中国平安 专业·价值 PING AN OF CHINA

中国平安财产保险股份有限公司
PING AN PROPERTY & CASUALTY INSURANCE COMPANY OF CHINA,LTD.

Ping An *GlobalSelect*[SM] International Healthcare Insurance
平安全球医疗保险

Application Form
投保申请书

Application Notice
投保须知

1. The Application Form is an important part of the insurance contract between the Applicant and the Insurer. Before applying for the insurance, please read this Application Notice, related product brochure and the policy clauses carefully in order to fully understand the coverage, exclusions and cancellation clauses.
本投保申请书为投保人和保险人所订立保险合同的重要组成部分，请投保人认真阅读本投保须知、相关的产品说明书和保险条款，在确认已充分理解保险责任、责任免除条款、保险合同解除条款后再作出投保决定。
2. Please fill in the form accurately and clearly in black ink. For all sections please ensure you give an answer to every question. An incomplete form will delay the processing of your application.
投保申请书应由投保人用黑色签字笔填写，字迹清晰，不得涂改，以下各部分内容必须填写，若有任何问题漏空未有填写，将会影响此申请的进度。
3. According to the Insurance Law, the Applicant and the Insured(s) have the duty to make true statements, otherwise, the Insurer has the right to cancel the contract, and has no obligation to pay any benefit for any insured event even occurring before such cancellation. All the representations should be made in writing. Verbal representation is void.
根据保险法的规定，投保人、被保险人应履行如实告知义务，否则保险人有权解除合同并对保险合同解除前发生的保险事故不承担责任。所有告知事项以书面告知为准，口头告知无效。
4. The insured's age should between 14 days and 74 years old. If the insured is below 18, the applicant should be one of his parent or guardian.
被保险人的投保年龄为14天到74周岁，若被保险人投保时未满18周岁，则投保人必须为其父母或监护人。

SECTION 1. 第一部份. Personal and Cover Details of Insured Person(s) 被保险人资料
Please complete for all family members applying for cover. 请填写所有投保本保险的家庭成员的完整资料。

1.1 Details About the Insurance Applicant
主被保人的详细资料

A. Insurance Applicant 主被保人

Title: Mr / Mrs /Miss / Ms / Dr 称号: 先生/ 女士/ 夫人/ 博士	First Name(s): 姓氏:	Surname (Family Name): 名字:	
Date of Birth: DD/MM/YY 出生日期: 日/月/年	☐ Male ☐ Female ☐ 男性 ☐ 女性	Height: ☐ cm ☐ in 高度: ☐ 公分 ☐ 英吋	Weight: ☐ kg ☐ lb 重量: ☐ 公斤 ☐ 磅
Occupation: 职业:			
Nationality on Passport: 国籍:	Type of Passport: 证件类型:	Passport Number: 证件号码:	

1.2 Details About Members of Applicant's Family Applying for Cover together with Applicant*
有关于与您一起申请投保的家庭成员的详细资料*

B. Spouse 配偶

Title: Mr / Mrs /Miss / Ms / Dr 称号: 先生/ 女士/ 夫人/ 博士	First Name(s): 姓氏:	Surname (Family Name): 名字:	
Date of Birth: DD/MM/YY 出生日期: 日/月/年	☐ Male ☐ Female ☐ 男性 ☐ 女性	Height: ☐ cm ☐ in 高度: ☐ 公分 ☐ 英吋	Weight: ☐ kg ☐ lb 重量: ☐ 公斤 ☐ 磅
Occupation: 职业:			
Nationality on Passport: 国籍:	Type of Passport: 证件类型:	Passport Number: 证件号码:	

C. First Child (below age19) 第一子女(十九岁以下)

First Name(s): 姓氏:		Surname (Family Name): 名字:	
Date of Birth: DD/MM/YY 出生日期: 日/月/年	☐ Male ☐ Female ☐ 男性 ☐ 女性	Height: ☐ cm ☐ in 高度: ☐ 公分 ☐ 英吋	Weight: ☐ kg ☐ lb 重量: ☐ 公斤 ☐ 磅
Nationality on Passport: 国籍:	Type of Passport: 证件类型:	Passport Number: 证件号码:	

D. Second Child (below age 19) 第二子女(十九岁以下)

First Name(s): 姓氏:		Surname (Family Name): 名字:	
Date of Birth: DD/MM/YY 出生日期: 日/月/年	☐ Male ☐ Female ☐ 男性 ☐ 女性	Height: ☐ cm ☐ in 高度: ☐ 公分 ☐ 英吋	Weight: ☐ kg ☐ lb 重量: ☐ 公斤 ☐ 磅
Nationality on Passport: 国籍:	Type of Passport: 证件类型:	Passport Number: 证件号码:	

E. Third Child (below age 19) 第三子女(十九岁以下)

First Name(s): 姓氏:		Surname (Family Name): 名字:	
Date of Birth: DD/MM/YY 出生日期: 日/月/年	☐ Male ☐ Female ☐ 男性 ☐ 女性	Height: ☐ cm ☐ in 高度: ☐ 公分 ☐ 英吋	Weight: ☐ kg ☐ lb 重量: ☐ 公斤 ☐ 磅
Nationality on Passport: 国籍:	Type of Passport: 证件类型:	Passport Number: 证件号码:	

