永诚财产保险股份有限公司
ALLTRUST INSURANCE COMPANY OF CHINA LIMITED

Application for Alltrust Individual High-End Medical Insurance

永诚个人高端医疗保险计划（臻享版）投保单

Instructions
投保指南

1. **Please read clauses and application requirements in the proposal carefully before you fill out the application form. Should you have any questions concerning the insurance benefits, please feel free to consult the sales representative.**
   在填写投保单前，请仔细阅读保险计划书中相关条款和投保条件。若对您的保险福利有疑问，请与您的销售代表进行确认。
2. **The complete application documents should include: Proposal, Application Form, ID Card/Passport (soft copy).**
   您的完整投保材料包括：保险计划书、投保单、有效证件复印件。
3. **Please completely fill out the application form and submit all required application documents, in case the enrollment process would be delayed. We would proceed with underwriting upon receipt of complete application documents.**
   请完整填写本投保单并递交以上材料，否则可能会延长投保流程。我们会在收到完整投保材料后进行审核。
4. **The application form is valid for 30 days from the date signed.**
   本投保单自签署之日起，有效期为 30 天。

Section 1-A: Enrollment Type
1-A 区：保全类型

☐ New Enrollment 新加保 ☐ Renewal 续保 ☐ Add Child 增加附属被保险子女 ☐ Other 其他 _____

☐ Add Spouse 增加附属被保险配偶 Date of Marriage 结婚日期 _____/_____/_____(MM/DD/YYYY) (月/日/年)

Section 1-B: Coverage Type
1-B 区：保障类型

☐ Diamond Plan 钻石计划 Annual Maximum 年度最高保额: ¥ 8,000,000		☐ Platinum Plan 白金计划 Annual Maximum 年度最高保额: ¥ 1,000,000
☐ Greater China Coverage 大中华保障 ☐ Greater China Plus Coverage 大中华增强保障 ☐ Mainland China Coverage 中国大陆保障		
Only for Diamond Plan 仅适用于钻石计划	Individual Annual Deductible 个人年免赔额	☐ ¥0 ☐ ¥800 ☐ ¥2,000 ☐ Other 其他 ¥_____
	Policy Co-payment 保单自付比例	☐ 0% ☐ 10% ☐ 20% ☐ 30%
	Provider Co-payment 通常惯例自付比例	
	Greater China Coverage and Greater China Plus Coverage 大中华保障和大中华增强保障	☐ 0% ☐ 100%
	Mainland China Coverage 中国大陆保障	☐ 100%

Section 1-C: Optional Benefit
1-C 区：可选福利

Maternity 生育福利	☐ No 不选择 ☐ Yes 选择

永诚财产保险股份有限公司
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Please complete sections 2 through 5 to provide additional information about yourself and your dependents (if applicable).

请按照您和您一同申请的附属申请人（如有）的实际情况完成 2 区至 5 区的问题。

Section 2-A: Applicant Details
2-A 区：申请人详细情况

Last Name: 姓：	First Name: 名：	Gender: 性别： ☐ Male 男 ☐ Female 女	Height :_____m/_____feet 身高：_____米/_____英尺 Weight:_____lbs/_____Kg 体重：_____磅/_____公斤	Marital Status: 婚姻状况： ☐ Single 单身 ☐ Divorced 离异 ☐ Married 已婚 ☐ Widowed 丧偶 ☐ Domestic Partner 同性伴侣
Date of Birth (mm/dd/yyyy) 出生日期（月/日/年）：	Citizenship: 国籍国：	Nationality: 出生国：	Country of Residence: 居住国：	Passport / ID Number: 证件号码（护照或身份证）：
Address: 地址：		City: 城市：	State / Province: 省/州：	Postal Code: 邮编： Country: 国家：
Phone Number: 座机号码： Cell Phone Number: 手机号码：			Have you ever been covered by Alltrust health insurance before? 是否曾经购买过永诚保险的健康险保单？	☐ Yes 是 ☐ No 否
Email Address: 电子邮箱地址：				
Employer Name: 公司名称：	Employer Address: 公司地址：			
Annual Salary (Specify Currency): 年薪（请指明货币种类）：	Date of Hire (MM/DD/YYYY): 入职日期(月/日/年)：		Number of Hours Worked per Week: 每周工作小时数：	
Occupation and Title (Please provide full description): 职业和职位（请详细描述）：	*Requested Effective Date (MM/DD/YYYY): *希望保单生效日期 (月/日/年)： *The actual effective date will be subject to underwriting review and based on the date on which the premium is effectively received by the Insurer. *保单实际生效日期取决于最终的核保意见以及有效保费被保险公司收到的日期。			

