AIA International Limited
(Incorporated in Bermuda
with limited liability)

CEO PRO - Health Declaration Form
企業至尊醫療計劃 - 健康申報表

Each proposed insured should complete his own Health Declaration Form. 每名準受保人需填寫一份其個人健康申報表。

A. EMPLOYEE INFORMATION 僱員資料

1. Name of Employer / Group Policyholder and Office Address
僱主名稱 / 團體保單之投保公司名稱及辦事處地址

2. CEO PRO Policy No. 企業至尊醫療計劃保單編號

3. Certificate Number 受保證書編號

4. Full Name of Employee / Insured Member (As shown on HKID Card)
僱員 / 受保成員姓名〔以香港身份證為準〕
Surname 姓 _____ Given Name 名 _____ Chinese 中文 _____

5. HKID Card No.
香港身份證號碼

6. Home Address 住宅地址

7. Telephone No. 電話號碼
Home 住宅 _____
Mobile 手提 _____
Office 公司 _____

8. Sex 性別 :
☐ Male 男性 ☐ Female 女性

9. Date of Birth 出生日期
MM 月 / DD日 / YY年

10. Age Last Birthday 現年歲數

11. Occupation 職業
a. Exact Duties 職務 _____
b. Nature of Business 公司業務性質 _____

12. Marital Status 婚姻狀況
☐ Single 單身 ☐ Widowed 鰥寡
☐ Married 已婚 ☐ Divorced 離婚

13. Race 種族

14. Is the proposed insured a US Citizen? **(Compulsory)**
準受保人是否乃美國公民？（**必須填寫**）
☐ Yes 是 ☐ No 否

15. E-mail Address 電郵地址

B. DEPENDENT DETAILS (if applicable) 家屬資料〔如適用〕

Please complete only if dependent coverage is available. One form is required for each proposed insured.
此項只供附有家屬保障時填寫，每名準受保人需填寫一份申報表。

1. Full Name of Dependent (As shown on HKID Card)
家屬姓名〔以香港身份證為準〕
Surname 姓 _____ Given Name 名 _____ Chinese 中文 _____

2. HKID Card No.
香港身份證號碼

3. Sex 性別 :
☐ Male 男性 ☐ Female 女性

4. Date of Birth 出生日期
MM 月 / DD日 / YY年

5. Age Last Birthday 現年歲數

6. Relationship with Employee 與僱員之關係
☐ Spouse 配偶 ☐ Child 子女
☐ Others 其他 _____

7. Race 種族

8. Is the proposed insured a US Citizen? **(Compulsory)**
準受保人是否乃美國公民？（**必須填寫**）
☐ Yes 是 ☐ No 否

9. Occupation 職業
a. Exact Duties 職務 _____ b. Nature of Business 公司業務性質 _____

C. IMPORTANT NOTE 注意事項

1. Proposed insured is 準受保人乃 ☐ Employee 僱員 ☐ Spouse 配偶 ☐ Child 子女 ☐ Others 其他
2. Proposed insured must answer all the questions from Section D onwards, if applicable. 準受保人必須回答D部份及其後之問題〔如適用〕。

D. MISCELLANEOUS

1. Are you now a member of any military force, or in the past five years have you engaged or contemplate to engage in any private flying or hazardous sports or race?
   你是否現役軍人，或於過去五年內曾否參加或意圖參加私人性質飛行，或有危險性之運動或競技？ ☐ Yes 是 ☐ No 否

2. Has any application for or reinstatement of life, accident, medical or other insurance ever been declined, postponed, rated or in any way modified?
   你曾否於申請人壽保險、意外保險、醫療保險或其他保險之申請或復保時被拒絕受保、延期、加費或修改合約條款？ ☐ Yes 是 ☐ No 否

3. Total amount of existing and / or concurrent application for insurance on your life 現時已有或正在申請之壽險保額

Company 承保公司	Life 人壽保險	Accident 意外保險	Medical / Other Insurance 醫療 / 其他保險	Date Issued 投保日期

E. HEALTH DETAILS 健康資料

1. (a) Height 身高 _____ cm 厘米 (b) Weight 體重 _____ kg 公斤

2. Has your weight been decreased by more than 3 kg in the last 12 months? If yes, please give reason (if known) and the amount of weight lost.
   過去12個月內，你的體重是否減少三公斤或以上？倘若「是」，請註明原因〔若知道〕及減少之體重。

