

HEALTH CERTIFICATE 健康證明書 (Only Applicable for Wealth Series) (只適用於財富系列)

Policy Number 保單號碼	Name of Insured 受保人姓名		Name of Owner 持有人姓名					
Area Code	Agency / Broker Name		Agent / Broker Co	de	A.Y.			
區域編號	營業員組別 / 經紀名稱			營業員號碼 / 經紀號碼				
Agency Code 營業員組別編號	Agent / TR's Name 營業員 / 業務代表姓名		Agent / TR's Tel. N 營業員 / 業務代表	No. 聯絡電話				
TR Membership Number 業務代表會員號	嗎 [] IA		ANG					
(For Brokers only 僅供經紀使用) TIPS: Check the checkbox (IA for HK; ANG for IA 提示: 選取方格 (IA-香港; ANG-澳門) 並填入特法 Remark: If the stated AIA financial planner / bro	定的登記號碼 [香港號碼由26 oker / IFA on this form is no	<i>個英文字母+4位數字組</i> ot my current servicing	成;澳門號碼由3個英 AIA financial planner	文字母+4位數字組成] / broker / IFA, I give con	sent to him/her to			
備註:倘若在上述表格上填寫的財務策劃顧問/ Please complete payor's information 請填寫付款人資料。	for reinstatement or a	addition of Payor	Benefit rider. 如隼	a請復效或增加付款人 [。]	保障附加契約,			
Other Policies 其他保單號碼 (The followin	g policies must belong t	to the same Insured	I / Payor 下列之保單	望須屬於同一受保人 / 作	†款人) ————————————————————————————————————			
			/E->L					
Please tick the appropriate box for application c 如申請復效, 請在適當的空格內劃上"X"號	if reinstatement	Reinstatement Redating	复数 重訂保單日期 [Reinstate Agent 申請	清復效營業員			
		Insured Name 受保人姓名:		Payor Name 付款人姓名:				
1. Occupation Title 職銜								
2. Exact Daily Job Duties 日常職務								
3. Nature of Business. Please give employer' 公司業務性質 / 僱主名稱 / 辦事處地址	s name and address.							
STATEMENT FOR COLLECTION O	F INFORMATION 資料	料收集聲明		ı				
(i) This questionnaire collects health-related in the applicants and decide the application reexplain the application results if requested be 中國政府 (中國政府)	sults. The underwriting product the customers.	cess that the Company	adopts should be fair	and reasonable, and the	Company should			
此問卷收集與健康相關的資料僅作為核保之的 因應客戶要求解釋申請結果。 (ii) As the applicant, you are required to provide	the Company with complete	e and accurate informa	ition requested in this o	questionnaire to the best o	of your knowledge			
and belief. Based on the information provide underwriting purpose. 作為申請人,閣下需要盡其所知所信,按本f								
進一步提供資料以作核保之用。 (iii) If there are any changes to or updates of the		is questionnaire after t	he time of submission	of this application and be	efore you receive			
the Policy, you are required to notify the Company in a timely manner. 若閣下在提交本申請表後至閣下收到保單前的期間就本問卷中提供的資料有任何改變或更新,閣下需要及早通知本公司。 (iv) Even after an insurance policy has been issued upon successful application, the insurance coverage for you may be affected or the policy may be terminated, voided or rescinded, or claims may be repudiated by the Company, if you have not provided the Company with complete and accurate information to the best of your knowledge and belief according to (ii), or if you have not notified the Company on any changes to or updates of the information in time according to (iii). 即使已成功投保並獲簽發保單,若閣下未按(ii)所述盡其所知所信向本公司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本公司,閣下的保險保障可能會受到影響,本公司亦可能因此終止、作廢或撤銷有關保單,或拒絕賠償。								
For Medical products (Hong Kong region - inc 附加契約):	luding VHIS and non-VH	IS basic plans or ride	rs) 醫療產品(香港區-	- 包括自願醫保及非自願				
Please complete Miscellaneous Information, Pa 請填寫雜項資料,甲部-基本資料及乙部-健康 For other Non-medical products (including Life,	資料 Critical illness, Cancer cove	erage etc.) 其他非醫療	產品(包括人壽,危疫		mation			
Please complete Miscellaneous Information, Part A – General Information, Part B – Health Information and Part C – Supplementary Health Information 請填寫雜項資料,甲部-基本資料、乙部-健康資料及丙部-附加健康資料 * Note: If Applicant applies for Payor's Benefit or Critical Illness Payor's Benefit, please complete all questions on Payor. 請注意:若同時申請付款人利益或危疾付款人利益保障,須填寫所有關於付款人之問題。								

