AIA International Limited
(Incorporated in Bermuda with limited liability)

HEALTH CERTIFICATE 健康證明書

Policy Number 保單號碼	**Name of Insured 受保人姓名**	**Name of Owner 持有人姓名**
Agent / Broker Name **營業員 / 經紀姓名**	**Agent / Broker Code 營業員 / 經紀號碼** **Area / Agency / Broker Code** **區域 / 營業員 / 經紀組別編號**	**Agent / Broker Tel. No** **營業員 / 經紀聯絡電話**
TR Membership Number (for Brokers only) **營業代表會員號碼（僅供經紀使用）**	☐ IA ☐☐☐☐☐☐	☐ ANG ☐☐☐☐☐☐☐

00042068

Please complete payor's information for reinstatement or addition of PB rider. 如申請復效或增加付款人保障附加契約，請填寫付款人資料。
Other Policies 其它保單號碼 (The following policies must belong to the same Insured / Payor 下列之保單須屬於同一受保人 / 付款人)

Please tick the appropriate box for application of reinstatement
如申請復效, 請在適當的空格內劃上 "X"號

☐ Reinstatement 復效
☐ Redating 重訂保單日期 ☐ Reinstate Agent 申請復效營業員

	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's name and address. 公司業務性質 / 僱主名稱 / 辦事處地址		
4. Present height and weight 現時身高 / 體重 * Delete if inappropriate 請刪除不適用者	Height of Insured 受保人身高: _____ **ft 呎 / cm 厘米*** Weight of Insured 受保人體重: _____ **lbs 磅 / kg 公斤***	Height of Payor 付款人身高: _____ **ft 呎 / cm 厘米*** Weight of Payor 付款人體重: _____ **lbs 磅 / kg 公斤***

		Insured 受保人		**Payor 付款人**	
		Yes 是	No 否	Yes 是	No 否
5. Have you ever been declined, postponed or accepted on modified terms for life, critical illness, medical health, disability or accident insurance? 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？	5	☐	☐	☐	☐
6. Do you fly other than as a fare-paying passenger or engage in any hazardous sports (e.g. diving, motor racing, mountaineering or rock-climbing, parachuting, sky diving or hang gliding etc.) or intended to do so in the future? If 'YES', please provide full details or complete a separate supplementary questionnaire. 您是否曾參與或打算參與飛行(以非乘客身份乘搭民航機除外) 或任何危險運動(例如：潛水、賽車、攀山或攀石、跳傘或滑翔等)？ 倘"是"，請提供詳細資料或另外填寫有關之問卷。	6	☐	☐	☐	☐
7. Did you travel or reside in other country for more than 6 months in the past 12 months? If 'YES', please state details below: 在過去十二個月內，您是否曾到其他國家旅遊或居住超過六個月？倘"是"，請提供詳細資料：	7	☐	☐	☐	☐

	Country(ies) 國家	Purpose 原因	Duration 逗留時間
Insured 受保人			
Payor 付款人			

Policy Number 保單號碼 | | | | | | | | | | |

		Insured 受保人		Payor 付款人	
		Yes 是	No 否	Yes 是	No 否

8. Do you smoke or have you ever smoked cigarette(s)? If 'YES', please state details below:
您是否吸煙或曾否吸煙？倘 "是" ，請於下列註明詳情:

	Average Daily Consumption 每天平均吸用量	Date ceased 停止日期
Insured 受保人		
Payor 付款人		

Note: I / We hereby declare that my / our answer(s) to Question 8 is completely consistent with the information (if any) that I / we have previously disclosed to AIA International Limited.
附註:本人 / 我們聲明有關問題 8 之答案與本人 / 我們過往向友邦保險(國際)有限公司披露的資料（如有）完全相符。

8 ☐ ☐ ☐ ☐

9. Do you have any existing insurance and / or concurrent application for insurance on your life? If 'YES', please state details below:
您是否已有或正在申請任何保險？倘 "是" ，請於下列註明詳情:

	Company 承保公司	Policy Currency 保單貨幣	Life 壽險	Hospital Income 住院入息	Critical Illness 危疾保險	Accident Indemnity 意外賠償	Accidental Death 意外死亡	Year of Policy Issue 保單繕發年份
Insured 受保人								
Payor 付款人								

9 ☐ ☐ ☐ ☐

10. Have any of your natural parents, brothers or sisters before the age of 60 had cancer (e.g. breast, colon or rectum, ovary or other types of cancer), diabetes, heart disease, Huntington's disease, polycystic kidney disease, stroke or any other hereditary disease? If 'Yes', please state details below:
您的親生父母、兄弟姐妹是否在六十歲以前診斷出癌症(例如：乳癌、結腸或直腸癌、卵巢癌或其他癌症）、糖尿病、心臟病、亨廷頓氏病、家族性多囊腎病、中風或其他遺傳性疾病？倘 "是" ，請於下列註明詳情：

	Relationship 關係	Disease(s) 疾病	Onset age 病發年齡
Insured 受保人			
Payor 付款人			

10 ☐ ☐ ☐ ☐

11. Do you consume alcohol on a daily / weekly basis? If 'YES', please state details of weekly consumption below:
您是否每天 / 每星期都飲酒？倘 "是" ，請於下列註明每星期飲用量：