☐ Tick if you have any further dependents and please provide details on a separate sheet.
如果您有其它须要承保的家庭成员，请在此加上勾号，并在另外纸张上提供细节。

* Any application for a person aged under 18 years must be signed by a parent or guardian.
若被保险人未满18周岁，则投保人必须为其父母或监护人。

1.3 Residential Address
住宅地址

Street Address: 街道地址:	
Town/City: 镇/城市:	State/County: 镇/城市:
Postal Code:. 邮政代码:	
Country: 国家:	

1.4 Mail Forwarding Address (if different from 1.3)
邮件递送地址（假若有别于 **1.3**）

Street Address: 街道地址:	
Town/City: 镇/城市:	State/County: 镇/城市:
Postal Code: 邮政代码:	
Country: 国家:	

1.5 Contact Details 联络细节

Primary Telephone: + 主要电话: +	Other Telephone: + 其它电话: +
Fax: + 传真: +	Email: 电邮:

1.6 Select the Geographical Area of Cover You Would Like (Tick One)
请选择您需要的承保地域（在对应选择区域前打√）

☐ **Area 1** – Europe 地域一 —— 仅限于欧洲
☐ **Area 2** – Worldwide excluding the USA and Canada 地域二 —— 全球，但美国和加拿大除外
☐ **Area 3** – Worldwide* 地域三 —— 全球*

*** Important Note: U.S. Citizens & Persons Applying for Cover in the USA**
***** 重要指引**:** 若投保人为美国公民或申请在美国的保障
U.S. Citizens: 若投保人为美国公民**:**

1. Date you did (or will) depart from the USA: _____/_____/_____ (DD/MM/YY)
   您何时（或将会于何时）离开美国: _____/_____/_____ (日/月/年)
2. Have you arranged to reside outside the USA for at least 180 consecutive days during the next 12 months? Yes ☐ No ☐
   在未来的十二个月内，您是否已计划在美国以外的地方连续居住不少于一百八十天？ 是 ☐ 否 ☐
3. If you or any family member applying for cover are located in the USA on the date of this application, the effective date of this insurance, if issued, will be the later of: a) The effective date requested on the application; or b) The date the insured Person departs the USA; or c) The date the application is accepted by the Insurer and payment of the first full premium is received and the Policy, including a certificate of insurance, is issued.
   如果您本人或一起申请本保障计划的家庭成员在提交本投保申请书时正身处于美国，则保险人出具的保险单的生效日期则为以下三个日期中最迟的日期：a) 投保申请书上填写的要求的生效日期，b) 投保人离开美国的日期，或c) 保险人接受了投保、投保人已缴纳应付保险费且保险人出具了保险单，包括保险凭证的日期。

Non USA Citizens applying for cover in the USA or located in the USA at time of application:
若投保人非为美国公民，但申请包含身处于美国时的保障、或填写此申请表时正身处于美国：
You must not have been (or arranged to be) located in the USA for any more than 24 consecutive months before or after the Effective Date and you must maintain a permanent residence outside the USA. You must provide a residence address outside the USA. If you do not, an Affidavit of Eligibility form must be completed by your insurance advisor/broker.
在本保险单生效日期前或后，您不可曾经在或正准备居住于美国连续超过二十四个月，且您必须在美国以外的地方拥有固定住址。您必须提供一个在美国以外的住址，否则，您的保险代理/经纪需要填写一份资格宣誓书。

1.7 Select Which Medical Insurance Sub-Plan and Option(s) You Would Like (Tick One Only)
请选择您需要的医疗保险子计划及免赔额方案（在对应方案前打√）
The voluntary medical excesses and premium discounts or increases apply only to this Medical Insurance Sub-Plan and not to optional and non-medical section of cover.
自决的医疗免赔额及相应保费增加或折扣只适用于此医疗保障子计划，故不适用于其它可选择的保障计划。

HeadStart 初级子计划	**Basic** 基本子计划	**Standard** 标准子计划	**Executive** 高级子计划
Standard Medical Excesses 标准医疗免赔额			
¥1,440 Standard Medical Excess 基本医疗免赔额¥1,440 ☐	¥1,440 Standard Medical Excess 基本医疗免赔额¥1,440 ☐	¥720 Standard Medical Excess 基本医疗免赔额¥720 ☐	¥360 Standard Medical Excess 基本医疗免赔额¥360 ☐
Optional Voluntary Medical Excesses 可选择医疗免赔额			
Not Applicable 不适用	Not Applicable 不适用	Nil Excess, 10% Premium Increase 无免赔额，保费递增10% ☐	Nil Excess, 10% Premium Increase 无免赔额，保费递增10% ☐
Not Applicable 不适用	Not Applicable 不适用	Not Applicable 不适用	¥720 Excess, 5% Premium Discount 免赔额¥720，保费递减5% ☐
Not Applicable 不适用	Not Applicable 不适用	¥1,440 Excess 10% Premium Discount 免赔额¥1,440，保费递减10% ☐	¥1,440 Excess 10% Premium Discount 免赔额¥1,440，保费递减10% ☐

