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在索取、列印或填寫表格前，請閣下先詳閱下文。

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當閣下填寫及簽署由網站下載之表格 [互聯網列印表格]，則被視作閣下已詳閱及明白電腦螢幕上出現之表格 [閱覽表格] 之內容，並同意表格內之所有條文。如該閱覽表格與互聯網列印表格出現任何不符、矛盾或分歧時，閣下同意並承諾不會提出任何異議。如閱覽表格與互聯網列印表格出現任何不符、矛盾或分歧時，概以閱覽表格為準。

周大福人壽有權隨時在認為適當情況下更新表格內容，並保留接受或拒絕閣下遞交之申請表格的權利。

更改申請書(附健康狀況問卷)
Change Form (with Health Questionnaire)

如上述保單為投資相連保險保單，請在方格內加上“√” 剔號
If the captioned policy is an investment-linked insurance policy, please tick “√” this box.
請在適當位置加上“√” 剔號及刪除所有不適用者。
Please tick “√” where appropriate and delete whichever is inappropriate.

保單號碼 Policy No. : _____

重要提示：保單持有人必需在此申請書上全部披露一切重要事項，因為您與周大福人壽保險有限公司的合約以此為依據，否則所有更改或復效將告無效。全面披露重要事實通常是指披露所有相關事實、訊息或情況，就與醫學有關的事實而言，如病史、吸煙狀況等會影響保險公司釐定保費及/或判斷是否加入不保事項及/或判斷是否承保有關風險決定的情況均會被視為重要事項。如您不確定某一項資料是否重要，您應該將該項資料在第二部份第12項的附註中披露。如要更改任何答案，保單持有人請在旁簽署。

Important Note: Policy Owner must fully disclose all material facts in this application form, which shall form the basis of the proposed contract between you and Chow Tai Fook Life Insurance Company Limited, otherwise any changes or reinstatement will be void or voidable. Full disclosure of material facts generally refers to the disclosure of all relevant facts, information or circumstances such as medical history, smoking status and etc., which would influence the decision of an insurer in setting premium and/or in determining whether to include exclusion(s) and/or in determining whether to insure relevant risk(s) or etc., are considered to be material facts. If you are uncertain as to whether or not a piece of specific information is material, you shall disclose it at Part II Q12. All changes should be initiated by the Policy Owner.

第一部份 Part I – 保單更改 Policy Change

1. 保單轉換 Policy Conversion

新保單編號：_____

需轉換之舊計劃 To be converted old plan	轉換後舊計劃之保額 [^] Sum insured of old plan after conversion [^]	轉換後之新計劃 New plan after conversion	新計劃之保額* Sum insured of new plan
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_____	_____	_____	_____
_____	_____	_____	_____

[^] 如全部保額轉換至新計劃或取消餘額，請填寫「0」。
If total Sum insured is converted to new plan or cancel the balance, please complete “0”.

* 如將定期保險計劃轉換至「摯愛」壽險計劃 I，舊計劃每1,000元保額可轉換為新計劃600元保額，而剩餘的400元保額將於轉換後自動被終止。此外，每受保人可透過定期保險計劃轉換至「摯愛」壽險計劃系列的個人最高總累積保額為125,000美元 / 1,000,000港元。
For term conversion to @MyLove Insurance Plan I, every \$1,000 sum insured of the old plan can be converted to \$600 sum insured of the new plan and the remaining \$400 sum insured will be automatically terminated after conversion. In addition, the maximum total accumulated sum insured of @MyLove Insurance Plan series through term conversion is USD125,000 / HKD1,000,000 per life for each insured.

重要事項 Important Notes:

- 如轉換後剩餘之保額低於最低投保額，該保障將自動被取消。
If the remaining balance of converted benefit is lower than minimum issue amount, it will be automatically deleted.
- 如轉換後舊保單之每年保費低於港幣800元，繳費方式將自動更改為年繳，須繳付更改年繳之差額（如有）。
If the annual premium of old policy is less than HKD800 after conversion, the payment mode will be automatically changed to annual. Premium difference, if any, is regard to pay for change of annual mode.
- 如轉換全部保額之保障為基本計劃，而沒有定期壽險附加保單或「危疾無憂百分百」附加保單，所有附加契約須同時轉換至新保單或取消。而所有醫療保障必須留在舊保單內。
If the converted sum insured is basic plan and no term rider or CI 100 Protector is attached, all riders must be converted to new plan or cancelled. All the medical benefit must be kept in old policy.

2. 更改計劃 Change of Coverage

(a) 如附加保障，此保障申請是否迎合您的危疾及或醫療需要作準備目標？(必須回答)
For adding of benefit, does this application meet your objective of preparation for **critical illness and or medical needs**? (Must answer)

- Yes是 → 您會考慮附加以下那類型的保障？(可√多項)
Which of the following type of benefit will you consider to add? (Can √ more than one)
- 住院期間的現金津貼產品 Product providing income subsidy during hospital confinement
 - 實報實銷住院期間醫療費用的產品 Product reimburse medical expense for hospital confinement
 - 在確認指定情況或接受特定治療後，支付預定的生存賠償金額的產品 Product paying a pre-defined amount of living benefit upon confirming specific conditions or undergoing certain treatments

其他 others _____

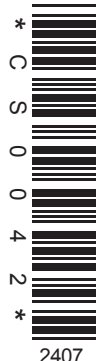
No 否

(b) 計劃名稱 / 編號 Plan Name / Code	新保額(以保單貨幣計算) New Sum Insured (in policy currency)	附加 Addition	增加 Increase	遞減 Decrease	取消 Deletion	備註 Remarks (例子 e.g. : CPACUR1 → CPAC4UR)
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

(如增加/附加保障，請填妥第二至六部份 For increasing/adding benefit, please complete Part II to VI)

3. 復效 Reinstatement (不適用於101/105投資相連保險保單 Not applicable to 101/105 Investment Linked Insurance Policy)
(請填妥第二至六部份 Please complete Part II to VI)

- 復效保單 Policy Reinstatement
(如繳費方式為月繳，請遞交填妥之直接付款授權書並預繳兩個月保費及保費徵費。)
(For monthly payment frequency, please submit a completed Direct Debit Authorization Form together with 2 months' premium and premium levy in advance)
- 以重訂保單生效日期方式復效 Reinstatement by Redating



4. 調整 / 刪除額外保費 / 不保事項 Adjustment or Removal of Loading / Exclusion
 (請填妥第二至六部份。如更改有關職業之額外保費, 請只需填妥第二部份之第7項。)
 (Please complete Part II to VI. For change of Occupational Rating, please complete Part II, Q7 only.)

額外保費 - 職業理由 Loading - Occupational Rating (請提供僱用信副本 Please provide a copy of employment letter)
 任職日期 (日 / 月 / 年) Employment Date (DD/MM/YY): _____

額外保費 - 健康理由 Loading - Medical Rating (請提供有關之健康證明文件 Please provide with relevant document of medical evidence)

不保事項 Exclusion (請提供有關之健康證明文件 Please provide with relevant document of medical evidence)

5. 「電子通知書」服務 "e-Notification" Service

接受「電子通知書」服務 Accept "e-Notification" Service

接受「電子通知書」服務後, 您所持有的周大福人壽保單將一併享有此服務。我們將不會郵寄相關通知書予您。您可隨時隨地於「周大福人壽」/ 「BOSS客戶網上服務」查閱及下載。
 Accept "e-Notification" Service, all your CTF Life polic(ies) will automatically be entitled to our "e-Notification" Service. We will no longer mail relevant notifications to you. You can view and download them from your "CTF Life" / "BOSS Customer e-Service" account, whenever and wherever you like.

