中国太平 CHINA TAIPING

太平财产保险有限公司
TAIPING GENERAL INSURANCE CO., LTD.

GLOBAL BENEFITS GROUP
Insurance Without Borders™

Enrollment Form / Health Statement
保险申请人健康告知

GROUP COVERAGE
团体保险

A. APPLICANT A. 申请人信息	**Requested Effective Date (DD/MMM/YYYY):** 要求生效日期(日/月/年)：	
Last Name 姓:	First Name 名:	Date of Birth (DD/MMM/YYYY): 出生日期（日/月/年）：
Citizenship (if dual, provide both) 国籍国:	Nationality (Place of Birth) 出生国:	
Marital Status 婚姻状况： ☐ Single 单身 ☐ Domestic Partner 同性伴侣 ☐ Married 已婚 ☐ Divorced 离异 ☐ Widowed 丧偶	Gender 性别：☐ Male 男性 ☐ Female 女性	Have you been covered by Taiping/GBG before? 您之前是否曾在太平或GBG投保 ☐ Yes 是 ☐ No 否
Passport / ID Card # and Issuing Country: 护照/身份证号及签发国：	Country of Residence while on Assignment: 工作时的居住国：	
Please answer below two questions if your country of residence is not China: 如果您的居住国不是中国，请填写以下两个问题：nia		
Departure Date for International Assignment: 海外工作出发日期：	Anticipated Length of Assignment: 预期工作时间长短：	
Email: 电子邮件：		

B. EMPLOYER B. 雇主信息	
Employer: 雇主名称：	Date of Hire (DD/MMM/YYYY): 入职日期（日/月/年）：
Applicant's Title and Occupation (provide brief description): 申请人的职业和职务（请详细描述）：	
Annual Salary (Specify Currency): 年薪（请指明货币种类）：	Hours worked per Week: 每周工作小时数：
Address: 雇主地址：	

C. **DEPENDENTS:** Only complete if enrolling dependents. C. 连带申请人信息（若有）			
Relationship 关系: **SPOUSE 配偶**	Last Name 姓:	Gender 性别: ☐ Male 男性 ☐ Female 女性	Height 身高: ☐ cm 厘米 ☐ ft 英尺 Weight 体重: ☐ kg 公斤 ☐ lb 磅
First Name 名:		Date of Birth (DD/MMM/YYYY): 出生日期（日/月/年）：	
Spouse's Occupation (optional): 配偶职业（可选）：		Spouse's Country of Residence: 配偶居住国：	
Relationship 关系: **CHILD 子女**	Last Name 姓:	Gender 性别: ☐ Male 男性 ☐ Female 女性	Height 身高: ☐ cm 厘米 ☐ ft 英尺 Weight 体重: ☐ kg 公斤 ☐ lb 磅
First Name 名:		Date of Birth (DD/MMM/YYYY): 出生日期（日/月/年）：	
Relationship 关系: **CHILD 子女**	Last Name 姓:	Gender 性别: ☐ Male 男性 ☐ Female 女性	Height 身高: ☐ cm 厘米 ☐ ft 英尺 Weight 体重: ☐ kg 公斤 ☐ lb 磅
First Name 名:		Date of Birth (DD/MMM/YYYY): 出生日期（日/月/年）：	
Relationship 关系: **CHILD 子女**	Last Name 姓:	Gender 性别: ☐ Male 男性 ☐ Female 女性	Height 身高: ☐ cm 厘米 ☐ ft 英尺 Weight 体重: ☐ kg 公斤 ☐ lb 磅
First Name 名:		Date of Birth (DD/MMM/YYYY): 出生日期（日/月/年）：	
Relationship 关系:	Last Name 姓:	Gender 性别: ☐ Male 男性 ☐ Female 女性	Height 身高: ☐ cm 厘米 ☐ ft 英尺 Weight 体重: ☐ kg 公斤 ☐ lb 磅
First Name 名:		Date of Birth (DD/MMM/YYYY): 出生日期（日/月/年）：	

