大众保险 DAZHONG INSURANCE

# 大众环球尊耀健康个人医疗保险计划

# 投保单

# Dazhong Worldwide Health Individual Insurance Plan – Application Form

aetna℠

**Administered by Aetna International**
**由 Aetna International 管理**

在填写本申请表前，请仔细阅读以下内容，并以正楷填写本申请表。

Please read through the following before completing this application and complete in BLOCK CAPITALS.

我们会严格保密您所提供的信息。您所提供的信息须为事实，失实的信息将会导致保单无效。失实及信息的错漏可能会影响保单的审核及是否承保的最后决定（如：既往病史、从事有危险性的活动等）。若您遇到您无法判断该事实，请一并告知。

All information supplied will be treated in strict confidence. **You** must disclose all material facts. Failure to do so may invalidate the **Policy**. A material fact is one which is likely to influence the assessment and acceptance of this application (e.g. a pre-existing health condition or involvement in hazardous activities). If **You** are in any doubt whether a fact is material, it should be disclosed.

作为申请人，您必须回答申请表中所有问题，并代表申请表中所有申请人在申请表上签字。请您保留一份提供给我们的信息资料（包含信件的副本）便于本保险合同的签署。

As the applicant, **You** should answer all the questions and sign the declaration on behalf of all persons included in this application. **You** should keep a record of all information (including copies of all letters) supplied to **Us** for the purpose of entering into this contract.

在填写完本表后，请将其寄回至以下地址：

Please return this completed form to **Us**.


安态（上海）企业服务有限公司
上海黄浦区西藏中路
18 号港陆广场，1806 单元

**电话:** （86）400 920 1291
**传真:** （8621） 6326 8525
**邮箱:** **DaZhongEnquiriesPSSShanghai@aetna.com**

Aetna (Shanghai) Enterprise Services Co.,Ltd
Suite 1806 Harbour Ring Plaza
18 Middle Xi Zang Rd., Shanghai

**T:** （86）400 920 1291
**F:** （8621） 6326 8525
**E:** **DaZhongEnquiriesPSSShanghai@AETNA.com**


**请保留本表副本作为记录**




GR-68581-79 DASH (1-13)

**第一部分 – 投保人（即直接被保险人）信息**

**Section 1 – Applicant's Details (First Person)**

<table>
<tr><td colspan="6">投保人/ 直接被保险人姓名 Applicant's / Direct Insurer's Name</td></tr>
<tr><td colspan="5">姓 Family Name</td><td>称谓 Title</td></tr>
<tr><td colspan="6">名 First Name(s)</td></tr>
<tr><td>婚姻状况 Marital Status</td><td>出生日期 (日/月/年)<br>Date of Birth<br>(Day/Month/Year)</td><td>性别 Gender<br>☐男 M ☐ 女 F</td><td>身高 （公分）<br>Height (cm)</td><td>体重（公斤）<br>Weight (kg)</td></tr>
<tr><td>从事行业 Industry</td><td colspan="2">工作 Occupation</td><td colspan="2">职位 Job Title</td></tr>
<tr><td>国籍（护照签发国家）<br>Nationality (Country of Passport issuance)</td><td>护照号码/身份证号码<br>Passport No./ ID Card Number</td><td colspan="3">居住国<br>Country of Residence</td></tr>
<tr><td colspan="2">居住地址 Residential Address</td><td colspan="3">通讯地址 Correspondence Address</td></tr>
<tr><td colspan="2">家庭电话 Home Telephone</td><td colspan="3">工作电话 Business Telephone</td></tr>
<tr><td colspan="2">手机 Mobile</td><td colspan="3">传真 Fax</td></tr>
<tr><td colspan="2">私人邮箱 Home E-mail</td><td colspan="3">工作邮箱 Business E-mail</td></tr>
</table>