6. 其他更改 Other Changes

第二部分 Part II		
7. 職業資料 Occupation Information	必須提供受保人以下的資料 The following information of the Insured must be provided (不適用於十八歲或以下的本港全日制學生) (Not applicable to HK full-time student whose age is 18 or below)	必須提供保單持有人以下的資料 The following information of the Policy Owner must be provided
僱主/學校名稱 Name of Employer/ School		
公司業務性質/行業 Nature of Business/ Industry		
職位及日常職務 Occupation Title and Job Duties		
工作性質 Job Nature	1. 是否自僱? Self-employed? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No 2. 有否高空工作(15米或以上)? Any work at height (15M or above)? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	1. 是否自僱? Self-employed? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No 2. 有否高空工作(15米或以上)? Any work at height (15M or above)? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
每月平均收入 Average Monthly Income	港幣 HK\$ _____ 包括所有工作收入來源(不包括投資及租金收入) Include all incomes from employment (Not from investment/rental income)	港幣 HK\$ _____ 包括所有工作收入來源(不包括投資及租金收入) Include all incomes from employment (Not from investment/rental income)
僱主/學校地址 Address of Employer/ School	_____ 室 Room/Flat 樓 Floor 座數/大廈 Block/Building _____ 街道名稱及號碼 No. and Name of Street/Road _____ 地區 District * HK / KLN / NT 香港/九龍/新界 _____ #省 Province #國家 Country #郵政編號 Postal Code #如非香港地址必須填寫此項 Must be completed for addresses out of HK	_____ 室 Room/Flat 樓 Floor 座數/大廈 Block/Building _____ 街道名稱及號碼 No. and Name of Street/Road _____ 地區 District * HK / KLN / NT 香港/九龍/新界 _____ #省 Province #國家 Country #郵政編號 Postal Code #如非香港地址必須填寫此項 Must be completed for addresses out of HK
其他職業及確實職務 (如有) Other Occupation & Exact Duties (if any)		



如增加 / 附加保障為簡易核保產品，請直接填寫第六部分

Please complete Part VI directly if you intend to increase / add simplified underwriting products

8. 「康復保險」申請資料 (如不適用，請刪去答案部分，不要留下空格)
Information for Application of "Disability Protector" (If inapplicable, please cross out the field instead of leaving it blank)

8.(a) 受保人受僱於現職多少年?
 How long has the Insured been employed in his/her current job(s)? _____ 年 Year(s)
 如少於一年，請說明前一份職業:
 If less than 1 year, please state his/her previous occupation: _____

8.(b) 如受保人因疾病或受傷不能工作，僱主會否給予任何報酬或薪金？若會，請註明：
 Would the employer(s) of the Insured pay any remuneration or salary to the Insured if the latter becomes unable to work during periods of injury or sickness? 會 Yes 否 No
 If yes, please state:
 (a) 給付期限 the payment period _____ ; and
 (b) 每月金額(港幣) monthly amount (HK\$) _____

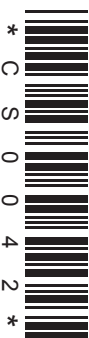
9. 已生效保單或正在處理中的其他保險申請 (倘"有"，請詳述保額號(以美元計算)。) Yes / 有 No / 沒有
若投保獨立自願醫保不需要填寫此部份
In-force Insurance Policy or Other Pending Insurance Applications (If "Yes", please specify the sum insured (in USD).)
Not applicable to standalone VHIS application

	承保公司 Insurance Co.	申請日期 Application Date	人壽 Life	危疾 Critical Illness	意外 Accident	意外每週賠償 Accidental Weekly Indemnity	住院入息 Hospital Income	傷殘入息 Disability Income
受保人 Insured	(1) _____	_____	_____	_____	_____	_____	_____	_____
	(2) _____	_____	_____	_____	_____	_____	_____	_____
	(3) _____	_____	_____	_____	_____	_____	_____	_____
保單持有人 Policy Owner	(1) _____	_____	_____	_____	_____	_____	_____	_____
如屬於子女投保，請同時提供父及母親之資料(子女保障額不可高於父或母其各自的保障額) Please provide both parents' information for Juvenile Application (Coverage of the Juvenile cannot be higher than that of the Parents)	(2) _____	_____	_____	_____	_____	_____	_____	_____
	(3) _____	_____	_____	_____	_____	_____	_____	_____

特別問題 - 若投保獨立自願醫保不需要填寫此部份；若沒有投保「付款人保障」，不需要填寫申請人部份。
Special Questions - No need to complete this section if apply standalone VHIS; No need to complete the Applicant's section if no Payor Benefit applied.

如第10及第11項問題的答案是「有」或「是」，請在第12項的附註中詳述情況。 If any answer to Q10 and Q11 is "Yes", please give the details of all such answer(s) as Remarks in Q12.	受保人 Insured		保單持有人 Policy Owner	
	有/是 Yes	否 No	有/是 Yes	否 No
10. 您或受保人的任何人壽、危疾、意外、醫療或傷殘保險的投保申請或保單復效申請或續保，曾否被拒絕、延期、加費或設有不保事項？如有，請在第12項的附註中註明保險公司名稱、日期、原因及其他詳情。 Have you or the Insured made any application for, reinstatement of or renewal of life, critical illness, accident, health or disability insurance which is eventually declined, postponed, or accepted with loading or coverage exclusion? If yes, please state the name of the insurance company, date, reason and other details as remarks in Q12.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. 您或受保人於過去或未來一年內曾否或會否離開您或受保人的原居地往外地居住超過六個月？倘曾經或將會，請於第12項附註中詳述逗留外地的原因/性質、時期/次數及城市/地區的名稱。 Have you or the Insured been, or will you or the Insured be, taking up residence away from your respective places of domicile for more than 6 months in the past or coming year? If yes, please provide the reason/nature, duration/frequency of the visit(s) and the name(s) of the resident city(ies)/region(s) as remarks in Q12.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. 附註 / 特別要求
Remarks / Special Requests



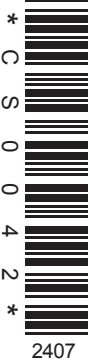
第三部分 — 基本資料
Part III – General Information

— 投保「付款人保障」需回答保單持有人部分 Please complete the Policy Owner's section if apply Payor Benefit

