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SUPPLEMENTARY QUESTIONNAIRES
補充問卷

LIFESTYLE SUPPLEMENTARY QUESTIONNAIRES
生活方式補充問卷

These can be used alongside the Application Form for Proposed Insured completion of known activities that require additional declaration:
準受保人可填寫下列補充問卷連同申請書一併遞交，以便對已申報的活動資料作額外聲明：

- AVIAQU | Aviation
  飛行問卷 | 飛行
- AVOQU | General Hazardous Pursuits
  一般風險活動問卷 | 一般風險活動
- DIVQU | Diving
  潛水問卷 | 潛水
- MOUNQU | Mountaineering
  攀山問卷 | 攀山

MEDICAL SUPPLEMENTARY QUESTIONNAIRES
健康狀況補充問卷

These can be used in a variety of ways:
補充問卷可作多種用途：

- alongside the Application Form for Proposed Insured completion of known medical conditions;
  連同申請書一併使用，供準受保人填寫已知的健康狀況；
- part of the reflex medical assessment handling;
  作為相應的健康評估的一部分；
- requested by the underwriter as part of additional disclosure requests; or
  根據核保師要求作為披露額外資料的一部分；或
- part of the APS process completed by the attending doctor.
  作為主診醫生填寫醫療報告之用。

This document contains supplementary questionnaires on the following:
此文件包括以下之補充問卷：

- BPQU | Blood Pressure
  血壓問卷 | 血壓
- DMQU | Diabetes
  糖尿病問卷 | 糖尿病
- GAQU | Gastric Disorders
  胃病問卷 | 胃病
- GMCQU | General Medical Condition
  一般狀況問卷 | 一般健康狀況
- GYNAEQU | Gynaecological Disorders
  婦科疾病問卷 | 婦科疾病
- MENQU | Mental/Anxiety/Depression
  心理及精神健康問卷 | 精神科疾病/ 焦慮症/ 抑鬱症
- RESPQU | Respiratory Disorders
  呼吸系統疾病問卷 | 呼吸系統疾病
- TUMQU | Tumours
  腫瘤問卷 | 腫瘤

TLB 022HKB SUPQ 1013

LIFESTYLE SUPPLEMENTARY QUESTIONNAIRES
生活方式補充問卷

Aviation
飛行

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy日/月/年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證/護照號碼	

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1. When and where did you learn to fly, and what flying qualifications do you hold?
閣下於何時及哪裏學習駕駛飛機？持有哪種飛行執照？

2. On average, how many hours per annum do you fly? 每年平均飛行多少小時？

3. When did you last fly? 上次駕駛飛機是何時？

4. Please confirm the type of aircraft that you fly, including details of the engine size: 請詳細列出閣下駕駛飛機的種類，包括引擎大小:

5. Do you fly for employment purposes? If so please provide details of the flying activities:
閣下是否因職業需要駕駛飛機？如是，請提供飛行活動詳情：

6. Do you fly for pleasure only? If so please provide details: 閣下駕駛飛機是否純作消閒？如是，請詳述：

7. Do you take part in competitions or displays? If so how many events do you take part in per annum?
閣下會否參加飛行比賽或飛行表演？如是，每年參加多少項賽事或表演？

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Authorised Signatures 授權簽署

Signature of the **Proposed Insured** **準受保人**簽署	Signature of **Witness** to Proposed Insured 準受保人之**見證人**簽署
X	X

Date 日期	(dd/mm/yyyy日/月/年)	Place 地點	Country國家	Name 姓名			
				Date 日期	(dd/mm/yyyy日/月/年)	Place 地點	Country國家

TLB 022HKB SUPQ 1013

LIFESTYLE SUPPLEMENTARY QUESTIONNAIRES
生活方式補充問卷

General Hazardous Pursuits
一般風險活動

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy 日/ 月/ 年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證/護照號碼	

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1. Please provide the details concerning any hazardous pursuits or pastimes that you follow, including but not limited to, caving, potholing, skydiving, parachuting, canoeing, rafting, etc.? Please provide details.
   請列出閣下參與任何風險活動或娛樂活動之詳情，包括（但不限於）洞穴探險、跳傘、獨木舟或激流等。

2. Do you take part in this activity on an amateur or a professional basis? 閣下以業餘還是職業身份參與此活動？

3. Do you participate in this activity only for pleasure, e.g. on holiday, and not for financial reward? Please provide details.
   閣下參與此活動是否僅為消閒（如度假）而非因金錢回報？請詳述。