							Policy	Numb	per 保單號碼							
MISCELLANEOUS 雜項:													ured 保人	*Pa *付		
4. (i)	I. (i) In the past 5 years, what amount of time do you spend in various city(ies), specifying any particular city(ies) in which you											YES 是	NO 否	YES 是	NO 否	
	spend more than 14 days per year in total and indicating the total time spent there and your reason for being there? If 'YES', please state details below. 閣下於過去五年內在其他國家居住的時間有多少?請註明如居住多於每年14天的城市及在該國家的總居住時間及原因。如 "是"者,請於下列註明詳情。									4(i)						
	City / Count	ry 城市 / 國家		Purpose 原因 Duration 居留時間							間					
(ii	and app	roximately wh	position changen do you expensed. 科此情況是否	ect this change	e to take place	e? Please	state details l	oelow.			J	4(ii)				
	City / Countr	y 城市 / 國家	Pur	pose 原因	Dura	ation 居留印	寺間 Time t	o mak	e the change	决定轉變	時間					
(;;	ii) Dlagas	an a aif curbiab	and the day of	hava narman	ant and tamps		anna atatua?									
(11	(iii) Please specify which country do you have permanent and temporary residence status? 請註明閣下在哪個國家持有永久或暫時居留身份?															
	Country	Residency Status (i.e. Citizen, PR, Work Permit, etc)							n Year							
Li	imited)? If 'Y	ES', please st	urance and / or ate details belo 任何保險(不包	ow:			• ,			Internat	ional	5				
		Company 承保公司	Policy Currency 保單貨幣	Life 壽險	Hospital Income 住院入息	Critic Illnes 危疾仍	al Accio	dent nnity	Accidental Death 意外死亡	Year of Iss 保單繕	ue ´					
	Insured 受保人															
	Payor 付款人															
6. I	Have you ev	ver been decli	ned, postpone	d or accepted	I on modified	terms for	life, critical il	lness,	medical healt	h, disab	ility or	6	П			П
	accident insu 你早本曾在由		:、緊痪、復務;	式音外保险性剂	波	閉罟巠 仔、	須繳付額 外4	書式 修	&动会幼修화 2							
ı	您是否曾在申請壽險、危疾、醫療、傷殘或意外保險時被拒絕受保、擱置受保、須繳付額外保費或修改合約條款? If "YES", please provide details:															
			Application date (year) 申請日期(年份) Type of insurance 保險種類 Final decision and the reason of the decision 核保結果及其原因													
	Insured 受伤															
	Payor 付款。	 人														

PA	RT A – GENERAL INFOR	MATION 甲部-基本資料							
Insured 受保人: *Payor *付款人:									
7.	7. Height 身高: Weight 體重: Height 身高: Weight 體						(lbs)/		
8.	Smoking habit 吸煙習慣					Г			
o.	Do you smoke or have you smok 您有沒有吸煙或在過去12個月內 For the purpose of this question	8							
	chewing tobacco and the use of	nicotine replacement products (such as e-ci 下限於香煙、雪茄、煙斗、嚼煙及使用尼古丁							
		Type of tobacco product Quantity of consumption 煙草產品種類 吸食份量							
	Insured 受保人								
	Payor 付款人								
9.	Alcohol consumption 飲酒				1		\vdash		
	在過去12個月內,您是否平均每該		han 3 times in a week?		9				
	If "Yes", please provide additiona 若"是",請提供更多資料:								
	Type of alcoholic beverage Quantity of consumption								
	Insured 受保人								
	Payor 付款人								
10.	Taking of drugs not prescribed	l by doctors 服用未經醫生處方之藥物			10				
	· · · · · · · · · · · · · · · · · · ·	ed any drugs (excluding dietary supplemen gs such as cocaine, ecstasy, heroin, methad							
	在過去5年內,您曾否持續超過1 美沙酮、同化性類固醇;惟不包持	個月使用未經醫生處方之藥物(包括成癮性 括營養補充品)?	生或消遣性藥物,例如可卡因、興奮劑	、海洛英、					
	If "Yes", please provide additiona 若 "是" ,請提供更多資料:	ll information:			1				
		Type of drugs 棄物種類	Duration, frequency an quantity of consumptio 用藥持續時間、頻密度及f	n					
	Insured 受保人								
	Payor 付款人								
11.		g activities within the last 12 months or will you	u engage/ intend to engage in the follow	ing activities	11				
	within the next 12 months? 您曾否在過去12個月內或會否在	未來12個月內參與以下活動?	(a)						
		ivities (such as diving, motor racing, mounta	aineering or rock climbing, parachuting	, sky diving,					
	hang gliding) 任何危險性運動或活動(例如 h)。	lulad t	(b)						
 flying activities other than as a fare-paying passenger of a licensed air service operating within recognised scheduled routes. 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) 									
		al information or complete a separate supple							
						1			