D. **TRAVEL PATTERN**: Anticipated travel pattern for the next 12 months. If applying for the War & Terrorism or Nuclear, Chemical, or Biological Perils Rider, please provide details of security arrangements in place.
D. **预期旅行计划调查**：预计在未来 12 个月的计划旅行。

Destination 目的地	Frequency 频率	Duration 时长	Duties 原因

E-1. MEDICAL QUESTIONNAIRE: Complete for all members applying for coverage.
E-1. 健康调查问卷：填写以下关于所有保险申请人的健康问卷。

1) Have you or any dependent(s) been treated, diagnosed, tested, hospitalized, or recommended for treatment for any of the following?
您或连带申请人是否因下列选项之一接受治疗，被诊断，检查，住院或被推荐治疗？

Question	Yes 是	No 否
1A) Seizures or seizure disorder; paralysis: multiple sclerosis; or any disorder of the central nervous system? 是否患有突发癫痫、瘫痪、多发性硬化或任何中枢神经系统的紊乱？	☐ Yes 是	☐ No 否
1B) Mental retardation; any mental, behavioral, emotional, or eating disorder; anxiety, depression, neurosis or psychosis; psychotherapy; psychological, or any form of counseling or therapy? 是否患有智力缺陷、任何精神、行为、情绪或者饮食紊乱、抑郁、神经衰弱症或精神错乱，接受精神疗法或任何形式的心理咨询或治疗？	☐ Yes 是	☐ No 否
1C) High blood pressure; heart attack, stroke, chest pain or palpitations, murmur, varicose veins, blood clot, anemia, or any other blood heart, or circulatory disorder or condition? If yes, most recent blood pressure reading _______________. Date __________. 是否患有高血压、心脏病、中风、心绞痛或心悸、心杂音、静脉区张、血栓、贫血或任何其他的心血管疾病或血循环障碍？如是，最近一次血压读取值是________测量日期是__________	☐ Yes 是	☐ No 否
1D) Asthma; emphysema; bronchitis; sinusitis; pneumonia; allergies; apnea; or any breathing difficulty, lung or respiratory disease, disorder or condition? 是否患有哮喘、肺气肿、支气管炎、窦炎、肺炎、过敏症、窒息或任何呼吸困难、肺部或呼吸道疾病或紊乱？	☐ Yes 是	☐ No 否
1E) Colitis; chronic diarrhea, or intestinal problems; hernia; ulcer of the stomach or duodenum; hemorrhoids or rectal disorder; hepatitis or liver disorder; gallbladder, pancreas, esophagus, or any other digestive disorder or condition? 是否患有大肠炎、慢性腹泻或肠腔疾病、疝气、胃溃疡或十二指肠溃疡、痔疾或直肠紊乱、肝炎或肝脏功能紊乱、胆囊、胰腺、食管或任何其他的消化功能紊乱或疾病？	☐ Yes 是	☐ No 否
1F) Cancer, tumor, growth, cyst, enlarged lymph nodes; psoriasis, keratosis, lesions of the skin or mouth or any other skin disorder? 是否患有癌症、肿瘤、增生、囊肿、淋巴扩大、牛皮癣、角化症、皮肤或口腔损伤或任何其他的皮肤功能紊乱？	☐ Yes 是	☐ No 否
1G) Disease or disorder of the breast; kidney; kidney stones; bladder; prostate; abnormal PSA, or any other urinary disorder or infection? 是否患有乳房疾病或功能紊乱、肾炎、肾结石、膀胱炎、衰竭、前列腺特异性抗原变异或任何其他形式的泌尿系统感染或紊乱？	☐ Yes 是	☐ No 否
1H) Disease or disorder of the genital or reproductive system; herpes, any sexually transmitted disease; endometriosis, or abnormal pap smear? 是否患有生殖系统疾病或功能紊乱、疱疹、任何性病、子宫内膜异位或子宫抹片检查变异？	☐ Yes 是	☐ No 否
1I) Been treated for infertility; taken any medication, or advised to seek treatment, medication, diagnostic tests or surgery for infertility? 是否曾接受过不育症治疗、或者为不孕不育服用任何药物或进行任何咨询、检测或医学诊断检查或手术治疗？	☐ Yes 是	☐ No 否
1J) Arthritis; rheumatism; gout; TMJ (temporomandibular joint syndrome); any injury to or disease or disorder of the spine, back, jaw, bones, muscles, or joints; joint replacement? 是否患有关节炎、风湿病、痛风、柯斯顿氏综合征、任何关于脊椎、背部、颌骨、骨骼、肌肉、关节及关节复位的损伤、疾病或功能紊乱？	☐ Yes 是	☐ No 否
1K) Pituitary, adrenal, or thyroid disorder; lupus; diabetes? If yes to diabetes, state type _________________ and most recent blood sugar reading _________________. Date recorded _________________. 是否患有脑垂体、肾上腺或甲状腺功能紊乱、红斑狼疮、糖尿病？如果有糖尿病，类型是________,最近一次测量血糖的数值为_________, 测量日期为___________	☐ Yes 是	☐ No 否
1L) Cataracts; glaucoma; or any eye disorder; hearing loss; or any ear, nose, or throat disorder? 是否患有白内障、青光眼或眼部功能紊乱、听力丧失、或任何耳、鼻、喉部的功能紊乱？	☐ Yes 是	☐ No 否
1M) Alcoholism; alcohol, drug or substance abuse or dependency? 是否曾有酒精中毒，对酒精、毒品或物质滥用及依赖？	☐ Yes 是	☐ No 否
1N) Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), HIV Positive, or other immune disorders? 是否患有获得性免疫缺损综合症（艾滋病）、艾滋病相关综合征、属于艾滋病毒携带者或患有其他免疫系统功能紊乱？	☐ Yes 是	☐ No 否
2) Have you been advised to have a surgical procedure, hospitalization, or undergo testing that has not yet been completed? 您是否正被建议实施外科手术、住院治疗或正在进行尚未结束的医学检查？	☐ Yes 是	☐ No 否
3) Are you currently pregnant? Expected Due Date: __________________. 您目前是否处于怀孕期？预产期是：___________	☐ Yes 是	☐ No 否