13.	受保人 Insured	身高 Height		厘米 centimetres (cm)	或 OR		呎 / 吋 feet / inches																								
	保單持有人 Policy Owner	身高 Height		厘米 centimetres (cm)	或 OR		呎 / 吋 feet / inches																								
14.	受保人 Insured	體重 Weight		公斤 kilogrammes (kg)	或 OR		磅 pounds (lbs)																								
	保單持有人 Policy Owner	體重 Weight		公斤 kilogrammes (kg)	或 OR		磅 pounds (lbs)																								
15.	<p>吸煙習慣Smoking habit</p> <p>「吸煙」在此問題的含義包括但不限於香煙、雪茄、煙斗、嚼煙及使用尼古丁補充劑產品（例如電子煙）。</p> <p>For the purpose of this question, the meaning of "smoking" includes but is not limited to cigarettes, cigars, tobacco pipes, chewing tobacco and the use of nicotine replacement products (such as e- cigarettes).</p> <p>您有沒有吸煙或在過去五年內曾否吸煙？ Do you smoke or have you smoked in the last 5 years?</p> <p style="text-align:right;">受保人 Insured <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No</p> <p style="text-align:right;">保單持有人 Policy Owner <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No</p> <p>如有，請詳述：If yes, please give details:</p> <p>a) 煙草產品種類 Type of tobacco product</p> <p style="text-align:right;">受保人 Insured _____</p> <p style="text-align:right;">保單持有人 Policy Owner _____</p> <p>b) 吸煙習慣的持續時間、頻密度及吸食份量 Duration of smoking habit, and frequency and quantity of consumption</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align:center;">吸煙習慣的持續時間 Duration of smoking habit</td> <td style="text-align:center;">頻密度及吸食份量 Frequency and quantity of Consumption</td> </tr> <tr> <td style="text-align:center;">受保人 Insured</td> <td style="text-align:center;">_____年 Year(s)</td> <td style="text-align:center;">_____支Piece(s)/ _____日day</td> </tr> <tr> <td style="text-align:center;">保單持有人 Applicant</td> <td style="text-align:center;">_____年 Year(s)</td> <td style="text-align:center;">_____支Piece(s)/ _____日day</td> </tr> </table> <p>若您現時已沒有吸煙 If you no longer smoke now,</p> <p>c) 請問您是何時戒煙的？ when did you quit smoking?</p> <p style="text-align:right;">受保人 Insured _____月MM _____年YYYY</p> <p style="text-align:right;">保單持有人 Policy Owner _____月MM _____年YYYY</p> <p>d) 是否醫生建議戒煙及原因為何？ are you advised by doctor to quit smoking and for what reason?</p> <p style="text-align:right;">受保人 Insured <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No 原因 Reason: _____</p> <p style="text-align:right;">保單持有人 Policy Owner <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No 原因 Reason: _____</p>								吸煙習慣的持續時間 Duration of smoking habit	頻密度及吸食份量 Frequency and quantity of Consumption	受保人 Insured	_____年 Year(s)	_____支Piece(s)/ _____日day	保單持有人 Applicant	_____年 Year(s)	_____支Piece(s)/ _____日day															
	吸煙習慣的持續時間 Duration of smoking habit	頻密度及吸食份量 Frequency and quantity of Consumption																													
受保人 Insured	_____年 Year(s)	_____支Piece(s)/ _____日day																													
保單持有人 Applicant	_____年 Year(s)	_____支Piece(s)/ _____日day																													
16.	<p>飲酒Alcohol consumption</p> <p>在過去十二個月內，您是否平均每週飲用酒精飲品超過三次？ In the last 12 months, on average do you drink alcoholic beverage for more than 3 times in a week?</p> <p style="text-align:right;">受保人 Insured <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No</p> <p style="text-align:right;">保單持有人 Policy Owner <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No</p> <p>如有，請詳述：If yes, please give details:</p> <p>a) 酒精飲品種類，飲酒習慣的持續時間、頻密度及飲用份量 Type of alcoholic beverage, duration of drinking habit, and frequency and quantity of consumption</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td colspan="4" style="text-align:center;">酒精飲品種類，頻密度及飲用份量 Type of alcoholic beverage, frequency and quantity of Consumption</td> <td style="text-align:center;">飲酒習慣的持續時間 Duration of drinking habit</td> </tr> <tr> <td></td> <td style="text-align:center;">啤酒 Beers (1罐can = 330毫升ml)</td> <td style="text-align:center;">餐酒 Wine (1杯glass = 100毫升ml)</td> <td style="text-align:center;">烈酒 Spirit (1小杯tot=30毫升ml)</td> <td style="text-align:center;">其他 Others</td> <td></td> </tr> <tr> <td style="text-align:center;">受保人 Insured</td> <td style="text-align:center;"><input type="checkbox"/> _____罐can / _____日day</td> <td style="text-align:center;"><input type="checkbox"/> _____杯glass/ _____日day</td> <td style="text-align:center;"><input type="checkbox"/> _____小杯tot/ _____日day</td> <td style="text-align:center;"><input type="checkbox"/> 種類Type _____ _____毫升ml/ _____日day</td> <td style="text-align:center;">_____年 Year(s)</td> </tr> <tr> <td style="text-align:center;">保單持有人 Policy Owner</td> <td style="text-align:center;"><input type="checkbox"/> _____罐can / _____日day</td> <td style="text-align:center;"><input type="checkbox"/> _____杯glass/ _____日day</td> <td style="text-align:center;"><input type="checkbox"/> _____小杯tot/ _____日day</td> <td style="text-align:center;"><input type="checkbox"/> 種類Type _____ _____毫升ml/ _____日day</td> <td style="text-align:center;">_____年 Year(s)</td> </tr> </table>								酒精飲品種類，頻密度及飲用份量 Type of alcoholic beverage, frequency and quantity of Consumption				飲酒習慣的持續時間 Duration of drinking habit		啤酒 Beers (1罐can = 330毫升ml)	餐酒 Wine (1杯glass = 100毫升ml)	烈酒 Spirit (1小杯tot=30毫升ml)	其他 Others		受保人 Insured	<input type="checkbox"/> _____罐can / _____日day	<input type="checkbox"/> _____杯glass/ _____日day	<input type="checkbox"/> _____小杯tot/ _____日day	<input type="checkbox"/> 種類Type _____ _____毫升ml/ _____日day	_____年 Year(s)	保單持有人 Policy Owner	<input type="checkbox"/> _____罐can / _____日day	<input type="checkbox"/> _____杯glass/ _____日day	<input type="checkbox"/> _____小杯tot/ _____日day	<input type="checkbox"/> 種類Type _____ _____毫升ml/ _____日day	_____年 Year(s)
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	<p>若您現時已沒有飲酒 If you no longer drink now,</p> <p>b) 請問您是何時戒酒的？ When did you quit drinking?</p> <p>c) 是否醫生建議戒酒及原因為何？ Are you advised by doctor to quit drinking and for what reason?</p>	<p>受保人 Insured _____月MM_____年YYYY</p> <p>保單持有人 Policy Owner _____月MM_____年YYYY</p> <p>受保人 Insured <input type="checkbox"/>有 Yes <input type="checkbox"/>否 No 原因 Reason: _____</p> <p>保單持有人 Policy Owner <input type="checkbox"/>有 Yes <input type="checkbox"/>否 No 原因 Reason: _____</p>
17.	<p>服用未經醫生處方之藥物 Taking of drugs not prescribed by doctors</p> <p>在過去五年內，您曾否持續超過一個月使用未經醫生處方之藥物（包括成癮性或消遣性藥物，例如可卡因、興奮劑、海洛英、美沙酮、同化性類固醇；惟不包括營養補充品）？ In the last 5 years, have you used any drugs (excluding dietary supplements) which are not prescribed by doctors (including habit-forming or recreational drugs such as cocaine, ecstasy, heroin, methadone, anabolic steroids) for a continuous period of more than 1 month?</p> <p>如有，請詳述： If yes, please give details:</p> <p>a) 藥物種類 Type of drugs</p> <p>b) 用藥持續時間、頻密度及份量 Duration, frequency and quantity of consumption</p>	<p>受保人 Insured <input type="checkbox"/>有 Yes <input type="checkbox"/>否 No</p> <p>保單持有人 Policy Owner <input type="checkbox"/>有 Yes <input type="checkbox"/>否 No</p> <p>受保人 Insured _____</p> <p>保單持有人 Policy Owner _____</p> <p>用藥持續時間 Duration of Consumption _____</p> <p>頻密度及吸食份量 Frequency and quantity of Consumption _____</p> <p>受保人 Insured _____年Year(s)</p> <p>保單持有人 Policy Owner _____年Year(s)</p>
18.	<p>您曾否在過去十二個月內或會否在未來十二個月內參與以下活動？ Have you engaged in the following activities within the last 12 months or will you engage / intend to engage in the following activities within the next 12 months?</p> <p>a) 任何危險性運動或活動（例如：潛水、賽車、攀山或攀石、跳傘、高空跳傘、懸掛滑翔飛行） Any hazardous sports or activities (such as diving, motor racing, mountaineering or rock climbing, parachuting, sky diving, hang gliding).</p> <p>b) 飛行活動（不包括以付費乘客身份乘搭由商業性民航客機提供並獲認可的定期航班服務） Flying activities other than as a fare-paying passenger of a licensed air service operating within recognised scheduled routes.</p> <p>如有，請詳述： If yes, please give details:</p> <p>c) 活動種類 Type of activity</p> <p>d) 參與活動的持續時間及頻密度 Duration and frequency of engagement in the activity</p>	<p>受保人 Insured <input type="checkbox"/>有 Yes <input type="checkbox"/>否 No</p> <p>保單持有人 Policy Owner <input type="checkbox"/>有 Yes <input type="checkbox"/>否 No</p> <p>受保人 Insured <input type="checkbox"/>有 Yes <input type="checkbox"/>否 No</p> <p>保單持有人 Policy Owner <input type="checkbox"/>有 Yes <input type="checkbox"/>否 No</p> <p>受保人 Insured _____</p> <p>保單持有人 Policy Owner _____</p> <p>參與活動的持續時間 Duration of engagement in the activity _____</p> <p>參與活動的頻密度 Frequency of engagement in the activity _____</p> <p>受保人 Insured _____年Year(s)</p> <p>保單持有人 Policy Owner _____年Year(s)</p>



