

Evidence Of Insurability
投保資格證明

- Notes 注意事項
 1 Please complete this form in BLOCK LETTERS and check the boxes where appropriate. Please initial any corrections you make on this form. 1 請用正楷填寫本表格，並於適當空格內加✓號。如須作出任何更改，請於刪改之位置旁簽署。
 2 Parents must complete and sign this form on behalf of their children. 2 父母必須替子女填寫及簽署此表格。

| | | | |
|-----------------------|-------|----------------------------|-------|
| Policy Number 保單編號 | _____ | Certificate Number 證書編號 | _____ |
|-----------------------|-------|----------------------------|-------|

A. APPLICANT INFORMATION 申請人資料

(As shown on HKID Card 必須與身份證相同)

Applicant's Full Name (Surname first) (in English) _____ (in Chinese) _____
 申請人姓名(以姓氏先排) 英文 中文

| | | | |
|---|-----------|---|--|
| Date of Birth 出生日期 DD 日 / MM 月 / YY 年 | Sex 性別 | Country of Residence 居住地* (Please complete if not in HK 若居住在香港，請無須填寫) | HKID Card / Passport No. 香港身份證 / 護照號碼 |
|---|-----------|---|--|

Occupation / Job Duties^ (Please specify % of time spent on manual work)
 職業/工作職務^ (請說明體力勞動工作佔工作職務時間的百分比) _____ (%)

Employee's Name (if Applicant is a Dependent)
 僱員姓名(如申請人為僱員家屬) _____

Relationship 關係 _____

* Please make sure that your Country of Residence is up-to-date in Manulife's Employee Benefits' Group policy record as that will determine the destination of any emergency evacuation or repatriation services under the policy. 請確保閣下備存於宏利僱員福利團體保險計劃內受保人的居住地址資料為正確無誤。如遇上緊急事故，宏利將以此資料作為有關之撤離或遣返安排之目的。
 ^ If you does not provide any information for the occupation / job duties here, it is deemed that you are a clerical worker with no time spent on manual work. If the space provided is insufficient, you can provide further descriptions on separate sheet. 如閣下沒有在此欄提供職業/工作職務資料，則視作閣下從事文職工作，當中沒有任何體力勞動工作的成分。閣下可自行以附頁提供更多有關閣下的職業/工作職務的資料。