4. Do you plan any record attempts, test or stunt flying? Please provide details. 閣下會否計劃嘗試創新紀錄、試驗活動或特技飛行？請詳述。

5. Do you participate in any form of competitions? Please provide details. 閣下會否參加任何形式的比賽？請詳述。

6. Do you always wear the required safety and/or protective clothing? 閣下是否於活動期間穿著活動所需的安全及/ 或保護裝束？

7. Please provide full details including how often you take part in this activity. 請提供詳情，包括參與此活動的頻密次數。

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X	X

Date 日期	(dd/mm/yyyy 日/ 月/ 年)	Place 地點	Country 國家	Name 姓名			
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TLB 022HKB SUPQ 1013

LIFESTYLE SUPPLEMENTARY QUESTIONNAIRES
生活方式補充問卷

Diving
潛水

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy 日/ 月/ 年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證 / 護照號碼	

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1. When did you learn to dive and what diving qualifications, if any, do you hold? 閣下已學習潛水多久？持有哪種潛水證書（如有）？

2. How frequently do you dive and when did you last dive? 閣下大概多久潛水一次？上一次潛水於何時？

3. Please confirm the average depth dived and the maximum depth that you have or intend to dive to:
請詳細列明閣下通常的潛水深度，以及曾經或計劃潛水最深極限。

4. Do you always use equipment that has been properly maintained and serviced, and checked before each dive? If you use a dive computer do you always dive within the safe limits that your computer allows? Please provide details.
閣下潛水時會使用妥善保養的設備嗎？每次潛水前會檢查設備嗎？如使用潛水儀錶，閣下會依照錶上所示安全深度潛水嗎？請詳述。

5. Do you dive for employment purposes? If so please detail diving activities, including details of any use of explosives and the location of dives (i.e. deep sea, coastal waters, lakes and rivers).
閣下是否因職業需要潛水？如是，請提供潛水活動詳情，包括有否使用爆炸品及潛水地點（如深海、近岸海域、湖泊及河流）。

6. Do you dive for pleasure only? If so please provide details of the country and location of dives:
閣下潛水是否僅為消閒？如是，請詳述潛水的國家及地點：

7. Do you dive alone or always in a group? 閣下獨自或是結伴潛水？

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X				X			
Date 日期	(dd/mm/yyyy 日/ 月/ 年)	Place 地點	Country 國家	Name 姓名			
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TLB 022HKB SUPQ 1013

LIFESTYLE SUPPLEMENTARY QUESTIONNAIRES
生活方式補充問卷

Mountaineering
攀山

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy 日/ 月/ 年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證 / 護照號碼	

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1. Do you participate in mountain climbing with or without safety equipment? Please provide details.
   進行攀山活動時閣下是否佩戴安全裝備？請詳述。

2. How frequently do you climb and when did you last climb?
   閣下大概多久攀山一次？上一次攀山於何時？

3. Please confirm where you climb and heights that you climb to:
   請詳細列明攀山地點及攀登高度：

4. Are you a member of mountaineering or climbing association(s)? Please provide details.
   閣下是不是攀山或攀登協會會員？請詳述。

5. Do you climb for pleasure only? If not, please provide details of your climbing activities.
   閣下攀山是否僅為消閒？如否，請提供攀山活動詳情。

6. Do you climb alone or as a group? Please provide details.
   閣下獨自或是結伴攀山？請詳述。

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Signature of the **Proposed Insured** 準受保人簽署				Signature of **Witness** to Proposed Insured 準受保人之**見證人**簽署			
X				X			
Date 日期	(dd/mm/yyyy 日/ 月/ 年)	Place 地點	Country 國家	Name 姓名			
				Date 日期	(dd/mm/yyyy 日/ 月/ 年)	Place 地點	Country 國家

TLB 022HKB SUPQ 1013

MEDICAL SUPPLEMENTARY QUESTIONNAIRES
健康狀況補充問卷

High Blood Pressure
高血壓

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy 日/ 月/ 年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證/護照號碼	

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1. When was the diagnosis first made and what were your blood pressure readings at that time?
   閣下何時確診患上高血壓？當時的血壓讀數是多少？

