Appendix B

AUTHORITY FOR PAYMENT TO A BANK

Health Care Voucher Scheme, Vaccination Subsidy Scheme and Residential Care Home Vaccination Programme

Enrolment Reference No.:______________________(Note A)

1. **Name and Address of Practice:** ______________________________________
   (Note B)
2. **Name and Address of Practice:** ______________________________________
3. **Name and Address of Practice:** ______________________________________
4. **Name and Address of Practice:** ______________________________________
5. **Name and Address of Practice:** ______________________________________

Part 1 – Bank Details (Note C)

Bank____

Branch ____

Bank Account Number (Notes D & E)

Bank Code	Branch Code	Account No.
☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐

Bank Account Name in English

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Part 2 – Declaration

I/We hereby agree that –

1. The Bank's acknowledgment to the Government of the Hong Kong Special Administrative Region (the "Government") of receipt of any sum paid by the Government into the above account shall be a sufficient discharge in lieu of any acknowledgment by me/us of such payment by the Government.

2. Nothing in this form shall give rise to any obligation on the Government to make any payment into the account specified above (the "Account") or to settle any sum that may be payable by the Government to me/any of us by payment into the Account.

3. Where, for any reason, insufficient details are furnished to the Bank to determine the account to be credited and any sum is held in suspense pending receipt of further information, the Government will not be responsible for any loss or inconvenience suffered by me/us as a result of the Account not being credited at the time when a payment is made, or attempted to be made, by the Government into the Account.

4. I/Each of us undertake(s) to refund to the Government any over-payment received in relation to the scheme(s) as specified in Part I of the Application Form.

By the Applicant

By the Medical Organization

Official Stamp

Authorized signature
For and on behalf of the Medical Organization

Signature _____
Name in block letters _____
H.K.I.C. No. _____
Telephone No. _____
Date _____

Name in block letters _____
Authorized Signatory Position _____
_____
Telephone No. _____
Date _____

NOTES

A. This number is available in the eHealth System (Subsidies) if an Applicant has submitted the details through the system. Otherwise, the Applicant should leave this field blank.

B. Fill in separate forms if you have different bank accounts for different practices.

C. This form must be accompanied by a copy of bank correspondence (e.g. bank statement) showing the full name and number of the bank account. If the bank correspondence relates to an Applicant, the copy must be certified to be a true and complete copy by the Applicant. If the bank correspondence relates to a Medical Organization, the copy must be certified to be a true and complete copy by the authorized signatory of the Medical Organization appearing in Part 2 – Declaration.

D. In completing Part 1, do not use one space for more than one letter or one digit. Where a complete word cannot be entered at the end of a row because of insufficient space, the whole word should be entered in the next row.

E. If you do not know the bank code of your bank account, please contact your banker.

Statement of Purpose

Purposes of Collection

1. The personal data provided will be used by the Government for one or more of the following purposes:
   (a) processing the application for enrolment in the scheme(s)/programme as specified in Part I of the Application Form, payment by the Government, and the administration and monitoring of the scheme(s)/programme as specified in Part I of the Application Form;
   (b) for statistical and research purposes; and
   (c) any other legitimate purposes as may be required, authorized or permitted by law.

2. The provision of personal data in the application form is voluntary. If you do not provide sufficient information, we may not be able to process your application.

Classes of Transferees

3. The personal data you provide are mainly for use within the Department of Health but may also be disclosed to other Government bureaux and departments, respective professional regulatory boards and councils and other organisations for the purpose stated in paragraph 1 above, if required.

Access to Personal Data

4. You have a right to request access to and to request the correction of your personal data under sections 18 and 22 and Data Protection Principle 6, Schedule 1 of the Personal Data (Privacy) Ordinance. A fee may be imposed for complying with a data access request.

Enquiries

5. Enquiries concerning the personal data provided, including the making of access and correction, should be addressed to the respective officer of the Department of Health:

For medical practitioners,

Executive Officer, Programme Management and Vaccination Division
2/F, 147C Argyle Street
Kowloon
Telephone No.: 2125 2125

For healthcare service providers in other professions,

Executive Officer, Health Care Voucher Division
Suites 901-4, 9/F, AXA Tower, Landmark East
100 How Ming Street, Kwun Tong, Kowloon Telephone
No.: 3582 4102