

暂行

国寿康优全球团体医疗保险 (B 型)
China Life Goodhealth International Healthcare Plan (Type B)



中国人寿保险股份有限公司
China Life Insurance Company Limited

全球医疗保险个人医疗问卷/保单转移申请表

International Healthcare Plan Individual Medical Questionnaire/Continuous Transfer Form

代理公司/经纪公司名称并盖章 Agent/Broker Name and Stamp	您所提供的信息都将被严格保密。所有重要事实必须如实告知，否则将影响此保险合同的有效性。重要事实是指可能会影响本次投保申请结果的信息。如果您遇到您无法判断其重要与否的事实，亦请一并告知。 All information supplied will be treated in strict confidential. You must disclose all material facts. Failure to do so may invalidate the Policy. A material fact is one which is likely to influence the assessment and acceptance of this application. If you are in any doubt whether a fact is material, it should be disclosed. 申请投保时，请回答所有的问题并代表此申请书下的所有人签署声明。 As the applicant you should answer all the questions and sign the declaration on behalf of all persons included in this application.
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请勾选您的投保类型。

Please tick which of the following applies to you.

首次投保 Apply for the first time	<input type="checkbox"/> 自其他保险公司转保至国寿康优全球 医疗保险保单 Apply to Continuous Transfer from another insurer to a China Life Goodhealth IHP policy	<input type="checkbox"/> 自 Goodhealth 现有保单转保至国寿 康优全球医疗保险保单 Apply to Continuous Transfer from an existing Goodhealth policy to a China Life Goodhealth IHP policy
您必须完整填写此份表格。如果为连续保单转移申请，您应一并附上您现有保单的保险金额表、所有批注的具体内容以及现有保单的原始保单生效日期的复印件。(仅当您现有保单的保障内容类似于您所申请的国寿康优全球医疗保险计划时，您方可申请连续保单转移。保单转移相关事项请与保险条款同时阅读。) You must complete this form in full and You should attach a copy of Your existing Policy Schedule, detailing any endorsements and the original Commencement Date of the expiring plan if Continuous Transfer is applied. (Continuous transfer can be offered where the China Life Goodhealth IHP plan for which You are applying are similar to those of Your current policy. These terms and conditions must be read in conjunction with the Policy Wording.)		

1. 投保资料 (主被保险人)

Details of Insured (First Person)

姓: Family Name:	名: First Name (s):	称谓: Title:
性别: Sex:	身高: Height:	体重: Weight:
出生日期(日/月/年): Date of Birth (Day/Month/Year):	婚姻状况: Marital Status:	国籍: Nationality:
护照签发国家: Country of Passport:	居住国家: Country of Residence:	身份证号/护照号码: ID/Passport Number:
公司名称: Employer Name:		职业: Occupation:

2. 附带被保险人信息

Supplementary Insured's Details

请注意：本保险计划下的子女附带被保险人必须在 18 周岁以下，在全日制学校就学并依赖被保险人供养者放宽至 23 周岁以下。
Please note children to be included under this plan must be under 18 years of age or under 23 years of age if they are in full time education and are fully dependant upon you.

姓名 Name	关系 Relationship	出生日期(日/月/年) Date of Birth (Day/Month/Year)	性别 Sex	职业 Occupation	身高 Height	体重 Weight	国籍 Nationality	身份证/护照号码 ID/Passport No.
	配偶 Spouse							
	子女 Dependant Child							
	子女 Dependant Child							

若您还有其他附带被保险人，请用另外的纸提供详细资料。
If you have any further Supplementary Insured, please provide details on a separate sheet.

3. 医疗问题调查 Medical Questionnaire

请对下列问题后的“是”或“否”打勾，若回答为“是”，请提供详细资料。（必要时请用另外的纸提供详细资料）。请在相应选项上打勾“√”。
Please reply to the following questions by ticking 'Yes' or 'No'. In case you have ticked 'Yes', please provide details. (Where there is insufficient space, please provide details on a separate sheet). Mark with '√' as appropriate.

a. 最近 5 年中，您或本申请表中所列的附带被保险人，是否接受过住院治疗？ Have you, or any one included in this application, been admitted to hospital or other similar establishment in the last five years?	是 否 Yes No <input type="checkbox"/> <input type="checkbox"/>
b. 最近 2 年中，医生是否为您或本申请表中所列的附带被保险人开过服用 7 天以上的处方药或建议过进行其他治疗？ Have you, or any one included in this application, been prescribed with a course of any drugs, medication, or treatments for a period in excess of seven days in the last two years?	是 否 Yes No <input type="checkbox"/> <input type="checkbox"/>
c. 就您所知，您或本申请表中所列的附带被保险人是否存在已知的或已预见的症状需要就医，或服用处方药，或接受住院治疗？ Have you, or any one included in this application, any known or foreseeable need to consult with a medical practitioner or any other health care professional and/or required to be prescribed any drugs or medication and/or to be admitted to a hospital or other similar establishment?	是 否 Yes No <input type="checkbox"/> <input type="checkbox"/>
d. 您或本申请表中所列的附带被保险人是否有上述没有提到的残疾、身体异常、复发性疾病、重大疾病或身体伤害？ Are you, or any one included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury not already noted above?	是 否 Yes No <input type="checkbox"/> <input type="checkbox"/>
上述问题中，如有答复为“是”的，请在本栏内填写详细情况，必要时另用纸张提供详细资料。 Please use this space to provide any additional information. (Where there is insufficient space, please provide details on a separate sheet).	

4. 保险生效日期：
Commencement Date (Day/Month/Year): _____

5. 请注意： 保险生效日期自您填写本投保申请之日后不得超过 30 天。任何情况下，本保单之保障不得向前追溯。
Note: The commencement date can be no more than 30 days from the completion of this application by you.
Under no circumstances will policies/coverage be backdated.

6. 声明 Declaration

<p>1. 本人声明所提供的信息均为真实的、完整的。 I declare that the answers given are to the best of my knowledge full, true and complete.</p> <p>2. 本人声明已完整告知所有重要事实。 I have declared all material facts which relate to this application.</p> <p>3. 本人授权本人曾就诊过的医生或医学专家向贵公司或贵公司授权的机构提供任何就医记录或病史。 I authorise any doctor, physician or Specialist who I have attended in any capacity to provide China Life, or their representatives, with any and all information in respect of such attendance and any known medical history.</p> <p>4. 本人理解本保险单生效后，如果在以后的理赔调查中发现有欺瞒或不如实告知则保险单将失效，并不退还保险费，且贵公司不负保险责任。 I understand that if any statement made above or, if accepted for cover, if any subsequent claims made are found to be fraudulent or unfounded my policy will be cancelled void 'ab initio' without refund of premiums and any benefits shall be forfeited and recoverable by China Life.</p> <p>申请人签名： _____ 日期(日/月/年) Signature of Applicant: _____ Date (Day/Month/Year)</p>