**请保留本表副本作为记录**

**第二部分 – 连带被保险人信息（请注意：本保险计划下的儿童需满足如下要求：年龄低于18周岁，在全日制学校就学并且依赖被保险人供养者年龄放宽至26周岁或以下。若您有更多的连带被保险人，请另外填写一张本表）**

**Section 2 – Other Insured Person/Dependant's Detail** (Please note children to be included under this plan must be under 18 years of age, 26 years of age or under if they are in full-time education and are fully dependant upon **You**. If **You** have any further **Dependants**, please provide details on a separate sheet.)

| | | | | | |
|---|---|---|---|---|---|
| **连带被保险人 1 Dependant 1** | 姓 Family Name | | | 名 First Name(s) | |
| | 其他缩写 Other Initials | 称谓 Title | 性别 Gender ☐ 男 M ☐ 女 F | 身高（公分） Height (cm) | 体重（公斤） Weight (kg) |
| | 与申请人的关系 Relationship to Applicant | | | 出生日期 (日/月/年) Date of Birth (Day/Month/Year) | |
| | 从事行业 Industry | 工作 Occupation | 职位 Job Title | 国籍（护照签发国家） Nationality (Country of Passport issuance) | 护照号码/身份证号码 Passport No/ ID Card No. |
| **连带被保险人 2 Dependant 2** | 姓 Family Name | | | 名 First Name(s) | |
| | 其他缩写 Other Initials | 称谓 Title | 性别 Gender ☐ 男 M ☐ 女 F | 身高（公分） Height (cm) | 体重（公斤） Weight (kg) |
| | 与申请人的关系 Relationship to Applicant | | | 出生日期 (日/月/年) Date of Birth (Day/Month/Year) | |
| | 从事行业 Industry | 工作 Occupation | 职位 Job Title | 国籍（护照签发国家） Nationality (Country of Passport issuance) | 护照号码/身份证号码 Passport No/ ID Card No. |
| **连带被保险人 3 Dependant 3** | 姓 Family Name | | | 名 First Name(s) | |
| | 其他缩写 Other Initials | 称谓 Title | 性别 Gender ☐ 男 M ☐ 女 F | 身高（公分） Height (cm) | 体重（公斤） Weight (kg) |
| | 与申请人的关系 Relationship to Applicant | | | 出生日期 (日/月/年) Date of Birth (Day/Month/Year) | |
| | 从事行业 Industry | 工作 Occupation | 职位 Job Title | 国籍（护照签发国家） Nationality (Country of Passport issuance) | 护照号码/身份证号码 Passport No/ ID Card No. |
| **连带被保险人 4 Dependant 4** | 姓 Family Name | | | 名 First Name(s) | |
| | 其他缩写 Other Initials | 称谓 Title | 性别 Gender ☐ 男 ☐ 女 | 身高（公分） Height (cm) | 体重（公斤） Weight (kg) |
| | 与申请人的关系 Relationship to Applicant | | | 出生日期 (日/月/年) Date of Birth (Day/Month/Year) | |
| | 从事行业 Industry | 工作 Occupation | 职位 Job Title | 国籍（护照签发国家） Nationality (Country of Passport issuance) | 护照号码/身份证号码 Passport No/ ID Card No. |

**请保留本表副本作为记录**

**第三部分 – 生效日期** ( 与本申请表的第十一部分保持一致。本保险合同生效日指保险人同意承保并书面签发保险单之日。若您希望推迟生效，请在下方填写告知我们。保险生效日期自您填写完成此申请书之日起，不得超过30日。任何情况下，本保险合同及保险责任有效期不得向前追溯。)

**Section 3 – Commencement Date** (Subject always to **Section 11** of this application form, the **Commencement Date** of this **Policy** will be the date on which this application is accepted in writing by **Us**. If **You** wish **Your** cover to start later, please indicate below. Please note the **Commencement Date** can be no more than 30 days from the date of completion of this application by **You**. Under no circumstances will **Policies** be backdated.)

| |
|---|
| **生效日期** (日/月/ 年)<br>**Commencement Date** (Day/ Month/ Year) |

**请保留本表副本作为记录**

**第四部分 – 保障选项** (以下表格仅供指导。详细的保障范围请见完整的保障计划一揽表和保险条款。)

**Section 4 – Options** (The table below is for guidance only. Please refer to the full **Benefit Grid** and **Policy Wording** for a detailed description of the **Benefits** of each plan option.)

**A) 产品** (按您个人需求勾选适合您自身的保障。请清楚勾选出您所选择的保障选项。保险人核保通过后将在此基础上签发保险单。)

**A) Product** (This plan enables **You** to choose various options to suit **Your** personal requirements. Please clearly check the option **You** have selected. **Your Policy** will be issued on this basis.)

| **保障 计划 Benefits Plan** | **经典计划 001 Major Medical OPTION 001** | **综合计划 002 Foundation OPTION 002** | **绚丽人生 003 Lifestyle OPTION 003** | **绚丽人生(增强版) 004 Lifestyle Plus OPTION 004** |
|---|---|---|---|---|
| 标准免赔额<br>Standard **Excess** | RMB 0 | RMB 800 | RMB 800 | RMB 800 |
| 每位被保险人在保险期内所获得的最高保险金额<br>Maximum Benefit per **Insured Person** per **Period of Cover** | RMB 12,800,000 | RMB 12,800,000 | RMB 12,800,000 | RMB 12,800,000 |
| 住院及日间留院<br>In-Patient and Day-Patient Care | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund |
| 癌症治療、电脑断层扫描、核磁共振<br>Oncology, CT and MRI Scans | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund |
| 妊娠并发症<br>Complications of Pregnancy | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund |
| 加床費（父母陪同未成年子女住院）<br>Parent Accommodation | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund |
| 护送转院<br>Evacuation | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund |
| 门诊<br>Out-Patient Care | 按双方约定限额<br>Subject to Limits | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund |
| 牙科意外伤害治疗<br>Emergency Dental Treatment | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund | 全额赔付<br>Full Refund |
| 每日住院現金津贴<br>Daily Hospital Cash Benefit | 按双方约定限额<br>Subject to Limits | 按双方约定限额<br>Subject to Limits | 按双方约定限额<br>Subject to Limits | 按双方约定限额<br>Subject to Limits |
| 艾滋/ 人体免疫缺损病毒<br>AIDS/HIV | 按双方约定限额<br>Subject to Limits | 按双方约定限额<br>Subject to Limits | 按双方约定限额<br>Subject to Limits | 按双方约定限额<br>Subject to Limits |
| 慢性病治疗<br>Management of **Chronic** Conditions | 本保单除外责任<br>No Cover | 本保单除外责任<br>No Cover | 按双方约定限额<br>Subject to Limits | 按双方约定限额<br>Subject to Limits |
| 生育保障<br>Pregnancy and Childbirth | 本保单除外责任<br>**No Cover** | 本保单除外责任<br>**No Cover** | 本保单除外责任<br>No Cover | 按双方约定限额<br>Subject to Limits |
| 例行及复杂牙科修复治疗<br>Routine and Restorative Dental Care | 本保单除外责任<br>**No Cover** | 本保单除外责任<br>**No Cover** | 本保单除外责任<br>No Cover | 按双方约定限额<br>Subject to Limits |
| **您的选择- 请确认您的选择**<br>**Your** Selection – please check **Your** choice | ☐ | ☐ | ☐ | ☐ |

所有的限制和免赔额，以￥表示的，均指以货币单位人民币为计。

ALL limits and **Excesses** expressed in ￥, shall in all instances mean RMB.

