



Unit 8E Golden Sun Centre 223 Wing Lok St Sheung Wan HK Tel. (852) 2530 2530 Fax (852) 2530 2535 Email: crew@navigator-insurance.com www.navigator-insurance.com

Hong Kong Branch Office

58/F One Island East 18 Westlands Road Island East, Hong Kong T: +852 2506 0311 F: +852 2506 1455 www.transamerica.com.hk

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

LIFESTYLE SUPI 生活方式補充問卷	PLEMENTARY	QUES	TIONNAIRES	Av: 飛行	iation			
Proposed Insured 準受保人	Given Name 名字			Surna 姓氏	ame			
Date of birth 出生日期			(dd/mm/yyyy日/月/年	≡)				
Producer Name 營業員姓名				Produ 營業員	ucer ID 員編號			
Policy Number 保單編號					ssport Number 登/護照號碼			
cancellation of the ir or acceptance of thi 請以 正楷 填寫,並確 請的事項。如未能確 1. When and wh	nsurance cover at is Application. If y 保答案準確完整 定事實是否重要	nd/or nor you are ir 。任何漏 ,應先予 m to fly, a	n-acceptance of future c n any doubt whether a fa 報或誤報重要事實或會構 以披露。 und what flying qualifica	laims. A r act is mat 靠成保險保	material fact is one terial, it should be 陰無效及/ 或索償	e which is disclosed	likely to ii l.	naterial facts may lead to influence the assessment 可能影響評估或接納此申
2. On average, I	how many hours	per annı	um do you fly?每年平均	飛行多少小	小時?			
3. When did you	u last fly?上次駕馬		何時?					
4. Please confir	m the type of aird	craft that	you fly, including detail	s of the e	ngine size: 請詳絲	田列出閣下	駕駛飛機區	的種類,包括引擎大小:
			If so please provide det 提供飛行活動詳情:	ails of th	e flying activities:			
6. Do you fly for	pleasure only? I	lf so plea	use provide details: 閣下	駕駛飛機	是否純作消閒?如	是,請詳如	<u>ì</u> :	
			splays? If so how many ,每年參加多少項賽事或		o you take part ir	per annu	m?	
I/We hereby declar Application Form d			ents are true and comp					ement together with the us and TLB.
								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 Sign	atures 授權簽署							
Si	gnature of the Pr 準受保 /		Insured		~	Witness 受保人之		sed Insured 署
Dota		Disas	X	News				Х
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

LIFESTYLE SUPPLEMENTARY QUESTIONNAIRES 生活方式補充問卷 Proposed Japured Given Name

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			
Please complete in BLOCK CAPITALS and ensure that your answers are true and complete. Failure to disclose all material facts may lead to					

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 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。

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 of Witness 準受保人之		
			Х				Х
Date 日期	L(dd/mm/yyyy日/月/年)	Place 地點	Country國家	Name 姓名			
				Date 日期	L	Place 地點	Country國家

LIFESTYLE SUPF 生活方式補充問卷	PLEMENTARY	QUES"	TIONNAIRES	Div 潛力	ving ¢		
Proposed Insured 準受保人	Given Name 名字			Surna 姓氏	ıme		
Date of birth 出生日期			(dd/mm/yyyy日/月/年	Ξ)			
Producer Name 營業員姓名				Produ 營業員	icer ID 員編號		
Policy Number 保單編號		1 1 1	1 1 1 1 1		ssport Number 纟/護照號碼		1 1 1 1 1 1
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. When did you	i learn to dive ai	nd what c	living qualifications, if a	ny, do yo	u hold?阁下已學育	曾潛水多久? 持有哪: 	<u></u> 理潛水證書(如有)?
2. How frequent	ly do you dive a	and when	did you last dive?閣下力	太概多久潛	水一次?上一次潛	水於何時?	
			ed and the maximum de 於經或計劃潛水最深極限。		you have or intend	d to dive to:	
dive compute	er do you always	dive with	as been properly mainta nin the safe limits that yo 次潛水前會檢查設備嗎?	our comp	uter allows? Plea	ase provide details	
location of div	ves (i.e. deep se	a, coasta	s? If so please detail di il waters, lakes and rive :潛水活動詳情,包括有否	rs).			
			ease provide details of t 水的國家及地點:	he count	ry and location o	f dives:	
7. Do you dive a	llone or always i	n a group	9?閣下獨自或是結伴潛水	?			
•	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 [
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 Signature of Witness to Proposed Insured							
準受保人 簽署 準受保人之 見證人 簽署					署		
			Х				х
Date L L L L L L L L L L L L L L L L L L L		Place 地點	Country 國家	Name 姓名		1	
(dd/11111/)	1333 [7] / 3/ 1]	- A.M	out of East	Date		Place	

