



博愛有心人每月捐款計劃表格 Pok Oi Friend Monthly Donation Form

(每月捐款熱線 Hotline: 2479 3300 電郵 Email: pohfriend@pokoi.org.hk)

請填妥以下表格，並寄回新界元朗坳頭博愛醫院賽馬會護理安老院大樓地下高座或傳真至 2479 5025 博愛醫院董事局企業傳訊及籌募部

Please return the completed form to UG/F., POH Jockey Club Care & Attention Home Building, Au Tau, Yuen Long. Attn: Corporate Communications & Fundraising Department, Pok Oi Hospital, Board of Directors or fax no. 2479 5025

捐款者資料 Donor's Information <input type="checkbox"/> 先生 Mr. <input type="checkbox"/> 女士 Mrs. <input type="checkbox"/> 小姐 Ms. 姓名 Name: _____(Eng) _____(Chi) 出生日期 Date of Birth: ____日 DD ____月 MM ____年 YYYY 日間聯絡電話 Daytime Tel. No.: _____ 電郵地址 Email Address: _____ 通訊地址 Postal Address: _____	捐款金額 Donation Amount <input type="checkbox"/> 我願意成為博愛有心人，每月捐贈以下款項： I want to be a Pok Oi Friend and donate the following <u>Monthly</u> sum: <input type="checkbox"/> HK\$1,000 <input type="checkbox"/> HK\$500 <input type="checkbox"/> HK\$250 <input type="checkbox"/> HK\$100 <input type="checkbox"/> 其他金額 Other amount will help HK\$ _____ (請填寫以下銀行戶口自動轉賬授權書 Please fill in the below Bank Monthly Direct Debit Authorization)
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銀行戶口每月自動轉賬授權書 Bank Monthly Direct Debit Authorization

收款之一方名稱(收款人) Name of party to be credited (the Beneficiary)	銀行編號 Bank no.	分行編號 Branch no.	收款賬戶之號碼 Account no. to be credited
博愛醫院 Pok Oi Hospital	0 2 4	2 2 1	1 6 6 3 3 3 0 0 1

本人(等)現授權下述之銀行(「該銀行」)，根據收款人不時給予該銀行之指示，自本人(等)下述戶口轉賬予收款人。但每次轉賬金額不得超過以下指定之限額。

本人(等)同意該銀行毋須證實該等轉賬是否已通知本人(等)。

如因該等轉賬而令本人(等)之下述戶口出現透支(或令現時之透支增加)，本人(等)會共同及各別承擔全部責任。

本人(等)確證在本授權書內之簽名，與本人(等)下述戶口於該銀行簽署紀錄完全相同。

本人(等)同意如下述戶口並無足夠款項支付有關轉賬，該銀行有權不予辦理且可收取有關之手續費用，該等費用一概由本人(等)支付。

本人(等)同意取消或更改本授權書之任何通知，須於取消或更改生效日最少兩個工作天之前交予該銀行。

本授權書將繼續生效直至另行通知為止或直至下列到期日為止(以兩者中最早之日期為準)。

I/We hereby authorize my/our below-named bank (the "Bank") to effect transfer from my/our below-mentioned account to the above-named Beneficiary in accordance with such instructions as the Bank may receive from the Beneficiary from time to time, provided always that the amount of any one such transfer shall not exceed the limit indicated below.

I/We agree that the 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 below-mentioned account which may arise as a result of any such transfer(s).

I/We confirm that my/our signature(s) on this authorization is/are the same as filed with the Bank for the operation of my/our below-mentioned account to be debited for the transfer.

I/We agree that should there be insufficient funds in my/our below-mentioned account to meet any transfer hereby authorized, the Bank shall be entitled, at its discretion, not to effect such transfer in which event the Bank may make the usual service charge to be paid by me/us.

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

This authorization shall have effect until further notice or until the below given expiry date (which shall first occur).

本人(等)之銀行及分行名稱 My/Our Bank Name and Branch	銀行編號 Bank No.	分行編號 Branch No.	本人(等)之賬戶號碼 My/Our Account No.
本人(等)在結單/存摺上所紀錄之名稱 My/Our Name as record on Statement/Passbook	本人(等)在結單/存摺上所紀錄之地址 My/Our Address as recorded on Statement/Passbook		
每月捐款之限額 Limit for Each Month	到期日(請參閱附註 1) Expiry Date (See Note 1)	本人(等)之簽名 My/Our Signature(s)	日期 Date
	D D M M Y Y		
捐款人之姓名(若非賬戶持有人) Name of Debtor (IF other than account holder)	由本機構填寫(支賬參考) For Pok Oi Hospital Use Only (Debtor's Reference)		
以下由銀行填寫 For Bank Use Only	Signature Verified		

附註 Notes:

1)本直接付款授權書將於到期日一欄中所填寫之日期自動撤銷。如欲使本直接付款授權書無限期有效(或直接予以撤銷為止)，即請將該欄留空。但該銀行將不受此限，並可將超過兩年未有任何過賬紀錄之直接付款授權宣告失效，及可刪除該授權紀錄而毋須另外通知。

2)本人(等)並授權實行可由本人(等)戶口內支取因執行此指示而所需之各項費用，特此聲明。

3)表格上如有任何塗改，請在旁簽署。

1)This Direct Debit Authorisation will be cancelled automatically on the date included in the box marked "Expiry Date". If you wish the Direct Debit Authorisation to have effect indefinitely (or until cancelled by you), please leave box blank. If there is no transaction being recorded under this direct debit authorization for over two years, the Bank may delete this direct authorization without giving any notice.

2)I/We hereby further authorize you to debit my account with all charges and expenses whatsoever in effecting my/our instruction.

3)Please sign against any alterations you make on this form.

一年內累積捐款港幣一百元以上可憑收據在香港申請扣減稅項。

Accumulated donations of HK\$100 annually or above are tax deductible with a receipt in Hong Kong.

請寄發收據。Please send me a receipt.

1. 若收據抬頭非捐款者本人，請列明受贈人姓名若與本人不同：
If the recipient is not the donor, please specify the recipient's name if it is different from the donor:

2. 若捐款人姓名及地址欠奉，恕未能寄發收據。Pok Oi Hospital regrets that it cannot provide receipts to donors who fail to provide either their name or address.

為幫助節省行政開支，本人不需收據。

To help save administration costs, please do not send me a receipt

由本機構填寫 For Pok Oi Hospital Use Only

DDA to bank:	Handled by:	Verified by:
Start date:		
Last value date:		
Close reason:		