   Reduced amount 減少之體重 _____ kg 公斤 Reason 原因 _____

3. Name & Address of your Attending Physician 請填寫主診醫生的姓名及地址

   _____

   _____

4. In the past 5 years, have you had or been told you had or received medical advice, investigation or treatment for:
   在過去五年內，你對下列病症曾否患有、被通知患有或曾接受診療，檢驗或治療：

a)	Asthma or any lung diseases 哮喘或肺部病症	a) ☐ Yes 是 ☐ No 否
b)	Raised cholesterol, high blood pressure or stroke 膽固醇偏高，高血壓或中風	b) ☐ Yes 是 ☐ No 否
c)	Chest pain, disease of the heart or blood disorders 胸部疼痛，心臟或血管之病症	c) ☐ Yes 是 ☐ No 否
d)	Stomach ulcer, bowel or digestive disorder, gall bladder disease, hepatitis or any other liver diseases 腸胃潰瘍，或消化器官，膽囊之疾病，肝炎或任何種類之肝病	d) ☐ Yes 是 ☐ No 否
e)	Urinary or kidney diseases 泌尿或腎病	e) ☐ Yes 是 ☐ No 否
f)	Epilepsy, diseases of the brain or nervous system, mental or psychiatric disorders 癲癇，腦部或神經系統疾病，任何精神不正常疾病	f) ☐ Yes 是 ☐ No 否
g)	Diabetes, cancer, cysts, tumor or lumps of any kind 糖尿病，癌症，囊腫，腫瘤或任何其他疾病	g) ☐ Yes 是 ☐ No 否
h)	Nasal bleeding, coughing or vomiting blood, passing blood per rectum or in urine 流鼻血，咳血或嘔血，便血或尿血	h) ☐ Yes 是 ☐ No 否
i)	Unexplained weight loss, night sweats, loss of appetite, recurrent fainting spells, or been advised to have further investigation, including biopsy, of a finding on medical examinations 莫名的體重下降，盜汗，食慾不振，週期性昏迷或在身體檢驗時被建議做進一步的檢查包括活體檢視	i) ☐ Yes 是 ☐ No 否

5. Have any of your natural parents, siblings, or children died or suffered from cancer, heart disease, diabetes, kidney disease, poliomyelitis, leukaemia, cirrhosis, hepatitis or been found to be a hepatitis B or hepatitis C carrier, paralysis or muscular dystrophy, multiple sclerosis or any hereditary disorder?
   你的生父母，兄弟姊妹或子女是否死於或患有癌症，心臟病，糖尿病，腎病，脊髓灰質，白血病，肝硬化，肝炎或曾發現為乙型或丙型肝炎帶菌者，癱瘓或肌肉萎縮症，多發性硬化症或任何遺傳性病症？ ☐ Yes 是 ☐ No 否

6. Have you attended within the past 2 years or plan to attend or have been advised to attend any hospital, clinic or doctor for medical tests or investigation? **If yes, please specify the date of medical check up / examination, the details of the tests, the results of the tests and provide reports if any.**
   你在過去兩年，有否到過或計劃或被建議到任何醫院、診所或由醫生進行醫療測試或檢驗？ **若有，請提供身體檢查日期、測試詳情、結果及報告。** ☐ Yes 是 ☐ No 否

Date of medical Check up / Examination 身體檢查日期〔MM月 / DD日 / YY年〕	Test Details & Results 測試詳情及結果	Please provide report 必須提供報告
		☐ Yes 有_____
		☐ Yes 有_____
		☐ Yes 有_____

7. In the past 2 years, have you been absent from work due to illness or injury for a continuous period of more than 7 days?
   在過去兩年，你有否因病或受傷而連續離開工作崗位七天或以上？ ☐ Yes 是 ☐ No 否

8. Have you or your spouse been told to have or received, any medical advice, investigation, counseling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related condition, or in the last 6 months have you had any of the following symptoms for more than 1 week continuously: fatigue, weight loss, diarrhea, enlarged glands or unusual skin lesion?
   你或你的配偶是否被知會有或曾接受任何有關性病，愛滋病及其有關病徵之診察，輔導或治療，或是否曾被告知有上述病症，或曾經接受愛滋病病毒抗體測驗，或在過去六個月中曾持續一星期以上有下列病症：疲倦，體重下降，腹瀉，淋巴核腫大或不尋常的皮膚疾患？ ☐ Yes 是 ☐ No 否

9. In the past 5 years, have you used any habit forming drugs or been treated for alcohol consumption or the taking of drugs? ☐ Yes 是 ☐ No 否
在過去五年內，你曾否使用任何成癮藥物、或接受酒精治療或戒毒？

