

**供公司使用 — 保险中介详情及印章**  
**For company use – intermediary details and stamp**

保险中介公司： Intermediary company:	传真号码： Fax number:
	电邮地址： Email address:
联络姓名： Contact name:	官方印章： Official stamp:
电话号码： Telephone number:	

如果您正在申请我们的个人与家庭医疗保险计划/团体医疗保险计划，而该计划的保障方式又与您现有的保单相似，则我们可为您提供保单转移服务，这意味着我们将无需要求您提供有关您本人/您的员工的既往病史详情，即可使原有的保障得到延续。等待期适用于任何新的保障。对于任何您之前保单所承保的保障，如果不在我们的个人与家庭医疗保险计划/团体医疗保险计划的承保范围之内，保单转移后将不承保此类保障。您现有保单的批单也将继续适用于您的新保险计划/团体保险计划。

请使用正楷字体填写本表格。您需要附上您现有保障一览表和保险凭证的副本，其中需列出任何批单的详情与现有保单的生效日期。

如未告知所有的重要事实，可能会导致本公司解除保险合同及/或日后的理赔申请不被受理。重要事实指可能会影响本公司是否同意承保或提高保险费的事实。如投保人不确定某事实是否属重要，投保人应披露该事实。请保留一份投保人向本公司提供有关本申请的所有数据的记录。

如在投保人的投保单填写后及在本公司的书面接受日期、支付保费日期或投保人的生效日期/参保日期（以最迟者为准）前，发生任何会影响投保人在本投保单所提供数据的事情（如投保人的健康状况或连带被保险人的健康状况发生变化），投保人须书面告知本公司该等变化。

请通过您的保险中介或直接向时康管理顾问（上海）有限公司寄送您填写的申请表格，转交：亚太财产保险有限公司，中国上海市虹口区吴淞路218号宝矿国际大厦11楼1103室-1105室，邮编：200080。您亦可将其扫描及电邮至ChinaSales@now-health.com或传真至+(86) 400 077 7900。

If the applicant applying for one of the insurer's policies/group policies with benefits similar to those of his/her current policy, the insurer may be able to offer the applicant a continuous transfer, which means that the insurer will not ask for details about the applicant/the applicant's employees medical history and cover can continue. For any new benefits the waiting period will apply. Any benefits covered under the applicant's previous policy but not covered under the insurer's policy/group policy will not be eligible for cover following the transfer. Any endorsements that applied to the applicant's existing policy will continue to apply to the applicant's new policy/group policy.

Please complete this form in BLOCK CAPITALS. The applicant should attach a copy of his/her existing policy schedule and certificate of insurance, detailing any endorsements and the start date of the existing policy.

Failure to disclose all material facts may lead to cancellation of the insurance policy by the insurer and/or non-acceptance of future claims. A material fact is one which is likely to influence the insurer to accept the application or to increase the premium rate. If the applicant is unsure whether a fact is material, the applicant should disclose it. Please keep a record of all information the applicant supplies to the insurer in connection with this application.

If, after completing the application form and before the latest of either the insurer's written acceptance, payment of premium or the applicant's start date/entry date, anything occurs which affects the information the applicant provided in this form, such as a change in the applicant's state of health or the state of health of any of the applicant's dependants, the applicant must tell the insurer in writing about the change.

Please send the completed application form via the applicant's intermediary or direct to Asia-Pacific Property & Casualty Insurance Co., Ltd., c/o: Now Health International (Shanghai) Limited, Room 1103-1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China. The applicant can also scan and email it to ChinaSales@now-health.com or fax it to +(86) 400 077 7900.

**保单转移要求：**  
**Request to transfer from:**

现有亚太财险《健享+》或《全球保》个人与家庭医疗保险计划转移至亚太财险《健享+》团体医疗保险计划 — 请填写第1 - 8b部分

An existing Asia-Pacific P&C ChinaCare or WorldCare individual policy to a Asia-Pacific P&C ChinaCare group policy – please complete sections 1 - 8b

现有其他保险人承保的保险计划转移至亚太财险《健享+》团体医疗保险计划 — 请填写第1 - 8b部分

Another insurer to a Asia-Pacific P&C ChinaCare group policy – please complete sections 1 - 8b

## 第一部分：购买过的医疗保险 Section 1: Previous Medical Insurance

保险单编号： Policy no.:	保障终止时间(日/月/年)： Date cover expires/expired (dd/mm/yyyy):	/	/
保险人(公司)的名称： Name of insurer:			
投保人打算继续维持现有保险吗？ Do you intend to continue with the existing insurance?			是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes No

## 第二部分：个人与家庭/团体员工 Section 2: Individuals and families/Group members

### 2.1 投保人姓名 Name of Policyholder

名： First name(s):	姓： Family name:
我们应如何称呼您？ What does the applicant like to be called?	

(如投保人的全名为 John Andrew Smith，您可能希望我们称您为 John 或 Smith 先生或 Andy。保险人将在所有通讯中以这种方式称呼您。)  
(If the applicant's full name is John Andrew Smith, the applicant might like to be called John or Mr Smith or Andy. The insurer will address all correspondence to the applicant in this way.)

### 2.2 投保人详情 Policyholder details

地址： Address:				
电邮地址： Email address:				
首选电话号码(包括国家代码)： Preferred telephone number (including country code):				
该号码为投保人的 Is this the applicant's	移动电话 <input type="checkbox"/> 家庭电话 <input type="checkbox"/> 办公电话 <input type="checkbox"/> Mobile Home Work	如果您需要开通短信通知服务，请告诉我们您的手机号码： If the applicant would like SMS notifications, please tell us his/her mobile number:		
性别： Gender:	男性 <input type="checkbox"/> 女性 <input type="checkbox"/> Male Female	出生日期(日/月/年)： Date of birth (dd/mm/yyyy):	/	/
居住国家： Country of Residence:	国籍(护照签发国家)： Nationality (Country of passport issuance):			
身份证/护照号码： ID/Passport number:	员工类别： Employee category:			
身高(厘米/英尺)： Height (cm/ft):	体重(公斤/磅)： Weight (kg/lbs):			
职业： Occupation:	行业： Occupation industry:			

### 2.3 连带被保险人详情 Dependant details

配偶详情 Spouse details				
名： First name(s):		姓： Family name:		
我们应如何称呼您？ What does he/she like to be called?				
性别： Gender:	男性 <input type="checkbox"/> 女性 <input type="checkbox"/> Male Female	出生日期(日/月/年)： Date of birth (dd/mm/yyyy):	/	/
居住国家： Country of Residence:	国籍(护照签发国家)： Nationality (Country of passport issuance):			
身份证/护照号码： ID/Passport number:	员工类别： Employee category:			
身高(厘米/英尺)： Height (cm/ft):	体重(公斤/磅)： Weight (kg/lbs):			
职业： Occupation:	行业： Occupation industry:			



连带被保险人详情 Dependant details	连带被保险人 1 Dependant 1	连带被保险人 2 Dependant 2	连带被保险人 3 Dependant 3	连带被保险人 4 Dependant 4
名： First name(s):				
姓： Family name:				
我们应如何称呼他/她们？ What does he/she like to be called?				
身份证/护照号码： ID/Passport number:				
性别： Gender:	男性 <input type="checkbox"/> 女性 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>	男性 <input type="checkbox"/> 女性 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>	男性 <input type="checkbox"/> 女性 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>	男性 <input type="checkbox"/> 女性 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>
出生日期(日/月/年)： Date of birth (dd/mm/yyyy):	/ /	/ /	/ /	/ /
居住国家： Country of Residence:				
国籍： Nationality:				
身高(厘米/英尺)： Height (cm/ft):				
体重(公斤/磅)： Weight (kg/lbs):				
与投保人的关系： Relationship to policyholder:				
职业(16岁以上者)： Occupation (ages 16+):				

#### 2.4 健康声明 Health declaration

如投保人有超过五位连带被保险人，请使用另一张纸，并将其随附于本申请表格。

If the applicant has more than five dependants, please use a separate sheet of paper and attach it to this application.

投保人无需披露有关普通感冒、疫苗接种、花粉过敏、简单性骨折或切除盲肠手术的事宜。

The applicant does not need to disclose matters related to common colds, vaccinations, hayfever, uncomplicated fractures, or appendectomy.

	投保人/ 主被保险人 Policyholder/ Direct Insured	连带被保险人 (配偶) Dependant (Spouse)	连带被 保险人1 Dependant 1	连带被 保险人2 Dependant 2	连带被 保险人3 Dependant 3	连带被 保险人4 Dependant 4
2.4.1 在近五年来您是否曾经接受任何外科手术或在医院、诊所、疗养院、护理院或其他医疗机构看病或接受治疗而因此停止工作超过一周，及/或接受超过10天的治疗？ Has the applicant in the last five years ever undergone any surgical procedure, been a patient or been treated in a hospital, clinic, sanatorium, nursing home or other medical institution where the applicant was off work for more than one week, and/or received more than 10 days' treatment?	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
2.4.2 您目前是否正在接受任何类型的药物(除口服避孕药外)或接受或计划接受任何治疗或测试、或预先安排任何日间留院或住院治疗？ Is the applicant currently taking any kind of medication (other than oral contraceptives), or is any treatment or tests currently being performed or planned, or any day or in-patient hospitalisation scheduled?	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
2.4.3 在过去五年，有以下不适症状、曾经被诊断或有治疗过以下情况： 反复咽痛、慢性咳嗽、咯痰、咯血、呼吸困难或其他呼吸系统症状、腰痛、尿频、尿急、尿痛、排尿困难、血尿、蛋白尿、尿量异常、夜尿增多、面部浮肿、食欲减退、腹胀、腹痛、呕血、黑便、便血、黄疸、吞咽困难、心悸、活动后气促、下肢水肿或静脉曲张、胸部不适或胸闷、晕厥、风湿热或心脏杂音、心律不齐、乏力、头昏、牙龈出血、皮下出血、紫癜、骨痛、腰痛、食欲异常、多汗、多饮、多尿、双手震颤、肥胖、色素沉着、眩晕、晕厥、记忆力减退、视力障碍、震颤、抽搐、惊厥、瘫痪、感觉异常、白内障、青光眼或其他眼疾、听力损失、任何身体障碍、先天性或遗传性障碍、残疾、复发性疾病、目前怀孕、任何妊娠并发症或胎儿有任何异常、重大损伤或医疗状况？ Any health problems or complaints, been diagnosed with, or had treatment for any of the following in the past 5 years: Repeated pharyngalgia, chronic cough, expectoration, hemoptysis, difficulty breathing or other symptoms of the respiratory system, back pain, frequent urination, urgency of urination, pain in urination, difficulty urinating, blood or protein in the urine, abnormal amount of urine, nocturia, swelling in the face, chronic loss of appetite, abdominal distention, abdominal pain, hematemesis, melena, hematochezia, jaundice, difficulty swallowing, palpitation, tachypnea after exercise, edema or varicose veins of lower extremity, chest discomfort or pressure, syncope, rheumatic fever or heart murmur, arrhythmia, fatigue, dizziness, subcutaneous, hemorrhage, purpura, pain in bone, neck pain and lumbar pain, abnormal appetite, hyperhidrosis, polydipsia, polyuria, tremor on hands, obesity pigmentation, vertigo, syncope, hypomnesia, disturbance of vision, tremor, convulsions, seizure, paralysis, sensory abnormality, cataracts, glaucoma, or any eye disorder, hearing loss, or any physical impairment, congenital or hereditary disorder, disability, recurrent illness, currently pregnant, any complications of pregnancy or abnormal of the fetus, major injury or medical condition.	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

## 附加资料

### Additional information

如您在第2.4.1题至2.4.3题中的任何一条问题的回答为「是」, 请在以下方框内提供详情。

If the applicant answered 'Yes' to any of questions 2.4.1 to 2.4.3, please provide details in the box below.

姓名 Name	问题编号 Question number	请提供最详尽细节, 包括诊断日期及性质、症状出现频率及严重程度、最近发作日期以及任何过往、目前或已知的日后治疗的详情。 Please provide as much detail as possible, including the date and nature of diagnosis, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future treatment.

### 2.5 医生的联络资料 Doctor's contact details

请提供您现时平常就诊的医生或对您的病历最熟悉的医生的详情。

Please give details of your current usual doctor or the one who is most familiar with your medical history.

#### 医生详情

##### Medical practitioner's details

姓名 : Name:	电话号码 : Telephone number:
地址 : Address:	
最近就诊的日期及原因 : Date of last attendance and reason:	

## 第三部分：公司

### Section 3: Companies

#### 3.1 投保人(公司)详情 Policyholder (Company) details

公司名称 : Company name:	
公司地址 : Company address:	
公司机构代码 : Company code:	
公司网址 : Company website address:	业务类型 : Type of business:



### 3.2 投保人(公司)保单管理人详情 Policyholder (Company) policy administrator details

名 :  
First name(s):

姓 :  
Family name:

我们应如何称呼您 ?  
What does he/she like to be called?

(如保单管理员的全名为 John Andrew Smith, 您可能希望我们称呼您为 John 或 Smith 先生或 Andy。保险人将在所有通讯中以这种方式称呼您。)  
(If the policy administrator full name is John Andrew Smith, the policy administrator might like to be called John or Mr Smith or Andy. The insurer will address all correspondence to the policy administrator in this way.)

职位 :  
Job title:

地址 (若与上述地址不同) :  
Address (if different from above) :

电话 :  
Telephone:

传真 :  
Fax:

电邮地址 :  
Email address:

### 3.3 被保险人 Membership

保险人需要每位被保险人的名单, 其中必须包含每位被保险人的详情如下。  
The insurer needs a full membership list as follows and it must include these details for each person to be covered

1. 名 First name(s)
2. 姓 Family name
3. 我们应如何称呼他/她们?  
What do they like to be called?  
(如您的员工的全名为 John Andrew Smith, 您可能希望我们称呼他为 John 或 Smith 先生或 Andy。保险人将在所有通讯中以这种方式称呼您的员工。)  
(If an employee's full name is John Andrew Smith, he might like to be called John or Mr Smith or Andy. The insurer will address all correspondence to him in this way.)
4. 性别 Gender
5. 出生日期 (日/月/年) Date of birth (dd/mm/yyyy)
6. 身份证/护照号码 ID/Passport number
7. 职业 Occupation
8. 员工类别 Employee category
9. 保险生效首日 (日/月/年) — 参保日期  
Entry date – first day of cover (dd/mm/yyyy)
10. 居住国家 Country of residence
11. 国籍 Nationality
12. 电邮地址 Email address
13. 电话号码 Telephone no.
14. 与主被保险人的关系 Relationship to direct insured
15. 连带被保险人应包括在内 Dependants to be included
16. 入职日期 (员工) (日/月/年)  
Start date of employment (employees only) (dd/mm/yyyy)

### 3.4 被保险人资格 Eligibility

请定义被保险人类别 :  
Please define the member category:

类别名称, 如董事、经理、一般员工等 Name of category e.g. directors, managers, general employees	被保险人量数 Number of members

- 统一投保 Compulsory  或 or 自愿 Voluntary
- 仅员工 Employees only  或 or 员工和连带被保险人 Employees and Dependants
- 外籍员工 Expatriates  和/或 and/or 本国员工 Local Nationals

新员工的保障生效日期:

Start Date for New Employees:

- 入职首日起 First date of employment
- 个月试用期后 After \_\_\_\_\_ month(s) probation period

如果连带被保险人年满18岁以上, 保险人可以要求其学校出具该连带被保险人接受全日制教育的书面确认材料。

For dependants aged over 18, the insurer may require written confirmation from their place of study that they are in full-time education.

#### 第四部分：生效日期 Section 4: Start Date

在保险人收到本投保单及正确保费，且投保人接受保险人的全部条款及条件后，保险方可生效。投保人可要求在本投保单填妥后的60日内保单开始生效。Cover cannot start until the applicant has accepted all of the insurer's terms and conditions following the insurer's receipt of this application form and the insurer has received the correct premium. The applicant can apply for cover to start at a future date within 60 days of completion of this application.

保险计划/团体保险计划将从(日/月/年)开始生效：

The date the policy/group policy will start from (dd/mm/yyyy):

/ /

#### 第五部分：付款人与保费的支付方式 Section 5: Payor and Frequency of premium payment

请注意，如投保人现根据指示性报价作出付款，在本公司审核本申请表格后，应付金额可能会发生变动。投保人须在保险开始前，同意并支付修改后的保费。请选择投保人支付保费的频率。请注意季度保费需支付3%的附加费。

Please note that if the payment the applicant is to make now is based on an indicative quote, the amount due may change once the insurer has reviewed this application. The applicant will need to both agree and pay the revised premium before cover can start. Please select the frequency the applicant would like to pay premiums in. Please note that quarterly premiums have a 3% surcharge.

如果本保险合同约定可以分期支付保险费，投保人在支付首期保险费后，投保人自保险人催告之日起超过三十日未支付当期保险费的，保险人可以解除保险合同，或者按照合同约定的条件减少保险金额。如果本保险合同约定为一次性支付保险费，但投保人没有支付保险费或者没有完全支付保险费，投保人自保险人催告之日起超过三十日仍未支付应当缴纳的保险费的，保险人可以解除保险合同，或者按照合同约定的条件减少保险金额。保险人解除保险合同的，自保险人解除合同之日起不承担保险责任。

If the premium of the policy is agreed to be paid by installments, where the policyholder has paid the first installment but does not pay any of the following installment after 30 days of the payment due date being notified, the insurer can terminate the policy or reduce the insurance liabilities of the contract. If the premium of the policy is agreed to be paid as one-off, where the policyholder does not pay or does not pay the required full premium after 30 days of the payment due date being notified, the insurer can void the policy or reduce the insurance liabilities of the contract. If the insurer decides to void the policy, the insurer will not be liable for the insurance liabilities incurred.

个人与家庭 Individuals and families	年缴 Annually
银行转账 Bank transfer	<input type="checkbox"/>
自动扣款(转账)授权 Direct Debit Authorisation * 请填写自动扣款(转账)授权书部份(见第九部分) * Please fill out the direct debit authorisation section (section 9)	<input type="checkbox"/>

开具发票的相关注意事项，请参见第十部分——“付款人及发票抬头要求”。

The matters related to fapiao issuance, please refer to Section 10 — “The Payor and the Issuance of Fapiao Request”.

公司 Companies	年缴 Annually	半年缴 Semi-annually	季缴(附加费3%) Quarterly (3% Surcharge)
银行转账 Bank transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## 第六部分：保险计划选项 Section 6: Policy options

有关保险计划/团体保险计划选择的详细资料，请参阅《健享+》保障一览表。投保人的保费支付的币种为人民币，且计划免赔额亦以该货币计值。请指明投保人的保险计划选择、免赔额及任何其他选项。

For detailed information about the policy/group policy choices available, please refer to ChinaCare benefit schedule. The currency the applicant pays his/her premium in is RMB and the policy excesses will also be denominated in this currency. Please indicate the applicant's plan choice, excess, and any additional options.

### 保险计划/团体保险计划选项 Choice of Policy/Group Policy

保险计划选项 Policy options	华安 Amber	华乐 Jade	华享 Crystal
年度最高计划限额 Maximum annual limit	100万人民币 RMB 1m	200万人民币 RMB 2m	300万人民币 RMB 3m
住院及日间留院护理 In-patient and day-patient care	▶	▶	▶
器官移植 Organ transplant	▶	▶	▶
癌症治疗 Cancer treatment	▶	▶	▶
转运和送返 Evacuation and transportation for returning to city of residence/home city	▶	▶	▶
日间留院或门诊手术 Day-patient or out-patient surgery	▶	▶	▶
门诊医生费用 Out-patient charges	▶	▶	▶
康复治疗 Rehabilitation	▶	▶	▶
先天性疾病 Congenital disorders	▶	▶	▶
慢性病症 Chronic condition cover	▶	▶	▶
生育保障 Maternity cover	▶	▶	▶
<b>请选择</b> <b>Please choose</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

▶ 全额赔偿 Full refund    ▶ 不予承保 Not covered    ▶ 有限承保 Limited cover

为公司提供的其他附加选项 Additional options for companies	华安 Amber	华乐 Jade	华享 Crystal
既往病史不赔 (适用于20名员工或以上的统一投保的团体保单) Medical history disregarded (Compulsory group policies 20+ employees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# 门诊直付医疗网络医院名单公布于<http://www.now-health.cn>。本公司对门诊直付医疗网络医院名单可能会进行不定期调整。在以上网址公布的门诊直付医疗网络医院名单，将视同通知并送达投保人及每一被保险人。每次就诊前，被保险人应及时上网查询最新的门诊直付医疗网络医院名单。因门诊直付医疗网络医院清单变动导致被保险人保障条件变化，本公司不承担责任。

# The Out-Patient Direct Billing list can be found from the web site at <http://www.now-health.cn>. This list may be updated from time to time. The changes made in the Out-Patient Direct Billing list is deemed to be available and known to the policyholder and each respective insured person. The insured person should check for any changes in the list before selecting a medical facility and prior to each medical visit. The insurer is not responsible for billing procedures or other consequences caused by changes to the network list.

## 个人保险/团体保险免赔额 Policy/Group Policy Excess

如投保人希望从标准的免赔额改为其他选项，请勾选适当方框。请注意下列的保险计划/团体保险计划免赔额用于每名被保险人于每个保险期间的每个医疗状况。

If the applicant would like to change from the standard excess to one of the other options, please tick the appropriate box. Please note that the policy/group policy excess is per insured person, per medical condition, per period of cover.

保障 Benefit	华安 Amber	华乐 Jade	华享 Crystal
标准免赔额 Standard Excess	零 Nil	零 Nil	零 Nil
自选免赔额 Optional Excess			
门诊就医免赔额方案 Out-patient Per Visit Excess	不适用 N/A	<input type="checkbox"/> 可供选项150人民币 Optional RMB 150	<input type="checkbox"/> 可供选项150人民币 Optional RMB 150

### 第七部分：重要备注 Section 7: Important notes

#### 注意:

- 请注意您的保险计划不承保投保前疾病及其相关疾病（不包括事先得到保险人书面同意承保的投保前疾病）  
投保前疾病的定义为任何疾病或损伤在保单起始日期或者保单加入日期前：
  1. 曾接受过治疗、测试或检查；或曾被确切诊断；或曾接受过住院治疗；或者
  2. 曾出现过症状，无论是否有过确切诊断
- 在上述详情维持不变的条件下，报价将在30天内有效，且报价按照亚太财产保险有限公司的《健享+》个人与家庭医疗保险计划/《健享+》团体医疗保险计划的条款、条件及责任免除发出。
- 所报保费是根据每人于报价日期的年龄计算。如在您于亚太财产保险有限公司的个人与家庭医疗保险计划的实际生效日期前，任何人士的年龄出现增长，保费可能会因此而改变。在本保险公司收到本投保单及正确保费，且您接受本保险公司的全部条款及条件后，保险方可生效。
- 所报保费是根据您的的身体质量指数在正常限度内厘定。

#### 资料保障

在审核您的投保申请以及与被保险人往来（如已向其出具保险计划）的过程中，保险人将收集到部分与被保险人相关的信息。该信息将被用于确认您的保障范围、管理已签发的保险计划以及处理赔案。被保险人的信息可能因为上述目的而被转交至核保人、医生、医疗援助公司及理赔管理人。

任何协助管理您的保险计划的第三方亦需承担相同的保密责任。除上述者外，被保险人的姓名及联系数据将不会向其他组织披露。

#### Remark:

- Pre-Existing Medical Conditions  
Your policy does not cover you for treatment of Pre-Existing Medical Conditions and Related Conditions unless accepted by the insurer in writing. A Pre-Existing Medical Condition means any disease, injury or illness for which:
  1. You have received treatment, tests or investigations for, been diagnosed with or been hospitalised for; or
  2. You have suffered from or experienced symptoms; whether the medical condition has been diagnosed or not, at any time before your start date/entry date into the plan.
- Quotations are valid for 30 days subject to the above details remaining the same and are issued in accordance with Asia-Pacific Property & Casualty Insurance Co., Ltd. medical insurance policy terms, conditions and exclusions.
- The premiums quoted have been calculated based on each person's age at the date of the quotation. Premiums may be subject to change if the age of any person increases prior to the actual start date of the applicant's Asia-Pacific Property & Casualty Insurance Co., Ltd. medical insurance policy. Cover cannot start until the applicant has accepted all of the insurer's terms and conditions following the receipt of this application form and the insurer has received the correct premium.
- The premiums quoted have been based on the applicant's body mass index being within normal limits.

#### Data protection

The insurer will collect certain information about the insured member in the course of considering the applicant's application and if a policy is issued to the insured member, conducting the insurer's relationship with the members. This information will be processed for the purposes of underwriting the insured member's insurance coverage, managing any policy issued and administering claims. The insured members' information may be passed to underwriters, medical practitioners, medical assistance companies and claims administrators for these purposes.

The same duty of confidentiality is required of any third parties to whom the administration of your policy may be subcontracted. The insured members' name and contact details will not be disclosed to other organisations (except as stated above).





## 第八部分：声明及授权

### Section 8: Declaration and authorisation

#### 《健享+》团体医疗保险声明及授权

投保人特此代表本投保单中列名的所有人士就上文指明的亚太财产保险有限公司《健享+》团体医疗保险计划申请保险。

投保人已知晓并阅读本团体保险计划的保障一览表、条款及条件、定义、保障和责任免除事项。投保人明白投保单、团体保险合同、保险凭证、保障一览表以及附有本团体保险计划条款和条件的团体保险条款，将构成我们双方之间的合同以及本团体保险计划合同的所有部分。投保人知道投保覆盖范围将根据协议提供。

- 投保人声明所填本投保单的数据乃属真实，就本投保单的各名人士作出的披露乃属完整，即便所提供的若干数据并非投保人亲笔书写。
- 投保人明白，投保人为欺诈或企图欺诈亚太财产保险有限公司而向亚太财产保险有限公司提供错误、不完整或有误导性的事实，贵公司有权拒绝承保或解除保险合同。
- 投保人明白投保人须在书面接受日期、支付保费日期或生效日期/参保日期（以最迟者为准）前，通知亚太财产保险有限公司关于本投保单内所载事实的任何变动，包括本投保单内列名的任何人士的健康状况的变化。
- 投保人声明，投保人已阅读并明白《健享+》团体医疗保险条款和《健享+》团体医疗保险协议的以下章节：
  - 取消和终止权利
  - 有关团体保单的法律及司法管辖区
  - 团体保单的用字及我们的服务
  - 赔偿安排
  - 责任免除
  - 时康管理顾问（上海）有限公司代表亚太财产保险有限公司安排及管理保单及支付索赔
- 投保人明白，如亚太财产保险有限公司因任何原因无法收取投保人的保费，且投保人未在亚太财产保险有限公司提出使用其他支付方式的要求后的七日内，向亚太财产保险有限公司提供其它支付方式，因而令投保人的团体保险计划失效，亚太财产保险有限公司对此不承担责任亦因此无需支付理赔。
- 投保人已知晓重要备注。
- 投保人同意上述声明并明白保险乃根据亚太财产保险有限公司《健享+》团体医疗保险的条款及条件提供。
- 本人同意如果投保单的中英文内容存在不一致时，以中文文本的内容为准。
- 本人明白，如果本人能够向其他保险保单索赔任何治疗费用或其他保障，亚太财产保险有限公司仅负责理赔总额中相应比例的部分。
- 本人和本保单其他的被保险人同意贵司在管理我们保单时，需要收集我们的个人信息和使用它们。其涵盖范围可能需要分享我们的个人信息与时康管理顾问公司，保险人，医疗机构和其他各方以方便其履行对我们的服务。据本人所知，我们的个人资料将被安全地保存，并在严格保密处理。
- 本人已经收到并仔细阅读保险条款，尤其是对责任免除、投保义务、被保险义务、赔偿限额、免赔额、自付比例等保险人用黑体字特别标明提醒本人特别注意的内容，保险人已经进行说明和解释，本人能够理解并知晓法律后果，对保险条款包括保险人用黑体字特别注明部分的内容没有异议，本人已经充分理解和清楚保险条款的全部内容。上述所填写内容均属实，同意以此投保单作为订立保险合同的依据。

#### Declaration and authorisation for companies and group members

I hereby apply for cover on behalf of all the persons named in this application form for a Asia-Pacific Property & Casualty Insurance Co., Ltd. group policy as specified above.

I have received and read the benefit schedule, terms and conditions, definitions, benefits and exclusions of this group policy. I understand that the application form, group agreement, certificate of insurance, benefit schedule and the policy wording incorporating the group policy terms and conditions make up the contract between the insurer and the policyholder and all form part of the group policy agreement. I am aware that cover shall be provided in accordance with the agreement.

- I declare that the information given in this application is true and that disclosure in respect of each person included in this application is complete, even if some of the information provided is not in my own handwriting.
- I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information to Asia-Pacific Property & Casualty Insurance Co., Ltd. for the purpose of defrauding or attempting to defraud Asia-Pacific Property & Casualty Insurance Co., Ltd. The insurer has the right to refuse underwriting or to terminate the insurance policy.
- I understand that I must notify Asia-Pacific Property & Casualty Insurance Co., Ltd. of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it, before the latest of either written acceptance, payment of premium or the start date/entry date.
- I declare that I have been made aware of the importance of and read and understood the following from the policy wording and group agreement:
  - cancellation and termination rights
  - law and jurisdiction of the group policy
  - language of the group policy and our service
  - compensation arrangements
  - exclusions
  - Now Health International (Shanghai) Limited is acting on behalf of Asia-Pacific Property & Casualty Insurance Co., Ltd. for the purposes of preparing and administering policy, and paying claims.
- I understand that Asia-Pacific Property & Casualty Insurance Co., Ltd. cannot be liable and therefore will not pay claims if my group policy is lapsed should Asia-Pacific Property & Casualty Insurance Co., Ltd. be unable to collect my premium for whatever reason and I do not provide Asia-Pacific Property & Casualty Insurance Co., Ltd. with an alternate method of payment within seven days of Asia-Pacific Property & Casualty Insurance Co., Ltd. requests for alternative methods of payment.
- I have read the important notes.
- I agree to the declaration above and understand that cover is provided in accordance with the terms and conditions of the Asia-Pacific Property & Casualty Insurance Co., Ltd. group policy.
- I agree that if there is any inconsistency between the Chinese and English version of the insurance application form, the Chinese version should prevail.
- I understand that if I am able to claim any costs from another insurance policy for the cost of any treatment or benefits received, Asia-Pacific Property & Casualty Insurance Co., Ltd. will only be liable for a proportional share of the total costs.
- I and those covered under this policy consent to the collection and use of our personal information in the administration of our policy. This may include sharing our personal information with Now Health offices, our insurer, medical providers and other parties to the extent needed to fulfill our policy. I understand that our data will be kept securely and handled in strict confidence.
- I have received and carefully read the insurance policy, especially for the insurance exclusions, the policyholder and the insured's obligations, maximum claim amount, co-insurance, deductible, excesses etc. which the sections have been bolded by the insurer to alert the policyholder to be careful in the content. The insurer has already explained and clarified the terms and conditions of the insurance policy. I am fully aware and understand the legal consequence. I have no disagreement to the particular sections including the policy wordings that are bolded. I fully understood and I am aware the content of all the policy wordings. All the above sections signed are truth and facts and I agree to use this application form as the base for our insurance contract.

签名 个人医疗保险计划/团体医疗保险计划（主被保险人/投保人）  
Signature (Insured/main applicant for individual plans or group members)

日期（日/月/年）：  
Date (dd/mm/yyyy):

/ /

签名 团体医疗保险计划（被授权人/保单管理员）  
Signature (Authorised person/policy administrator for company plans)

日期（日/月/年）：  
Date (dd/mm/yyyy):

/ /

保险合同由亚太财产保险有限公司签发，并委托时康管理顾问(上海)有限公司进行保单管理。  
亚太财产保险有限公司地址：中国深圳市福田区中心区福华一路免税商务大厦29-30楼，邮编：518048  
时康管理顾问(上海)有限公司地址：中国上海市虹口区吴淞路218号宝钢国际大厦11楼1103室-1105室，邮编：200080  
Policies are issued by Asia-Pacific Property & Casualty Insurance Co., Ltd. Registered Office: 29-30F, Dutyfree Business Building, 1st Fuhua Road, Futian CBD, Shenzhen 518048, China. Policies are administered by Now Health International (Shanghai) Limited. Room 1103-1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China.





**第九部分：自动扣款（转账）授权**  
**Section 9: Direct Debit Authorisation**

账户持有人名称 (仅限于投保人，必须与银行系统中账户名完全一致)： The bank account holder's name (Limited to the policyholder. Must match the account holder name) :	
银联借记卡号： UnionPay Debit Card Number :	
开户银行名称： Bank Name (please fill in the Chinese bank above):	
身份证件/护照号码： ID / Passport number :	

**请阅读以下授权声明：**

本人授权亚太财产保险有限公司与开户银行，按保险合同约定的保险费缴付时间和保险费金额，从上述账户以转账方式自动扣划各期保险费。如该账户终止或余额不足以缴纳保险费，由此所产生的保险契约自此不产生效力或保险合同中止或终止的任何责任由本人承担。本人清楚，如本人终止保险费自动扣款（转账）授权或变更付款账户，应提前30天向亚太财产保险有限公司递交书面申请。

**Please read the following authorised statement:**

I hereby authorise Asia-Pacific Property & Casualty Insurance Co., Ltd. and the account opening bank to automatically debit the insurance premium payment from the above authorised bank account as per the premium and the payment period from my insurance policy contract. If the above bank account has been terminated or the balance is not sufficient to pay for the insurance premium, I am responsible for any liabilities that may arise, related to the above payment arrangement, including my insurance contract becoming void, terminated or lapsed. I am aware that should I wish to terminate the direct debit authorisation or change my bank account, I should submit my written request to Asia-Pacific Property & Casualty Insurance Co., Ltd. at least 30 days in advance.

**备注：**

若申请自动扣款（转账）授权，请投保人同时提供银行卡复印件，供我公司从相关银行划扣保险费之用。

**Note:**

If the policyholder would like to apply for the direct debit authorisation, they should provide a copy of their bank card.

签名：  
Signature (policyholder):

日期(日/月/年)：  
Date (dd/mm/yyyy):

/ /

保险合同由亚太财产保险有限公司签发，并委托时康管理顾问(上海)有限公司进行保单管理。  
 亚太财产保险有限公司地址：中国深圳市福田区中心区福华一路免税商务大厦29-30楼，邮编：518048  
 时康管理顾问(上海)有限公司地址：中国上海市虹口区吴淞路218号宝矿国际大厦11楼1103室-1105室，邮编：200080  
 Policies are issued by Asia-Pacific Property & Casualty Insurance Co., Ltd. Registered Office: 29-30F, Dutyfree Business Building, 1st Fuhua Road, Futian CBD, Shenzhen 518048, China. Policies are administered by Now Health International (Shanghai) Limited. Room 1103-1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China.



**第十部分：付款人及发票抬头要求**

**Section 10: The Payor and the Issuance of Fapiao Request**

若以下未做选择/填写，将默认为个人付款(选择 1)，开具投保人为抬头的发票。

**Personal payment and Fapiao under policyholder name (option 1) is the default option if the below is not specified/filled.**

1. 个人付款(以投保人姓名开具发票)。  
The premium will be paid from my personal account. Fapiao is issued under the Policyholder name (in its Chinese Name).
2. 个人付款，工作单位\_\_\_\_\_将补偿本人保险费。请以工作单位名称开具发票  
(仅适用于年缴保单)。  
The premium will be paid from my personal account, and the Working Company \_\_\_\_\_ will reimburse me the premium. Please issue the Fapiao to the Working Company Name **(Applicable to annual mode ONLY)**.
3. 保费将通过工作单位\_\_\_\_\_账户支付。请以工作单位开具发票。  
The premium will be paid by the Working Company \_\_\_\_\_. Please issue the Fapiao to the Working Company Name.

**若选择 2 或 3: If option 2 or 3 is selected:**

- 所有与上述安排相关税务问题应由本人与工作单位负责解决；本人与工作单位应依法申报、缴纳所有税务事宜；所有税务相关法律责任均由本人与工作单位连带承担，亚太财产保险有限公司不承担任何责任。  
The Policyholder hereby acknowledges and confirms that the Policyholder and the Working Company shall be the sole parties to be responsible for solving all taxation-related issues in connection with the payment arrangement mentioned above. The Policyholder and the Working Company shall make all taxation-related declarations and pay all relevant taxes in accordance with applicable laws and regulations. The Policyholder and the Working Company shall always be the sole parties to be responsible for all taxation-related obligations and responsibilities and be jointly and severally responsible for holding Asia-Pacific P&C harmless from any such obligations and responsibilities.
- 如果保单生效后投保人申请退保的，则请亚太财产保险有限公司将所退费用以转账方式退回工作单位账户。  
If the Policyholder cancels the said insurance policy after the policy has come into effect, please refund the premium directly to the bank account of the Working Company.

**投保人签名及工作单位盖章**

**Policyholder signature and Company chop**

投保人(签名): Policyholder (Signature):	工作单位(盖章): Working Company (Company Chop):
日期(日/月/年): Date (dd/mm/yyyy):	日期(日/月/年): Date (dd/mm/yyyy):

- \* 若最终付款人及发票抬头要求与上述填写的不一致，保险公司审核后，保留是否同意收取该笔首期，分期保费/或续期保费以及默认开具首期，分期保费/或续期保费发票给投保人的权利。**发票一旦开具，任何情况下不能重新开具。**
- \* If the final payer and fapiao title request is different from the above provided information, the insurer reserves the right to return the initial or next installment and renewal premium paid by third party and issue the fapiao to the default policyholder's name.  
**Re-issuance of the fapiao is NOT accepted under any circumstance.**

保险合同由亚太财产保险有限公司签发，并委托时康管理顾问(上海)有限公司进行保单管理。  
亚太财产保险有限公司地址：中国深圳市福田区中心区福华一路免税商务大厦29-30楼，邮编：518048  
时康管理顾问(上海)有限公司地址：中国上海市虹口区吴淞路218号宝矿国际大厦11楼1103室-1105室，邮编：200080  
Policies are issued by Asia-Pacific Property & Casualty Insurance Co., Ltd. Registered Office: 29-30F, Dutyfree Business Building, 1st Fuhua Road, Futian CBD, Shenzhen 518048, China. Policies are administered by Now Health International (Shanghai) Limited. Room 1103-1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China.