PART B - HEALTH INFORMATION 乙部 - 健康資料 Note for applicant(s): Questions of Part B do not require the applicant(s) to disclose information regarding the medical conditions or treatments below –												
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. 申請人須知:無需於乙部問題披露以下健康狀況或治療一												
常規	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。											
12.	Have you ever been diagnosed with any of the following diseases or medical conditions?		Insured 受保人		*Payor *付款人							
	您是否曾被確診下列疾病或健康狀況?		YES	NO NO		NO						
		12	是	否	是	否						
	(a) Cancer or carcinoma in situ 癌症或原位癌	(a)										
	(b) Brain tumor 腦部腫瘤	(b)										
	(c) Heart disease 心臟疾病	(c)				닖						
	(d) Stroke (including transient ischemic attack (TIA)) 中風(包括短暫性腦缺血, 俗稱「小中風」)	(d)				밁						
	(e) Hypertension 高血壓	(e)		H	H	밁						
	(f) Diabetes mellitus or impaired glucose tolerance 糖尿病或葡萄糖耐量異常	(f)		H	H	님						
	(g) Kidney disease 腎病 (b) Drainsond interpretable disease degrees the pains conditions 性則較空山式炎性泪化性疾病	(g)		H	H	님						
	(h) Prolapsed intervertebral disc or degenerative spine conditions 椎間盤突出或脊椎退化性疾病	(h)		H	H	님						
	(i) Diseases or medical conditions requiring a medical device or prosthesis to be implanted within the body 需要植入醫療儀器或義肢的疾病或健康狀況	(i)										
	(j) Human immunodeficiency virus ("HIV") infection 人體免疫力缺乏病毒(愛滋病病毒)感染	(j)		\sqcup	\sqcup	븨						
	(k) Congenital conditions (medical, physical or mental abnormalities that existed at the time of or before birth)	(k)	Ш	\sqcup	Ш	\sqcup						
	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)					$_{\square}$						
	(I) Physical defects, impairments, deformities, and/or conditions affecting mobility, sight, speech or hearing	(I)	Ш	Ш	Ш	\sqcup						
	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	()		\neg	\Box	\neg						
	(m) Mental health conditions (such as depression, anxiety, schizophrenia, eating disorders or bipolar disorders)	(m)	Ш	Ш	Ш	ᅵᅵ						
	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)	(m)				\neg						
	(n) Hypercholesterolemia or Hyperlipidemia 高膽固醇症或高血脂症	(n)				님						
	(o) Liver disorder (such as hepatitis B or hepatitis C (including tested positive), fatty liver or cirrhosis of liver) 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)	(o)		닏	믜	ᅵ						
	(p) Multiple sclerosis 多發性硬化症	(p)										
40												
13.	Do you currently have any of the following diseases or medical conditions?	13										
	您目前是否患有下列疾病或健康狀況? (a) Hernia 疝氣(俗稱「小腸氣」)	(2)		\neg		\neg						
		(a)				믜						
	(b) Breast lesion (tumour / mass / lump / cyst / nodule / growth) 乳房病變 (腫爛 / 梗塊 / 灌塊 / 囊腫 / 結節 / 增生) (c) Uterine or ovarian lesion (tumour / mass / lump / cyst / polyp / nodule / growth)	(b)		빔		믜						
	子宮或卵巢病變 (腫瘤 / 硬塊 / 腫塊 / 囊腫 / 瘜肉 / 結節 / 增生)	(c)	Ш	Ш	Ш	Ш						
	(d) Benign prostatic hypertrophy 良性前列腺肥大	(-I\		\neg		\neg						
	(e) Gall bladder stone or urinary stone (renal stone, ureteric stones or urinary bladder stone)	(d)		H		H						
	膽結石或泌尿道結石(腎結石、輸尿管結石或膀胱結石)	(e)	Ш	Ш	Ш	\sqcup						
	(f) Cataract, glaucoma or retinopathy 白內障、青光眼或視網膜病變	(f)		\Box		\Box						
	(g) Arthritis or other joint disorder 關節炎或其他關節疾病	(g)										
14.	In the last 5 years, have you ever had or been advised to have any regular or ongoing (such as monthly, every 2 months,			\Box	\neg	一						
	half-yearly, annually) follow-up consultations or medical care with a healthcare professional (such as specialist doctor,	14	Ш	Ш	Ш	\sqcup						
	physiotherapist, psychiatrist) for any disease or medical condition?											
	在過去5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?											
15.	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	15										
	needed as directed by doctor) for a continuous period of more than one month? 在過去5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1個月的處方藥物?											
16												
10.	In the last 5 years, have you been admitted into a hospital? 在過去5年內,您是否曾入住醫院?	16										
17.	In the last 5 years, have you undergone a surgical procedure (including endoscopy or biopsy) without being admitted into a hospital? 在過去5年內,您是否曾在非住院情况下接受外科程序(包括內籍鏡檢查或活組織化驗)?	17	$ \Box $									