¥3,600 Excess, 20% Premium Discount 免赔额¥3,600，保费递减20% ☐	¥3,600 Excess, 20% Premium Discount 免赔额¥3,600，保费递减20% ☐	¥3,600 Excess, 20% Premium Discount 免赔额¥3,600，保费递减20% ☐	¥3,600 Excess, 20% Premium Discount 免赔额¥3,600，保费递减20% ☐
¥7,200 Excess, 25% Premium Discount 免赔额¥7,200，保费递减25% ☐	¥7,200 Excess, 25% Premium Discount 免赔额¥7,200，保费递减25% ☐	¥7,200 Excess, 25% Premium Discount 免赔额¥7,200，保费递减25% ☐	¥7,200 Excess, 25% Premium Discount 免赔额¥7,200，保费递减25% ☐
¥14,400 Excess, 30% Premium Discount 免赔额¥14,400，保费递减30% ☐	¥14,400 Excess, 30% Premium Discount 免赔额¥14,400，保费递减30% ☐	¥14,400 Excess, 30% Premium Discount 免赔额¥14,400，保费递减30% ☐	¥14,400 Excess, 30% Premium Discount 免赔额¥14,400，保费递减30% ☐
¥36,000 Excess, 35% Premium Discount 免赔额¥36,000，保费递减35% ☐	¥36,000 Excess, 35% Premium Discount 免赔额¥36,000，保费递减35% ☐	¥36,000 Excess, 35% Premium Discount 免赔额¥36,000，保费递减35% ☐	¥36,000 Excess, 35% Premium Discount 免赔额¥36,000，保费递减35% ☐
¥72,000 Excess, 40% Premium Discount 免赔额¥72,000，保费递减40% ☐	¥72,000 Excess, 40% Premium Discount 免赔额¥72,000，保费递减40% ☐	¥72,000 Excess, 40% Premium Discount 免赔额¥72,000，保费递减40% ☐	¥72,000 Excess, 40% Premium Discount 免赔额¥72,000，保费递减40% ☐
¥144,000 Excess, 45% Premium Discount 免赔额¥144,000，保费递减45% ☐	¥144,000 Excess, 45% Premium Discount 免赔额¥144,000，保费递减45% ☐	¥144,000 Excess, 45% Premium Discount 免赔额¥144,000，保费递减45% ☐	¥144,000 Excess, 45% Premium Discount 免赔额¥144,000，保费递减45% ☐

Remarks: Details of content of coverage please refer to Ping An GlobalSelect International Healthcare Insurance Policy Wording and the Schedule of Cover and Excesses stated in it. 备注：保险方案详细内容请见《平安全球医疗保险条款》及其《保障计划和免赔表》。

SECTION 2. Health Declaration
第二部份. 健康状况声明

Please answer all questions for each applicant applying for cover. 每位投保人必须对以下所有问题作答。		If YES, show FAMILY MEMBER Using Letters from Section 1 若有作答为“是”，请按照第一部份填上投保人代号
1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities? 您本人或其它投保人，是否现在身体有残疾，正在怀孕，或不能从事正常活动？	☐ Yes ☐ No ☐ 是 ☐ 否	
2. Are you or any other applicant presently hospitalised, or scheduled for or in need of hospitalization or Surgery? 您本人或其它投保人，是否目前正在住院，或已预定，或需要安排住院或做术？	☐ Yes ☐ No ☐ 是 ☐ 否	
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder? 您本人或其它投保人是否有被检验出或被诊断有获得免疫性缺陷综合症（艾滋病）、艾滋病有关的病症、淋巴结病综合症、获得性免疫缺陷综合症病毒或任何其它免疫系统失调，或正接受上述其中一项的治疗？	☐ Yes ☐ No ☐ 是 ☐ 否	
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)? 您本人或其它投保人，是否曾进行，或曾被建议接受，或已被安排等候器官移植（角膜移植除外）？	☐ Yes ☐ No ☐ 是 ☐ 否	
If any applicant answered YES to any of the above four questions, he or she does not qualify for this insurance. Thank you for your interest. 假若有任何投保人，在上述四条问题中，有其中一条问题中的答案为“是”，很抱歉，他已不合符申请这保单的资格。谢谢您对此保单的兴趣。		
5. Have you or any other applicant been diagnosed with or treated for any of cancer or pre-cancerous condition during the past 5 years? If yes, please complete Section 3.2. 您本人或其它投保人，是否曾经在过去的五年内，被诊断有癌症或癌症前征兆，又或是曾经接受此病况的治疗？假若为「是」，请填写第3.2份。	☐ Yes ☐ No ☐ 是 ☐ 否	
6. If a non-USA citizen, have you or any other applicant resided continuously in the US for the last 5 years? 假如您本人或其它投保人不是美国公民，请问您本人或其它投保人，有否在过去五年，曾在美国居留过？	☐ Yes ☐ No ☐ 是 ☐ 否	
If any applicant answered YES to either of the above two questions, he or she may not qualify for this insurance. 假若有任何投保人，在上述二条问题中，有其中一条问题中的答案为“是”，很抱歉，他已不合符申请这保单的资格。		

