

團體醫療 / 團體人壽保險健康申報表
Group Medical / Group Life Insurance Health Declaration Form



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請由僱員以正楷填寫 To be completed by Employee in Block Letters

公司名稱 (保單持有人) Employer Name (Policyholder)		團體醫療保單編號 Group Medical Policy No.	
附屬公司名稱 Affiliated Company Name		團體人壽保單編號 Group Life Policy No.	
僱員姓名 (與身份證 / 護照相同) Employee Name (Same as ID Card / Passport)		出生日期 Date of Birth (日DD / 月MM / 年YYYY) / /	
英文姓氏 Surname in English	英文名字 Given Name in English	中文姓名 Name in Chinese	性別 Sex <input type="checkbox"/> 男性 Male <input type="checkbox"/> 女性 Female
僱員編號 (如有) Staff no. (If any)	僱員類別 Employee Type	職位 Position	受僱日期 (日 / 月 / 年) Employment Date (DD / MM / YYYY) / /
家屬保障 Dependant Coverage (如適用 If applicable)			
家屬姓名 (中英文) Name of Dependants (English and Chinese)	關係 Relationship	出生日期 (日 / 月 / 年) Date of Birth (DD / MM / YYYY)	身份證 / 護照號碼 ID Card / Passport No.
1			
2			
3			
4			
5			

註：家屬包括僱員未滿69歲之配偶及僱員之未婚子女而年齡超過14日但未滿19歲、及已滿19歲但未滿25歲而正在接受全日制教育機構教育 (請附上證明文件)。
 Note : Dependants include employee's spouse under the age of 69 and the employee's unmarried children who are over the age of 14 days but under 19 years old, and those at or above the age of 19 but under 25 who are receiving full time education at an educational establishment. (Please provide evidential proof).

1. 閣下或 貴配偶 (如適用) 的體重及身高? What is your and your spouse's (if applicable) weight and height?	僱員 Employee : _____ 千克 kg _____ 米 m 配偶 Spouse : _____ 千克 kg _____ 米 m
2. 閣下是否全職僱員及現時是否正在職工作? Are you now employed on a full-time basis and actively-at-work?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
3. 閣下或 貴家屬 (如適用) 有否吸煙? Do you or your dependant (if applicable) smoke? 如有, 請提供吸煙者姓名及每日吸煙平均數量 If yes, please name the person who smokes and the average daily consumption: _____	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
4. 閣下或 貴家屬 (如適用) 是否現正持有其他醫療、意外或人壽保單? Do you or your dependant (if applicable) currently have any other medical, accident or life insurance?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
5. 閣下或 貴家屬 (如適用) 曾否有任何醫療、意外或人壽保險的投保申請被保險公司拒絕、或保單被取消、增加保費、附加限制或拒絕續保? Have you or your dependant (if applicable) ever had any medical, accident or life insurance application rejected or policy cancelled, rated or restricted or renewal declined?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
6. 閣下或 貴家屬 (如適用) 的直系親屬中是否有兩位或更多成員於六十歲前患有遺傳性疾病? Have you or your dependant (if applicable) had any two or more of your immediate family members who are known to have any hereditary disease before age 60?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
7. 閣下或 貴家屬 (如適用) 是否打算參加有危險性之活動, 如賽車、潛水、攀石或飛行活動 (除民航乘客身份購票者外)? Do you or your dependant (if applicable) have any intention of engaging in hazardous pursuits, e.g. motor sports, diving, rock climbing, flying other than as a fare paying passenger?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No

以上問題編號 4 - 7, 如答案為是者, 請提供詳細說明包括姓名:
 Provide details including name for the above question no. 4 - 7 answered "Yes":

