

被保险人告知声明书  
Insured Person's Health Declaration Form

团体编号  
Company No  
保险合同号码  
Policy No  
单位名称  
Company Name

请被保险人本人使用水笔或钢笔并用正楷填写 (如有任何资料更改, 请加以签名确认)  
Please complete in ink and BLOCK letters. (If any change, please chop with the company seal.)

<b>被保险人资料 Information of Insured Person</b>						
姓名 Name: _____ 性别 Gender: _____ 身高 Height: _____ (厘米 cm) 体重 Weight: _____ (公斤 KG)						
证件类型 ID Type: <input type="checkbox"/> 身份证 ID Card <input type="checkbox"/> 护照 Passport <input type="checkbox"/> 军人证 Military Card <input type="checkbox"/> 其他 Others 证件号码 ID No. _____						
具体工作内容 Details of job _____						
<b>参保家属情况 (仅参保家属按核保规则需要健康告知时方需填写)</b>						
<b>Information of Family Members (Please complete if the declaration is needed by underwriting rules)</b>						
姓名 Name	性别 Gender	身份证/护照/军人证/其他 ID Card/Passport/Military Card/Others	与员工关系 Relationship with Insured	职业 Occupation	身高 (厘米) Height (cm)	体重 (公斤) Weight (KG)
_____	_____	_____	_____	_____	_____	_____

<b>其他资料 Other Information</b>	
<p>1. 您是否在本公司或其他保险公司投保时被拒保、延期或附加条件承保? Were you declined, postponed or offered insurance with restricted benefit or other than standard rates? by MSL or other insurance companies? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No</p> <p>2. 您是否 1 年内将要出境或工作地点在境外? Are you going to leave China in one year or working abroad? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No</p> <p>3. 您是否会从事危险运动或有竞技的嗜好? 若“是”, 请填写有关问卷。 Do you participate in any hazardous sports or races? If the answer is “Yes”, please complete the questionnaire. <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No</p>	<p>若问题 1-3 回答为“是”, 请详述。 If the answer for question 1-3 is “Yes”, please provide the details.</p>

<b>员工及其家属健康资料 (参保家属按核保规则需要健康告知时方需填写)</b>			
<b>Health Details of Employee and Family Members (Please complete if the declaration is needed by underwriting rules)</b>			
您或您的家属是否患有以下症状或疾病、机体功能失调、或曾接受任何治疗? Do you or your families have symptom, disease and functional disorder or take any medical treatments?	本人 Employee 是 Yes 否 No	配偶 Spouse 是 Yes 否 No	子女 Child 是 Yes 否 No
<p>4. 是否吸烟每天平均约 20 支, 并已吸烟 20 年以上? Do you smoke average 20-a- day and have been smoking for more than 20 years? 是否曾使用任何成瘾的药物、吸毒或过量喝酒或曾接受戒毒、戒酒治疗? Do you ever have any drug addiction, drug abuse or excessive alcohol or take drug treatment, abstinence ever?</p> <p>5. 有无身体残障状况? Do you have disability/disabilities?</p> <p>6. 目前是否尚在住院或病假中? 过去 1 年内是否有住院或接受手术或不能正常工作累计达到 10 个工作日以上? 或因身体原因减轻劳动量、全休、半休? Are you in hospital or taking sick leave? In last one year do you have hospitalization or surgery or cannot work properly totally over 10 days? Do you cannot work full-time or enjoy reduced labor due to health conditions?</p> <p>7. 过去的 1 年内是否患有除感冒外任何疾病需要观察、手术、接受药物治疗、被要求住院治疗、主动或被医师建议去做过进一步医学检查或治疗? Within the past one year, if any diseases except colds need to observe, surgery, drug treatment, hospitalization or was suggested further medical examination or treatment?</p> <p>8. 近 6 个月内, 是否有任何身体不适症状和体征? 如持续发热、疼痛、眩晕、胸痛、咳嗽、咯血、腹痛、便血、紫斑、消瘦 (体重下降超过 5 公斤)? Within the past six months, if there are any physical symptoms and signs? Such as persistent fever, pain, dizziness, chest pain, cough, hemoptysis, abdominal pain, blood in the stool, purpura, weight loss (weight loss of more than 5 KG)?</p> <p>9. 肿瘤、癌、息肉、结节或其它任何包块或肿物? Tumors, cancer, polyps, nodules, or any other mass or tumor?</p> <p>10. 高血压、冠心病、心衰、风湿性心脏病或其它心血管系统疾病? Hypertension, coronary heart disease, heart failure, rheumatic heart disease or other cardiovascular diseases?</p> <p>11. 哮喘、慢性阻塞性肺病、呼吸衰竭或其它呼吸系统疾病? Asthma, chronic obstructive pulmonary disease, respiratory failure or other respiratory diseases?</p> <p>12. 肝炎、肝硬化、消化性溃疡、胰腺炎、或其他胃、肝、胆、肠等消化系统疾病? Hepatitis, cirrhosis, peptic ulcer, pancreatitis, or other stomach, liver, gall bladder, intestines and other digestive diseases?</p>	<p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>