Questions 7 – 26 below must be answered for the applicant and every other member of your family applying for cover. For any questions answered “YES”, please identify the family member to whom the answer applies (use the letter that corresponds to the family member from Section 1), and provide complete details of the medical condition at issue in the space provided in Section 3.2 of this application, including the name, address and telephone number of all attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. The Insurer reserves the right to request additional medical information. 所有投保人（包括主投保人、需要一同承保的配偶及各子女）必须填写以下第7 – 26 题问题。 若有任何作答为“是”，请按照第一部份标识各投保人，并于第3.2部份的空白处提供相关问题提及的健康状况的详细资料，包括所有主治医生的名字、联络地址及电话，所有相关的诊断，诊治日期、诊治项目、预期治疗的后果及当前进行的治疗。保险人保留要求额外相关的医疗资料的权利。

Health Declaration - Continued 健康状况申报－续		If YES, show FAMILY MEMBER Using Letters from Section 1. 若有作答为“是”，请按照第一部份填上投保人代号
7. During the last 12 months, have you or any other applicant experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous conditions? If yes, please complete Section 3.2. 在过去十二个月内，您本人或其它投保的被保险人是否曾经历、健康、精神、身体或神经状况或症状，或就其曾被诊断、会诊、检查、测试或治疗（包含药物治疗）？	☐ Yes ☐ No ☐ 是 ☐ 否	

8. Have you or any other applicant ever had an application for health, life or disability insurance or reinstatement rejected, cancelled, rated, declined, modified or postponed? If yes, please explain in Section 3.2. 您本人或其它投保人，是否曾经申请任何健康、人寿、或残疾保险，又或申请复原上述保险时，但被拒绝、取消、调高保费、不被接纳，调整内容或延迟考虑？若作答为“是”，请于第3.2部份的空白处作解释。	☐ Yes ☐ No ☐ 是 ☐ 否	
Have you or any other applicant ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following: 您本人或其它投保人，是否曾在以下相关连的任何的疾病、情况、病患、医疗问题上，被证实或有症状，曾患有，曾寻求咨询、检查、测试或曾接受任何治疗，或曾被诊断患有：		
Health Declaration - Continued 健康状况申报－续		If YES, show FAMILY MEMBER Using Letters from Section 1. 若有作答为“是”，请按照第一部份填上投保人代号
9. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rtheumatic fever, or heart murmur? If yes, please complete the following: 心脏的、心脏病的、心血管的及/或循环系统的，包含但不限于：充血的心脏衰竭、心脏病发作、心绞痛、胸痛、动脉硬化、血压的升高、高血压、脚/踝肿、血栓形成、静脉炎或心脏杂音。若作答为“是”，请对以下问题作答： a. Date of most recent BP reading? _____ 最近一次在何时量度血压？ b. Result: _____ 是次度数： c. Medications taken (Types & Dosage) _____ 所服用的药物（种类及数量）	☐ Yes ☐ No ☐ 是 ☐ 否	
10. Blood, blood vessels, arteries, veins or disorders of the blood, including, but not limited to: anaemia, haemophilia, leukemia, hepatitis, lymph glands, or high cholesterol? 血液、血管、动脉、静脉或血液失调, 包括但不限于: 贫血、血友病、白血病、肝炎、淋巴结或高胆固醇？	☐ Yes ☐ No ☐ 是 ☐ 否	
11. Diabetes, hyperglycemia or hypoglycemia? If Yes to diabetes, please complete the following: 糖尿病、血糖过高或血糖过少症？若作答糖尿病为“是”，请对以下问题作答： a) Diabetic Type I _____ or II _____ 糖尿病类型 I _____ 或 II _____ b) Date diagnosed 诊断日期_____ c) Controlled by diet only Yes ____ No ____ 只以饮食控制病情? 是 ____ 否 ____ d) Medications (Type and Dosage) 药物治疗（类型及剂量） _____ e) Date of most recent HbA1c Test? _____ 最近糖化血色素检查之日期 f) Results of HbA1c Test (1 – 10) _____ 糖化血色素检查 (1 – 10) 的结果	☐ Yes ☐ No ☐ 是 ☐ 否	
12. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump or growth of any kind? 癌症、肿瘤、囊肿、息肉、黑素瘤、卡波济氏肉瘤、细胞失调、带状疱疹、肿块或任何类形的新增？	☐ Yes ☐ No ☐ 是 ☐ 否	
13. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity? 肝、胰腺、胆囊、内分泌失调, 包括但不限于：脑垂体、甲状腺或新陈代谢失调、肥胖？	☐ Yes ☐ No ☐ 是 ☐ 否	
14. Kidney, urinary tract functions, kidney or bladder stones or infections? 肾、尿道功能，肾或膀胱石或感染？	☐ Yes ☐ No ☐ 是 ☐ 否	
15. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysemia, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia? 呼吸系统疾病包括但不限于：结核病、肺失调、肺气肿、慢性咳嗽、支气管炎、支气管哮喘、胸膜炎或肺炎？	☐ Yes ☐ No ☐ 是 ☐ 否	
16. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating disorders? 精神及神经系统紊乱，包括但不限于：精神病、精神或行为失常、滥用或依靠化学药品或药物、酗酒、精神辅导及/或支持小组、抑郁、焦虑、慢性疲劳、饮食失调？	☐ Yes ☐ No ☐ 是 ☐ 否	
17. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks? 神经系统失调，包括但不限于：多发性硬化、肌肉萎缩症、Lou Gehrigs disease、帕金森氏病、瘫痪、癫痫、惊厥（抽筋）、癫痫、偏头痛、慢性头痛、中风或短暂缺血性中风？	☐ Yes ☐ No ☐ 是 ☐ 否	
18. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease, vertebrae, or any other back condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation? 肌肉、骨骼、脊椎、骨或关节，包括但不限于：脊柱侧凸、盘病、脊椎骨或任何其它背脊疾病、风湿病、关节炎、痛风、腱炎、骨质疏松或炎症？	☐ Yes ☐ No ☐ 是 ☐ 否	
19. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment? 若投保的被保险人为女仕，流产、因怀孕或分娩引致的并发症、或有关不育上的咨询、建议、诊断或治疗？	☐ Yes ☐ No ☐ 是 ☐ 否	
20. Congenital, genetic or hereditary condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect? 先天、基因或遗传的疾病或缺陷，包括但不限于：精神发育迟缓（弱智）、唐氏症或其它染色体失调、身体失调、残缺或缺陷？	☐ Yes ☐ No ☐ 是 ☐ 否	
21. Digestive system, stomach, or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders? 消化系统、胃或肠道，包括但不限于：食道回流、胃炎、溃疡、结肠或直肠失调？	☐ Yes ☐ No ☐ 是 ☐ 否	
22. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus? 生殖系统，包括但不限于：前列腺水平升高、阴道出血、纤维瘤、小结、乳房囊肿、输卵管、卵巢或子宫？	☐ Yes ☐ No ☐ 是 ☐ 否	
23. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ? 眼，耳，鼻，口，咽喉或颚，包括但不限于：白内障、青光眼、鼻中隔偏移、慢性鼻窦炎或颞下颌关节？	☐ Yes ☐ No ☐ 是 ☐ 否	