僱員姓名 Employee Name _____

8. 在過去五年內，閣下或 貴家屬 (如適用) 是否曾患有或曾接受任何嚴重疾病、身體機能失調、身體上的缺陷或嚴重受傷的治療? 是 Yes 否 No
Have you or your dependant (if applicable) suffered from or been treated for any serious diseases, disorder, physical impairment or severe injury in the last 5 years?
9. 在過去五年內，閣下或 貴家屬 (如適用) 曾否接受過外科手術、或曾在醫院或療養院留院接受治療或觀察? 是 Yes 否 No
Have you or your dependant (if applicable) had a surgical operation or been confined in hospital or sanatorium for treatment or observation in the last 5 years?
10. 在過去五年內，閣下或 貴家屬 (如適用) 有否接受或被建議接受任何診斷性檢驗 (例如: X-光、心電圖或血液檢驗)? 是 Yes 否 No
Have you or your dependant (if applicable) had, or been advised to have any diagnostic tests (e.g. X-ray, ECG or blood test) in the last 5 years?
11. 閣下或 貴家屬 (如適用) 現時是否正接受病理觀察、治療或藥物或有任何顯示健康異常之徵狀出現? 是 Yes 否 No
Are you or your dependant (if applicable) currently under medical observation or receiving any treatment or medication or aware of any symptoms which may indicate a disorder?
12. 閣下或 貴家屬 (如適用) 曾否接受過下列疾病之治療或曾被告知患上下列疾病: 心臟病、高血壓、糖尿病、癌症、瘤、潰瘍、肺結核、哮喘、癲癇、氣腫、胸膜炎、結腸炎、風濕性發熱、梅毒、或任何疾病關於腦部、中樞神經、腸胃、肝臟、胰臟、生殖排洩系統、甲狀腺、骨髓、後天免疫力缺乏症 (愛滋病)、與愛滋病有關的併發症或狀況? 是 Yes 否 No
Have you or your dependant (if applicable) ever been treated for or been told of heart trouble, high blood pressure, diabetes, cancer, tumor, ulcer, tuberculosis, asthma, epilepsy, emphysema, pleurisy, colitis, rheumatic fever, syphilis or any other disease of the brain, central nervous system, gastro-intestinal tract, liver, pancreas, genito-urinary, thyroid gland, bones, AIDS, AIDS-related complication or AIDS-related condition?

以上問題，如答案為是者，請提供詳細說明：
Provide name and details of each question answered "Yes" :

問題編號 Question No. 8 - 12	僱員 / 家屬姓名及項目說明 Name of Employee / Dependand & Details of Item	治療日期 Treatment Period 由 From 至 To	痊癒日期及程度 Date & Degree of Recovery	診治醫生姓名及地址 Name & Address of Attending Doctor

聲明及授權 DECLARATION AND AUTHORISATION

本人謹此聲明上述一切所提供之資料均屬正確無誤，並同意此健康申報表將成為發出任何保單之基礎及其中一部份。同時，本人知悉任何虛假、不正確及誤導之聲明均會引致相關保單無效及作廢。

本人或代表被保人 (如有不同) 授權任何醫生、醫院、保險公司或機構，可以將部分或全部有關本人 / 被保人任何傷患之醫療記錄 (包括但不限於診症、診斷性檢驗結果、藥方或治療資料) 給予富衛保險有限公司或富衛人壽保險 (百慕達) 有限公司或其已獲授權之代理人作評估及處理本申請。此授權書之副本與正本具同等效力。

本人確認已閱畢夾附的收集個人資料聲明，並明白本人就本人的個人資料方面的權利及義務，亦同意收集個人資料聲明所指該等個人資料可被使用或處理的方式。

I hereby declare that all the information supplied above is true and correct and I hereby agree that this Declaration form shall form the basis and become a part of any policy issued. I understand that any false, incorrect or misleading statement may render the relevant insurance policy null and void.

I authorise or authorise on behalf of the insured (if different) the physician, hospital, insurance company or organization to furnish part of or all medical history (including but not limited to information in respect of consultants, diagnostic test results, prescriptions or treatments) with respect to any illness or injury of me or the insured to FWD General Insurance Company Limited or FWD Life Insurance Company (Bermuda) Limited or its authorised representative for the purpose of assessing and processing this application. A photocopy of this authorisation shall be considered as effective and valid as the original.

I hereby also confirm that I have read the attached Personal Information Collection Statement ("PICS") and understand my rights and obligations in relation to my personal data and consent to the manner in which the personal data may be used or dealt with as specified in the PICS.

僱員簽署 Signature of Employee _____

簽署日期 (日/月/年) Date Signed (DD/MM/YY) _____

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