B. HEALTH DECLARATION 健康狀況聲明

| | | | |
|---|---|---|---|
| 1 Height _____ cm 體高 _____ 厘米 | Weight _____ kg 體重 _____ 公斤 | | |
| 2 Weight change during past twelve months? 過去十二個月體重的變更? | _____ kg 公斤 | please specify reason for the change 請列明原因 _____ | Yes是 No否 |
| 3 Have you smoke cigarettes within the last twelve months? If yes, 閣下在過去十二個月內有否吸煙習慣? 如有， | | | <input type="checkbox"/> <input type="checkbox"/> |
| (a) Average number of cigarettes daily? 平均每日吸食的香煙數量? _____ | (b) For how many years have you smoked? 閣下的吸煙年期? _____ | | |
| 4 Within the past five years have you 過往五年內閣下曾否 | | | |
| (a) Had any pension and/or claimed payment for any sickness, accident or injury? 因疾病、意外或受傷而取得賠償或退休金? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (b) Been absent from work because of sickness or injury and need further medical advice, or operation, or hospital treatment during the last six months? 在過去六個月內因疾病或受傷而不能工作並需醫療跟進或接受手術或住院治療? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (c) Participated or do you intend to participate in aviation (in any capacity other than as a passenger), racing, scuba diving, sky diving or other hazardous sports? If "YES", give details including frequency of participation annually and complete "Skin and Scuba Diving Questionnaire". 參與或意欲參與飛行(乘客除外)、賽車、潛水、跳傘或其他危險的運動? 如答「是」者，請詳述並列出每年參加次數及填寫潛水問卷。 | | | <input type="checkbox"/> <input type="checkbox"/> |
| (d) Any condition for which medical consultation or treatment is contemplated or has been advised? 在任何情況下被勸告或準備接受醫生診治? | | | <input type="checkbox"/> <input type="checkbox"/> |
| 5 Have you ever consulted a physician, ever been treated for, or had any known indication of the following disease or disturbance of 閣下曾被醫生診斷或治療下列之病症: | | | |
| (a) The heart such as heart murmur, chest pain, angina, heart disease, hypertension, irregular pulse or heart rhythm, or shortness of breath? 心臟如雜聲、胸痛、心絞痛、心臟病、高血壓、不規則脈搏跳動及氣速? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (b) The respiratory system such as emphysema, asthma, tuberculosis, chronic bronchitis, shortness of breath, chronic obstructive airway disease or other respiratory disorders? 呼吸系統如肺氣腫、哮喘病、肺結核病、慢性支氣管炎、氣速、慢性氣管疾病或其呼吸疾病? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (c) The abdominal organs such as peptic ulcer, colitis or colon disease, bleeding, diverticulitis, gallstones, jaundice, hernia, hemorrhoids, liver or gall bladder disease, or being a Hepatitis B carrier? 腹部器官例如胃潰瘍、腸炎、出血、腸塞、膽石、黃膽症、疝氣、痔瘡、肝或膽的疾病，或已是乙形肝炎帶菌者? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (d) The kidneys, genito-urinary organs such as stones, infections and any other disorders; albumin, sugar, blood or pus in urine? 腎、膀胱、生殖器官如結石、發炎或任何其他疾病；尿中有蛋白質、糖、血液或膿? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (e) The neurological system such as epilepsy, convulsion, migraine, dizziness, paralysis or stroke, mental and/or emotional disorders, impairment of sight or hearing? 神經系統如癲癇、抽搐、偏頭痛、暈眩、癱瘓或中風，精神或與情緒失調，視覺或聽覺障礙? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (f) The endocrine (glandular) system such as diabetes, thyroid, enlarged lymph glands, blood disorders such as anemia, leukemia or other blood disorders, breast disease, allergies and other skin disorders, or congenital disorders? 內分泌(腺體)毛病如糖尿病、甲狀腺或淋巴腺發大，血液毛病如貧血，白血病或其他血液毛病，乳房疾病，皮膚敏感或其他皮膚毛病，或先天的疾病? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (g) The musculo-skeletal system such as trauma or disorders of the muscles, bones, joints, neck spine, or nerves including neuritis, sciatica, rheumatism, arthritis or gout? Amputation, paralysis or deformity? 肌肉及骨骼系統如任何創傷、或肌肉、骨、關節、脊骨神經線包括神經線炎、坐骨神經痛、類風濕症、關節炎或痛風症? 或任何部份切除、癱瘓或殘缺? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (h) Carcinoma (cancer), tumour, or cyst 癌症、腫瘤、或囊腫? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (i) Excessive use of alcohol or drug abuse? 酗酒或濫用藥物? | | | <input type="checkbox"/> <input type="checkbox"/> |
| 6 Have you had any form of sexually transmitted disease, AIDS, AIDS-related complex or AIDS-related conditions? 閣下曾否有任何性病或愛滋病、與愛滋病有關的併發症或狀況? | | | <input type="checkbox"/> <input type="checkbox"/> |
| 7 Have you had test results indicating exposure to the HIV virus? 閣下曾否有檢查報告顯示受愛滋病毒感染? | | | <input type="checkbox"/> <input type="checkbox"/> |
| 8 Within the past five years have you had any: 閣下在過去五年內曾否: | | | |
| (a) Diagnostic tests such as x-ray, ultrasound, electrocardiogram, advance scanning, or blood test? 接受斷証檢查如X光，超音波，心電圖，先進X-ray顯影或血液檢查? | | | <input type="checkbox"/> <input type="checkbox"/> |
| (b) Hospital treatment, surgical operation, medical treatment or observation not mentioned above? 接受住院治療、外科手術、醫科治療或跟進觀察病於以上並未提及? | | | <input type="checkbox"/> <input type="checkbox"/> |
| 9 Have you ever had an application for life or health insurance declined, postponed or modified in any way? Please provide details. 閣下曾否申請人壽或醫療保險而被拒絕或保單須更改或被拒絕續? 請說明之。 | | | <input type="checkbox"/> <input type="checkbox"/> |