Insured 受保人:

Tick if applicable 請在下列加上✓號	Type 種類	Amount (per week) 數量 (每星期)
☐	Beer 啤酒	___ can(s) 罐
☐	Wine 餐酒	___ glass(es) 杯
☐	Spirit 烈酒	___ unit(s) 單位

Payor 付款人:

Tick if applicable 請在下列加上✓號	Type 種類	Amount (per week) 數量 (每星期)
☐	Beer 啤酒	___ can(s) 罐
☐	Wine 餐酒	___ glass(es) 杯
☐	Spirit 烈酒	___ unit(s) 單位

Remarks 備註：
Beer: (1 can = 330ml) 啤酒: 1罐 = 330毫升
Wine: (1 glass = 100 ml) 餐酒：1杯 = 100毫升
Spirit: (1 unit = 30ml) 烈酒：1單位 = 30毫升

11 ☐ ☐ ☐ ☐

12. Have you ever received counseling, medical advice or treatment for any of the following? If 'YES', please provide full details of condition, dates and any treatment (whether prescribed or otherwise) or complete a separate questionnaire.
您是否曾因下列各種狀況而接受輔導、醫療咨詢或治療？倘 "是" ，請填寫有關病情、日期和所有治療(醫生處方與否)的詳細資料或填寫另外有關之問卷。

12

(i) Any chest or respiratory problem (e.g. asthma, bronchitis, sleep disordered breathing (including Obstructive Sleep Apnea), tuberculosis or other respiratory problem including nasal bleeding)? (except influenza, coughs and colds that lasted for less than 7 days)
任何胸部或呼吸系統問題(例如：哮喘、支氣管炎、睡眠呼吸障礙(包括睡眠窒息症)、肺結核或其他呼吸器官問題，包括流鼻血)？(流感、咳嗽及感冒持續少於七天者除外)
(i) ☐ ☐ ☐ ☐

(ii) Any heart problem or chest pain / discomfort (e.g. rheumatic fever, raised blood pressure, angina, murmur, heart attack) or other problem of the blood or blood vessels?
任何心臟的疾病或胸口疼痛 / 不適(例如：風濕性發熱、高血壓、心絞痛、心臟雜音、心臟驟停)，或其他血液或血管疾病?
(ii) ☐ ☐ ☐ ☐

(iii) Any digestive system problem, liver (including hepatitis or hepatitis carrier status), stomach, bowel or rectal bleeding, any kidney, bladder or genitourinary disorder including renal stones, endocrine disease, diabetes or thyroid gland problem?
任何消化系統問題，肝(包括肝炎或肝炎帶菌者)、胃、腸或直腸出血；任何腎、膀胱或泌尿及生殖系統疾病，包括腎石、內分泌疾病、糖尿病或甲狀腺疾病？
(iii) ☐ ☐ ☐ ☐

(iv) Any mental or brain disorder or problem affecting the nervous system including depression, schizophrenia, psychosis, anxiety, autism, learning disorder, epilepsy, paralysis, numbness, dizziness, prolonged headache, loss of balance or fits?
任何精神或腦部失常或問題而影響神經系統，包括抑鬱、精神分裂、思覺失調、焦慮、自閉、學習障礙、癲癇、癱瘓、麻痺、頭暈、長期頭痛、身體失去平衡或抽搐？
(iv) ☐ ☐ ☐ ☐

(v) Cancer or tumour, cyst, lump, growth or abnormal swelling?
癌症或腫瘤、囊腫、腫塊、贅生物或不正常腫脹？
(v) ☐ ☐ ☐ ☐

(vi) Any skin disorder, pain or other problem in your back, spine, muscle or joint, gout or other physical disability or condition affecting sight, speech or hearing?
任何皮膚問題，背部、脊椎、肌肉或關節疼痛或其他疾病，痛風或其他身體殘疾或任何影響視力、說話能力和聽覺的疾病?
(vi) ☐ ☐ ☐ ☐

13. Do you plan to attend, or are you currently attending or have attended in the last 5 years any hospital, clinic or doctor for :
您是否打算或現正、或曾於過去五年內在任何醫院、診所或醫務所接受：

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(i) Investigations such as X-ray, scan, biopsy, ECG, blood or urine etc. (Except general medical check-up, annual medical check-up and employment check-up with a normal result and without any follow-up consultation or treatment)?
一些檢查如X光、掃描、活體檢視、心電圖、驗血或驗尿等？(檢查結果正常並無需接受進一步諮詢或治療的例行身體檢查及就職檢查除外)
(i) ☐ ☐ ☐ ☐

(ii) Illness, operation or other medical advice or treatment not stated under any previous questions?
以上各題沒有提及的疾病、手術或其他醫療諮詢或治療？
(ii) ☐ ☐ ☐ ☐

14. Have you ever received, or do you expect to receive, any counselling, medical advice, treatment or any test(s) in connection with AIDS, HIV infection or any sexually transmitted disease?
您是否曾接受、或打算接受與愛滋病、HIV抗體或任何由性接觸而傳染的疾病之有關輔導、醫療諮詢、治療或任何檢驗?