Policy Number 保單號碼

				F	Policy Number 保單號碼						
									ired 呆人	*Pay	
		nave you ever had or been advis			uch as blood or urine tes	, ECG, X-ray,		YES 是	NO 否	YES 是	
	ultrasound, CT scan, MRI, PET scan, HIV test, Hepatitis B test, Hepatitis C test)? 在過去5年內,您是否曾接受或曾被建議接受檢查(例如驗血、驗尿、心電圖、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)? If the answer is "Yes", do your investigation result(s) include the followings?										
	(a) Normal test result(b) Abnormal test re	您的檢查結果是否包括下列情況? ilt is advised 檢驗結果正常 esult is advised 檢驗結果異常 iiting test / test result 您正等候檢點		生里			(a) (b) (c)				
	(d) Test result is inc	onclusive or uncertain (retesting o	or follow u				(d)				
	(e) Medical advice h or calcification / l 就檢驗結果已尋	論或不確定(需要重新或進一步檢 nas been sought or treatment is red lung or breast or thyroid calcificatio :求醫療意見或需要接受治療(例 現肺部或乳房或甲狀腺出現鈣化)	quired for on discov	ered on imaging test, th	at may not require immedi	ate treatment)	(e)				
		you have already disclosed, do yo 外,您是否有下列情況?	ou have ar	ny of the following cond	litions?		19				
	* *	ng (such as vaginal bleeding, recta 如陰道出血、便血、流鼻血或咳血		•	ighing up of blood) for at le	ast one month	(a)				
	specialist doctor 在過去1年內,您	ɪr, you had or have been required , physiotherapist, psychiatrist) for 您有任何健康狀況或病徵及症狀曾 给	any medi	cal condition or sign an	d symptom	,	(b)				
	醫生)的跟進診治 (c) 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 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										
	20. [For insured children aged 6 or below only 只適用於六歳或以下之受保兒童] Was the insured child born before 37th week of pregnancy and / or born with body weight less than 2.5 kg (5.5 lbs)? 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)?										
	若"是",請提供更	of pregnancy was the insured chil	ld born?	(ii) Body weight at bi 出生時體重	rth						
	More than 37 v 32 – 37 weeks 28 – 31 weeks Less than 28 w	28-31週		More than 2.5kg 多於2.5公斤(5.5 1.5-2.5kg(3.31 1.5-2.5公斤(3. 0.751-1.499kg(0.751-1.499公斤	1磅) - 5.51lbs) 31 - 5.51磅) 1.651 - 3.3lbs) f(1.651 - 3.3磅)						
				Less than or equal 等於或少於0.75亿	al to 0.75kg (1.65lbs) ≿斤(1.65磅)						
	conditions at or before	ge, have any of your parents or sibli re age 60: 父母或兄弟姊妹曾否於六十歲或以		· ·	h any of the following disea	ses or medical	21				
	(a) Cancer 癌症 (b) Coronary heart of	disease 冠心病					(a) (b)				
	(c) Diabetes mellitus						(c) (d)				
	(e) Multiple sclerosis						(e)				
	(f) Stroke 中風 (g) Parkinson's dise	ase 柏金遜症					(f) (g)				
	(h) 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 o Huntington's disease. 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、多囊性腎病或亨丁頓舞蹈症。 If the answer to any of the questions of Q21 is "Yes", please provide additional information: 若第21項任何一項問題之答案為 "是", 請提供更多資料:										
		Which disease? 哪種疾病?	Whic	ch family member? 哪個親屬?	Onset age of dis 病發年齡	sease					
	Insured 受保人				age at or below 39 age 40-49(40-49歲 age 50-59(50-59歲 age 60(60歲)	į)					
	Payor 付款人				age at or below 39 age 40-49(40-49歲 age 50-59(50-59歲 age 60(60歲)	<u>(</u>					