第四部分 — 健康資料
Part IV – Health Information

- 投保「付款人保障」需回答保單持有人部分
Please complete the Policy Owner's section if apply Payor Benefit

- 無需披露以下健康狀況或治療 –
Do not require to disclose information regarding the medical conditions or treatments below –

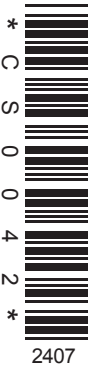
傷風 / 感冒 / 喉嚨痛、腸胃炎 / 食物中毒（已痊癒）、消化不良（無需檢查）、痤瘡、肌肉扭傷（已痊癒）、鵝口瘡、常規產前掃描 / 血液檢驗（檢驗結果正常）、常規子宮頸細胞塗片檢驗（檢驗結果正常）、常規健康檢查（檢查結果正常）、預防疫苗、荷爾蒙補充治療（更年期）、不育治療或胎兒生長情況正常的懷孕、近視 / 遠視 / 散光 / 老花。

Cold / flu / sore throat, gastroenteritis / food poisoning (fully recovered), indigestions (no investigations required), acne, muscle sprained (fully recovered), thrush, routine scan / blood test for pregnancy (normal result), routine cervical smear (normal result), routine health check (normal result), preventive vaccination, Hormonal Replacement Therapy (menopause), infertility treatment or uncomplicated pregnancy, myopia / hyperopia / astigmatism / presbyopia.

- 若以下第19至26及第30題中任何一項問題之答案為「是」者，請於第五部分健康資料補充回答相關的跟進問題。
If your answer to any of the questions 19 – 26 and 30 below is "Yes", please proceed to answer relevant follow-up questions in Part V Supplementary Health Information.

Please ✓ the appropriate boxes.
請在適當方格上填上 ✓

		受保人 Insured		保單持有人 Policy Owner	
		是 Yes	否 No	是 Yes	否 No
19.	您是否曾被確診下列疾病或健康狀況？ Have you ever been diagnosed with any of the following diseases or medical conditions?				
	a) 癌症或原位癌 Cancer or carcinoma in situ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) 腦部腫瘤 Brain tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) 心臟疾病 Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) 中風（包括短暫性腦缺血，俗稱「小中風」） Stroke (including transient ischemic attack (TIA))	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e) 高血壓 Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f) 糖尿病或葡萄糖耐量異常 Diabetes mellitus or impaired glucose tolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g) 腎病 Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h) 椎間盤突出或脊椎退化性疾病 Prolapsed intervertebral disc or degenerative spine conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i) 需要植入醫療儀器或義肢的疾病或健康狀況 Diseases or medical conditions requiring a medical device or prosthesis to be implanted within the body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	j) 人體免疫力缺乏病毒（愛滋病病毒）感染 Human immunodeficiency virus ("HIV") infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	k) 先天性疾病（指於出生時或之前已存在的醫學、生理或精神上的異常） Congenital conditions (medical, physical or mental abnormalities that existed at the time of or before birth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	l) 身體缺陷、不健全、畸形，及 / 或影響活動能力、視力、說話能力或聽力的狀況 Physical defects, impairments, deformities, and / or conditions affecting mobility, sight, speech or hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	m) 精神健康狀況（例如抑鬱、焦慮、精神分裂、飲食失調或躁狂抑鬱症） Mental health conditions (such as depression, anxiety, schizophrenia, eating disorders, or bipolar disorders)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	n) 高膽固醇症或高血脂症 Hypercholesterolemia or Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	o) 肝臟疾病（例如乙型或丙型肝炎（包括測試呈陽性反應）、脂肪肝或肝硬化） Liver disorder (such as hepatitis B or hepatitis C (including tested positive), fatty liver or cirrhosis of liver)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	p) 多發性硬化症 Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	您目前是否患有下列疾病或健康狀況？ Do you currently have any of the following diseases or medical conditions?				
	a) 疝氣（俗稱「小腸氣」） Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) 乳房病變（腫瘤 / 硬塊 / 腫塊 / 囊腫 / 結節 / 增生） Breast lesion (tumour / mass / lump / cyst / nodule / growth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) 子宮或卵巢病變（腫瘤 / 硬塊 / 腫塊 / 囊腫 / 瘰肉 / 結節 / 增生） Uterine or ovarian lesion (tumour / mass / lump / cyst / polyp / nodule / growth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) 良性前列腺肥大 Benign prostatic hypertrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e) 膽結石或泌尿道結石（腎結石、輸尿管結石或膀胱結石） Gall bladder stone or urinary stone (renal stone, ureteric stones or urinary bladder stone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f) 白內障、青光眼或視網膜病變 Cataract, glaucoma or retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g) 關節炎或其他關節疾病 Arthritis or other joint disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>




		受保人 Insured		保單持有人 Policy Owner	
		是 Yes	否 No	是 Yes	否 No
21.	在過去五年內，您是否曾經或被建議定期或持續（例如每月、每兩個月、每半年、每年）為任何疾病或健康狀況接受專業醫護人員（例如專科醫生、物理治療師、精神科醫生）的跟進診治或醫療護理？ In the last 5 years, have you ever had or been advised to have any regular or ongoing (such as monthly, every 2 months, half-yearly, annually) follow-up consultations or medical care with a healthcare professional (such as specialist doctor, physiotherapist, psychiatrist) for any disease or medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	在過去五年內，您是否曾被醫生建議定期（例如按醫生指示每日 / 每週一次 / 有需要時）服用為期超過一個月的處方藥物？ In the last 5 years, have you been advised by your doctor to take any medications (such as to be taken daily / once per week / as needed as directed by doctor) for a continuous period of more than 1 month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	在過去五年內，您是否曾入住醫院？ In the last 5 years, have you been admitted into a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	在過去五年內，您是否曾在非住院情況下接受外科程序（包括內窺鏡檢查或活組織化驗）？ In the last 5 years, have you undergone a surgical procedure (including endoscopy or biopsy) without being admitted into a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	在過去五年內，您是否曾接受或曾被建議接受檢查（例如驗血、驗尿、心电图、X光、超聲波、電腦掃描、磁力共振、正電子掃描、愛滋病測試、乙型肝炎測試、丙型肝炎測試）？ In the last 5 years, have you ever had or been advised to undergo investigations (such as blood or urine test, ECG, X-ray, ultrasound, CT scan, MRI, PET scan, HIV test, Hepatitis B test, Hepatitis C test)? 如果答案屬「是」，您的檢查結果是否包括下列情況？ If the answer is "Yes", do your investigation result(s) include the followings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	a) 檢驗結果正常 Normal test result is advised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) 檢驗結果異常 Abnormal test result is advised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) 您正等候檢驗或檢驗結果 You are still awaiting test / test result	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) 檢驗結果為無定論或不確定（需要重新或進一步檢驗） Test result is inconclusive or uncertain (retesting or follow up test is required)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e) 就檢驗結果已尋求醫療意見或需要接受治療（例如一些未必需要即時治療的情況如肝囊腫 / 腦囊腫 / 關節退化或鈣化 / 於成像檢測中發現肺部或乳房或甲狀腺出現鈣化） Medical advice has been sought or treatment is required for the test result (such as liver cyst / brain cyst / joint degeneration or calcification / lung or breast or thyroid calcification discovered on imaging test, that may not require immediate treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	除了您在第19至25項問題中已披露的資料外，您是否有下列情況？ Apart from anything you have already disclosed in Questions 19 - 25, do you have any of the following conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	a) 在過去一年內，體重無故地減少了5公斤（11磅）以上 Unintentional weight loss by more than 5 kg (11 lbs) over past 1 year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) 不正常出血（例如陰道出血、便血、流鼻血或咳血）至少一個月 Abnormal bleeding (such as vaginal bleeding, rectal bleeding, nose bleeding or coughing up of blood) for at least one month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) 在過去一年內，您有任何健康狀況或病徵及症狀曾經接受或需要接受專業醫護人員（例如專科醫生、物理治療師、精神科醫生）的跟進診治 In the last 1 year, you had or have been required to have follow-up consultation with a healthcare professional (such as specialist doctor, physiotherapist, psychiatrist) for any medical condition or sign and symptom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) 其他健康狀況或病徵及症狀（例如腫塊、頭痛、持續咳嗽、胸痛或上腹痛）而正在或打算尋求醫療意見 Other medical conditions or sign and symptom (such as lump, headache, persistent coughing, chest pain or epigastric pain) that you are seeking or intend to seek medical advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	<u>只適用於女性 For Female only</u> 您現時是否懷孕？ Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		如是，請詳述： If yes, please give details: a) 預產日期： Expected date of delivery : _____日DD_____月MM_____年YY			
28.	<u>只適用於六歲或以下之受保兒童 For insured children aged 6 or below only</u> 受保兒童是否於懷孕第37週前出生，及 / 或出生時體重少於2.5公斤（5.5磅）？ Was the insured child born before 37th week of pregnancy and / or born with body weight less than 2.5 kg (5.5 lbs)? 如是，請詳述： If yes, please give details:	<input type="checkbox"/>	<input type="checkbox"/>		
	a) 受保兒童在孕期哪一週出生？ At which week of pregnancy was the insured child born?				
	多於37週 more than 37 weeks	<input type="checkbox"/>			
	32至37週 32 to 37 weeks	<input type="checkbox"/>			
	28至31週 28 to 31 weeks	<input type="checkbox"/>			
	少於28週 less than 28 weeks	<input type="checkbox"/>			