14 ☐ ☐ ☐ ☐

Policy Number 保單號碼

		Insured 受保人		Payor 付款人	
		Yes 是	No 否	Yes 是	No 否
15. In the past 10 years, have you taken any habit forming drugs (including but not limited to marijuana, amphetamines, ecstasy, hallucinogens and cocaine) or been treated or advised in connection with your alcohol consumption or the taking of drugs? 於過去十年內，您是否曾服食導致上癮的藥品(包括但不止於大麻、安非他命、興奮劑、迷幻劑及可卡因)或曾因飲酒，吸毒或服用藥物而需接受治療或輔導？	15	☐	☐	☐	☐
16. **For female age 16 or above (只適用於十六歲或以上之女性):**	16				
(i) Have you ever had any consultation or treatment involving female organs, or had history of irregular, painful, or excessive menstruation or any other problems? 您是否曾就女性器官問題而求診或接受治療，或遇上月經出現異常情況、痛楚或過多，或其他有關問題？	(i)	☐	☐	☐	☐
(ii) Have you ever had, or have been advised to have investigations and / or treatment of the cervix, uterus, fallopian tubes, vagina, ovaries or the breasts, such as ultrasound, mammogram or surgery, cone biopsy, colposcopy or been advised to have a repeated pap smear within 6 months? (If 'YES', please submit a copy of investigation report for review.) 您有否或曾被建議就子宮頸、子宮、輸卵管、陰道、卵巢或乳房接受檢查及 / 或治療，如超聲波、乳房造影檢查或手術、錐形活組織檢查、陰道窺鏡檢查、柏氏抹片檢查，或被建議在六個月重做柏氏抹片檢查？(倘“是”，請附上有關檢查報告副本以供審閱。)	(ii)	☐	☐	☐	☐
For Lady Care Pro with Optional Benefit or Lady Care Protection Plan: **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** (iii) 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	(iii)	☐	☐	☐	☐
(iv) 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?	(iv)	☐	☐	☐	☐
17. **For juvenile insured age 17 or below and apply for specific product(s) (只適用於十七歲或以下之受保兒童及投保指定之計劃)**	17				
(i) Has the child had or been told to have or received treatment for, any physical or developmental impairments or abnormalities or premature birth, sight, hearing or speech impairments? 受保兒童是否曾患有，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?	(i)	☐	☐	☐	☐
(ii) Has the child's regular physicians identified any delay in the child's developmental milestones? 受保兒童的主診醫生是否曾表示他 / 她有任何發育延遲？	(ii)	☐	☐	☐	☐
(iii) Is any of the siblings of the child suffered from any birth defect / congenital disorders, developmental disorders, genetic disorders, intellectual impairments or autism? 受保兒童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？	(iii)	☐	☐	☐	☐
18. **FOR ACCIDENT INSURANCE PLANS ONLY 只適用於意外保險計劃** Do you and / or your Insured's spouse, and / or any of the covered members have any physical defects, disability, impairment, deformities and / or condition affecting mobility, sight, speech and / 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有任何身體損傷、殘疾、殘廢、缺陷及 / 或其他狀況而影響行動、視覺、說話能力及 / 或聽覺? 倘“是”，請提供詳細資料。	18	☐	☐	☐	☐

If any of the answers to questions 5 to 18 is "YES", please give full particulars below by noting the question numbers.
上述第5至第18項問題中，如有任何答案"是"，請詳述之:

Question 題號	Disease / Tests done 疾病 / 檢驗名稱 (attach reports if available 請附上檢驗報告,如有)	Onset Date / Date of Test Done 病發 / 檢驗日期	Details of Treatment / Result 詳細治療內容及結果	Date of Last Attack / Consultation 最後病發 / 覆診日期	Full name, address and phone number of doctor(s) or hospital 醫院或主診醫生姓名、地址及聯絡電話

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 International Limited. (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.

Furthermore, I hereby irrevocably authorize (a) 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 notwithstanding 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. (b) 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.

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. 2. I / We hereby declare that my / our answer(s) to Question 8 is completely consistent with the information (if any) that I / we have previously disclosed to AIA International Limited.

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/我們亦明白由友邦保險(國際)有限公司(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貴公司核准後,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。

再者,本人茲授權:

(a)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記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。(b)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。

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透露。2. 本人/我們聲明有關問題八之答案與本人/我們過往向友邦保險(國際)有限公司披露的資料(如有)完全相符。

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Signature of Insured (Age 18 or over)
受保人簽名(年齡十八歲或以上)

On 於 MM月 / DD日 / YYYY年

Signature of Owner / Trustee
(if other than insured, if multiple owners, all owners need to sign)
持有人 / 信託人簽名
(倘非受保人,如有多名持有人,所有持有人皆需簽署)

On 於 MM月 / DD日 / YYYY年

Signature of Payor
付款人簽名
(if other than owner
倘非持有人)

On 於 MM月 / DD日 / YYYY年

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