10. Do you use, or in the past 2 years have you used any tobacco products (including but not limited to cigarettes, cigars, pipes and chewing tobacco)? **If yes, please state the daily consumption and for how long have you been smoking.** ☐ Yes 是 ☐ No 否

Daily consumption:_____; Length of smoking:_____year(s)

在過去兩年，你有否使用任何煙草製成品（包括但不限於香煙，雪茄，煙斗及可咀嚼的煙草）？**若有，請說明每日吸煙的數量和吸煙的年數。**

每日吸煙的數量：_____ ； 吸煙年數：_____年

11. For female applicants only 只適用於女性申請人：

a) Are you now pregnant? **If "Yes", please state expected delivery date:** _____. ☐ Yes 是 ☐ No 否

你是否現正懷孕？**若是，請說明預產期：**_____。

b) Have you ever suffered from any complication during the previous pregnancy or delivery? ☐ Yes 是 ☐ No 否
在過去的懷孕或生產中，有否引起任何併發症？

c) Have you suffered from any disorder of the breast or reproductive organs including abnormal smear test(s) and irregular menses? ☐ Yes 是 ☐ No 否
你曾否患有乳房或女性生殖器官包括不正常之柏氏塗片和月經不調之問題？

12. Remarks in connection with Insurance applied for 備註：

_____

_____

13. **If any of the answer to above questions is "Yes", please give full particulars in the space below by noting question number and giving the name(s) and address(es) of doctor(s) consulted, date of admission, and hospital / clinic registration number. (A copy of the hospital / clinic patient card will be helpful in obtaining an Attending Physician Statement)**
若以上問題中有答案為「是」，請將詳細的資料填寫在下列空位內，並註明題號、診治醫生的姓名、地址、診症日期及入院日期、醫院 / 診所的登記號碼。（醫院 / 診所的登記卡副本將有助獲得診治醫生的報告）

_____

_____

F. DETAILS OF LIFE INSURANCE APPLIED FOR (if applicable) 壽險資料〔如適用〕

1. a. Group Life Policy Number 團體人壽保單編號	b. Certificate Number 受保證書編號
2. a. Group Life Sum Assured 團體人壽保險金額	b. Excess over Group Life NEL 免體檢最高限額以外之保金 (For AIA use only 友邦保險專用)
3. a. Critical Illness Sum Assured 危疾保險金額	b. Critical Illness NEL 危疾保險免體檢最高限額 (For AIA use only 友邦保險專用)

DECLARATION AND AUTHORIZATION

I declare and agree on behalf of myself and any person or persons, firm or corporation, who may have or claim any interest in any insurance on this health declaration that:

(a) No statement, information or agreement made or given by or to the person soliciting or making this health declaration or by or to any other persons, shall be binding on AIA International Limited (herein called "AIA"), unless reduced to writing, and then only if presented to and approved by an officer specified in the relevant policy.

(b) All the foregoing statements and answers in this health declaration form together with those in any required medical examination, questionnaire or amendments, are full, complete and true, and I understand that AIA, believing them to be such will rely and act on them, otherwise any policy issued hereunder may be void.

(c) Any insurance herein applied for shall not take effect unless and until the relevant policy or policies is / are issued and delivered to me pursuant to my health declaration as completed and the first premium under the policy or policies requested is actually paid in full during my lifetime and good health, provided, however, that if any payment of premium is made in cash at the time of signing this health declaration and a conditional receipt issued. Therefore, the terms of the receipt shall apply hereto and are agreed to.

(d) I confirm that I have read and understood the AIA Personal Information Collection Statement ("AIA PIC"). On behalf of myself and my covered dependents (if applicable), I declare and agree that any personal data and other information relating to me or my covered dependents (if any) or my / our policy(ies) or investments contained in this health declaration form or collected, obtained, compiled or held by AIA by any means from time to time may be collected and utilized in accordance with the AIA PIC. I acknowledge and consent to the transfer of my personal data (and that of my covered dependents, if any) outside of Hong Kong for the purposes and to the types of transferee as set out in the AIA PIC.
The updated version of AIA PIC is available for download from its website: www.aia.com.hk, and is made available upon request.

(e) All my declarations herein made, and my statements or answers in this health declaration form and any required questionnaire or amendments together with the relevant policy shall constitute the entire contract between the parties thereto in so far as it may be relevant to the policy or policies I have requested.

