

**环球团体医疗保险员工申请表**
**Employee Application Form**

申请人（主被保险人）资料 Details of Applicant (First Insured)									
被保险人名 First Name						姓 Surname			
出生日期 Date of Birth		性别 Gender		身高(cm) Height(cm)		体重(kg) Weight(kg)			
证件类型 ID Type						证件号码 ID No.			
联系地址 Contact Address						邮政编码 Postcode			
电话： Phone						电子邮箱 Email			
国籍所在国 Home Country						护照所列国籍 Nationality on Passport			
居住所在国 Country of Residence						居住所在城市 City of Residence			
单位名称 Company Name						参加工作时间 Date of Employment			
职务以及职业类型 Job Title									
你每周为单位工作不少于 30 个小时吗？ Do you work at least 30 hours per week for this employer?			是      否 Yes      No		选择主要治疗国家 Elected Country ( for major treatment)				
附属被保险人资料 Details of Dependants									
姓名 Name	与被保险人关系 Relationship to the First Insured	年龄 Age	证件类型 ID TYPE	证件号码 ID No.	性别 Gender	出生日期 Date of Birth	身高(cm) Height	体重(kg) Weight	

请选择投保计划 / Please choose the insurance program :

精选型 Select      舒适型 Premier      菁英型 Elite      其他 Other

**健康问卷**  
Health Questionnaire

提示：所有内容必须填写。不填写可能导致拒绝理赔。下述内容均可作为我公司判断是否能承保的依据，是保险公司同意承保及续保的重要证明文件。若对于某些情况是否属实存在怀疑，请如实填写。

Important: All material facts must be disclosed. Failure to do so could result in the rejection of a claim. Material facts are those that can be reasonably regarded as likely to influence the assessment and acceptance of this proposal. If there is any doubt about whether certain facts are material, these facts should be disclosed.

<p>1、您目前是否能正常地全天工作？ Are you currently active at work on a full-time basis?</p>	<p>是 Yes</p>	<p>否 <input type="checkbox"/> No</p>
<p>2、您或附属被保险人是否被寿险或其他健康险保险公司拒保、延期处理、加费或特约承保？ Have you (or anyone to be insured) ever been refused by a life or any other form of health insurance company, or ever had a policy postponed, special rated, or accepted on special terms?</p>	<p>是 <input type="checkbox"/> Yes</p>	<p>否 No</p>
<p>3、最近五年您或附属被保险人有无寻找医生进行咨询、治疗或检查？ During the last five years have you (or anyone to be insured) consulted, or been treated or examined by a doctor?</p>	<p>是 Yes</p>	<p>否 <input type="checkbox"/> No</p>
<p>4、最近五年您或附属被保险人是否接受过外科手术、在医院门诊、住院治疗，或接受过（包括正在等待）特殊检查？ During the last five years have you (or anyone to be insured ) undergone a surgical operation or been referred to any hospital, clinic etc., either as an in-patient or out-patient, or either had (or be awaiting for) any special tests or investigation?</p>	<p>是 Yes</p>	<p>否 <input type="checkbox"/> No</p>
<p>5、您或附属被保险人现在是否服用药品或药物（无论是否由医师开具处方）以及接受其它类型的治疗？ Are you (or anyone to be insured) currently taking any medicine or drugs (whether or not prescribed by a doctor) or receiving any other type of treatment?</p>	<p>是 <input type="checkbox"/> Yes</p>	<p>否 No</p>
<p>6、您或附属被保险人是否有如下疾病？请在正确的方框内标记，在涉及的疾病/治疗上划线。若您或附属被保险人有其他持续症状或治疗的时间超过 14 天的情况，请另外说明。所有问题都必须回答。 Do you have or have you previously had any of the following illnesses/disorders? Please tick the appropriate box and underline the illness/condition referred to OR any other illness lasting or requiring treatment for more than 14 days? All questions must be answered.</p>	<p>是 <input type="checkbox"/> Yes</p>	<p>否 No</p>