24. Any other disease, medical problem, illness, injury or condition of any kind not listed? 是否有以上没有列出的任何疾病，医疗问题，疾病，伤害或任何其它形式的状况？	☐ Yes ☐ No ☐ 是 ☐ 否	
25. Do you or any other applicant currently use or during the past 5 years have you or any other applicant used tobacco in any form? 您本人或其它投保人现在或在过去五年内是否有抽任何类形的烟草？	☐ Yes ☐ No ☐ 是 ☐ 否	
26. Have you or any other applicant ever applied for or purchased insurance through the Insurer or IMG? (if yes, please provide certificate number and details) 您本人或其它投保的被保险人是否曾经申请或购买过保险人或IMG的产品？（若作答为“是”，请在以下提供相关保险单号码及详情。） Certificate Number 保单号码：_____ Policy Undertaken 保单详情：_____	☐ Yes ☐ No ☐ 是 ☐ 否	

SECTION 3. Confidential Medical Information
第三部份. 机密的医疗资料

3.1 Medical Practitioner's Details 执业医生详请

The Name and address of my usual family doctor is as follows:
本人的家庭医生的名称及联络地址如下:

Doctor's Name: 医生名称:	Telephone: + ( ) ( ) 联络电话: + ( ) ( )
Address: 联络地址:	
Country: 国家:	Postal/Zip Code: 邮政代码:
Date last seen: 上一次求诊日期:	Reason: 求诊原因:

☐ If the above details are different for any other applicant, please give details on a separate sheet and indicate that you have done so by ticking this box.
☐如果其它任何投保人的家庭医生有别于上述者，请于此方格加上勾号，并在另外纸张上提供详情。

3.2 Further Medical Information / Prior Insurance 进一步的医疗资料 / 投保前

For any question answered "YES" in Section 2, please identify each applicant for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospitals(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. Please attach additional pages as necessary.
如果在第二部份中有任何回答为“是”，请根据第一部份填上被保险人相应的代号，并提供其医疗状况的详情，包括被保险人的主治医生、医院、诊所及所有相关的医疗机构的名字、地址及联络电话，相关诊断，所有治疗日期，治疗的类别，预诊结果及正在接受的疗程。若有需要，请在另外纸张上提供详情。

Question Number From Section 2 第二部份的问题号码	FamilyMember (USE LETTERS FROM SECTION 1.) 投保人（按照第一部份填上投保人的代号）	Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s) 身体状况/相关诊断、预诊结果、过去曾接受及正在接受的疗程	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone 投保人的主治医生、医院、诊所及所有相关的医疗机构的名字、地址及联络电话	Date(s) of Treatment 治疗日期

If any applicant applying for cover has ever had an application for health, life, or disability insurance or reinstatement rejected, cancelled, rated, declined, modified or postponed (see Section 2, Question 8), please explain below.
若有任何申请投保的被保险人曾经申请过任何健康、人寿或残疾保险，又或申请复原上述保险时，但被拒绝、取消、调高保费、不被接纳，调整内容或延迟考虑的，请在以下解释原因。

(attached additional pages as necessary) (若有需要，请在另外纸张上提供详情)