		受保人 Insured		保單持有人 Policy Owner																																								
		是 Yes	否 No	是 Yes	否 No																																							
	b) 出生時體重 Body weight at birth 多於2.50公斤 / 5.51磅 more than 2.50 kg / 5.51 lbs 1.51 - 2.50 公斤 / 3.32 - 5.51 磅 1.51 - 2.50 kg / 3.32 - 5.51 lbs 1.00 - 1.50 公斤 / 2.20 - 3.31 磅 1.00 - 1.50 kg / 2.20 - 3.31 lbs 少於 1.00 公斤 / 2.20 磅 less than 1.00 kg / 2.20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
29.	就您所知，您的親生父母或兄弟姊妹曾否於六十歲或以前被確診下列疾病或健康狀況： At your best knowledge, have any of your parents or siblings by blood been diagnosed with any of the following diseases or medical conditions at or before age 60:																																											
	a) 癌症 Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
	b) 冠心病 Coronary heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
	c) 糖尿病 Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
	d) 運動神經元疾病 Motor neuron disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
	e) 多發性硬化症 Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
	f) 中風 Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
	g) 帕金森症 Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
	h) 遺傳病 - 包括囊性纖維化、家族性大腸腺息肉病、亞茲海默氏症、家族性心肌病、遺傳性血病（血友病、地中海貧血、鐮刀型貧血）、肌肉萎縮症、多囊性腎病或亨廷頓舞蹈症。 Hereditary diseases - including cystic fibrosis, familial adenomatous polyposis, Alzheimer's disease, familial cardiomyopathy, inherited blood disorders (hemophilia, thalassemia, sickle cell disease), muscular dystrophy, polycystic kidney disease or Huntington's disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
	如是，請詳述： If yes, please give details:																																											
	<table border="1"> <thead> <tr> <th colspan="2">(1) 哪個親屬 Which family member relationship</th> <th>(2) 疾病 Disease</th> <th colspan="2">(3) 病發年齡 Onset age of disease</th> </tr> </thead> <tbody> <tr> <td rowspan="4">受保人 Insured</td> <td>父親 Father</td> <td></td> <td><input type="checkbox"/> 30歲或以下 age at or below 30</td> <td><input type="checkbox"/> 41-50 歲 age 41-50</td> </tr> <tr> <td>母親 Mother</td> <td></td> <td><input type="checkbox"/> 31-40 歲 age 31-40</td> <td><input type="checkbox"/> 51-60 歲 age 51-60</td> </tr> <tr> <td>兄弟 Brother</td> <td></td> <td><input type="checkbox"/> 30歲或以下 age at or below 30</td> <td><input type="checkbox"/> 41-50 歲 age 41-50</td> </tr> <tr> <td>姐妹 Sister</td> <td></td> <td><input type="checkbox"/> 31-40 歲 age 31-40</td> <td><input type="checkbox"/> 51-60 歲 age 51-60</td> </tr> <tr> <td rowspan="4">保單持有人 Policy Owner</td> <td>父親 Father</td> <td></td> <td><input type="checkbox"/> 30歲或以下 age at or below 30</td> <td><input type="checkbox"/> 41-50 歲 age 41-50</td> </tr> <tr> <td>母親 Mother</td> <td></td> <td><input type="checkbox"/> 31-40 歲 age 31-40</td> <td><input type="checkbox"/> 51-60 歲 age 51-60</td> </tr> <tr> <td>兄弟 Brother</td> <td></td> <td><input type="checkbox"/> 30歲或以下 age at or below 30</td> <td><input type="checkbox"/> 41-50 歲 age 41-50</td> </tr> <tr> <td>姐妹 Sister</td> <td></td> <td><input type="checkbox"/> 31-40 歲 age 31-40</td> <td><input type="checkbox"/> 51-60 歲 age 51-60</td> </tr> </tbody> </table>	(1) 哪個親屬 Which family member relationship		(2) 疾病 Disease	(3) 病發年齡 Onset age of disease		受保人 Insured	父親 Father		<input type="checkbox"/> 30歲或以下 age at or below 30	<input type="checkbox"/> 41-50 歲 age 41-50	母親 Mother		<input type="checkbox"/> 31-40 歲 age 31-40	<input type="checkbox"/> 51-60 歲 age 51-60	兄弟 Brother		<input type="checkbox"/> 30歲或以下 age at or below 30	<input type="checkbox"/> 41-50 歲 age 41-50	姐妹 Sister		<input type="checkbox"/> 31-40 歲 age 31-40	<input type="checkbox"/> 51-60 歲 age 51-60	保單持有人 Policy Owner	父親 Father		<input type="checkbox"/> 30歲或以下 age at or below 30	<input type="checkbox"/> 41-50 歲 age 41-50	母親 Mother		<input type="checkbox"/> 31-40 歲 age 31-40	<input type="checkbox"/> 51-60 歲 age 51-60	兄弟 Brother		<input type="checkbox"/> 30歲或以下 age at or below 30	<input type="checkbox"/> 41-50 歲 age 41-50	姐妹 Sister		<input type="checkbox"/> 31-40 歲 age 31-40	<input type="checkbox"/> 51-60 歲 age 51-60				
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30.	除獨立申請自願醫保計劃外，必須回答。 Applicable to all application except standalone VHIS application 您是否曾被告知有慢性阻塞性氣道疾病、阻塞性睡眠窒息症、癲癇症、自閉症、注意力不足過動症、任何腫瘤/硬塊/腫塊/囊腫/瘰癧/肉/結節/增生/異常腫脹，或心悸、心臟雜音、麻痺、蛋白尿或血尿的任何病徵或症狀？ Have you ever been advised to have chronic obstructive airways disease, obstructive sleep apnoea, epilepsy, autism, ADHD, any tumour/mass/lump/cyst/polyp/nodule/growth/abnormal swelling, or any signs and symptoms of palpitation, heart murmur, numbness, albuminuria or haematuria?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							

* C S 0 0 4 2 *



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第五部分 — 健康資料補充
Part V – Supplementary Health Information

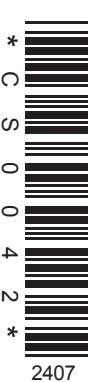
若第四部分第19至26及第30題任何一項問題之答案為「是」者，請在適用的問題提供更多資料
If the answer to any of the questions 19-26 and 30 in Part IV is "Yes", please provide additional information as applicable
請盡量提供齊全資料（例如在未能回憶確實日期的情況下提供年份及月份）以便作出公平核保決定。
Please provide information as detailed as possible (e.g. provide year and month if exact date could not be recalled) for the sake of fair assessment in underwriting.
如以下空位不足，請填寫「保險服務補充聲明書(只適用於保單續發後)」
If the following space is not sufficient, please complete "Supplementary Statement Form for Policy Services (only applicable after policy issuance)"

題號 Question No.			
* 請刪去不適用者 * Please delete as appropriate	_____ *受保人 / 保單持有人 *Insured / Policy Owner	_____ *受保人 / 保單持有人 *Insured / Policy Owner	_____ *受保人 / 保單持有人 *Insured / Policy Owner
(1) 疾病 / 健康狀況 / 病徵及症狀 Disease / medical condition / sign and symptom			
(2) 首次出現病徵及症狀的日期 Date of first occurrence of sign and symptom	_____ (日DD/月MM/年YY)	_____ (日DD/月MM/年YY)	_____ (日DD/月MM/年YY)
(3A) 已進行的治療 / 檢查 / 測試 / 掃描 Treatment / investigations / tests / scans that have been performed			
(3B) 有關治療 / 檢查 / 測試 / 掃描日期 Date of such treatment / investigation / tests / scan	_____ (日DD/月MM/年YY)	_____ (日DD/月MM/年YY)	_____ (日DD/月MM/年YY)
(4) 現況 (例如是否已完全康復、有否跟進 / 服用跟進藥物 / 下次覆診日期) Present condition (such as whether fully recovered, follow up action / medication / next follow up date)			
(5) 最後覆診 / 治療日期 Date of last follow-up medical consultation / treatment	_____ (日DD/月MM/年YY)	_____ (日DD/月MM/年YY)	_____ (日DD/月MM/年YY)
(6) 治療有關疾病 / 不適 / 健康狀況 / 病徵及症狀的醫生姓名 Name of doctor who treated the disease / sickness / medical condition / sign and symptom	(注意：在保險公司聯絡保單持有人 / 受保人的醫生以獲取其醫療記錄前，需獲得保單持有人 / 受保人的書面同意。) (Note: written consents from Policy Owner / Insured are needed before an insurance company may approach the Policy Owner's / Insured's doctor for access to his / her medical records)		
(7) 醫院名稱 (如適用) Name of Hospital, where applicable	(注意：在保險公司聯絡保單持有人 / 受保人的醫生以獲取其醫療記錄前，需獲得保單持有人 / 受保人的書面同意。) (Note: written consents from Policy Owner / Insured are needed before an insurance company may approach the Policy Owner's / Insured's doctor for access to his / her medical records)		

資料收集聲明
Statement for Collection of Information

以下聲明闡述收集健康相關的資料之目的，以及保單持有人須盡其所知所信提供完整及準確的資料。
The following statement states the purpose of collecting health-related information and the Policy Owner is required to provide the complete and accurate information to the best of his/her knowledge and belief.