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PART C-SUPPLEMENTARY HEALTH INFORMATION: 丙部-附加健康資料:	Insu 受伤		ured 保人		yor 飲人
22. Have you ever had: 您是否曾患有:	22	YES 是	NO 否	YES 是	NO 否
(a) Any tumour, mass, cyst, nodule, polyp, lump, growth, or abnormal swelling?	(a)				
任何腫瘤,硬塊,囊腫,結節,息肉,腫塊,增生或不正常腫脹? (b) Blood disorder, such as anaemia 血液問題,例如貧血	(b)	$ \Box$			
(c) Sleep disordered breathing (including Obstructive Sleep Apnoea)? (For Payor and / or Insured age 16 or above only) 睡眠呼吸障礙(包括睡眠窒息症)(只適用於付款人及/或十六歲或以上之受保人)					
(d) Spinal or joint disorder (including back pain, neck pain, fractures or gout)	(d)				
(f) Eye, ear, nose or throat disorders (Do not disclose for allergic rhinitis, astigmatism, short sightedness, long sightedness or presbyopia) 眼睛,耳朵、鼻或咽喉疾病(鼻敏感、散光、近視、遠視或老花無需在此申報)	(e) (f)				
(g) Nervous system disorder, such as: seizure or epilepsy 神經系統疾病, 例如:抽搐或癲癇 (h) Respiratory disease such as: asthma, bronchitis, tuberculosis (Do not disclose for influenza, coughs and colds that lasted for	. (g)				
less than 7 days) 呼吸系統疾病,例如:哮喘、支氣管炎、肺結核(流感、咳嗽及感冒持續少於七天者無需在此申報)	(h) (i)			H	H
(i) Stomach or intestinal disease, such as gastritis, haemorrhold 胃部或腸臟疾病,例如:胃炎,痔瘡(j) Skin disorder 皮膚問題	(i)				ı
(k) Female disorder, such as: menstrual disorder, abnormal pap smear (For female age 16 or above only) 女性疾病,例如:月經問題、異常柏氏抹(只適用於十六歲或以上之女性)	(k)				$ \sqcup $
(I) Prostate disorders (For male age 41 or above only) 前列腺疾病(只適用於四十一歲或以上之男性)	(I)				
For juvenile Insured age 17 or below and apply for specific product(s) only: 只適用於十七歲或以下之受保兒童及投保指定之計劃:	23				
23. (i) Has the Insured had or been told to have or received treatment for, any physical or developmental impairments or	(i)				
abnormalities or premature birth, sight, hearing or speech impairments? 受保人是否曾患有,或被告知患有或因下列問題接受治療,包括發育障礙、身體缺陷、又或早產,或視覺、聽覺或語言					
障礙? (ii) Has the insured's regular physicians identified any delay in the insured's developmental milestones?	(ii)				
受保人的主診醫生是否曾表示受保人有任何發育延遲? (iii) Is any of the siblings of the insured suffered from any birth defect/congenital disorders, developmental disorders,	(iii)	$ \Box$	$ \Box $		
genetic disorders, intellectual impairments or autism? 受保人的兄弟姐妹是否患有任何先天缺陷、發育障礙、遺傳性疾病,智力障礙或自閉症?					
適用於投保「摯愛妳」保障計劃及可附加保障惠益,或「惠賢保」保障計劃: 24. (i) Are you now pregnant? If 'YES', please state expected delivery date. 您現在是否懷孕?倘 "是" ,請填寫預產期。 MM月 DD日 YYYY年 (ii) In the past 12 months, have you suffered from or had disseminated intravascular coagulation during pregnancy, ectopic pregnancy, hydatidform mole, miscarriage, termination of pregnancy due to foetal problem or any other pregnancy or delivery complication not mentioned above? 過去十二個月內,您是否在懷孕期間患有瀰漫性血管內凝血、宮外孕、葡萄胎、或曾流產、因胚胎出現問題而終止懷孕或以上沒有提及的其他懷孕或妊娠期併發症?	24 (i)				
FOR ACCIDENT INSURANCE PLANS ONLY 只適用於意外保險計劃 25. Have you and/or your Proposed Insured's spouse, and / or any of the covered members ever been diagnosed with physical defects, impairments, deformities, and / or conditions affecting mobility, sight, speech or hearing? If the answer is 'YES', please provide details. 您及 / 或受保配偶;及 / 或任何受保成員是否曾被確診身體缺陷、不健全、畸形,及 / 或影響活動能力、視力、説話能力或聽力的狀況? 倘"是",請提供詳細資料。"	25				
If the answer to any of the questions 12-19 and 22-25 is "Yes", please provide additional information 若第12至19項及第22至25項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-	ition	as a	ppiic	able	
Question 題號					
Disease / medical condition 疾病 / 健康狀況					
(a) Investigations that have been performed 已進行的檢查 (b) Date of such investigation					
有關檢查日期					_
(a) Treatment that has been performed 已進行的治療 (b) Date of such treatment 有關治療日期					
Date of last follow-up 最後覆診日期					
Present condition 現況					
Name of doctor and name of Hospital, where applicable 醫生姓名及醫院名稱 (如適用) Remarks: 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 assessm	ont in	adom: "'	ing		
Kemarks: Please provide information as detailed as possible (e.g. provide year and mointn it exact date could not be recalled) for the sake of fair assessmithet in the sake of the provide year and the provided in the pro	∠⊓t III UΠ	uc:Will	ıy.		