Mountaineering LIFESTYLE SUPPLEMENTARY QUESTIONNAIRES 攀山 生活方式補充問卷 Proposed Insured Surname Given Name 準受保人 名字 姓氏 Date of birth _____(dd/mm/yyyy日/月/年) 出生日期 Producer Name Producer ID 營業員姓名 營業員編號 Policy Number ID/Passport Number 保單編號 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. 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。 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 Signature of Witness to Proposed Insured 準受保人簽署 準受保人之**見證人**簽署 Х Χ Date Place Name

姓名

Date

日期

Country國家

Place

Country國家

地點

(dd/mm/yyyy 日/月/年)

日期

(dd/mm/yyyy 目/月/年)

地點

MEDICAL SUPPLEMENTARY QUESTIONNAIRES

High Blood Pressure

健康狀況補充問卷		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)	(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					
cancellation of the ir or acceptance of thi 請以 正楷 填寫,並確	BLOCK CAPITALS and ensure that your answers ar surance cover and/or non-acceptance of future class Application. If you are in any doubt whether a fack 保答案準確完整。任何漏報或誤報重要事實或會構成定事實是否重要,應先予以披露。	nims. A material fact is one ot is material, it should be	e which is likely to influence the assessment disclosed.				
	e diagnosis first made and what were your blood p 患上高血壓?當時的血壓讀數是多少?	oressure readings at that	time?				
	what your current blood pressure readings are? If 一次的血壓嗎?如知道,請註明:	f so, please provide deta	ils:				
	e details of your treatment, including names of me 情,包括藥物名稱、劑量及服食次數:	edication, dosage and fro	equency of dosage:				
i) currently 現	.時						
ii) in the past	過往						
medical cond	uired more than 5 consecutive days off work, or h ition? If so please provide dates and duration: 血壓而需要連續休假五日以上,或日常生活因此受限制						
137777		2 - 2 - 12 - M2 - 12 - 12 - 12 - 12 - 12					
results. Pleas	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。						
	any other medical condition (e.g. kidney or heart c 状嗎 (如腎病、心臟疾病、高膽固醇/血脂)?如有,訂		erol/lipids)? If so please provide details:				

High Blood Pressure (Continued) 高血壓 (續)

8.	Do you currently smoke? If yo 閣下現時是否吸煙?如有,每日			er day?			
9.	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	完(如與上	述不同) 的名稱及地址,包含	包括其他治	台療師:		
	State your last follow-up date	e上次覆診	:日期:		(dd/mm/yyyy日/月/年)		
	Next follow-up date下次覆診	日期:		(dd/mm/y	yyy日/月/年)		
	If discharged from any follow 如無需覆診,請列明最近一次覆		se confirm the discharg	e date	(dd/mm/yyyy日/月/年)		
I/We	hereby declare that the above	e stateme	ents are true and comp	ete and	agree that this supplementary statement together with the		
Appl	cation Form dated		(dd/mm/yyyy) sh	all be the	basis of the contract between me/us and TLB.		
本人	¹ 吾等謹此聲明上述陳述為準確?	完整,並同	司意此補充陳述及於		(日/月/年)簽署的投保申請書將會成為本人/吾等		
	美人壽百慕達簽訂合約之依據。						
		_					
Auth	orised Signatures授權簽						
	Signature of the Pr 準受保		Insured		Signature by Attending Doctor (if applicable) 主診醫生 簽署 (如適用)		
			X		X		
Dat 日其		Place 地點	Country國家	Date 日期	L(dd/mm/yyyy 日/月/年)		
	Signature of Witness						
	準受保人之 」	己證人 簽署	2				
			Х				
Nai 姓名							
Dat		Place 地點	Country國家				
	(dd/mm/yyyy日/月/年)		Country國家				