SECTION 4. Optional Additional Insurance Application Form
第四部份. 可选附加保险投保单

Please complete for all family members applying for cover.
请填写所有投保本保险的家庭成员的完整资料。

Personal Accident Insurance 意外伤害保险		
A. Insurance Applicant 主被保人	For each Unit, Sum Insured is ¥50,000. The Applicant can purchase one or more Units. 每份保险金额50000元人民币。投保人可购买若干份。	☐_____Unit(s)份 Max 10 units 最高投保10份
B. Spouse 配偶		☐_____Unit(s)份 Max 10 units 最高投保10份
C. First Child 第一子女 *		☐_____Unit(s)份 Max 2 units 最高投保2份
D. Second Child 第二子女 *		☐_____Unit(s)份 Max 2 units 最高投保2份
E. Third Child 第三子女 *		☐_____Unit(s)份 Max 2 units 最高投保2份

Remarks: Please refer to Ping An Accident Insurance Policy Form for details of cover.
备注：意外伤害保险责任内容请见《平安意外伤害保险条款》。
Any application for a person aged under 18 years must be signed by a parent or guardian.
若被保险人未满18周岁，则投保人必须为其父母或监护人。

For each individual applying for Personal Accident Insurance, please indicate: 请填写身故受益人信息：			
A. Insurance Applicant 主被保人	Primary Beneficiary * : 第一身故保险金受益人*:	Relationship of Beneficiary with Insured 受益人与被保人关系：	% of Death Benefit: 身故受益比例%:
	Contingent Beneficiary * : 第二身故保险金受益人*:	Relationship of Beneficiary with Insured 受益人与被保人关系：	% of Death Benefit: 身故受益比例%:
B. Spouse 配偶	Primary Beneficiary * : 第一身故保险金受益人*:	Relationship of Beneficiary with Insured 受益人与被保人关系：	% of Death Benefit: 身故受益比例%:
	Contingent Beneficiary * : 第二身故保险金受益人*:	Relationship of Beneficiary with Insured 受益人与被保人关系：	% of Death Benefit: 身故受益比例%:
C. First Child 第一子女	Primary Beneficiary * : 第一身故保险金受益人*:	Relationship of Beneficiary with Insured 受益人与被保人关系：	% of Death Benefit: 身故受益比例%:
	Contingent Beneficiary * : 第二身故保险金受益人*:	Relationship of Beneficiary with Insured 受益人与被保人关系：	% of Death Benefit: 身故受益比例%:
D. Second Child 第二子女	Primary Beneficiary * : 第一身故保险金受益人*:	Relationship of Beneficiary with Insured 受益人与被保人关系：	% of Death Benefit: 身故受益比例%:
	Contingent Beneficiary * : 第二身故保险金受益人*:	Relationship of Beneficiary with Insured 受益人与被保人关系：	% of Death Benefit: 身故受益比例%:
E. Third Child 第三子女	Primary Beneficiary * : 第一身故保险金受益人*:	Relationship of Beneficiary with Insured 受益人与被保人关系：	% of Death Benefit: 身故受益比例%:
	Contingent Beneficiary * : 第二身故保险金受益人*:	Relationship of Beneficiary with Insured 受益人与被保人关系：	% of Death Benefit: 身故受益比例%:

* If not mentioned then the beneficiary demanded by court will be followed.
若未填写身故受益人，则身故保险受益人为法定。

SECTION 5. Method of Payment
第五部份. 保费缴付方式

Please choose your method of payment
请选择缴付保费方式
If paying by bank transfer or cheque: To avoid delays, we recommend you check your premium calculation and any taxes (if applicable) with us or your agent.
如果以银行户口转账或支票方式支付保险费：为减少延误，我们建议您先向保险人或您的代理/经纪查询正确的保险费金额（包含适用的税项）。

☐ **A. Bank Transfer 银行户口转账**

Once your Application has been processed, the necessary bank transfer information will be forwarded to you and your payment is required within 14 days. [Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on any transfer.] Liability for any bank transfer which does not clearly identify the proposer will not be accepted by the Insurer.
您的申请一经被接纳，我们便会实时寄上转账的详请，而所列如下的保费则需于十四天内缴付。［请在转账时，清楚列明所有的投保人的名字（按照本申请书第一部份所填写的）］。所有因名字不对照的转账而产生的责任，保险人概不接受。

☐ **B. Bank Check 银行支票**

Please make payment to: 抬头名称为： **Ping An Property and Casualty Insurance Company of China, Ltd._____Branch** 中国平安财产保险股份有限公司_____分公司	Please ensure that the name of the Applicant (as declared in Section 1 of this form) is clearly stated on the reverse of the check. 请确认在票的背面写上各投保人的名字（如本投保申请书第一部分）

☐ **C. Cash 现金**

You can pay at the Cashier Counter of our Branch Office. 您可到平安的各分行的门市以现金交付保费。

☐ 个人缴费 Paid by individual	☐ 单位缴费 Paid by Organization	☐ 单位代缴 Paid via Organization

INTERNAL USE ONLY
以下只供本公司填写

Medical Premium 基本医疗保费	x	Medical Excess Rate Factor 医疗选择免陪额因子	+	Optional Insurance Premium 可选附加保险保费	=	Total Premium Due 总应缴保费

Total Annual Premium Due:
总应缴全年保费:

SECTION 6. Requested Start Date
第六部份. 保单有效起保日

Date on which you wish your Ping An GlobalSelect International Healthcare Insurance to commence:
您希望您的《平安全球医疗保险》于何时起生效：