2. Do you know what your current blood pressure readings are? If so, please provide details:
   閣下知道最近一次的血壓嗎？如知道，請註明：

3. Please provide details of your treatment, including names of medication, dosage and frequency of dosage:
   請提供治療詳情，包括藥物名稱、劑量及服食次數：

   i) currently 現時 _____

   ii) in the past 過往 _____

4. Have you required more than 5 consecutive days off work, or have any limitation to your daily activities in any way due to your medical condition? If so please provide dates and duration:
   閣下曾否因高血壓而需要連續休假五日以上，或日常生活因此受限制？如有，請註明休假日期及日數：

5. Have you had any x-rays, tests or other investigations for this condition? If so, please provide details, including dates and results. Please attach a copy of the medical report(s) with this questionnaire if available.
   閣下曾否因此症狀而接受任何X光檢查、測試或其他檢查？如有，請詳述（包括日期及結果），並附上醫療報告副本（如有）。

6. Have tests on your urine always been normal? If not, please provide details.
   閣下的尿液測試結果是否正常？如不正常，請詳述。

7. Do you have any other medical condition (e.g. kidney or heart disorders, raised cholesterol/lipids)? If so please provide details:
   閣下有其他症狀嗎（如腎病、心臟疾病、高膽固醇/ 血脂）？如有，請詳述：

8. Do you currently smoke? If yes, how many cigarettes/cigars per day?
閣下現時是否吸煙？如有，每日吸多少支煙／雪茄？

9. Please provide the name and address of your current treating doctor and/or Hospital if different from above, including any alternative therapy practitioners:
請提供現時主診醫生及／或醫院（如與上述不同）的名稱及地址，包括其他治療師：

State your last follow-up date上次覆診日期：⌊ ⌋（dd/mm/yyyy日/月/年）

Next follow-up date下次覆診日期：⌊ ⌋（dd/mm/yyyy日/月/年）

If discharged from any follow-up, please confirm the discharge date
如無需覆診，請列明最近一次覆診日期：⌊ ⌋（dd/mm/yyyy日/月/年）

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Authorised Signatures授權簽署

Signature of the **Proposed Insured** 準受保人簽署				Signature by **Attending Doctor** (if applicable) **主診醫生**簽署（如適用）	
X				X	
Date 日期	⌊ ⌋ (dd/mm/yyyy日/月/年)	Place 地點	Country國家	Date 日期	⌊ ⌋ (dd/mm/yyyy日/月/年)

Signature of **Witness** to Proposed Insured 準受保人之**見證人**簽署			
X			
Name 姓名			
Date 日期	⌊ ⌋ (dd/mm/yyyy日/月/年)	Place 地點	Country國家

MEDICAL SUPPLEMENTARY QUESTIONNAIRES
健康狀況補充問卷

Diabetes
糖尿病

☑ Select the box that applies
請選擇合適空格

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy日/月/年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
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1. Please confirm exact diagnosis:
   閣下確診患上：

☐ Insulin Dependent/Type I
胰島素依賴型糖尿病/一型糖尿病

☐ Non-Insulin Dependent/Type II
非胰島素依賴型糖尿病/二型糖尿病

☐ Impaired Glucose Tolerance
血糖耐量異常

2. When was the diagnosis first made?
   首次確診為何時？

3. What type of treatment are you currently taking?
   閣下正接受哪一種治療？

- Oral medication (state name medication and dosage)
  口服藥物（請列明藥物名稱及劑量）_____
- Insulin (state type if insulin and dosage)
  胰島素（請列明胰島素類型及劑量）_____
- Diet control
  控制飲食 _____

4. Diabetic follow-up consultations. Please provide the following details:
   請提供以下覆診詳情：

- Name of Doctor醫生姓名 _____
- Frequency of follow up覆診次數 _____
- Result of laboratory test (if known)化驗測試結果（如已知）_____

Fasting sugar空腹血糖 _____ Date日期 (dd/mm/yyyy日/月/年)

HbA1c糖化血紅素 _____ Date日期 (dd/mm/yyyy日/月/年)

Lipids血脂 _____ Date日期 (dd/mm/yyyy日/月/年)

Urine尿液 - Sugar帶糖 _____ Protein帶蛋白 _____ Blood帶血 _____

Date日期 (dd/mm/yyyy日/月/年)

5. Do you currently suffer from any of the following symptoms:
閣下現時是否有以下症狀：

- ☐ Heart disease心臟病
- ☐ Protein / Blood in the urine蛋白尿／血尿
- ☐ Numbness of hands and/or feet手及／或足痲痺
- ☐ Stroke中風
- ☐ Skin ulceration皮膚潰瘍
- ☐ Eye problems (other than short and long sightedness)眼疾（近視及遠視除外）