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Declaration & Authorization

I / We hereby declare and agree that

(a) I / We have read the application or the same was interpreted to me / us, and the answers entered in the application are mine / ours. (b) I / We hereby certify, on behalf of myself / ourselves and behalf of any person who may have or claim any interest in the said Policy, that each of the above answers is full, complete and true and I / We understand that AIA. (hereinafter called the Company) believing them to be such, will rely and act on them, otherwise the proposed application, reinstatement, change or addition may be void. (c) such application, reinstatement, change or addition shall not be considered as effected by reason of any money paid, or settlement made in payment of, or on account of any premium or levy (for Hong Kong policies), until this certificate is received by the Company during the life time of the Insured and the Owner and is finally approved by an authorized officer of the Company. (d) if my / our application, reinstatement, change or addition of supplementary contract be accepted by the Company, the Incontestability and Suicide Provisions thereof shall have effect from the approval date of my / our application, reinstatement, change, or addition. (e) the correspondences, including notification letter & / or pending memo etc (if any), of this application will be delivered to me via the Insurance Intermediaries, who submitted this application for my / our policies.

I, the Insured, have been informed by the policy owner that the Company will collect, use and disclose my personal information for the purposes necessary to process the application for the policy, to investigate, to settle claims and to administer the policy once issued to the policy owner. I have read the AIA PIC and agree that the Company will collect and use my personal data and any information relating to me in accordance with the AIA PIC. I consent that the Company will transfer my personal information to the type of transferees as set out in the AIA PIC.