☐ On Acceptance or ☐ Other / / (DD/MM/YY)

☐ 在被接纳日起保 或 ☐ 其它日期 / / (日/月/年)

Must be within 30 days after signature. Cover will in no event be effective until approved. Please note we cannot commence your plan until we have accepted your Application and received your first or annual premium payment
起保日必须为填写并签署本投保申请书之日期起三十（30）天内，但前提条件是本投保申请书必须被保险人接纳。请注意我们仅在接纳本投保申请并收到您的首期或全年保险费后方开始向您提供保障

SECTION 7. Renewal Contact Information
第七部份. 续保联络方式

Please specify the best way to contact you when it comes to renewing your cover:
请说明续保时联络您的最佳方式**:**

☐ Mail (please provide address):
邮寄（请于空格填上邮寄地址）：_____

☐ Fax (please provide fax number):
传真（请于空格填上传真号码）：_____

☐ Email (please provide email address):
电邮（请于格填上电邮地址）：_____

Please select the address where you would like your Certificate express mailed (as indication in Section 1)
请在以下选择您希望保险单寄往的地址（参考第一部分）：

☐ Residence address 住宅地址 ☐ Mail Forwarding Address 邮件递送地址 ☐ Other (NO P.O. Boxes please) : _____ 其它（不接受邮局地址）

SECTION 8. Applicant ' s Declaration
第八部份. 投保人声明

I (we) understand and hereby agree that:
本人（我们）明白并谨此同意：

(1) I (we) apply for Ping An GlobalSelect International Healthcare Insurance.
本人(我们)申请投保平安全球医疗保险。

(2) Cover will be provided in accordance with the Policy Wording; and I (we) will read it upon receipt and be bound by it unless I (we) cancel the plan after receiving the Policy Wording.
此投保书所提及的保障内容是与保单一致的；当收到保单后本人(我们)将会阅读并明白保障内容是受保单约束，除非本人(我们) 于收到保单后消有关之保障计划。

(3) I (we) have read all statements, questions and responses contained In this Application Form or they have been read to me (us) and I (we) understand them.
本人(我们)已阅读或他人向本人（我们）阅读了本投保申请书中所有陈述，问题和回答，且全部理解。

(4) My (our) responses to the statements and questions contained in this Application are true, accurate complete and correctly recorded in all respects. This Application will be the basis for and form a part of any insurance issued. I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto. I(we) understand that if I (we) conceal truth or make untrue representation, the insurer has the right to cancel the contract and has no obligation to pay any benefit for any insured event even occurring before such cancellation. I (we) will supplement such responses within ten (10) days upon my (our) receipt of the Policy in the event of any change or addition thereto.
本人（我们）在本投保申请书填写的各项内容均属真实，并作为本保险合同的组成部分。如在保单生效日前有任何改变或增加，本人（我们）将补充有关资料。如有隐藏或不实告知，保险人有权解除保险合同，并对保险合同解除前发生的保险事故不承担保险责任。如果存在错误或遗漏，本人（我们）将于收到保险合同后10日内书面通知保险人。

(5) I (we) understand and agree that the effect of the insurance is subject to the approval and policy issuance of the insurer upon collection of full premium. The Insurer will issue the Policyholder with a policy validated with an authorized signature of the insurer.
本人（我们）同意本保险合同生效须经本人(我们)一次缴付本合同的应付保费并经保险人签发保险单确认，本人(我们)切记向代理人或保险人索取经保险人签章后的保险单。

(6) No cover will be effective unless and until this Application has been duly accepted in writing by the Insurer, and there has been no change since the date of this Application Form in the insurability of all persons proposed for cover or in any responses in the statements and questions in this Application.
保险人在接受本人(我们)的投保申请、收到保费并出具保险单后，并且本人(我们)在可承保的范围内或是对投保书里任何声明及问题的回答，并无作出任何更改，保障才开始生效。

(7) Premiums will be applied from the effective date forward and there will be no cover for any claim that begins prior to the effective date.
保费将由保单生效日开始应用，而在保单生效日前发生的索赔并无保障。

(8) I (we) hereby fully understand and agree the brochure, application notice and terms and conditions of this Policy, especially the exclusions and cancellation clauses.The Insurer has carefully introduced to me(us) the terms and conditions, clauses and the application notice of the Policy, and especially, the insurer has explicitly explained the Exclusions and the Obligation of the Applicant and the Insured. I (we) understand and agree the coverages and benefits are in accordance with those stated in this insurance contract. Only written amendments or endorsements issued by the insurer are valid. The insurer is not liable for any verbal agreement or written documents made by any third party.
本人（我们）已认真阅读并理解产品说明、投保须知、所投保险种条款，且保险人已向本人（我们）详细介绍了本保险的内容、条款及投保须知，并就该条款和投保须知中有关责任免除和投保人、被保险人义务做了明确说明，本人（我们）确认对其中各项内容尤其是责任免除、合同解除条款均已完全理解并同意遵守。并知晓所有保险责任均以保险合同所载为准，除由贵公司经正式程序修改或批注的内容外，其它任何人的口头书面陈述、报告或合约，均属无效，贵公司无需负责。

