item	Expenses (HK$)	**For Official Use** Submitted Documentary proof
		☐N/A ☐Submitted Documentary Proof (Please specify)

2. Exceptional circumstances (Applicable for non – eligible person. Applicant must fill this section and submit relevant documentary proof)

Details of exceptional circumstances	**For Official Use** Submitted Documentary proof
	☐N/A ☐Submitted Documentary Proof (Please specify)

3. Other specific and compassionate personal & family circumstances

4. Other Declaration (e.g. CSSA agent)

Section 4. Declaration and Undertaking (a) Signed by Patient and Applicant

The Patient / Applicant understands and consents that provision of incomplete, inaccurate, not up-to-date or false information by way of application or declaration may result in rejection of the application or withdrawal of waiving of medical fees (in whole or in part) if approved and/or criminal prosecution. In such circumstances, any medical fees waived prior to withdrawal shall be recoverable by the Hospital Authority (HA) as a debt repayable on demand and the Patient/Applicant undertakes to repay to the HA the medical fees waived.

If the financial status of the patient's household changes after the submission of the application so as to affect the patient's eligibility for waiving of medical fees, the patient and the applicant (if the patient is not the applicant), by his/her signature below, agrees to, as soon as he/she becomes aware of it, immediately notify such change (whether or not the change relates to the patient or any household member) and provide all relevant information to the HA/Social Welfare Department(SWD). The HA/SWD may withdraw and/or vary the terms and conditions of waiving of medical fees (in whole or in part including the amount of the medical fees waived) in the event of any such change.

The patient, by his/her signature below, declares that all information (including the supporting data) in this application form are complete, accurate, up-to-date and true. The patient also irrevocably consents to the HA/SWD verifying (including by means of data matching, visiting, interviewing and telephone contact) all information (including the supporting data) with himself/herself and/or his/her duly authorized agent (if any) and/or any third party (including Government, bank or employer) or from any source within the HA/SWD pertaining to himself/herself and for such third party or source within the HA/SWD to disclose such information. The patient authorizes such third party, including but not limited to government department, bank, employer and other parties providing all details of the requested data and records to the HA/SWD (including all individual or/and joint bank account data and records of the patient).

The applicant (whose relationship with the patient is described above and who is authorized by the patient to deal with the application or who is applying on behalf of the patient), by his/her signature below, declares that all information (including the supporting data) in this application form are complete, accurate, up-to-date and true. The applicant (who is the parent or guardian of the patient, if a minor or who is the legal guardian of the patient appointed under the Mental Health Ordinance) irrevocably consents to the HA/SWD verifying (including by means of data matching, visiting, interviewing and telephone contact) all the patient's information (including the supporting data) with the applicant and/or any third party (including Government, bank or employer) or from any source within the HA/SWD pertaining to the patient and for such third party or source within the HA/SWD to disclose such information. The applicant authorizes such third party, including but not limited to government department, bank, employer and other parties providing all details of the requested data and records to the HA/SWD (including all individual or/and joint bank account data and records of the patient).

The undersigned has read the above statement and well understood and agreed to it.

Signature of **Patient**^	Name of **Patient**	Date

(* HKID / Birth Cert. No. / Travel Document No. : _____)

The undersigned has read the above statement and well understood and agreed to it.

Signature of **Applicant**^	Name of **Applicant**	Date

(* HKID / Travel Document No. : _____)

[Note: If the applicant is also a patient's household member, he/she should additionally sign this Section 4 (b) in his/her capacity as a patient's household member]

^The signature should be identical to the specimen signature preserved by bank.

Attention

Acquiring medical fee waiver by deception is a Criminal Offence. In addition to the consequence of being ineligible for the medical fee waiver, the patient / the applicant / the patient's household member(s) shall be liable on conviction upon indictment to imprisonment of 10 years under the Theft Ordinance (Chapter 210 of the Laws of Hong Kong).

Section 4. Declaration and Undertaking (b) Signed by Patient's Household Member(s)

The Member(s) of the patient's household understands and consents that provision of incomplete, inaccurate, not up-to-date or false information by way of application or declaration may result in rejection of the application or withdrawal of waiving of medical fees (in whole or in part) if approved and/or criminal prosecution. In such circumstances, any medical fees waived prior to withdrawal shall be recoverable by the Hospital Authority (HA) as a debt repayable on demand.

If the financial status of the patient's household member(s) changes after the submission of the application so as to affect the patient's eligibility for waiving of medical fees, the household member, by his/her signature below, agrees to, as soon as he/she becomes aware of it, immediately notify such change and provide all relevant information to the patient and the applicant (if the patient is not the applicant) and the relevant member(s) of the patient's household agrees to immediately notify such change relating to him/her to the HA/Social Welfare Department(SWD) and provide all relevant information to the HA/SWD. The HA/SWD may withdraw and/or vary the terms and conditions of waiving of medical fees (in whole or in part including the amount of the medical fees waived) in the event of any such change.

Each of the member(s) of the patient's household (if any), by his/her signature below, declares that all information (including the supporting data) in this application form relating to himself/herself are complete, accurate, up-to-date and true. He/she (whether or not he/she is the applicant) also irrevocably consents to the HA/SWD verifying (including by means of data matching, visiting, interviewing and telephone contact) all his/her information relating to himself/herself (including the supporting data) with himself/herself and/or any third party (including Government, bank or employer) or from any source within the HA/SWD and for such third party or source within the HA/SWD to disclose such information. The undersigned authorizes such third party, including but not limited to government department, bank, employer and other parties providing all details of the requested data and records to the HA/SWD (including all individual or/and joint bank account data and records of the household member(s)).

The undersigned has read the above statement and well understood and agreed to it.

Signature^ of **Patient's Household Member**	Name of **Patient's Household Member**	Date

(* HKID / Travel Document No. : _____)

[Note: If the patient's household member is also the applicant, he/she should additionally sign this Section 4 (a) in his/her capacity as the applicant]

The undersigned has read the above statement and well understood and agreed to it.

Signature^ of **Patient's Household Member**	Name of **Patient's Household Member**	Date

(* HKID / Travel Document No. : _____)

The undersigned has read the above statement and well understood and agreed to it.

Signature^ of **Patient's Household Member**	Name of **Patient's Household Member**	Date

(* HKID / Travel Document No. : _____)

^ The signature should be identical to the specimen signature preserved by bank.

Attention

Acquiring medical fee waiver by deception is a Criminal Offence. In addition to the consequence of being ineligible for the medical fee waiver, the patient / the applicant / the patient's household member(s) shall be liable on conviction upon indictment to imprisonment of 10 years under the Theft Ordinance (Chapter 210 of the Laws of Hong Kong).

EWS - MSSCSF - 2

Application Form for Waiving of Medical Charges
PART A. ANNEX (1) - Monthly Income of Patient and Household Members

Name of Patient: ______________________

This Annex is a part of page 3 of the application form.
If there is not enough space in the application form to fill in all information, please supplement the information by appending this Annex to the application form.

Attention:
- Please complete the form clearly with black or dark blue pen. Please cross out any incorrect entries and sign against all amendments. **Do not use** correction fluid.
- The amount of value ($) to be stated as the integer without decimal places.

* Delete whichever is inappropriate
❍ Please tick (✓) as appropriate
☐ Please tick (✓) as appropriate
⅄ Please fill in or circle the appropriate date

Part A. Monthly Income of Patient and Household Members (con't)

1. Please state the situation of the patient and household members for the most recent 6 months before the submission of the application form

Household Member(s)

Personal particulars	Situation (if the person is employed, please state information – e.g. industry, post/ name & contact tel. no. of the employer)	Average Monthly Income (HK$)	For Official Use Submitted Documentary proof
Name:________ Gender:______ Age:______ HKID / Travel Doc No.:______ Relationship with patient：* ☐Wife / Husband ☐Son / Daughter ☐Father / Mother ☐Brother / Sister, who is dependent ❍ Yes, type i / ii (please refer to the note 3) ❍ No ☐Other (Please specify)：______	☐Full-time:______ ☐Part-time:______ ☐Unemployed, from ______ (M/Y) ⅄ to ______ (M/Y) / Present ☐Retired * with / without Pensions ☐Full-time Housewife (no income) ☐Infant / Student ☐Others (Please specify): ______		☐BB ☐BS ☐IC ☐O: ______ ☐N/A: ______
Name:________ Gender:______ Age:______ HKID / Travel Doc No.:______ Relationship with patient：* ☐Wife / Husband ☐Son / Daughter ☐Father / Mother ☐Brother / Sister, who is dependent ❍ Yes, type i / ii (please refer to the note 3) ❍ No ☐Other (Please specify)：______	☐Full-time:______ ☐Part-time:______ ☐Unemployed, from ______ (M/Y) ⅄ to ______ (M/Y) / Present ☐Retired * with / without Pensions ☐Full-time Housewife (no income) ☐Infant / Student ☐Others (Please specify): ______		☐BB ☐BS ☐IC ☐O: ______ ☐N/A: ______
Name:________ Gender:______ Age:______ HKID / Travel Doc No.:______ Relationship with patient：* ☐Wife / Husband ☐Son / Daughter ☐Father / Mother ☐Brother / Sister, who is dependent ❍ Yes, type i / ii (please refer to the note 3) ❍ No ☐Other (Please specify)：______	☐Full-time:______ ☐Part-time:______ ☐Unemployed, from ______ (M/Y) ⅄ to ______ (M/Y) / Present ☐Retired * with / without Pensions ☐Full-time Housewife (no income) ☐Infant / Student ☐Others (Please specify): ______		☐BB ☐BS ☐IC ☐O: ______ ☐N/A: ______

Sub-total of Part A. Annex (1) ($) __________

Name of Applicant: ______________ Signature^ of Applicant: ______________ Date: __________

^ The signature should be identical to the specimen signature preserved by bank.

EWS-MSSWAE-1

Application Form for Waiving of Medical Charges
PART B. ANNEX (2) - Total Assets of Patient and Household Members

Name of Patient: ______________________

This Annex is a part of page 4 of the application form.
If there is not enough space in the application form to fill in all information, please supplement the information by appending this Annex to the application form.

Attention:
- Please complete the form clearly with black or dark blue pen. Please cross out any incorrect entries and sign against all amendments. **Do not use** correction fluid.
- The amount of value ($) to be stated as the integer without decimal places.

Part B. Total Assets of Patient and Household Members (con't)
(including all assets individually and jointly held by the patient and the above household members in Hong Kong or outside Hong Kong)

2. Deposits & Savings in Bank / Financial Institutions (including all savings (HKD, foreign currencies), time deposits, current, club deposits, integrated accounts, investment accounts and others)

All Personal Bank A/Cs & Joint Bank A/Cs of **the patient and the above household members**.
(# HKSBC = HK & Shanghai Bank Corp; HSB = Hang Seng Bank; BOC = Bank of China; SCB = Standard Chartered Bank; BEA = Bank of East Asia)

Name of Account Holder(s)	Name of Bank *(# Please circle the appropriate Bank)* / Account No. (A/C No.)	Amount (HK$)	**For Official Use** Submitted Documentary proof
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Bank Name: # HKSBC/ HSB/ BOC/ SCB/ BEA /Others，Please specify: A/C No.:	As at_____D_____M______Y **Balance($)**	☐BB ☐BS ☐O:__________ ☐N/A:________
	Sub-total of Part B. Annex (2)	**($)**	

Name of Applicant: ______________________ Signature^ of Applicant: ______________________ Date: ______________

^ The signature should be identical to the specimen signature preserved by bank

E W S - M S S W A E - 2

Application Form for Waiving of Medical Charges

PART B. ANNEX (3) - Stocks / Shares / Warrants / Funds / Bonds / Other Investments - Non-owner occupied property (Domestic) / Shops / Commercial Buildings / Factories / Carpark / Land / Others

Name of Patient: ______________________

This Annex is a part of page 4 of the application form.
If there is not enough space in the application form to fill in all information, please supplement the information by appending this Annex to the application form.

Attention:
- Please complete the form clearly with black or dark blue pen. Please cross out any incorrect entries and sign against all amendments. **Do not use** correction fluid.
- The amount of value ($) to be stated as the integer without decimal places.

Part B. Total Assets of Patient and Household Members (con't)
(including all assets individually and jointly held by the patient and the above household members in Hong Kong or outside Hong Kong)

3. Stocks / Shares / Warrants / Funds / Bonds / Other Investments

Name of Owner	Investments Items Name / Code & Quantity	Current Market Value (HK$)	For Official Use Submitted Documentary proof
		As at_____D_____M______Y **Balance($)**	☐Monthly Statement / Funds Statement ☐Stocks / Warrants bills ☐O______ ☐N/A______
		As at_____D_____M______Y **Balance($)**	☐Monthly Statement / Funds Statement ☐Stocks / Warrants bills ☐O______ ☐N/A______
		As at_____D_____M______Y **Balance($)**	☐Monthly Statement / Funds Statement ☐Stocks / Warrants bills ☐O______ ☐N/A______
		As at_____D_____M______Y **Balance($)**	☐Monthly Statement / Funds Statement ☐Stocks / Warrants bills ☐O______ ☐N/A______
		As at_____D_____M______Y **Balance($)**	☐Monthly Statement / Funds Statement ☐Stocks / Warrants bills ☐O______ ☐N/A______
		As at_____D_____M______Y **Balance($)**	☐Monthly Statement / Funds Statement ☐Stocks / Warrants bills ☐O______ ☐N/A______

4. Property (Domestic) / Shops / Commercial Buildings / Factories / Carpark / Land / Others
(Exclude the first property (owned or rented) occupied by patient and above family members when submitting the application form)

Name of Owner	Address of Property	Estimated Current Net Value (HK$) [(i.e. estimated current market value **deduct** outstanding loan) x total percentage of shares of ownership of patient & the above household members (%)]	For Official Use Submitted Documentary proof
			☐D/N for Rates / D/N for Government Rent ☐Mortgage Repayment Schedule ☐O____________ ☐N/A__________

Sub-total of Part B. Annex (3) ($) ______________

Name of Applicant: ______________________ Signature^ of Applicant: ______________________ Date: ______________

^ The signature should be identical to the specimen signature preserved by bank

E W S - M S S W A E - 3

Ver. 1/2026 (effective from 1 Jan 2026)

Application Form for Waiving of Medical Charges
PART B. ANNEX (4) - Insurance Policies / Others

Name of Patient: ____________________

This Annex is a part of page 5 of the application form.
If there is not enough space in the application form to fill in all information, please supplement the information by appending this Annex to the application form.

Attention:
- Please complete the form clearly with black or dark blue pen. Please cross out any incorrect entries and sign against all amendments. **Do not use** correction fluid.
- The amount of value ($) to be stated as the integer without decimal places.

Part B. Total Assets of Patient and Household Members (con't)
(including all assets individually and jointly held by the patient and the above household members in Hong Kong or outside Hong Kong)

5. Annuity scheme / Insurance policies with investment or saving element
(e.g.: Investment-linked insurance policies; cash value , dividend and other disposable value provided by life insurance/ annuity scheme, but the one-off lump-sum or instalment premium payment placed under annuity scheme would not be counted)

[Attention: Please check with the respective insurance company or agent if there is any query about the cash value and dividend of the insurance etc. which are required to report.]

Name of Owner	Insurance Co Name. and Policy No.	Current Amount (HK$)	For Official Use Submitted Documentary proof
		As at_____D_____M______Y **($)**	☐Annual Report / Monthly Report ☐Certificate of Insurance ☐O__________ ☐N/A_________
		As at_____D_____M______Y **($)**	☐Annual Report / Monthly Report ☐Certificate of Insurance ☐O__________ ☐N/A_________
		As at_____D_____M______Y **($)**	☐Annual Report / Monthly Report ☐Certificate of Insurance ☐O__________ ☐N/A_________
		As at_____D_____M______Y **($)**	☐Annual Report / Monthly Report ☐Certificate of Insurance ☐O__________ ☐N/A_________

6. Other realizable assets and valuable possession (excluding tools of trade)
(e.g. Vehicle, Gold, Jewellery, Assets held in trust by others, E-wallet and Others etc.)

Name of Owner	Asset Type	Current Amount (HK$)	For Official Use Submitted Documentary proof
			☐Vehicle Licence ☐O__________ ☐N/A_________
			☐Vehicle Licence ☐O__________ ☐N/A_________
			☐Vehicle Licence ☐O__________ ☐N/A_________

Sub-total of Part B. Annex (4) **($)** ____________

Name of Applicant: ____________________ Signature of Applicant: ____________________ Date: ____________

^ The signature should be identical to the specimen signature preserved by bank

EWS-MSSWAE-4

Information Submission in Medical Assistance Application – Confirmation Form

Please Provide Complete Information

- **While applying for Medical Assistance Programme, the patient / patient's household member(s) must provide all information including supporting documents accurately.**
- **Provision of incomplete, inaccurate, not up-to-date or false information may constitute deception and will result in serious consequences:**

  Your application may be delayed, rejected and you may be required to refund any paid financial assistance.

  Acquiring Medical Fee Assistance by deception is a criminal offence, and shall be liable to conviction up to 10 years of imprisonment.

I, the undersigned, have reviewed the reported income and asset of this medical assistance application and by signing below I hereby confirm as follows:

1) I declare that **all sources of personal income** have been reported accordingly, which includes but not limited to:
   - Income earned from Full-time or Part-time job/ Self-employed or Self-owned business (e.g. Salary / Bonus / Double-salary / Remuneration / Commission / Tips / Allowances / Profit etc.)
   - Other sources of income which includes Pension / Rental income / Alimony / Remittance / 3rd Party Contribution / Subsidy
2) I affirm that **all assets under my name** (including those individually or jointly held, in Hong Kong or outside Hong Kong) have been reported accordingly, which includes but not limited to:
   - All types of bank deposits and accounts
   - All types of insurance policies and investment (e.g. Stocks / Warrants / Bonds / Funds etc.)
   - All Asset held in trust for others / Lent Asset / Asset entrusted to others
   - All Property / Land / Parking Space / Vehicles (Self-occupied, rented or vacant)

Signature of Patient	Name of Patient (HKID/ Travel Document No.：)	Date (dd/mm/yyyy)
Signature of Household Member	Name of Household Member (HKID/ Travel Document No.：)	Date (dd/mm/yyyy)
Signature of Household Member	Name of Household Member (HKID/ Travel Document No.：)	Date (dd/mm/yyyy)
Signature of Household Member	Name of Household Member (HKID/ Travel Document No.：)	Date (dd/mm/yyyy)