6. Have you ever been admitted at a hospital, clinic, sanatorium, or other medical institution for this condition? Or, is any in-patient treatment planned? If so please provide full details including the name of the hospital and consulting physician/ consultant.
閣下曾否因此症狀而住院、前往診所、入住療養院或其他醫療機構？閣下是否計劃接受任何住院治療？如有，請詳述（包括醫院名稱及主診醫生／醫生的姓名）。

7. Do you suffer from any other medical condition not already disclosed? If yes, please provide details.
閣下是否還有其他未申報的症狀？如有，請詳述：

I/We hereby declare that the above statements are true and complete and agree that this supplementary statement together with the Application Form dated ⌊ ⌋ (dd/mm/yyyy) shall be the basis of the contract between me/us and TLB.

本人／吾等謹此聲明上述陳述為準確完整，並同意此補充陳述及於 ⌊ ⌋（日／月／年）簽署的投保申請書將會成為本人／吾等與全美人壽百慕達簽訂合約之依據。

Authorised Signatures授權簽署

Signature of the **Proposed Insured** 準受保人簽署				Signature by **Attending Doctor** (if applicable) 主診醫生簽署（如適用）	
X				X	
Date 日期	⌊ ⌋ (dd/mm/yyyy日／月／年)	Place 地點	Country國家	Date 日期	⌊ ⌋ (dd/mm/yyyy日／月／年)

Signature of **Witness** to Proposed Insured 準受保人之**見證人**簽署			
X			
Name 姓名			
Date 日期	⌊ ⌋ (dd/mm/yyyy日／月／年)	Place 地點	Country國家

MEDICAL SUPPLEMENTARY QUESTIONNAIRES
健康狀況補充問卷

Gastric Disorders
胃病

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy 日/ 月/ 年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證/護照號碼	

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1. Please provide details of the exact diagnosis, if known:
   請提供疾病的明確診斷（如已知）：

2. When was the diagnosis first made?
   首次確診日期？

3. Please state the nature and frequency of your symptom(s). If fully recovered, please state date of recovery.
   請列明症狀性質及發病次數。如已痊癒，請列明痊癒日期。

4. Have you had any x-rays, tests or other investigations for this condition? If so, please provide details, including dates and results. Please attach a copy of the medical report(s) with this questionnaire if available.
   閣下曾否因此症狀而接受任何X光檢查、測試或其他檢查？如有，請詳述（包括日期及結果），並附上醫療報告副本（如有）。

5. Please provide details of your treatment, including names of medication, dosage and frequency of dosage:
請提供治療詳情，包括藥物名稱、劑量及服食次數：

i) currently 現時 _____

ii) in the past 過往 _____

I/We hereby declare that the above statements are true and complete and agree that this supplementary statement together with the Application Form dated |_|_|_|_|_|_|_|_| (dd/mm/yyyy) shall be the basis of the contract between me/us and TLB.

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Authorised Signatures 授權簽署

Signature of the **Proposed Insured** 準受保人簽署				Signature by **Attending Doctor** (if applicable) 主診醫生簽署（如適用）	
X				X	
Date 日期	(dd/mm/yyyy 日／月／年)	Place 地點	Country 國家	Date 日期	(dd/mm/yyyy 日／月／年)

Signature of **Witness** to Proposed Insured 準受保人之**見證人**簽署			
X			
Name 姓名			
Date 日期	(dd/mm/yyyy 日／月／年)	Place 地點	Country 國家

MEDICAL SUPPLEMENTARY QUESTIONNAIRES
健康狀況補充問卷

General Medical Conditions
一般症狀

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy日/月/年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證/護照號碼	

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1. Please provide details of the exact diagnosis, if known:
   請提供疾病的明確診斷（如已知）：

2. When was the diagnosis first made?
   首次確診日期？

3. Do you still have symptoms? If symptoms are current, please provide details, including the frequency, severity and any limitation to your daily activities in any way:
   閣下現時是否仍有有關病徵？如有，請詳述，包括發病次數、嚴重程度及對日常活動的任何影響：

4. When did you experience your last symptoms?
   最近一次發病日期？

5. Please provide details of your treatment, including names of medication, dosage and frequency of dosage:
   請提供治療詳情，包括藥物名稱、劑量及服食次數：

   i) currently現時 _____

   ii) in the past過往 _____

6. Have you required more than 5 consecutive days off work due to your medical condition? If so, please provide dates and duration.
   閣下曾否因此症狀而需要連續休假五日以上？如有，請註明休假日期及日數。