- (i) 第三、四、五部分及保險服務補充聲明書(只適用於保單續發後)收集與健康相關的資料僅作為核保之用途，而核保是周大福人壽評估保單持有人的健康風險及決定申請結果的程序。周大福人壽採用的核保程序為公平合理，並會因應客戶要求解釋申請結果。
Parts III, IV, V and Supplementary Statement Form for Policy Services (only applicable after policy issuance) collect health-related information solely for the purpose of underwriting which is a process for CTF Life to evaluate the health risk of the Policy Owner and decide the application results. The underwriting process that CTF Life adopts shall be fair and reasonable, and CTF Life should explain the application results if requested by the customers.
- (ii) 作為保單持有人，閣下需要盡其所知所信，按本問卷中要求向周大福人壽提供完整及準確的資料。周大福人壽根據閣下提供的資料，可能會提出跟進問題或查詢而需要閣下進一步提供資料以作核保之用。
As the Policy Owner, you are required to provide CTF Life with complete and accurate information requested in this questionnaire to the best of your knowledge and belief. Based on the information provided, CTF Life may have follow-up questions or enquiries that require you to provide further information for underwriting purpose.
- (iii) 若閣下在提交本申請表後至閣下收到確認文件前的期間就本問卷中提供的資料有任何改變或更新，閣下需要及早通知周大福人壽。
If there are any changes to or updates of the information provided in this application after the time of submission of this application and before you receive the confirmation documents, you are required to notify CTF Life in a timely manner.
- (iv) 即使已成功批核，若閣下未按 (ii) 所述盡其所知所信向周大福人壽提供完整及準確的資料，或未按 (iii) 所述就資料的任何改變或更新而及早通知周大福人壽，閣下的保險保障可能會受到影響，周大福人壽亦可能因此終止、作廢或撤銷有關保單或申請，或拒絕賠償。
Even after successful application, the insurance coverage for you may be affected or the policy or application may be terminated, voided or rescinded, or claims may be repudiated by CTF Life, if you have not provided CTF Life with complete and accurate information to the best of your knowledge and belief according to (ii), or if you have not notified CTF Life on any changes to or updates of the information in time according to (iii).



第六部分 - 健康狀況聲明 (簡易核保產品)
Part VI – Health Declaration (Simplified Underwriting Product)

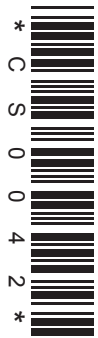
適用於非投資相連之簡易核保產品
Applicable to Simplified Underwriting Products of Non-ILAS

1. 受保人現在是否住院或是否於過去36個月連續住院6日以上，或受保人是否曾被建議因身體狀況於未來6個月內需要住院或接受診斷性之檢查? 如是，請提供日期、疾病性質、治療詳情、現時情況(如適用) 是 否
Yes No
- Has the Insured currently hospitalized or has been hospitalized for more than 6 consecutive days in the past 36 months or has the Insured been advised that he/she is having medical condition that will need to be hospitalized or required diagnostic checkup in the next 6 months? If yes, please provide the date, nature of illness, details of treatment, current condition (if applicable).

適用於投資相連簡易核保產品
Applicable to ILAS Simplified Underwriting Products

2. 受保人是否曾：Has the Insured:
- (a) EVER been diagnosed or treated for AIDS or any kind of terminal cancer or tumor; or
被診斷患有愛滋病或任何種類之末期癌症或腫瘤或曾接受與上述任何一項有關的治療；或
 - (b) been hospitalized for 30 days or more for any disease within the past 6 months; or
於過去6個月內，因任何疾病而須留院30日或以上；或
 - (c) been postponed for any life insurance application in the past 6 months; or
於過去6個月內，被延期接受任何人壽投保申請；或
 - (d) been declined for any life insurance application in the past year?
於過去1年內，被拒絕任何人壽投保申請？
- 是 否
Yes No

如是，請提供日期、疾病性質、治療詳情、現時情況、人壽投保申請被延期 / 拒絕的原因、保險公司名稱及保單號碼(如適用)。
If yes, please provide the date, nature of illness, details of treatment, current condition, reason of your life insurance application being postponed / declined, name of insurance company and policy number (if applicable).



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佣金披露聲明 Commission Disclosure Statement

保單持有人明白、確知及同意，周大福人壽會就保單持有人購買周大福人壽發發的保單，從保單開始及於保單仍生效期間，向獲授權保險經紀支付佣金。這包括但不限於續保、復效、增加附加保障及提升起訂明保費。假如保單持有人為法人團體，代表保單持有人簽署的獲授權人員須向周大福人壽確認他/她已獲法人團體授權簽署。
The Policy Owner understands, acknowledges and agrees that, as a result of purchasing the policy issued by CTF Life, CTF Life will pay the authorized insurance broker commission from inception and while the policy remains in force. These include, but may not be limited to, renewals, reinstatement, additional of supplementary cover and increases in the initial contracted premium. Where the Policy Owner is a business association, the authorized person who signs on behalf of the Policy Owner further confirms to CTF Life that he or she is authorized to do so.

保單持有人亦明白周大福人壽必須取得保單持有人的同意，方可以維持保單的有效性。
The Policy Owner further understands that the above agreement is necessary for CTF Life to continue the policy.

保單持有人繳付保費，則視作允許周大福人壽就所發發的保單支付佣金予有關的獲授權保險經紀。
If the Policy Owner pays the premium, the Policy Owner is deemed to have given permission to CTF Life to pay the commission to the authorized insurance broker in relation to the policy issued by CTF Life.

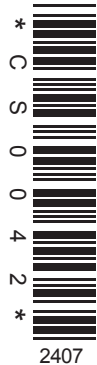
X _____
保單持有人簽署
Signature of the Policy Owner

簽署日期(日 / 月 / 年)
Date of Signature (DD/MM/YY)

個人資料收集聲明 Personal Information Collection Statement

本人 / 我們確認本人 / 我們已閱讀及明白周大福人壽保險有限公司（以下簡稱“周大福人壽”）之個人資料收集聲明（“該聲明”）。本人 / 我們聲明及同意貴公司可根據該聲明所述的任何目的收集及 / 或持有、使用及/或披露/分享任何個人資料（不論是否從此表格或以其他方式獲得）。本人 / 我們明白本人 / 我們必須於此表格提供所須資料，否則貴公司將可能無法執行該聲明之目的及 / 或向本人 / 我們提供產品或服務。本人 / 我們確認及同意本人 / 我們的個人資料可能披露/共享給該聲明所指明的第三方；執法機構；保險業就現有資料而對所提供的資料作出分析和檢查而使用的數據庫或登記冊作出於該聲明所述的任何目的。本人/我們明白該聲明的最新版本可於周大福人壽的網址下載：www.ctflife.com.hk，及可向貴公司索取。

I /We confirm that I/we have read and understood Chow Tai Fook Life Insurance Company Limited (“CTF Life”)’s Personal Information Collection Statement (“PICS”). I/We declare and agree that any personal data CTF Life may collect and/or hold, use and/or disclose/share with (whether contained in this form or otherwise obtained) in accordance with the Purposes as set out in the PICS. I/We understand that if I/we do not provide the required personal data, CTF Life may not be able to perform the Purposes and/or provide products or services to me/us. I/We acknowledge and agree that my/our personal data may be disclosed/shared with specified parties in the PICS; law enforcement authorities; databases or registers used by the insurance industry to analyse and check information provided against existing information for any of the Purposes stated in the PICS. I/We understand the updated version of the PICS is available for download from CTF Life’s website: www.ctflife.com.hk, and will be made available upon request.



