

Donation Information

(Please tick the relevant box(es). * Please delete where inappropriate.)

- I would like to make a monthly donation : HK\$99 HK\$199 HK\$_____ to support Yan Chai Hospital
- | | | |
|--|--|---|
| <input type="checkbox"/> Emergency Assistance Relief Fund | <input type="checkbox"/> Tetraplegic Fund | <input type="checkbox"/> Various Services Fund |
| <input type="checkbox"/> Medical Fund | <input type="checkbox"/> Free Consultation and Medicine Charitable Fund | <input type="checkbox"/> Social Services Fund |
| <input type="checkbox"/> Educational Services Fund | <input type="checkbox"/> Moral and Civic Education Award Fund | <input type="checkbox"/> MY Rehabilitation Foundation |
| <input type="checkbox"/> Caring Fund For Severely Disabled | <input type="checkbox"/> Re-development Fund | <input type="checkbox"/> Others (please list): _____ |
| <input type="checkbox"/> YCH Little Leaders Monthly Donation and Volunteer Programme | <input type="checkbox"/> "One Heart with Humanity" Sponsorship Programme | |
| <input type="checkbox"/> Yan Chai Old Age Allowance Donation Scheme | | |

Donor's Information

Name	* Mr /Ms /Miss	Tel							
Name on receipt	* Mr /Ms /Miss	Address							
<input type="checkbox"/> To save administration costs, no donation receipt is required.		Email							

Donation Method

Bank Monthly Auto-Pay Authorization Form

(Only original is accepted, any alteration requires signature.)

Name of Party to be credited (The Beneficiary)		
Yan Chai Hospital Controlling Account		
Bank No.	Branch No.	Account No. of Party
0 0 4	0 0 1	5 4 5 8 8 8 0 0 1
My/Our Bank Name and Branch		
Bank No.	Branch No.	My/Our Account No.
My/Our Name as recorded on Statement/Passbook		
My / Our Hong Kong Identity Card No.		
Limit for each monthly payment		
My / Our Signature(s) (Same as the signature(s) of your bank account.)		
Date	[YCH] Reference No.	For Bank Use
1. I/We hereby authorize my/our above-named bank (the "Bank") to effect transfers from my/our above-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 above. 2. 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. 3. I/We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our above-mentioned account which may arise as a result of any transfer(s). 4. 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 above-mentioned account to be debited for the transfer. 5. I/We agree that should there be insufficient funds in my/our above-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. 6. 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. 7. This authorization shall have effect until further notice.		

PayPal (monthly donation)

Donation Date: _____

Reference no.: _____

(Last 5 digits of reference no.)



Credit card (monthly donation) (Please fax to 2412 0245)

- Visa Master Yan Chai CUP Dual Currency Credit Card

Card Issuing Bank			
Cardholder's Name	* Mr /Ms /Miss		
Card No.			
Expiry Date	/ (Month / Year)		
Cardholder's Signature		Date	
1. Please ensure that the signature used is the same as that on your credit card, and sign all amendments in the same way. 2. I/We hereby authorize Yan Chai Hospital to charge my/our card account for the relevant amounts specified above. I/We agree that this authorization shall have effect after the valid date of the credit card or replacement of the credit card until further notice.			

Personal Information Collection Statement

Yan Chai Hospital ("YCH") shall comply with the Personal Data (Privacy) Ordinance in handling and keeping your personal data. YCH will not sell and/or provide your personal data to any third party. YCH intends to use your personal data for future correspondences, fund-raising appeals, conducting survey or promotional activities. YCH will not use your personal data for the above purposes unless you give your consent. If you do not agree to the use of your personal data for the above purposes, please indicate by putting a tick in the box below. You have the right to access, correct and request YCH to stop using your personal data for the above purposes at any time and at no charge by calling 187 2828 during office hours.

- I object to the use of my personal data by YCH for the above purposes.

I have read, understood and agreed with the statement regarding the collection, use and provision of personal data by YCH.

Signature : _____ Date : _____

#Tax-deductible receipts will be issued to donation of HK\$100 or above. (Applicable to Hong Kong residents).