(9) The agent/broker assigned to or assisting with this Application is the representative of me (us) and is not an agent/broker of the Insurer, International Medical Group, Inc. or IMG Europe Ltd..
被分派或协助此申请的代理/经纪，乃是代表本人 (我们)，而并非代表保险人、International Medical group, Inc. 或 IMG Europe Ltd.。

(10) No agent/broker has the authority to modify or waive any statement, question or response in this Application or to modify or waive any term of the plan, or to waive any of the rights or requirements of the Insurer, International Medical group, Inc. or IMG Europe Ltd..
任何代理或经纪并无权修改或撤回此投保单所有的陈述、问题及回答或修改或撤回此投保单的任何条款，或撤回保险人于此投保单之权利或要求。

(11) I (we) understand that for any Insured Person under 18 years old, if he/she has a death benefit (including this insurance contract and all other related commercial insurance) exceeding the limit stipulated by China Insurance Regulatory Commission(i.e. RMB100,000 in Beijing, Shanghai, Guangzhou, Shenzhen and RMB50,000 in other areas), the excessive part will be void. The insurer will not undertake any liability exceeding such limit.
本人（我们）明白任何年龄在18岁以下的被保险人，如果其以死亡为给付责任的保险金额（包括在所有商业保险公司所购买的保险）超出中国保监会所规定的限（北京、上海、广州、深圳地区为100,000元人民币，其它地区为50,000元人民币），超出限额部分的保险责任无效，保险人不承担任何超出部分的赔偿金额。

(12) The subjects, risks and benefits of insurance for which I (we) apply for cover under the plan are not intended or considered by me (us) to be resident, located or performed in any state in the USA or any particular country other than the People ' s Republic of China.
本人(我们) 申请此保障计划内保险的对象，风险及利益，并非本人(我们)刻意用于作为定居、身处并履行于美国的任何州或除了中华人民共和国以

外的任何特定的国家的行径。

(13) The Insurer, International Medical Group, Inc. and IMG Europe Ltd., their employees, representatives, agents and any other persons or organizations performing services for them or on their behalf, may use, disclose or transfer to any organization any information about me (us) obtained or collected in connection with this Application (whether contained in this Application or otherwise) for the purpose of : (1) assessing this Application and providing on-going insurance and customer service; (2) processing and giving effect to payments; (3) providing marketing material in respect of insurance related services of the Insurer or its associated companies; and (4) processing claims or analyzing the insurance.
保险人、International Medical Group, Inc. 及 IMG Europe Ltd.，其员工，其代表、代理或任何代表这些单位提供服务或的任何人士或机构可能会使用、透露或转交予其它机构有关本人(我们) 在本投保申请书中所提供或相关的数据(不论是包含于本申请表中或其它地方)，作以下用途: (1) 评估本投保申请及提供保险及客户服务；(2) 处理付款；(3) 提供与保险人或其附属公司的有关保险服务的市场资料；(4) 理赔或作保险计划上的分析。

(14) AUTHORISATION: For purposes of determining my (our) insurability, I (we) authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, pharmacy, medical records service, prescription history clearinghouse, other insurer, government agency, employer, social worker or family member to provide information about me (us),including my (our) entire medical record, to the Insurer, International Medical group, Inc. and IMG Europe Ltd., their employees, representatives, agents and any other persons or organizations performing insurance services for them or on their behalf. By my (our) signature below. I (we) acknowledge that any prior agreement I (we) have made to restrict or limit the disclosure of information about my (our) health does not apply to this authorization. This authorization is valid from the date of my (our) signature shown below. A copy, image or facsimile of this authorization is as valid as the original.
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Signature of Applicant or Guardian: 投保人或监护人签署：	Signature of Spouse: 配偶签字：	Signature of Child(Children): 子女签字：
Date日期：	Date日期：	Date日期：

SECTION 9. Column for Insurer ' s Users
第九部份. 保险人使用栏

Name of Sales: 业务员姓名：	Code of Sales: 业务员代码：
Code of Agent/Broker: 机构代码：	Source of Business: 业务来源：
Source of Channel: 渠道来源：	Temporary Premium Receipt No.: 暂收收据流水号：
No. of Application Form: 投保单号码：	No. of Certificate of Insurance: 保险单号码：
Copy of Insured Person: Set(s) 被保险人清单： 份	Other Copy: Set(s) 其它材料： 份
Initial Underwriter: 初审人员：	Checking Date: 初审日期： 年Y 月M 日D
Inputting Clerk: 录单受理人员：	Inputting Date: 受理日期： 年Y 月M 日D
Printing Clerk: 承保人员：	Printing Date: 承保日期： 年Y 月M 日D
Comment of underwriter: 核保人员意见：	
Signature of Underwriter 核保人签字	年Y 月M 日D

Insurance Advisor / Broker Use Only:
保险代理/经纪人使用栏

Agent / Broker : 代理人/经纪人:	Phone: + ( ) ( ) 电话
Company Name: 公司名称	Contact Name: 联系人姓名

Please mail or fax this application to
请邮寄或传真此申请书至：

Remark: Address change information or additional contact information should also be directed to this contact information.
备注：所有日后有地址改变或其它联络方式的改动，亦请邮寄或传真至此。

Ping An Branch Office:	Contact Numbers: