

**Evidence Of Insurability
投保資格證明**

Notes:

- Please complete this form in BLOCK LETTERS and check the boxes where appropriate. Please initial any corrections you make on this form.
- Parents must complete and sign this form on behalf of their children.

注意事項

- 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。
- 父母必須替子女填寫及簽署此表格。

Policy Number 保單編號 <table style="width:100%; border: none;"> <tr> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> <td style="border: none; width: 20px; height: 20px;"> </td> </tr> </table>																					Certificate Number 證書編號 _____
Employer Name (if applicable) 僱主名稱 (如適用) _____																					

A. APPLICANT INFORMATION 申請人資料

(As shown on ID Card 必須與身份證相同)			
Applicant's Full Name (Surname first) 申請人姓名(以姓氏先排)		(in English) 英文	(in Chinese) 中文
Date of Birth 出生日期	Sex 性別	Country of Residence 居住地* (Please complete if not in HK/Macau 若居住在香港 / 澳門，請無須填寫)	ID Card / Passport No. 身份證 / 護照號碼
DD 日 MM 月 YYYY 年			
Occupation / Job Duties* (Please specify % of time spent on manual work, if applicable) 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，如適用)		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 do not provide any information of your occupation/job duties here, it is deemed that you are a clerical staff 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 體高	cm 厘米	Weight 體重	kg 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 smoked cigarettes within the last twelve months? If yes, (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?			3 <input type="checkbox"/> <input type="checkbox"/>
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?					4 (a) <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?					(b) <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 the respective questionnaire. 參與或意欲參與飛行(乘客除外)、賽車、水肺潛水、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有關之問卷。					(c) <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?					(d) <input type="checkbox"/> <input type="checkbox"/>
5	Have you ever had and/or been treated for and/or been told you had and/or had known indication of any of the following disease or disturbance of: 閣下曾否患有及/或被提及患有及/或有徵兆患有以下疾病或機能失調及/或因此接受治療:					
	(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?					5 (a) <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、慢性阻塞性肺病或其他呼吸疾病?					(b) <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，或已是乙型肝炎帶菌者?					(c) <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?					(d) <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，精神及/或情緒失調，視覺或聽覺障礙?					(e) <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?					(f) <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?					(g) <input type="checkbox"/> <input type="checkbox"/>
	(h) Carcinoma (cancer), tumour, or cyst 癌症、腫瘤或囊腫?					(h) <input type="checkbox"/> <input type="checkbox"/>
	(i) Excessive use of alcohol or drug abuse? 酗酒或濫用藥物?					(i) <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?					6 <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?					7 <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?					8 (a) <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?					(b) <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延續? 請說明之。					9 <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。

Question No. 問題編號	Diagnosis/Symptoms details (such as onset date, frequency, last attack date) 診斷 / 病徵詳情 (如病發日期、次數、最近病發日期)	Treatment /Check up details (such as type, date, frequency, last follow up date) 治療 / 檢查詳情 (如種類、日期、次數、最後覆診日期)	Current condition/Check up result (such as recovery degree/complications) 現時情況 / 檢查結果 (如康復程度 / 併發症)	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 聲明及授權

It is understood and agreed that

- I have obtained all necessary authorization from my dependent (if applicable) to supply their information to Manulife if my dependent is to be covered. I also understand that the information requested in this form is required in order for Manulife to process my application. Failure to disclose any material facts or information which may influence or which Manulife would regard as likely to influence the assessment and acceptance of my application, may render voidable by Manulife the insurance coverage that may be issued pursuant to this application. In the event of doubt as to whether a fact or information is material, it should be disclosed in this form.
- Information collected from me and in respect of me and/or my dependent can enable Manulife to carry on its insurance/financial business and may be:
 - 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; and/or
 - 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 regulatory bodies, 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; and/or reinsurance of the policy.

All data processes may involve a transfer of information to places either within or outside the Hong Kong Special Administrative Region.
- By writing to the Privacy Officer of Manulife - Employee Benefits, I can request access to and correction of my personal data (if appropriate).
- All information may be treated by Manulife in the same manner as mentioned in the "Notice to Customers relating to the Personal Data (Privacy) Ordinance (version 20130401-01)" ("Notice") (for Hong Kong Policy)/Manulife Personal Information Collection Statement (version 20150119 M)" (Statement)" (for Macau Policy). In case I have not read the Notice/Statement before, I can obtain such Notice/Statement from my Manulife's intermediary or through Manulife's website at www.manulife.com.hk.
- I certify that all information provided by me in this form is complete and true to the best of my knowledge and belief.
- 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. Such authorization shall survive me and shall be irrevocable. A photocopy of this authorization shall be as valid as the original.
- I undertake that if there is any change in the information provided, I shall notify Manulife as soon as reasonably practicable. I also undertake to supply additional information in respect of me to Manulife upon request for the purpose of complying with the Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance (for Hong Kong policy)/Guidelines on Prevention and Combating Money Laundering and Financing of Terrorism in Insurance (for Macau policy).

本人明白並同意下列各項

- 本人已向所有受保家屬取得授權 (如適用), 可向宏利提供其資料。本人亦明白本表格內提供的資料是讓宏利作處理本人的申請之用。如未有披露任何重要事實或資料, 而該等重要事實或資料足以影響宏利評估及接受本人的申請, 宏利有權將所簽發的保險宣告無效。假如未能確定事實或資料重要性, 則須於本表格披露該等事實或資料。
- 從本人收集及關於本人及/或受保家屬的資料, 旨在確保宏利的保險業務得以順利運作, 而該等資料可供:
 - 宏利或其聯營公司作以下用途: (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; 及/或
 - 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監管機構、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; 與及安排再保險。

所有資料處理過程或會涉及資料移轉至香港特別行政區及以外地區。
- 本人有權以書面通知宏利僱員福利部之個人資料主任, 要求索閱及更改個人資料 (如需要)。
- 宏利可按於《有關〈個人資料 (私隱) 條例〉的客戶通知 (20130401-01 版本)》(通知) - (適用於香港保單) / 宏利個人資料收集聲明 (20150119 M 版本)》(聲明) - (適用於澳門保單) 所述, 處理有關資料。假如本人未有細閱該通知 / 聲明, 本人可從本人的宏利中介人或透過宏利網址 www.manulife.com.hk 取得該通知 / 聲明。
- 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真確無誤。
- 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受保家屬的記錄或健康狀況資料, 提供予宏利。此授權書是不可撤銷的, 即使本人去世, 此授權仍然生效。此授權書的影印本將與正本同樣有效。
- 本人承諾假使所提供的資料有任何更改, 本人將於合理的切實可行範圍內盡快通知宏利有關之改動。本人並承諾會因應宏利的要求提供本人的附加資料以遵守《打擊洗錢及恐怖分子資金籌集 (金融機構) 條例》(適用於香港保單) / 《保險業務防止及打擊洗黑錢及恐怖主義融資活動指引》(適用於澳門保單)。

Date Signed 簽署日期 (DD日/MM月/YYYY年)

Signature of Employee/Applicant 僱員/申請人簽署

Please return the completed form to 請把填妥的表格寄交:

For Hong Kong Policy - Employee Benefits, Manulife (International) Limited, P.O. Box 70302, Kowloon Central Post Office.
For Macau Policy - Manulife (International) Limited, Macau Administration Office, Avenida De Almeida Ribeiro No. 61, Circle Square, 14 andar A, Macau.
香港保單 - 九龍中央郵局, 郵政信箱70302號宏利人壽保險 (國際) 有限公司僱員福利部
澳門保單 - 澳門新馬路61號永光廣場14樓A宏利人壽保險 (國際) 有限公司, 澳門分行行政部

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。