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES", PLEASE PROVIDE DETAILS IN THE AREA PROVIDED ON THE REVERSE SIDE OF THIS PAGE. 如在上述任何問題答「是」者，請在背頁詳述之。

(For office use only 公司專用)

Please affix the policy no. here (if applicable)
請在此貼上保單編號(如適用)



| Question No. 問題編號 | Details or Name of Condition Concerned 有關狀況之詳情或名稱 | Treatment Duration 治療日期 | Treatment, Results (Recovery or Remaining Effects) 治療結果(完全康復或後遺影響) | Names and Address of Attending Doctors or Hospitals 主診醫生或醫院之名稱及地址 |
|----------------------|--|----------------------------|--|---|
| | | | | |

C. DECLARATION AND AUTHORIZATION 聲明與授權

It is understood and agreed that

- 1 I have obtained the necessary authorization from my Dependent to supply their information to Manulife if my Dependent is to be covered.
- 2 Information provided herein together with any subsequent alterations or supplements of it ("data") are collected to enable Manulife to carry on its insurance/financial business and may be:
 - i) used by Manulife or its associated companies for the purpose of (a) approving and administering the policy or any alterations, cancellation or renewal of it; (b) underwriting and any claims or analysis of it; (c) statistical or actuarial research of Manulife, Manulife's associated companies or the insurance/financial industry; (d) providing/promoting the insurance or financial related products or services to me through insurance intermediaries or direct marketing; and/or
 - ii) transferred to (a) any related company or other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business or any association or federation of insurance companies that exists or is formed from time to time; (b) any person/organization to fulfill any of the above purposes and/or for the purpose of data verification by way of matching procedures or otherwise.
- 3 By writing to Manulife - Employee Benefits, I can request access to and correction of my personal data (if appropriate), I also understand that consent to the use of my personal information to offer me products and services is optional and if I wish to discontinue such use I may write to Manulife at the address shown below.
- 4 I certify that all information provided by me in this form is complete and true to the best of my knowledge and belief.
- 5 I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my Dependent to provide to Manulife any such information. A photocopy of this authorization shall be as valid as the original.

本人明白並同意下列各項

- 1 本人已向所有受保家屬取得授權(如適用), 可向宏利提供其個人資料。
- 2 本人於本表格內提供之資料及日後作出之任何修訂或補充(「資料」), 旨在確保宏利的保險或金融業務得以順利運作, 而該等資料可供
 - i) 宏利作以下用途: (a) 批核及管理本保單, 或其後進行任何修訂、取消保單或續保事宜; (b) 核保、分析及處理賠償申請; (c) 供宏利、聯營公司或保險/金融業作統計或精算研究用途; (d) 透過保險中介人或直接推廣方式向本人提供/推廣宏利或聯營公司之保險或金融產品資料; 及/或
 - ii) 轉交予(a)任何有關連公司; 其他從事與保險或再保險有關業務之公司; 或保險業中介人、提供理賠、調查或其他保險業相關服務之供應商或現時已存在或日後組成之保險公司聯會或組織; (b)任何人士/機構以作上述用途及/或以配對或其他方法核實資料。
- 3 本人有權以書面通知宏利的僱員福利部, 要求索閱及更改個人資料(如需要)。本人亦可致函要求宏利不要向本人寄發宣傳推廣資料。
- 4 本人謹此證明, 本人於本表格所提供的一切資料為本人所知的全部及為真確無誤。
- 5 本人授權任何醫生、醫學界執業人士、醫院、診所或其他與醫療有關的機構、保險公司或其他組織、機關或人士, 將其所有關於本人及家屬的記錄或健康狀況資料, 提供予宏利。此項授權書的影印本與正本同樣有效。

Date Signed 簽署日期

Signature of Applicant 申請人簽署

Please return the completed form to Manulife (International) Limited, P.O. Box 70302, Kowloon Central Post Office.
請把填妥的表格寄交九龍中央郵政局郵政信箱70302號宏利人壽保險(國際)有限公司。

The Chinese version of this form is for reference only. In the event of discrepancies between the Chinese and English versions, the English version shall prevail.
本表格之中文譯本只供參考用途, 若與英文版本有異, 一概以英文版本為準。