聲明及授權 Declaration and Authorization

本人謹此要求本人之保單按照本申請書的第一部份之選擇作出更改。本人代表本人及所有受保人明白及同意(1)要求復效、更改或增加保額時所需之可保證明將包括本申請書第一至第六部份，並須符合下列條件後方可生效：(a)繳清所有申請所需之款項及(b)周大福人壽保險有限公司之總公司於受保人生存和繼續可保的情況下批准此申請；(2)更改之要求如不需可保證明將只包括本申請書之第一部份並由申請日期生效，特別指定一較遲日期除外，唯該更改必須是保單內列為可更改事項或經本公司許可；(3)保單內之不得異議條款及自殺豁免條款將應用於所有復效、更改或增加保額或附加保障之申請，但條款內指定之時限將由公司批核日期起計；(4)本申請書及所需之可保證明將成為保單更改之根據並成為保單之一部份，如有特別註明者除外。

I hereby request that my policy to be changed in accordance with the particulars set out in Part I of the application and I UNDERSTAND AND AGREE on behalf of myself and all the Insured(s) that: (1) The request for reinstatement, change of addition which requires evidence of insurability shall consist of Part I to Part VI and shall not take effect unless all of the following conditions are met: (a) any required payment for the application is paid in full and (b) the application is approved by Chow Tai Fook Life Insurance Company Limited at its Head Office during the lifetime and continued insurability of the person insured by the policy; (2) the request for change which does not require evidence of insurability shall consist of Part I only and shall be effective from the date of this request unless a later date is specifically indicated, but only if the change is provided by the policy or is allowed by Chow Tai Fook Life Insurance Company Limited under the policy; (3) The incontestability Provision and Suicide Exclusion Provision in the policy shall apply upon reinstatement, changes or addition of sum insured or supplements and the period of time specified in the said provisions shall run from the date of approval of this application by Chow Tai Fook Life Insurance Company Limited; (4) This form and the evidence of insurability of the person or persons insured if required by Chow Tai Fook Life Insurance Company Limited shall be the basis for change in the policy and will form part of the policy unless otherwise specified.

本人謹此代表本人及所有受保人聲明及同意(1)上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所言，均為確實無訛之全部事實；(2)上述問題的所有答案及此申請書將成為更改保單的根據，並作為保單之一部份；(3)本人對任何人所作出的任何聲明，如沒有在此申請書上填寫或印出，貴公司不需受其約束。

I HEREBY DECLARE AND AGREE on behalf of myself and all the Insured(s) that (1) all statements and answers to the questions whether or not written by my own hand are to the best of my knowledge and belief, complete and true; (2) all answers to such questions, together with this application, shall form the basis for the proposed reinstatement, change or addition and become a part of the policy; (3) Chow Tai Fook Life Insurance Company Limited is not bound by any statement which I may have made to any person if not written or printed here.

本人/我們謹此授權任何註冊西醫、醫院診所、保險公司、其他機構或人士，凡知道或擁有任何有關本人或任何受保人記錄者，均可將該等資料提供給周大福人壽有限公司，本授權書的影印本與正本有同等效力。

I/we HEREBY AUTHORIZE any registered medical practitioner, hospital, clinic or insurance company, institution or person, that has any records or knowledge of me, to give to Chow Tai Fook Life Insurance Company Limited any such information. A photocopy of this authorization shall be as valid as the original.

本人/我們明白若此更改申請書(附健康狀況問卷)的中、英文兩個版本有任何抵觸或不相符之處，應以英文版本為準。

I/We understand that if there is any inconsistency or ambiguity between the English version and the Chinese version of this Change Form (with Health Questionnaire), the English version should prevail.

產品選擇聲明 (只適用於附加保障) Product Selection Declaration (only applicable to addition of benefit):

本人謹此聲明及確認 (i) 本人已收到所選擇產品之產品小冊子；(ii) 本人具有足夠知識及經驗充分理解所選擇產品之特色、保障範圍、賠償限額、賠償限制、費用及收費、退保費用、主要條款及細則、相關的風險及主要不保事項 (如適用)；(iii) 本人已充分考慮及確認所選擇產品及保額適合本人的需要、箇中優次和實際情況；及(iv)本人能夠負擔及預計會於整個保障期內持續支付所選擇產品的保費。

I HEREBY DECLARE and CONFIRM that (i) I have received the product brochure(s) of the selected product; (ii) I have sufficient knowledge and experience to fully understand the product features, coverages, benefit limits, benefit restrictions, fees and charges, surrender penalties, key terms and conditions, the associated risks and key exclusions (where applicable); (iii) I have duly considered and confirm that the selected product(s) and the sum insured suit my needs, priorities and circumstances; and (iv) I can afford and expect to pay the required premiums throughout the coverage period continuously.

取消保單權益及發還保費連同保費徵費 (只適用於自願醫保計劃的附加或增加)

Cancellation Right and Refund of Premium(s) with Premium Levy (Only Applicable to VHIS Product Addition or Increase)

本人明白本人有權以書面通知要求取消計劃，取回所有已繳保費及保費徵費；但是本人必須簽署該通知，並確保周大福人壽於九龍海濱道123號綠景NEO大廈7樓的辦事處於以下時段內直接收到該通知：批註交付本人/本人的代表後或投保批核通知書發予本人/本人的代表後，起計的21個曆日內(以較早者為準)。

I understand that I have the right to cancel the plan and obtain a refund of any premium(s) and premium levy paid by giving a written notice. Such notice must be signed by me and received directly by CTF Life at 7/F, NEO, 123 Hoi Bun Road, Kowloon within 21 calendar days after the delivery of the endorsement or issuance of the Notice of Approval of Insurance application to Policy Holder or the Policy Holder's representative, whichever is the earlier.

Signed at _____ on _____

簽署地 Place	簽署日期(日/月/年) Date of Signature (DD/MM/YY)	見證人簽署 Signature of Witness	保單持有人 / 受讓人簽署 Signature of Policy Owner / Assignee	受保人簽署 Signature of Insured
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姓名：
Name: _____

身份證號碼 / 保險顧問編號：
ID No. / Consultant Code: _____

由顧問填寫 To be completed by Advisor

獨立理財顧問公司編號 IFA Company Code: _____ - _____ - _____

保單請送回 Policy Return To: 保單持有人 Policy Owner

獨立理財顧問公司編號 IFA Company Code _____ - _____ - _____



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