MEDICAL SUPPL 健康狀況補充問卷	LEMENTARY QUESTIONNAIRE	s	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/	/уууу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 confir 閣下確診患上	m exact diagnosis: :					
			pendent/Type II 糖尿病/ 二型糖尿病	☐ Impaired (血糖耐量§	Glucose Tolerance 異常	
2. When was the 首次確診為何	e diagnosis first made? 時?					
3. What type of 閣下正接受哪	treatment are you currently taking? 一種治療?					
	ation (state name medication and do 情列明藥物名稱及劑量)	osage) 				
	te type if insulin and dosage) 列明胰島素類型及劑量)					
- Diet contro 控制飲食	ol 					
4. Diabetic follow 請提供以下覆i	w-up consultations. Please provide th 診詳情:	ne following deta	ails:			
- Name of De	octor醫生姓名					
- Frequency	of follow up 覆診次數					
- Result of la	aboratory test (if known) 化驗測試結果	!(如已知)				
Fasting sug	gar 空腹血糖		_ Date日期 <u> </u>		(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/yy	/yy日/月/年)				

Diabetes (Continued) 糖尿病 (續)

	Select the box that applies
	請選擇合適空格

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					
	$\hfill \Box$ Eye problems (other than short and long sightedness) $\hfill \amalg \chi $	(近視及遠視除外)				
6.	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.	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	elete and agree that this supplementary statement together w	ith the			
Appli	cation Form dated (dd/mm/yyyy) sh	nall 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			
與全身	人壽百慕達簽訂合約之依據。					
Auth	orised 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)				
	Х		х			
Date 日期		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					
Nan		-				
姓名						
Date 日期						

Gastric Disorders **MEDICAL SUPPLEMENTARY QUESTIONNAIRES** 胃病 健康狀況補充問卷 Proposed Insured Surname Given Name 準受保人 名字 姓氏 Date of birth ______(dd/mm/yyyy日/月/年) 出生日期 Producer Name Producer ID 營業員姓名 營業員編號 Policy Number ID/Passport Number 保單編號 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 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×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)。

Gastric Disorders (Continued) 胃病 (績)

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. 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** Signature by **Attending Doctor** (if applicable) **準受保人**簽署 主診醫生簽署(如適用) Χ Χ Place Date Date (dd/mm/yyyy日/月/年) 日期 地點 日期 Country國家 Signature of Witness to Proposed Insured 準受保人之**見證人**簽署 Χ Name 姓名 Date Place 日期 地點 (dd/mm/yyyy日/月/年) Country國家

MEDICAL SUPF 健康狀況補充問卷	PLEMENTARY QUESTIONNAIRES	S General Medical 一般症狀	Conditions
Proposed Insured 準受保人	Given Name 名字	Surname 姓氏	
Date of birth 出生日期	(dd/mm/y	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	
cancellation of the or acceptance of t 請以 正楷 填寫,並	insurance cover and/or non-acceptance his Application. If you are in any doubt	e of future claims. A material fact is on whether a fact is material, it should be	lure to disclose all material facts may lead to the which is likely to influence the assessment to disclosed. 賞被拒。重要事實指可能影響評估或接納此申
	ide details of the exact diagnosis, if kn 的明確診斷 (如已知):	nown:	
2. When was t 首次確診日其	he diagnosis first made? 引?		
limitation to	l have symptoms? If symptoms are o your daily activities in any way: 5仍有有關病徵?如有,請詳述,包括發約		luding the frequency, severity and any 影響:
4. When did yo 最近一次發症	ou experience your last symptoms? 时期?		
	ide details of your treatment, including 详情,包括藥物名稱、劑量及服食次數:	names of medication, dosage and fr	requency of dosage:
i) currently	現時		
ii) in the pas	st過往		
	quired more than 5 consecutive days of 比症狀而需要連續休假五日以上?如有,請		? If so, please provide dates and duration.
results. Plea	ad any x-rays, tests or other investigates attach a copy of the medical report 比症狀而接受任何X光檢查、測試或其他材	t(s) with this questionnaire if available	
			al institution for this condition? Or, is a 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)。