Furthermore, I hereby irrevocably authorize

- (a) The Company to enter into arrangements with Panel Network Providers to provide specified medical services to me / us (if and as applicable).
- (b) any organization, institution, or individual that has any record or knowledge of my / the Insured's health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to the Company such information. This authorization shall bind my / the Insured's successors and assigns and remain valid not with standing my / the Insured's death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.
- (c) The Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and test to underwrite and evaluate my / the Insured's health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.
- (d) The Company to access and use my / the Insured's information in the Company's record to verify my / the Insured's information provided in this application.

Notes: 1. The Company recognizes the right of individuals to privacy and shall at all times keep all results of any such tests confidential and use thereof shall only be for the purpose of applications for insurance, reinstatement, change or addition with the Company and any claim under the policies issued pursuant to such applications. Except where such disclosure is required by any proper Government Authority or by law, the results of such tests will be released only at your specific request or consent. Important Note: Payment does not guarantee immediate approval of the application or at all. The reinstatement/addition of rider/change of plan / increasing sum assured/ removal of exclusion/removal of medical rating, whichever is applicable, will only become effective when we receive the relevant documents and any required amount, including but not limited to the health certificate and full premium, as well as any outstanding levy amount due and overdue (for Hong Kong policies), and provided that we accept and approve the satisfactory proof of the insured's current health condition and other necessary requirements are met to our satisfaction. We reserve the right to withhold, refuse and/or reject any application.

聲明及同意

本人/我們聲明及同意:(a)已閱讀此申請書或曾接受別人向本人/我們解釋此申請書之內容。(b)本人/我們代表與此保單有利益關係之人士保證以上每一項答案均為完全和正確。本人/我們亦明白由友邦(以下一律稱為"貴公司")以上述資料為審核依據,如上述資料不符,任何根據此健康證明書所作的申請、申請恢復保單效力,更改或增加,可被視作無效。(c)本人/我們明白這健康證明書必須於受保人及持有人在生時遞交及經貴公司負責人批准後方可恢復保單效力,而此申請、更改或增加將不因任何付款或付款協定或保費或保費徵費(香港保單適用)關係而產生效力。(d)本人/我們承諾此申請、續保、更改或加購附加契約之申請經費公司核准後,不得異議及自殺條款將改由申請書批准日期起計算。(e)此申請有關的信件,包括通知書及/或待決通知書等(如有),將會經由代本人/我們遞交有關保單申請的保險中介人,轉交給我。

本人,受保人,已由保單持有人所告知有關貴公司將收集、使用及披露本人的個人資料所述目的用作處理保單申請,調查,解決理賠事項和管理繕發予保單持有人的保單。本人已閱讀及同意就AIA個人資料收集聲明所述目的視乎情況貴公司將收集及使用本人的個人資料及關於本人的其他資料。本人同意貴公司將轉讓本人的個人資料予AIA個人資料收集聲明所載的資料承讓人。

再者,本人茲授權:

- (a) 貴公司為本人/我們安排醫療網絡組織之服務提供者進行指定之醫療服務(如適用)。
- (b) 任何知悉或擁有本人/受保人之健康狀況及病歷或任何治療或諮詢紀錄及曾為或將為本人/受保人診治之機構、組織或人士,向貴公司透露有關資料,不得撤回。 即使本人/受保人死亡或喪失能力,而本人/受保人之繼承人及轉讓人亦會受此授權書約束。此授權書之正本與副本同屬有效。
- (c) 貴公司或任何其認可驗身醫生或化驗所,替本人/受保人進行所需之醫療評估及測試,並對本人/受保人之健康狀況進行審核及評估,作為處理本申請及其後 與之有關的賠償事宜。此等化驗會包括,但並不限於,膽固醇及有關之血脂肪、糖尿病、腎或肝功能失常、愛滋病或感染人體免疫力缺乏病毒、免疫系統失常 或體內藥物、毒品、尼古丁及其化產物之含量等化驗。
- (d) 貴公司存取和使用本人/受保人在貴公司記錄中的資料來驗證本人/受保人在此申請中提供的資料。