7. Have you had any x-rays, tests or other investigations for this condition? If so, please provide details, including dates and results. Please attach a copy of the medical report(s) with this questionnaire if available.
   閣下曾否因此症狀而接受任何X光檢查、測試或其他檢查？如有，請詳述（包括日期及結果），並附上醫療報告副本（如有）。

8. Have you ever been admitted at a hospital, clinic, sanatorium, or other medical institution for this condition? Or, is any in-patient treatment planned? If so, please provide full details including the name of the hospital and consulting physician/consultant.
   閣下曾否因此症狀而住院、前往診所、入住療養院或其他醫療機構？閣下是否計劃接受任何住院治療？如有，請詳述（包括醫院名稱及主診醫生/醫生的姓名）。

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9. Please provide the name and address of your current treating doctor and/or Hospital if different from above, including any alternative therapy practitioners:
請提供現時主診醫生及/或醫院(如與上述不同)的名稱及地址,包括任何其他治療師:

State your last follow-up date上次覆診日期: ⌊ ⌋ (dd/mm/yyyy日/月/年)

Next follow-up date下次覆診日期: ⌊ ⌋ (dd/mm/yyyy日/月/年)

If discharged from any follow-up, please confirm the discharge date
如無需覆診,請列明最近一次覆診日期: ⌊ ⌋ (dd/mm/yyyy日/月/年)

I/We hereby declare that the above statements are true and complete and agree that this supplementary statement together with the Application Form dated ⌊ ⌋ (dd/mm/yyyy) shall be the basis of the contract between me/us and TLB.

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Authorised Signatures授權簽署

Signature of the **Proposed Insured** 準受保人簽署				Signature by **Attending Doctor** (if applicable) 主診醫生簽署(如適用)	
X				X	
Date 日期	⌊ ⌋ (dd/mm/yyyy日/月/年)	Place 地點	Country國家	Date 日期	⌊ ⌋ (dd/mm/yyyy日/月/年)

Signature of **Witness** to Proposed Insured 準受保人之**見證人**簽署			
X			
Name 姓名			
Date 日期	⌊ ⌋ (dd/mm/yyyy日/月/年)	Place 地點	Country國家

MEDICAL SUPPLEMENTARY QUESTIONNAIRES
健康狀況補充問卷

Gynaecological Disorders
婦科疾病

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy 日/ 月/ 年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證/護照號碼	

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1. Do you have any gynaecological problems or still have symptoms? If so, please provide details, including the exact diagnosis, frequency, severity and any limitation to your daily activities in any way:
閣下過去或現時是否患有任何婦科疾病？如有，請詳述，包括確實診斷、發病次數、嚴重程度及對日常活動的任何影響：

2. When did you experience your last symptoms?
最近一次發病日期？

3. Please provide details of your treatment, including names of medication, dosage and frequency of dosage:
請提供治療詳情，包括藥物名稱、劑量及服食次數：

   i) currently 現時 _____

   ii) in the past 過往 _____

4. Have you required more than 5 consecutive days off work due to your medical condition? If so, please provide dates and duration.
閣下曾否因此症狀而需要連續休假五日以上？如有，請註明休假日期及日數。

5. Have you had any x-rays, tests or other investigations for this condition? If so, please provide details, including dates and results. Please attach a copy of the medical report(s) with this questionnaire if available.
閣下曾否因此症狀而接受任何X光檢查、測試或其他檢查？如有，請詳述（包括日期及結果），並附上醫療報告副本（如有）。

6. Have you had any surgery for this condition? Or, is any surgery planned? If so, please provide full details including the name of the hospital and consulting physician/ consultant.
閣下曾否因此症狀接受任何手術或計劃接受任何手術？如有，請詳述（包括醫院名稱及主診醫生/ 醫生的姓名）。

7. Please provide the name and address of your current treating doctor and/or Hospital if different from above, including any alternative therapy practitioners:
請提供現時主診醫生及／或醫院（如與上述不同）的名稱及地址，包括任何其他治療師：

State your last follow-up date 上次覆診日期：⌊ ⌋ (dd/mm/yyyy 日／月／年)

Next follow-up date 下次覆診日期：⌊ ⌋ (dd/mm/yyyy 日／月／年)

If discharged from any follow-up, please confirm the discharge date
如無需覆診，請列明最近一次覆診日期：⌊ ⌋ (dd/mm/yyyy 日／月／年)

I/We hereby declare that the above statements are true and complete and agree that this supplementary statement together with the Application Form dated ⌊ ⌋ (dd/mm/yyyy) shall be the basis of the contract between me/us and TLB.