General Medical Conditions (Continued) 一般症狀 (續)

0		1/ 11 1/ 10				
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:	l/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:					
I/We	hereby declare that the above statements are true and compl	e and agree that this supplement	ary statement together with the			
Appli	cation Form dated (dd/mm/yyyy) sh	be the basis of the contract betw	een 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/日/年)答署	的投保由詩書將會成為本人/ 吾等			
		(日/万/千/双有	137文体中的自闭自风氛个人/ 百寸			
與全 🤊	美人壽百慕達簽訂合約之依據。					
Auth	orised Signatures 授權簽署					
	Signature of the Proposed Insured 準受保人 簽署	Signature by Attending 主診醫生 簽署	, , , ,			
	Х		X			
Date 日期		7 #0				
	0:					
	Signature of Witness to Proposed Insured 準受保人之 見證人 簽署					
	Signature of Witness to Proposed Insured 準受保人之 見證人 簽署					
Nan	準受保人之 見證人 簽署					
Nan 姓名	準受保人之 見證人 簽署 X					
	準受保人之 見證人 簽署 X					

Gynaecological Disorders 婦科疾病 MEDICAL SUPPLEMENTARY QUESTIONNAIRES

健康似沈州尤问仓		邓行沃州			
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					

	ceptance of this Application. If you are in any doubt whether a fact is material, it should be disclosed.
	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/或素償被拒。重要事實指可能影響評估或接納此申 事項。如未能確定事實是否重要,應先予以披露。
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: 图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)。

Gynaecological Disorders (Continued) 婦科疾病 (續)

	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/y	ууу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:				
I/We h	ereby declare that the above statements are true and compl	ete and	agree that this supplementary statement together with the		
Applic	ation Form dated (dd/mm/yyyy) sha	all be the	basis of the contract between me/us and TLB.		
本人/ 音	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。				
Autho	prised 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)		
	х		Х		
Date 日期	Place (dd/mm/yyyy日/月/年) 中點 Country國家	Date 日期	L		
	Signature of Witness to Proposed Insured 準受保人之 見證人 簽署				
	х				
Name 姓名	е				
Date 日期	L				

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	

Please complete in BLOCK CAPITALS and ensure that your answers are true and complete. Failure to disclose all material facts may lead to

or a	cellation of the insurance cover and/or non-acceptance of future claims. A material fact is one which is likely to influence the assessment cceptance of this Application. If you are in any doubt whether a fact is material, it should be disclosed. .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
	. 正信 項為,业唯体合系华唯元差。任何廟報以設報里安争員以首傳成体際体學無效及/ 以系頂板起。里安争員指可能影響計值以按約此中 事項。如未能確定事實是否重要,應先予以披露。
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)。
0	However over been as in nations as day postions as been tall alimin constant we asked modical institution for this condition?
0.	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)。

Mental/Anxiety/Depression (Continued) 精神科疾病/焦慮症/抑鬱症(嶺)

9.	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.	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.	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/y	yyy日/月/年)		
	If discharged from any follow-up, please confirm the discharg 如無需覆診,請列明最近一次覆診日期:	e date	(dd/mm/yyyy日/月/年)		
asses	e use the space below to provide us with any additional inforssment: 以下空白位置提供閣下認為可能相關的任何額外資料,以協助我們記				
I/We	hereby declare that the above statements are true and compl	ete and	agree that this supplementary statement together with the		
			basis of the contract between me/us and TLB.		
	「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 L 美人壽百慕達簽訂合約之依據。		(口/月/平)敛者的投係中請責將買风為华人/ 音等		
Auth	orised 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)		
Date	e Place	Date	X		
日期		日期	(dd/mm/yyyy日/月/年)		
	Signature of Witness to Proposed Insured 準受保人之 見證人 簽署				
Nar					
姓名 Date	e Place				
日期	(dd/mm/yyyy日/月/年) 地點 Country國家				