註:1.為注重個人私隱權,本公司將所有檢驗結果保密,及只用作審核投保申請、續保、更改或增加和與此投保書有關的理賠事項。除政府要求或法律規定外, 這類檢驗結果只會於閣下特別要求或同意下才會誘露。

重要事項:已付款並不保證申請獲即時批核。有關之復效/增加附加契約/更改基本保險計劃/增加保額/刪除不保事項/刪除額外保費(以適用者為準)申請,將於本公司收妥相關文件及所需金額,包括但不限於健康證明書,全數保費,及任何到期及逾期而未繳清之保費徵費(香港保單適用),並獲本公司接納及批准受保人的健康現況證明,及其他所需要求後,方為正式生效。本公司保留權利擱置,拒絕及/或駁回任何申請。

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PERSONAL DATA COLLECTION AND USE

I / We confirm that I / we have read, understood and agreed to the Personal Information Collection Statement(s) of my / our policy issuer(s) and/or pension scheme provider(s), i.e. AIA International Limited (Hong Kong Branch), AIA International Limited (Macau Branch) and / or AIA Company Limited where applicable, (the "PICS") which is available for download: https://www.aia.com.hk/en/privacy-statement-main.

I / We declare and agree that any personal data and other information relating to me / us or my / our policy(ies), account(s) or investments contained in this application or collected, obtained, compiled or held by my / our policy issuer(s) and / or pension scheme provider(s) by any means from time to time may be collected and utilized in accordance with the PICS.

I / We acknowledge and consent to the transfer of my / our personal data to parties within or outside Hong Kong (for policy(ies) / pension scheme(s) issued in Hong Kong) or Macau (for policy(ies) / pension scheme(s) issued in Macau), as the case may be, for the purposes as set out in the PICS.

The latest version of the PICS which complies with the relevant rules and regulations is / are available for download from the above website and upon request.

個人資料收集及使用

我 / 我們確認我 / 我們已閱讀、明白及同意我 / 我們的保單繕發人及 / 或退休金計劃服務提供者(即友邦(國際)有限公司(香港分行)、友邦(國際)有限公司(澳門分行)及/或友邦保險有限公司(如適用))的個人資料收集聲明(「該聲明」),該聲明可在以下網址下載https://www.aia.com.hk/zh-hk/privacy-statement-main。

我/我們聲明及同意在本申請所載或我/我們的保單繕發人及/或退休金計劃服務提供者不時以任何方法收集、 獲得、編製或持有的任何個人資料及關於我/我們的保單、帳戶或投資的其他資料,可根據該聲明收集及使用。 我/我們知悉及同意就該聲明所述目的轉移我/我們的個人資料至香港境外/境內(如保單/退休金計劃在香港 繕發)或澳門境外/境內(如保單/退休金計劃在澳門繕發)(視乎情況而定)予該聲明所載的資料承讓人。 該聲明的符合相關守則及法規之最新版本可於以上網址下載及可供索取。

Signature of Insured 受保人簽名 (Age 18 or over) (年齡十八歲或以上)	on DD目 YYYY年		
Signature of Owner / Trustee 持有人 / 信託人簽名 (if other than insured, if multiple owners, all owners need to sign) (倘非受保人,如有多名持有人, 所有持有人皆需簽署)	on DD目 YYYY年	Signature of Payor 付款人簽名 (if other than owner 倘非持有人)	on DD日 YYYY年

PLEASE SIGN & RETURN IMMEDIATELY BUT NO LATER THAN 14 DAYS 請簽署後即時但不遲於14天內遞交 PLEASE DO NOT SIGN ON BLANK FORM 請勿在空白表格上簽署

"AIA" shall refer to AIA International Limited (Incorporated in Bermuda with limited liability), AIA Company Limited (Incorporated in Hong Kong with limited liability), as the case may be, depending on the issuing company of the relevant insurance policies this form / request / correspondence is subject to.

。 "AIA"指友邦保險(國際)有限公司(於百慕達註冊成立之有限公司),友邦保險有限公司(於香港註冊成立之有限公司)(視情況而定),具體取決 於本表格/要求相關保單的簽發公司。