为了您的利益着想请勿误填或隐瞒健康资料

13. 肾炎、慢性肾脏疾病或其他泌尿生殖系统疾病? Nephritis, chronic kidney disease or other diseases of the genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. 糖尿病、甲状腺疾病或其它内分泌或代谢疾病? Diabetes, thyroid disease or other endocrine or metabolic disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. 脑血管疾病、癫痫、中风、精神病或其它脑、神经系统疾病或精神疾病? Cerebrovascular disease, epilepsy, stroke, mental illness or other brain, nervous system disease or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. 白血病、再生障碍性贫血、淋巴瘤、骨髓疾病或其它血液系统疾病? Leukemia, aplastic anemia, lymphoma, bone marrow disease or other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. 系统性红斑狼疮或其他骨骼、肌肉、或皮肤疾病? 眼、耳、鼻、口腔、咽喉疾病? Systemic lupus erythematosus or other bone, muscle, or skin disease? Eyes, ears, nose, mouth, throat disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. 结核病、感染或携带 HIV 病毒、艾滋病或其它传染性疾病? 先天性或遗传性疾病? Tuberculosis, with HIV infection or AIDS or other infectious diseases? Congenital or hereditary disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. 是否有任何以上未提及的身体失能、残障、反复发作的疾病, 重大疾病或受到意外伤害? Are there any physical incapacity, disability, recurrent disease, critical illness or accidental injury not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>女性适用 (12 周岁及以上适用) Questions for the women (12 years old and above)</b>					
20. 您现在是否怀孕? 如是, 请说明预产期 _____ Are you pregnant now? If yes, please specify expected date?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. 如果您正处在怀孕期, 是否被诊断为高危妊娠? If you are in the pregnancy, whether been diagnosed with high-risk pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. 您过去 5 年内曾否患子宫、乳房、卵巢等生殖系统方面疾病? Have you ever suffer from the uterus, breast, ovarian and other reproductive system diseases over the past five years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2 周岁以下儿童适用 Questions for the children under 2 year old</b>					
23. 若超过 7 天或出院时患有任何疾病, 请具体说明。 If insured suffered from any illness or discharged more than 7 days, please provide details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

上述问题中如有答案为“是”, 请附上该题题号, 并具体说明: 求诊日期、诊断结果、治疗方法、目前情况、医院和医生名称等。并请提供病历资料。

If the answer for the question above is “Yes”, please provide the number of question and attendances date, diagnosis, treatment, current situation, hospitals and doctor’s name. Please also provide the medical records.

#### 谨此声明 Statement

本人已仔细阅读上述内容并如实答复, 确认所有答复均为真实和正确的, 同时本人明白上述答复的真实性是保险合同成立的重要依据, 确认并同意下列各项:

I have carefully read the above-mentioned contents and respond truthfully, I hereby confirm that all the responses are true and correct. I acknowledge that the authenticity of the above responses is an important basis for the conclusion of the insurance contracts.

- 本人同意向贵公司提供个人资料, 供贵公司使用。  
I hereby agree to provide personal information to MSL.
- 本人已取得所有家属的同意及授权, 可向贵公司提供其个人资料。他们均同意该资料可供贵公司使用, 已使保险业务得以顺利运作。  
My family agree and authorize me to provide the personal information to MSL. They agree MSL to use this information to make sure the insurance policy will be enrolled.
- 本人同时授权任何内外科医生、医院、诊所、保险公司或其他持有本人或本人家属健康状况记录的组织、机构或人士可提供有关本人或本人家属的健康资料予贵公司。  
I hereby authorize any doctor, hospital, clinic, insurance company or other organization who holds my personal health state record to offer my health information or personal data to MSL.
- 由于特殊情况理赔款不能自动转账至本人账户, 本人同意授权投保单位转交。  
Because of the special circumstances claim amount cannot automatically transfer to my account, I agree to authorize the insured company forwarded.
- 本保险合同受益人为符合法律规定的继承人。若有特别指定, 另附申请告知。  
Beneficiaries of this contract are heir at law. If any special request, please submit applications.
- 本人的保险责任只有在本《被保险人告知声明书》被保险公司接受、利益保障生效日被批准后, 保险公司方开始承担。  
The insurance benefits will start when this declaration form is accepted and the enrollment date is permitted.
- 本人已就投保相关的问卷及文件如实完整地予以告知, 所有告知以书面告知为准。如果未履行如实告知义务, 贵公司有权依照保险法解除保险合同, 并对保险合同解除前发生的保险事故不负任何责任。  
I already fully and faithfully disclose all the necessary information requested in this declaration form and any other questionnaire or documents related to the application. Any verbal or non-verbal disclosure is subject to the written disclosure made in this application form and the other relevant documents. If there is any misrepresentation, MSL will have the right to rescind the contract according to law and shall not be held liable for any insured incident which occurs before the contract is rescinded.
- 本人同意由上海加拿大商会为本人及本人配偶、子女投保本中宏保险计划(含身故保险责任)的相关事宜, 并已确认保险条款中的保险责任, 责任免除、等待期、免赔额、免赔率、比例赔付或者给付等免除或者减轻贵公司责任的条款。  
I agreed Canadian Chamber of Commerce in Shanghai to apply MSL employee benefit plan(include death benefit)for my dependent (spouse and children)and I, and already confirmed the content of insurance liabilities as well as provisions that exempt or restrict the

由宏利和中化合资组建

A joint venture between Manulife and Sinochem

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客户服务热线: 40081 88888 80082 03998 网址: www.manulife-sinochem.com

company's liabilities such as liability exemption, waiting period, deductible amount, deductible ratio, claim ratio etc.

9) 如本投保单中英文表述不一致, 应以中文为准。

Should there be any discrepancy between the Chinese and English versions, the Chinese version shall prevail.

员工签名  
Signature of Employee

见证人  
Signature of Witness

签署日期  
Execution date

签署地  
Execution Place

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