3A) If yes, is there a history of complications with previous pregnancies or are complications anticipated with this pregnancy? 如果上项填是，之前一次怀孕过程中是否有并发症史或是否在此次怀孕中并发症预期会发生？预计分娩日期是________	☐ Yes 是	☐ No 否
3B) Is this pregnancy the result of infertility treatment? 本次怀孕是否因为接受不育治疗后发生的？	☐ Yes 是	☐ No 否
4) Have you gained or lost more than 12 kilos or 25 pounds during the last 12 months? 在过去的 12 个月中您是否增加或减轻体重超过 12 公斤或是 25 磅？	☐ Yes 是	☐ No 否
5) Have you ever been declined, postponed, rated, or limited for Life, Health, or Accident Insurance? 您是否曾经被保险公司拒保、延期、调整保险费率或被限定人寿、健康、或意外保险保险金额？	☐ Yes 是	☐ No 否
6) Have you been hospitalized for any reason? 在过去的 10 年中您是否曾经接受过住院治疗？	☐ Yes 是	☐ No 否
7) Have you consulted or been advised to consult a medical practitioner, or do you suffer from any significant physical impairment, deformity sickness, or injury other than revealed in questions above? 除了以上这些问题以外，您是否曾经咨询过或被建议去咨询执业医师，或身体正在经受明显的损害、损伤或疾病困扰？	☐ Yes 是	☐ No 否
8) Do you engage in any profession, sport, or hobby that could be considered hazardous? 您是否正在从事某项职业、运动或业余爱好，而此类活动会大大提高您的投保风险？	☐ Yes 是	☐ No 否
9) Do you receive any disability pension or work accident pension? 您正在接受伤残抚恤金或工伤抚恤金吗？	☐ Yes 是	☐ No 否
10) Primary Insured's Current Height: 主被保险人当前身高：	☐ ft 英尺 ☐ cm 厘米	
11) Primary Insured's Current Weight: 主被保险人当前体重：	☐ ft 英尺 ☐ cm 厘米	