1)	肿瘤：良性或恶性肿瘤 Tumours: Benign/Malignant	<input type="checkbox"/>	
2)	偏头痛/神经紊乱/癫痫 Migraine / Neurological Disorders / Epilepsy	<input type="checkbox"/>	
3)	神经疾病 Mental Illness	<input type="checkbox"/>	
4)	眼疾 Eye Diseases	<input type="checkbox"/>	<input type="checkbox"/>
5)	肺结核/哮喘/过敏症/肺部病 Tuberculosis / Asthma / Allergies / Pulmonary Diseases	<input type="checkbox"/>	
6)	心血管疾病/动脉硬化、高血压 Cardiovascular Diseases / Arterial Hypertension	<input type="checkbox"/>	
7)	肝脏/胰脏/胃/肠疾病 Liver / Pancreas / Stomach / Intestinal Diseases	<input type="checkbox"/>	
8)	糖尿病/其他激素疾病 Diabetes / other Hormone Diseases	<input type="checkbox"/>	
9)	泌尿系统疾病和肾脏疾病/性器官疾病 Urinary Tract and Kidney Diseases / Diseases of the Sexual Organs	<input type="checkbox"/>	
10)	风湿病/肌肉、关节疾病 Rheumatism / Muscle, Joint or Bone Diseases	<input type="checkbox"/>	
11)	背部疾病 Back Problems	<input type="checkbox"/>	
12)	皮肤疾病 Skin Diseases	<input type="checkbox"/>	<input type="checkbox"/>
13)	整容手术 Cosmetic Operations	<input type="checkbox"/>	
14)	其他疾病/异常情况/事故 Any other Diseases / Disorders / Accidents	<input type="checkbox"/>	
15)	您是否作过 HIV 抗体测试 Have you been tested for HIV-antibodies		<input type="checkbox"/>
	若作过，结果如何 If YES, what was the result:		
	HIV 阳性 HIV-Positive		
	HIV 阴性 HIV-Negative		

如果您在 2 - 6 选项中有选择“是”选项，请认真填写以下栏目，清楚地说明您所回答的问题

If you have chosen answered, “yes” for question No. 2~6, please give full details into the blocks below. Indicating which question(s) you are answering.

编号 No.	接受治疗人员姓名 Full name of person treated	治疗开始时间 From (YYYY/MM/DD)	治疗截止时间 To (YYYY/MM/DD)	痊愈程度 Degree of Recovery
	有关疾病特征的全部信息 Full information on Nature of Illness	主治医师的名称、地址以及电话/传真号码 Name, Complete Address and Tel/Fax No. of Attending Doctor		
编号 No.	接受治疗人员姓名 Full name of person treated	治疗开始时间 From (YYYY/MM/DD)	治疗截止时间 To (YYYY/MM/DD)	痊愈程度 Degree of Recovery

	有关疾病特征的全部信息 Full information on Nature of Illness	主治医师的名称、地址以及电话/传真号码 Name, Complete Address and Tel/Fax No. of Attending Doctor		
编号 No.	接受治疗人员姓名 Full name of person treated	治疗开始时间 From (YYYY/MM/DD)	治疗截止时间 To (YYYY/MM/DD)	痊愈程度 Degree of Recovery
	有关疾病特征的全部信息 Full information on Nature of Illness	主治医师的名称、地址以及电话/传真号码 Name, Complete Address and Tel/Fax No. of Attending Doctor		

若上述空间不够填写，请另附表格填写

Please continue on a separate sheet if the space is insufficient

附加的页数：

Number of Additional Pages Attached:

### 申请人声明/ Applicant Declaration

1. 本人确认上述陈述是完整的，与保单条款等相关资料一起作为环球团体医疗保险责任的基础。

I declare that to the best of my knowledge and belief that the statements made above are complete and, together with the policy terms and conditions, shall form the basis of the coverage.

2. 我知道任何健康上的变化应在保单生效前通知贵公司，由于未如实告知重要情况将会导致拒赔。

I understand that any change to my health (or that of anyone else to be insured) must be notified to Taiping Life prior to the commencement date of the contract and that failure to disclose all material facts may result in the rejection of a claim.

3. 我授权所有拥有本人以及附属被保险人健康信息的执照医师、医疗从业者、医院、诊所或其它医疗机构、保险机构或个人，可提供给贵公司有关该保险责任的相关信息。

I authorize any organization and any medical practitioner in possession of my records or my dependants' record to provide Taiping Life with the information in relation to this coverage. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medical related facility, insurance company, institution or person that has any records or knowledge of me, my dependants or my health to provide Taiping Life with any information they may require in respect of this coverage.

**申请人签名/**

**Applicant Signature**

**日期**

**Date**

影印件与原件具有同样的效力 A photocopy of this authorization shall be valid as the original.

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