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Authorised Signatures 授權簽署

Signature of the **Proposed Insured** 準受保人簽署				Signature by **Attending Doctor** (if applicable) 主診醫生簽署（如適用）	
X				X	
Date 日期	(dd/mm/yyyy 日／月／年)	Place 地點	Country 國家	Date 日期	(dd/mm/yyyy 日／月／年)

Signature of **Witness** to Proposed Insured 準受保人之**見證人**簽署			
X			
Name 姓名			
Date 日期	(dd/mm/yyyy 日／月／年)	Place 地點	Country 國家

MEDICAL SUPPLEMENTARY QUESTIONNAIRES
健康狀況補充問卷

Mental/Anxiety/Depression
精神科疾病/焦慮症/抑鬱症

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy 日/月/年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證/護照號碼	

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1. Please provide details of the exact diagnosis, if known:
   請提供疾病的明確診斷（如已知）：

2. When was the diagnosis first made?
   首次確診日期？

3. Do you still have symptoms? If symptoms are current, please provide details, including the frequency, severity and any limitation to your daily activities in any way:
   閣下現時是否仍有有關病徵？如有，請詳述，包括發病次數、嚴重程度及對日常活動的任何影響：

4. When did you experience your last symptoms?
   最近一次發病日期？

5. Please provide details of your treatment, including names of medication, dosage and frequency of dosage:
   請提供治療詳情，包括藥物名稱、劑量及服食次數：

   i) currently 現時 _____

   ii) in the past 過往 _____

6. Have you required more than 5 consecutive days off work due to your medical condition? If so, please provide dates and duration:
   閣下曾否因此症狀而需要連續休假五日以上？如有，請註明休假日期及日數。

7. Have you had ever had treatment as a hospital out-patient or seen a psychiatrist or other specialist for this condition? If so, please provide details, including dates and results. Please attach a copy of the medical report(s) with this questionnaire if available.
   閣下曾否因此症狀到醫院門診求診或向精神科醫生或其他專科醫生求診？如有，請詳述（包括日期及結果），並附上醫療報告副本（如有）。

8. Have you ever been an in-patient or day-patient at a hospital, clinic, sanatorium, or other medical institution for this condition? Or, is any in-patient or day-patient treatment planned? If so please provide full details including the name of the hospital and consulting physician/consultant
   閣下曾否因此症狀於醫院、診所、療養院或其他醫療機構接受住院或日間治療？閣下是否有計劃入院接受治療或接受日間治療？如有，請詳述（包括醫院名稱及主診醫生/醫生的姓名）。

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9. Are you aware of any trigger or underlying cause of your medical condition? If yes, please provide details:
閣下是否知道發病原因或誘因?如知道，請詳述:

10. Have you ever tried to take your own life? If yes, please provide details:
閣下曾否試圖自殺?如有，請詳述:

11. Please provide the name and address of your current treating doctor and/or Hospital if different from above, including any alternative therapy practitioners:
請提供現時主診醫生及/或醫院(如與上述不同)的名稱及地址，包括任何其他治療師:

State your last follow-up date 上次覆診日期: |_|_|_|_|_|_|_|_| (dd/mm/yyyy 日/月/年)

Next follow-up date 下次覆診日期: |_|_|_|_|_|_|_|_| (dd/mm/yyyy 日/月/年)

If discharged from any follow-up, please confirm the discharge date
如無需覆診，請列明最近一次覆診日期: |_|_|_|_|_|_|_|_| (dd/mm/yyyy 日/月/年)

Please use the space below to provide us with any additional information you feel may be relevant in helping us with your application assessment:
請於以下空白位置提供閣下認為可能相關的任何額外資料，以協助我們評估閣下的申請:

I/We hereby declare that the above statements are true and complete and agree that this supplementary statement together with the Application Form dated |_|_|_|_|_|_|_|_| (dd/mm/yyyy) shall be the basis of the contract between me/us and TLB.

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Authorised Signatures 授權簽署

Signature of the **Proposed Insured** 準受保人簽署				Signature by **Attending Doctor** (if applicable) 主診醫生簽署(如適用)	
X				X	
Date 日期	(dd/mm/yyyy 日/月/年)	Place 地點	Country 國家	Date 日期	(dd/mm/yyyy 日/月/年)

Signature of **Witness** to Proposed Insured 準受保人之**見證人**簽署			
X			
Name 姓名			
Date 日期	(dd/mm/yyyy 日/月/年)	Place 地點	Country 國家

MEDICAL SUPPLEMENTARY QUESTIONNAIRES
健康狀況補充問卷

Respiratory Disorders
呼吸系統疾病

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy 日/ 月/ 年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證/護照號碼	

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1. Please provide details of the exact diagnosis, if known:
   請提供疾病的明確診斷（如已知）：

2. When was the diagnosis first made?
   首次確診日期？

3. Do you still have symptoms? If symptoms are current, please provide details, including the frequency, severity and any limitation to your daily activities in any way:
   閣下現時是否仍有有關病徵？如有，請詳述，包括發病次數、嚴重程度及對日常活動構成任何影響：

4. When did you experience your last symptoms?
   最近一次發病日期？

5. Please provide details of your treatment, including any steroids. Please confirm names of medication, dosage and frequency of dosage:
   請提供治療詳情，包括有否使用類固醇。請列明藥物名稱、劑量及服食次數：

   i) currently 現時 _____

   ii) in the past 過往 _____

6. Have you required more than 5 consecutive days off work due to your medical condition? If so, please provide dates and duration.
   閣下曾否因此症狀而需要連續休假五日以上？如有，請註明休假日期及日數。

7. Have you had any x-rays, tests or other investigations for this condition? If so, please provide details, including dates and results. Please attach a copy of the medical report(s) with this questionnaire if available.
   閣下曾否因此症狀而接受任何X光檢查、測試或其他檢查？如有，請詳述（包括日期及結果），並附上醫療報告副本（如有）。

8. Have you ever been admitted as an emergency at a hospital, clinic, sanatorium, or other medical institution for this condition? Or, is any in-patient treatment planned? If so please provide full details including the name of the hospital and consulting physician/consultant.
   閣下曾否因此症狀被緊急送往醫院、診所、療養院或其他醫療機構？閣下是否計劃接受任何住院治療？如有，請詳述(包括醫院名稱及主診醫生/ 醫生的姓名)。

TLB 022HKB SUPQ 1013

9. Are you aware of any trigger or underlying cause of your medical condition (e.g. stress, exercise, and allergy)? If yes, please provide details:
閣下是否知道發病原因或誘因嗎（如壓力、運動及過敏）？如知道，請詳述：

10. Do you monitor your respiratory function? If yes, please provide details of the last three months lowest and highest readings:
閣下有否監察自己的呼吸系統功能？如有，請提供過去三個月的最低及最高讀數：

11. Please provide the name and address of your current treating doctor and/or Hospital if different from above, including any alternative therapy practitioners:
請提供現時主診醫生及／或醫院（如與上述不同）的名稱及地址，包括任何其他治療師：

State your last follow-up date上次覆診日期：|_|_|_|_|_|_|_|_| (dd/mm/yyyy日/月/年)

Next follow-up date下次覆診日期：|_|_|_|_|_|_|_|_| (dd/mm/yyyy日/月/年)

If discharged from any follow-up, please confirm the discharge date
如無需覆診，請列明最近一次覆診日期：|_|_|_|_|_|_|_|_| (dd/mm/yyyy日/月/年)

Please use the space below to provide us with any additional information you feel may be relevant in helping us with your application assessment:
請於以下空白位置提供閣下認為可能相關的任何額外資料，以協助我們評估閣下的申請：

I/We hereby declare that the above statements are true and complete and agree that this supplementary statement together with the Application Form dated |_|_|_|_|_|_|_|_| (dd/mm/yyyy) shall be the basis of the contract between me/us and TLB.