E-2. MEDICAL QUESTIONNAIRE: Give details of each item answered "Yes" in Section E-1. If more space is needed, attach separate page(s) which must be signed and dated.
E-2.健康调查问卷：在 E-1 部分中回答"是"的项目请在下表中逐项填写详细情况。如果填写内容需要更多表格，请另外附加文页，并附上签名及日期。

Patient's Name 病人姓名	Question No. 问题编号	Condition/ Diagnosis 状况/诊断	Treatment (Surgery/ Medication) 治疗方法 （手术/药物）	Treatment Dates (From and To) 治疗日期 （起/止）	Ongoing or Date of Recovery 正在进行或痊愈日期	Name and Address of Physician/Facility 医师/设施的名称及地址

E. MEDICATION: List all current prescriptions for you and your family.
E. 药物治疗：请列明目前正在为您或您的连带申请人实施的所有药物治疗内容

☐ **Check if you and your family members do not take any prescriptions. 请核实您和您连带申请人是否未服用任何处方药。**

Patient's Name 病人姓名	Medication Name 药物名称	Dosage 剂量	Frequency 用药频率	Reason for Use 使用原因

G. FAMILY PHYSICIAN
G.家庭医师

Physician's Name: 医师姓名：	Country: 国家：

H. ACKNOWLEDGEMENTS AND AUTHORIZATIONS
H. 确认和授权

I, the Undersigned Hereby:
我，据此签名：

1. Declare that the foregoing answers to the best of my knowledge and belief are true and accurate and are offered as an inducement to grant insurance.
   我声明上述答案，根据我所知的信息和信仰，是真实和正确的，是确认保单计划生效的前提条件。
2. Declare that I am currently actively at work and mentally and physically capable of conducting the regular duties of my employment and have not been absent from work for more than 10 consecutive days in the preceding twelve months.
   我声明我目前就职工作并且精神和身体能够胜任雇佣期间的日常岗位，在前述的 12 个月里缺席工作不超过连续 10 天。
3. Agree that there shall be no insurance until the Insurer has approved this application.
   我同意直到保险人核准接受本次申请，本保险责任方始得以生效。
4. Authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide the Insurer or their authorized representative information, including copies of records, concerning advice, care, or treatment provided to me, including without limitation, information relating to mental illness or use of drugs or alcohol.
   我授权任何医疗专家、医院、诊所、其他医学或医疗相关机构、政府代理人、或其他人员或公司向保险人或他们的授权代表提供信息，包括病历记录复印件、相关咨询建议、护理或治疗方案，包括并不限于关于精神疾病或药物、酒精滥用的信息。
5. Understand that such information will be used by the Insurer for the purpose of evaluating my application for insurance, or by Insurer representatives involved in evaluating, determining, or administering claims for insurance benefits. I understand that any authorized representative or I will receive a copy of this authorization upon request.
   我明白保险人会根据以上信息评估我的投保申请或保险人的授权代表会据此涉及处理保险责任的评估、判断或理赔管理。我明白任何授权代表或我将收到基于以上要求的授权书副本。
6. **ANY CHANGES THAT OCCUR TO YOUR MEDICAL HISTORY PRIOR TO ISSUE OF THE POLICY MUST IMMEDIATELY BE REPORTED TO THE INSURER.**
   在保单计划生效前， 既往疾病一旦发生任何变化，需立即上报保险公司。

Name 姓名:	Date 日期:

Signature 签名

By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.
表格这里输入的电子签名的法律效力等同于亲笔手写签名。