(f) I am fully aware of the limits as to my Medical Insurance, if applicable. I hereby undertake to settle any account in excess of my entitlement, or that not within the insurance coverage. I hereby agree with and authorize AIA to deduct the reimbursement of claims payment in the event that I, and / or my dependents, if applicable, have any shortfall amount, for whatever reason, due to AIA. And I am fully aware that my and / or my dependent(s)' coverage (if applicable) will be suspended or terminated if the shortfall is not settled by the specified due date.

(g) If I request AIA to provide copy of results of my medical examination initiated by AIA, AIA shall reserve the right to charge a corresponding service fee at AIA's then-current charges.

Furthermore,

I hereby irrevocably authorize:

(i) any organization, institution, or individual that has any record or knowledge of my employment, sick leave records, accident or loss details (of any sorts), health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to AIA such information. This authorization shall bind my successors and assignees and remain valid notwithstanding my death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

(ii) AIA or any of its approved medical examiners or laboratories to perforrm the necessary medical assessment and tests, to underwrite and evaluate my health status in relation to this health declaration 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 immue deficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.

聲明及授權

本人代表本人所有依據本健康申報表所繕發壽險之有權利關係之人，或行號公司，完全承認下列各項：

(a) 除用書面經友邦保險（國際）有限公司（以下稱「友邦保險」）執行職員簽字批准外，其他收受或遞送此健康申報表之人，或任何人員，與任何人間，在口頭或書面上所作之陳述之報告或合約，友邦保險一概不負責任。

(b) 本健康申報表內所列各項答案及E部份內對友邦保險驗體醫師之任何檢驗時或對經理員之答語，完全確實無偽，本人更承認友邦保險根據上述各項而繕發保單，否則任何按本健康申報表而繕發之保單將可能無效。

(c) 倘根據此健康申報表繕發之有關保單尚未送交本人或第一期保費尚未繳付時，本人已生疾病或死亡，則本保險不生效力。如在簽署本健康申報表時，已將第一期應繳保費全數交付友邦保險，則按照所繕發之第一期保費臨時收據內之條款辦理。

(d) 本人確認本人已閱讀及明白AIA個人資料收集聲明(「AIA個人資料收集聲明」)。本人及本人謹代表的受保家屬(如適用)等聲明及同意在本健康申報表所載或AIA不時以任何方法收集所得、編製或持有的任何個人資料及關於本人或本人的受保家屬（如有）或本人的保單或投資的其他資料，可根據AIA個人資料收集聲明收集及使用。本人知悉及同意就AIA個人資料收集聲明所述目的轉讓本人(和本人的受保家屬（如有))的個人資料至香港境外予AIA個人資料收集聲明所載的資料承讓人。
AIA個人資料收集聲明的最新版本可於AIA網址下載：www.aia.com.hk,及可向AIA索取。

(e) 本人在健康申報表內之陳述及答覆驗身醫生或對友邦保險授權營業員之簽語暨與上述有關之保單將作為雙方間契約之全部。

(f) 本人聲明本人已清楚知道本人醫療保險(如適用)的保障範圍。本人亦同意並負責支付任何超出本人之保險最高賠償金額或不受保事項的費用。本人同意及授權友邦保險於任何賠償金額上扣除本人及／或本人家屬(如適用)尚未清還友邦保險之任何欠款。而本人亦清楚了解如未能在指定之限期內清還欠款，本人及／或本人家屬(如適用)之醫療保障將會被暫停或終止。

(g) 若本人要求友邦保險提供本人由友邦保險安排驗身之報告，友邦保險將保留權利向本人收取友邦保險於當時適用之服務費用。

再者，

本人茲授權

(i) 任何知悉或擁有本人之工作、病假記錄、意外或損失（任何類別）之詳情、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診治之機構、組織或人士，向友邦保險透露有關資料，不得撤回。即使本人死亡或喪失能力，此授權書仍然存有法律效力，而本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。

(ii) 友邦保險或任何其認可之驗身醫生或化驗所，替本人進行所需之醫療評估及測試，並對本人之健康狀況進行審核及評估，作為處理本健康申報表及其後與之有關的賠償事宜，不得撤回。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、肝或腎功能失常、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、尼古丁及其代謝物之含量等化驗。

Signature of Employee / Insured Member 僱員 / 受保成員簽署	Signature of Proposed Insured 準受保人簽署 (If proposed insured is under age 18, signature of Employee / Insured Member is required) 〔若準受保人年齡在十八歲或以下，請由僱員 / 受保成員簽署〕	Date Signed (MM / DD / YY) 簽署日期〔月 / 日 / 年〕