本人／吾等謹此聲明上述陳述為準確完整，並同意此補充陳述及於 |_|_|_|_|_|_|_|_| (日/月/年)簽署的投保申請書將會成為本人／吾等與全美人壽百慕達簽訂合約之依據。

Authorised Signatures授權簽署

Signature of the **Proposed Insured** 準受保人簽署				Signature by **Attending Doctor** (if applicable) 主診醫生簽署（如適用）	
X				X	
Date 日期	(dd/mm/yyyy日/月/年)	Place 地點	Country國家	Date 日期	(dd/mm/yyyy日/月/年)

Signature of **Witness** to Proposed Insured 準受保人之**見證人**簽署			
X			
Name 姓名			
Date 日期	(dd/mm/yyyy日/月/年)	Place 地點	Country國家

MEDICAL SUPPLEMENTARY QUESTIONNAIRES
健康狀況補充問卷

Tumours
腫瘤

Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/yyyy 日/ 月/ 年)		
Producer Name 營業員姓名		Producer ID 營業員編號	
Policy Number 保單編號		ID/Passport Number 身份證/護照號碼	

Please complete in BLOCK CAPITALS and ensure that your answers are true and complete. Failure to disclose all material facts may lead to cancellation of the insurance cover and/or non-acceptance of future claims. A material fact is one which is likely to influence the assessment or acceptance of this Application. If you are in any doubt whether a fact is material, it should be disclosed.

請以**正楷**填寫，並確保答案準確完整。任何漏報或誤報重要事實或會構成保險保障無效及/ 或索償被拒。重要事實指可能影響評估或接納此申請的事項。如未能確定事實是否重要，應先予以披露。

1. Please provide the date and details of the exact diagnosis, if known. **Please attach a copy of the pathology medical report(s) with this questionnaire if available:**
   請提供確診日期、診斷詳情（如已知）。**請附上病理報告（如有）：**

2. When and in what part of the body was the tumour, growth, cyst or lump first discovered?
   於何時及哪個部位首次發現腫瘤、增生、囊腫或腫塊？

3. Have you had any x-rays, tests or other investigations for this condition? If so, please provide details, including dates and results. Please attach a copy of the medical report(s) with this questionnaire if available.
   閣下曾否因此症狀而接受任何X光檢查、測試或其他檢查？如有，請詳述（包括日期及結果），並附上醫療報告副本（如有）。

4. Have you had the tumour removed and any surgery for this condition? Or, is any surgery planned? If so, please provide full details including the name of the hospital and consulting physician/consultant.
   閣下是否已切除腫瘤？閣下曾否因此症狀接受任何手術或計劃接受任何手術？如有，請詳述（包括醫院名稱及主診醫生/ 醫生的姓名）。

5. Please provide details of your treatment, including names of medication, dosage and frequency of dosage. For any cancer medication, chemotherapy, radiotherapy and please specify the dates of commencement and completion of such treatment:
   請提供治療詳情，包括藥物名稱、劑量及服食次數。如曾接受任何癌症藥物治療、化療或放射治療，請列明療程開始及完成日期。

   i) currently 現時 _____

   ii) in the past 過往 _____

6. Do you have any current symptoms? If so, please provide details, including the frequency, severity and any limitation to your daily activities in any way:
   現時仍患有病徵嗎？如有，請詳述，包括發病次數、嚴重程度及對日常活動構成任何影響：

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7. Please provide the name and address of your current treating doctor and/or Hospital if different from above, including any alternative therapy practitioners:
請提供現時主診醫生及／或醫院（如與上述不同）的名稱及地址，包括任何其他治療師：

State your last follow-up date 上次覆診日期：｜｜｜｜｜｜｜｜｜｜（dd/mm/yyyy 日／月／年）

Next follow-up date 下次覆診日期：｜｜｜｜｜｜｜｜｜｜（dd/mm/yyyy 日／月／年）

If discharged from any follow-up, please confirm the discharge date
如無需覆診，請列明最近一次覆診日期：｜｜｜｜｜｜｜｜｜｜（dd/mm/yyyy 日／月／年）

I/We hereby declare that the above statements are true and complete and agree that this supplementary statement together with the Application Form dated ｜｜｜｜｜｜｜｜｜｜ (dd/mm/yyyy) shall be the basis of the contract between me/us and TLB.

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Authorised Signatures 授權簽署

Signature of the **Proposed Insured** 準受保人簽署				Signature by **Attending Doctor** (if applicable) 主診醫生簽署（如適用）	
X				X	
Date 日期	｜｜｜｜｜｜｜｜｜｜ (dd/mm/yyyy 日／月／年)	Place 地點	Country 國家	Date 日期	｜｜｜｜｜｜｜｜｜｜ (dd/mm/yyyy 日／月／年)

Signature of **Witness** to Proposed Insured 準受保人之**見證人**簽署			
X			
Name 姓名			
Date 日期	｜｜｜｜｜｜｜｜｜｜ (dd/mm/yyyy 日／月／年)	Place 地點	Country 國家

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