Section 2-B: Dependent Information (Complete below only if enrolling dependents)
2-B 区：附属申请人信息（如有） If none, check this box: ☐ 若无，请勾选此项：☐

Relationship 与申请人的关系	Last Name 姓	First Name 名	Date of Birth (mm/dd/yyyy) 出生日期（月/日/年）	Gender 性别	Country of Residence 居住国	Height :____m/ _____feet 身高：____米/_____英尺 Weight:____ lbs/_____Kg 体重:____磅/_____公斤	Passport / ID Number 护照号或身份证号
Spouse 配偶							
Child 子女							
Child 子女							
Child 子女							
Child 子女							

Section 3-A: Medical Questionnaire: Please complete for all members applying for coverage **3-A 区：健康问卷：请填写以下关于所有保险申请人的健康问卷**	
1) Do you and your dependent have the Social Medical Insurance or Public Health Care? 您和您的附属申请人是否享有“社会医疗保险”或“公费医疗保障”？	☐ Yes 是 ☐ No 否
2) Within the past 10 years, have you or any dependent been treated, diagnosed, tested, hospitalized, or recommended for treatment for any of the following? 在过去的 10 年中，您或其他附属被保险人申请者是否因下列选项之一接受治疗，被诊断，检查，住院或被推荐治疗？	
A. Seizures or seizure disorder; paralysis: multiple sclerosis; or any disorder of the central nervous system? 突发癫痫、瘫痪、多发性硬化或任何中枢神经系统的紊乱？	☐ Yes 是 ☐ No 否
B. Mental retardation; any mental, behavioural, emotional, or eating disorder; anxiety, depression, neurosis or psychosis; psychotherapy; psychological, or any form of counselling or therapy? 智力缺陷、任何精神、行为、情绪或者饮食紊乱、抑郁、神经衰弱症或精神错乱，接受精神疗法或任何形式的心理咨询或治疗？	☐ Yes 是 ☐ No 否
C. High blood pressure; heart attack, stroke, chest pain or palpitations, murmur, varicose veins, blood clot, anaemia, or any other blood heart, or circulatory disorder or condition? If yes, most recent blood pressure reading_____. Date recorded_____ 高血压、心脏病、中风、心绞痛、胸痛或心悸、心杂音、静脉区张、血栓、贫血或任何其他的心血管疾病或血循环障碍？ 如是，最近一次血压读取值是_____ 测量日期是_____	☐ Yes 是 ☐ No 否
D. Asthma; emphysema; bronchitis; sinusitis; pneumonia; allergies; apnea; or any breathing difficulty, lung or respiratory disease, disorder or condition? 哮喘、肺气肿、支气管炎、鼻窦炎、肺炎、过敏症、窒息或呼吸暂停或任何呼吸困难、肺部或呼吸道疾病或紊乱？	☐ Yes 是 ☐ No 否
E. Colitis; chronic diarrhea, or intestinal problems; hernia; ulcer of the stomach or duodenum; hemorrhoids or rectal disorder; hepatitis or liver disorder; gallbladder, pancreas, esophagus, or any other digestive disorder or condition? 大肠/结肠炎、慢性腹泻或肠腔疾病、疝气、胃溃疡或十二指肠溃疡、痔疾或直肠紊乱、肝炎或肝脏功能紊乱、胆囊、胰腺、食管或任何其他的消化功能紊乱或疾病？	☐ Yes 是 ☐ No 否
F. Cancer, tumour, growth, cyst, enlarged lymph nodes; psoriasis, keratosis, lesions of the skin or mouth or any other skin disorder? 癌症、肿瘤、增生、囊肿、淋巴扩大、牛皮癣、角化症、皮肤或口腔损伤或任何其他的皮肤功能紊乱？	☐ Yes 是 ☐ No 否
G. Disease or disorder of the breast; kidney; kidney stones; bladder; prostate; abnormal PSA, or any other urinary disorder or infection? 乳房疾病或功能紊乱、肾炎、肾结石、膀胱炎、衰竭 、前列腺疾病或功能紊乱、前列腺特异性抗原变异或任何其他形式的泌尿系统感染或紊乱？	☐ Yes 是 ☐ No 否
H. Disease or disorder of the genital or reproductive system; herpes, any sexually transmitted disease; endometriosis, or abnormal pap smear? 生殖系统疾病或功能紊乱、疱疹、任何性病、子宫内膜异位或子宫抹片检查变异？	☐ Yes 是 ☐ No 否
I. Been treated for infertility; taken any medication, or advised to seek treatment, medication, diagnostic tests or surgery for infertility? 受过不育症治疗、或者为不孕不育服用任何药物或进行任何咨询、检测或医学诊断检查或手术治疗？	☐ Yes 是 ☐ No 否
J. Arthritis; rheumatism; gout; TMJ (temporomandibular joint syndrome); any injury to or disease or disorder of the spine, back, jaw, bones, muscles, or joints; joint replacement? 关节炎、风湿病、痛风、柯斯顿氏综合征、任何关于脊椎、背部、颌骨、骨骼、肌肉、关节及关节复位的损伤、疾病或功能紊乱？	☐ Yes 是 ☐ No 否
K. Pituitary, adrenal, or thyroid disorder; lupus; diabetes? If yes to diabetes, state Type : _____ and most recent blood sugar reading _____. Date recorded_____. 脑垂体、肾上腺或甲状腺功能紊乱、红斑狼疮、糖尿病? 如果有糖尿病，类型是_____，最近一次测量血糖的数值为 _____，测量日期为_____。	☐ Yes 是 ☐ No 否

L. Cataracts; glaucoma; or any eye disorder; hearing loss; or any ear, nose, or throat disorder? 白内障、青光眼或眼部功能紊乱、听力丧失、或任何耳、鼻、喉部的功能紊乱？	☐ Yes 是 ☐ No 否
M. Alcoholism; alcohol, drug or substance abuse or dependency? 是否曾有酒精中毒，对酒精、毒品或物质滥用及依赖？	☐ Yes 是 ☐ No 否
N. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), HIV Positive, or other immune disorders? 是否患有获得性免疫缺损综合症（艾滋病）、艾滋病相关综合征、属于艾滋病毒携带者或患有其他免疫系统功能紊乱？	☐ Yes 是 ☐ No 否
3) Have you been advised to have a surgical procedure, hospitalization, or undergo testing that has not yet been completed? 您是否正被建议实施外科手术、住院治疗或进行尚未结束的医学检查？	☐ Yes 是 ☐ No 否
4) Are you currently pregnant? 您目前是否怀孕？	☐ Yes 是 ☐ No 否
A. If yes, is there a history of complications with previous pregnancies or are complications anticipated with this pregnancy? Expected Due Date: _____ 如已经怀孕，之前是否有难产及其并发症，或其可能会影响这次怀孕？ 预产期是_____	☐ Yes 是 ☐ No 否
B. Is this pregnancy the result of infertility treatment? 是否因为不育治疗而引起此次怀孕？	☐ Yes 是 ☐ No 否
5) Have you gained or lost more than 12 kilos or 25 pounds during the last 12 months? 在过去的 12 个月中您是否增加或减轻体重超过 12 公斤或是 25 磅？	☐ Yes 是 ☐ No 否
6) Are you being covered by other related health insurance? 是否已投保与本合同保障范围有关的其他健康保险合同？	☐ Yes 是 ☐ No 否
If yes,若已投保， Product：1 Life、2 Critical Illness、3 Hospitalization Medical、4 ADD、5 Other; 产品：1 人寿保险、2 重大疾病险、3 住院医疗险、4 意外险、5 其他保险； Have you ever been declined, postponed, rated, or limited for Life, Health, or Accident Insurance? 您是否曾经被保险公司拒保、延期、调整保险费率或被限定人寿、健康、或意外保险的保险金额？ If yes,若是， Result: 1 Declined、2 Extension、3 Additional conditions or surcharge cover、4 Applied or got the claims 其结果为：1 拒保、2 延期、3 附加条件或加费承保、4 提出或已经得到理赔；	Number 序号:_____ ☐ Yes 是 ☐ No 否 Number 序号:_____
7) Have you been hospitalized in the last 10 years for any reason? 在过去的 10 年中您是否曾经接受过住院治疗？	☐ Yes 是 ☐ No 否
8) Have you consulted or been advised to consult a medical practitioner, or do you suffer from any significant physical impairment, deformity sickness, or injury other than revealed in questions above? 除了以上这些问题以外，您是否因为明显的身体损伤、畸形疾病及伤害等原因曾经咨询过或被建议去咨询执业医师？	☐ Yes 是 ☐ No 否
9) Do you engage in any profession, sport, or hobby that could be considered hazardous? 您是否正在从事某项具有危险性的职业、运动或业余爱好？	☐ Yes 是 ☐ No 否
10) Do you receive any disability pension or work accident pension? 您是否领取某项伤残年金或工伤抚恤金？	☐ Yes 是 ☐ No 否

Section 3-B: Medical Questionnaire: Give details of each item answered "Yes" in Section 3-A
3-B 区：健康问卷：如果在 3-A 区选择"是"，则需要在下表中逐项填写详细情况
If more space is needed, attach separate page, which must be signed and dated.
如果填写内容需要更多表格，请另外附加文页，并附上签名和日期

Name 姓名	Question No. 问题编号	Condition/ Diagnosis 状况/诊断	Treatment (Surgeries/Medications) 治疗方法（手术/药物）	Treatment Date From/To 治疗日期 起/至	Ongoing or Date of Recovery 正在进行或痊愈日期	Name，Location or Telephone Number of Physician, Hospital/Institution 医师、医院/医学院的名称、地址或电话号码

Section 3-C: Medication: List all medications that are currently prescribed for you or a family member
3-C 区：请列举您和其他保险申请人正在使用的药物
If none, check this box: ☐ 若无，请勾选此项：☐

Name 姓名	Medication Name 药物名称	Dosage 剂量	Frequency 用药频率	Reason For Use 用药原因

Section 4: Residence Verification
4 区：长期居住地确认

Anticipated travel pattern for the next 12 months outside Mainland China 预计在未来的 12 个月内在中国大陆以外地区的旅行计划

Name 姓名	Destination 目的地	Frequency 频率	Duration 时长	Duties 原因

I understand by signing this application, that I am certifying I /and or my dependents are NOT residing in the United States. I understand that I must notify the Alltrust immediately of any change in my and /or my dependents residency or any change on the travel pattern above. Failure to do so may result in the denial of claims as well as recovery of any claims already paid.

我明白，在签署本居住地确认时，我保证我和/或我的附属申请人不居住在美国。我明白我必须在我和/或我的附属被保险人的居住状况或上述旅行计划发生改变时第一时间通知永诚保险。不履行如上义务会导致理赔被拒绝和已支付的款项被认定为拒赔。

Section 5: Authorization for Release of Information
5 区：客户信息授权

By signing this Authorization for Release of Information, I certify that I and/or my dependents authorize any physician or other healthcare professional, hospital or healthcare-related facility, pharmacy, medical service provider, employer, benefit plan administrator, and any Federal, State or Local Government Agency, with a complete copy of any and all medical information for use and disclosure as described in this authorization. Further to release any medical and other information in your possession or control to Alltrust, GBG and Medilink (Beijing) TPA Services Co., Ltd. and/or their attorneys, either directly or through a representative agent acting on their behalf, any and all medical information they may request, including but not limited to, medical records, reports, charts, graphs, notes x-rays, films, and laboratory reports. I and/or my dependents also hereby authorize the release of all medical information regarding diagnosis, care and treatment for alcohol abuse, drug abuse or mental health. In addition, I and/or my dependents authorize the release of any and all billing records and statements in your possession or control.

在签署客户信息授权书时，我保证本人和/或本人的附属被保险人授权任何医生或其他医疗专业人士，医院或医疗保健相关的机构，药店，医疗服务提供者，雇主，医疗保险工作者，及任何中央或地方的机构，使用此授权书中提及的本人和/或本人的附属被保险人的医疗信息复印件或者公开相关的任何信息。本人和/或本人的附属被保险人进一步授权上述所有机构有权对永诚保险，GBG，中间带（北京）TPA 服务有限公司，及/或他们的律师，公开所掌握的医疗或其他信息，无论他们直接或通过其代理人代理，其中信息包括但不限于，医疗记录，医疗报告，病历，医疗图，X-射线拍图，医学胶片和化验报告。本人和/或本人的附属被保险人亦授权可以公开所有关于酗酒，滥用药物和精神疾病的诊断、护理及治疗的信息。此外，本人和/或本人的附属被保险人授权可以公开所有账单支付与声明。

I and/or my dependents also authorize Alltrust，GBG and Medilink (Beijing) TPA Services Co., Ltd. its representatives or their agents to release information that is obtained pursuant to this authorization to providers of healthcare, insurers, re- insurers, or claims administrators, and any government agency as it deems appropriate solely for the purpose of evaluating and administering any claim for benefits. I and/or my dependents further understand that information may be released as follows:

同时，本人和/或本人的附属被保险人授权永诚保险，GBG，中间带（北京）TPA的服务有限公司, 其代表或其代理商有权向医疗提供商（医院），保险公司，再保险人，理赔人员，其它任何可以评估、管理理赔的政府部门，公开此授权书允许公开的信息。本人和/或本人的附属被保险人理解信息可能以如下的方式公开：

- **To other persons or organizations performing business or legal services in connection with any claim;**
  向与任何理赔涉及到的个人或机构公开；

- **As may be otherwise lawfully required;**
  法律要求公开的；

- **To any person or legally authorized representative as I and/or my dependents have so indicated;**
  向任何本人和/或本人的附属被保险人授权过的个人或合法代表公开；

- **As I and/or my dependents may further authorize; or as necessary to prevent or detect the perpetration of fraud.**
  协助防止或侦破诈骗时公开。

This "Authorization For Release of Information" is subject to revocation at any time except to the extent that action has been taken in reliance hereon and, if not earlier revoked in writing, it shall remain valid for two (2) years from date of signature. I and/or my dependents agree that a photocopy, e-mailed copy or facsimile (FAX) copy of the authorization shall be accepted and as valid as the original. I know that I may request to receive a copy of this Authorization.

此授权书随时可以撤销，授权行为已经发生除外。除非提前以书面形式撤销，否则该授权书自签字之日起两年内有效。复印件，电邮副本或传真与原件同样有效。本人和/或本人的附属被保险人有权要求获得该授权书的副本。

Section 6: Representations, Acknowledgements and Authorizations
6 区：陈述，确认和授权

The insurance plan shall be governed exclusively by the laws PRC as applicable.
本保险计划仅适用中华人民共和国的法律管辖。

The premium and benefits currency used is in Chinese Yuan. The only premium payment method available is annual payment.
保费与保障福利赔付货币都为人民币。本保单仅接受年缴保费方式。

I hereby declare that I am currently actively at work and mentally and physically capable of conducting the regular duties of my employment and have not been absent from work for more than 10 consecutive days because of illness in the preceding twelve months.
我在此申明本人目前在职工作并且精神上和生理上能够胜任雇佣期间的日常岗位，并且在过去的12个月中因病缺席工作时间不超过连续10天。

I agree that there shall be no insurance until this application has been accepted by the Insurer, and the first full premium has been paid, and that payment has been effectively received by the Insurer.
我同意直至本投保申请为保险公司接受，且第一次全额保险费支付及付款有效并为保险公司收到之前，保险公司始终不承担保险责任。

I understand that there is no refund of premium if claims have been made on this policy.
我明白产生任何理赔的情况下保费不予退还。

I authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide the Insurer or their authorized representative information, including copies of records, concerning advice, care, or treatment provided to me, including without limitation, information relating to mental illness or use of drugs or alcohol.
我授权任何医疗专家、医院、诊所、其他医学或医疗相关机构、政府代理人、或其他人员或公司向保险公司或他们的授权代表提供信息，包括病历记录复印件、相关咨询建议、护理或治疗方案，包括并不限于关于精神疾病或药物、酒精滥用的信息。

I understand that such information will be used by the Insurer for the purpose of evaluating my application for insurance, or by Insurer representatives involved in evaluating, determining, or administering claims for insurance benefits. I understand that I or any authorized representative will receive a copy of this authorization upon request.
我明白保险公司会根据以上信息评估我的投保申请或保险公司的授权代表会据此涉及处理保险责任的评估、判断或理赔管理。我明白任何授权代表或我本人可在提出要求后获得此授权书副本。

I have been informed of the terms and conditions of the insurance plan. I accept these terms and conditions, including "Residence Verification" and "Authorization for Release of Information". I declare that to the best of my knowledge and belief the statements made in this Application form are true and complete. I understand that failure to disclose information in this application may be the basis for cancellation of policy or claims denial.
我已经被告知保险计划的条款和投保条件。我接受所述条款和投保条件，包括"长期居住地确认"和"客户信息授权"，并正式申明，尽我所能提供在本投保申请表中的陈述内容是准确的和完整的。我明白未尽如实告知义务会导致本保险合同被取消或理赔被拒绝的后果。

Applicant Signature 投保申请人亲笔签名

Date Signed 亲笔签署日期