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MEDICAL SUPPL 健康狀況補充問卷	EMENTARY QUESTIONNAIRES	呼吸系統疾病
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健康狀況補充問卷		吁吸尔烷疾病			
Proposed Insured Given Name 名字		Surname 姓氏			
Date of birth 出生日期	L(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			
cancellation of the ir or acceptance of thi 請以 正楷 填寫,並確 請的事項。如未能確	BLOCK CAPITALS and ensure that your answers an insurance cover and/or non-acceptance of future clais Application. If you are in any doubt whether a face 保答案準確完整。任何漏報或誤報重要事實或會構設事實是否重要,應先予以披露。	aims. A material fact is one act is material, it should be	e which is likely to influence the assessment disclosed.		
	de details of the exact diagnosis, if known: 明確診斷 (如已知):				
2. When was the 首次確診日期	e diagnosis first made? ?				
limitation to y 閣下現時是否	have symptoms? If symptoms are current, plea rour daily activities in any way: 仍有有關病徵?如有,請詳述,包括發病次數、嚴重				
4. When did you 最近一次發病	u experience your last symptoms? 日期?				
dosage:	de details of your treatment, including any steroids情,包括有否使用類固醇。請列明藥物名稱、劑量及		of medication, dosage and frequency of		
i) currently 玛					
ii) in the past					
	uired more than 5 consecutive days off work due to 症狀而需要連續休假五日以上?如有,請註明休假日期		If so, please provide dates and duration.		
results. Pleas	d any x-rays, tests or other investigations for the attach a copy of the medical report(s) with this 症狀而接受任何X光檢查、測試或其他檢查?如有,	questionnaire if available			

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)。

Respiratory Disorders (Continued) 呼吸系統疾病 (續)

pro	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:				
44 DI-			· · · · · · · · · · · · · · · · · · ·	-1	and/authoritalit different from alconomical discount
alte	ease provide the name and ernative therapy practition 提供現時主診醫生及/ 或醫院	ers:			nd/or Hospital if different from above, including any 其他治療師:
Sta	ate your last follow-up date	·····································	期: 」 」		(dd/mm/yyyy日/月/年)
				,	- (- (-)
Ne	xt follow-up date下次覆診!	∃期:		(dd/mm/y	yyy 日/ 月/ 年)
	discharged from any follow 無需覆診,請列明最近一次覆		confirm the discharg	e date	(dd/mm/yyyy日/月/年)
Please us	se the space below to pro	vide us wit	h any additional infor	mation y	ou feel may be relevant in helping us with your application
assessme 請於以下	ent: 空白位置提供閣下認為可能 <mark></mark>	目關的任何額	頁外資料,以協助我們記	平估閣下的	5申請:
I/We here	eby declare that the above	e statemen	ts are true and comp	lete and a	agree that this supplementary statement together with the
Applicati	on Form dated		(dd/mm/yyyy) sh	all be the	basis of the contract between me/us and TLB.
本人/吾等	等謹此聲明上述陳述為準確?	完整,並同意	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。				
Authori	sed Signatures授權簽	聖			
	Signature of the Pr		sured		Signature by Attending Doctor (if applicable)
	準受保力	簽署			主診醫生簽署 (如適用)
			X		Х
Date 日期	L(dd/mm/yyyy日/月/年)	Place 地點	Country國家	Date 日期	(dd/mm/yyyy日/月/年)
	Signature of Witness		d Insured		
	準受保人之 身	記入 簽署			
			Х		
Name 姓名					
Date		Place			
日期	(dd/mm/yyyy日/月/年)	地點	Country國家		

Tumours **MEDICAL SUPPLEMENTARY QUESTIONNAIRES** 腫瘤 健康狀況補充問卷 Surname Proposed Insured Given Name 準受保人 名字 姓氏 Date of birth _____ (dd/mm/yyyy 日/月/年) 出生日期 Producer Name Producer ID 營業員姓名 營業員編號 Policy Number ID/Passport Number 身份證/護照號碼 保單編號 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:

Tumours (Continued) 腫瘤 (續)

alternative therapy practitioners:	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 如無需覆診,請列明最近一次覆診日期:	e date (dd/mm/yyyy日/月/年)		
I/We hereby declare that the above statements are true and compl	ete and agree that this supplementary statement together with the		
Application Form dated (dd/mm/yyyy) sha	all 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	х		
Date 日期	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			