**请保留本表副本作为记录**

| **B) 免赔额** (若您欲调整标准免赔额，查看以下选项后，请在合适的方框内打钩选择)<br>**B) Excess** (Please select where **You** wish to change from the standard **Excess** applicable by checking the appropriate box.) | | | | |
|---|---|---|---|---|
| 0 | ☐ | ☐ | ☐ | ☐ |
| ￥400 | 不适用<br>N/A | ☐ | ☐ | ☐ |
| ￥2,000 | 不适用<br>N/A | ☐ | ☐ | ☐ |
| ￥4,000 | 不适用<br>N/A | ☐ | 不适用<br>N/A | 不适用<br>N/A |
| ￥8,000 | ☐ | ☐ | 不适用<br>N/A | 不适用<br>N/A |
| ￥16,000 | 不适用<br>N/A | ☐ | 不适用<br>N/A | 不适用<br>N/A |
| ￥40,000 | ☐ | ☐ | 不适用<br>N/A | 不适用<br>N/A |

| **C) 附加条款** (请打钩选择您的保险计划.)<br>**C) Additional** (Please check **Your** choices.) | | | | |
|---|---|---|---|---|
| 美国境内选择性治疗 - [005]<br>USA **Elective Treatment** - [005] | 不适用<br>N/A | ☐ | ☐ | ☐ |
| **双人病房限制** - [006]<br>*仅适用于居住地为香港时*<br>**Semi-Private Room** Restriction - [006]<br>*Only available to residents of Hong Kong.* | ☐ | ☐ | ☐ | ☐ |
| 中国大陆境内单人病房限制 - [007]<br>*仅适用于居住国为中国大陆时*<br>China Private Room Restriction - [007]<br>*Only available to residents of mainland China.* | ☐ | ☐ | ☐ | ☐ |
| **直付网络** - [008]<br>适用于某些国家。仅适用于选择标准免赔额的被保险人。*详情请直接与销售人员联系。*<br>**Direct Settlement Network** - [008]<br>*Only available with standard **Excess**.*<br>*Available in certain countries. Please check with **Your** local sales representative.* | 不适用<br>N/A | ☐ | ☐ | ☐ |
| **护送转院额外保障** - [009]<br>Extended **Evacuation** - [009] | ☐ | ☐ | 已包含<br>Included | 已包含<br>Included |

**请保留本表副本作为记录**

**第五部分 – 保险费支付** (请填写完整所有与之相关的信息。)
**Section 5 – Premium Payment** (Please complete all details relevant to that method.)

☐ **银行转账 (年付).** 请在转账时，清楚地列明所有投保人的姓名（按本申请书第一部分中所填写的）。

**Bank Transfer (annual only).** Please ensure the name of the **applicant** (as declared in **Section 1** of this form) is clearly stated on any transfer.

大众保险账户:
Dazhong Insurance Premium Account

收款人账户名称: 大众保险股份有限公司上海分公司
Account Name of Payee: Dazhong Insurance Co.,Ltd. of China Shanghai Branch

银行账号(RMB Account): 31643403001019038
Bank Account Number: 31643403001019038

开户银行: 上海银行江苏路支行
Bank of Deposit: Bank of Shanghai Jiangsu Road Sub-branch

**第六部分 – 医生信息** (请详细说明您的常用医生姓名、地址、专业资格，以及其他被保险人的常用医生信息。若填写空间不足，请写在另一张纸上。)

**Section6 – Medical Practitioner Details** (Please give the details, including name, address and qualifications of **Your** usual **Medical Practitioner**, and in respect of anyone else included in this application. Please use a separate sheet if this space is insufficient.)

**第七部分 – 既往病史**
**Section 7– Pre-existing Condition(s)**

本保险福利保障计划不涵盖投保日前接受治疗、出现症状、本人知晓或诉诸医生建议的病症。但若投保人连续提出的续保申请经保险人核保通过，且在首次投保日之后连续两年内，该病症未出现或因该病症就医/寻求建议，可在后续保险期间内将此病症纳入医疗保险责任范围。

**Benefits** will not be available for any **Medical Condition** or **Related Condition** for which **You** have received medical **Treatment**, had symptoms of, or to the best of **Your** knowledge existed, or sought **Advice** prior to **Your Date of Entry**, until two consecutive years have elapsed, after the **Date of Entry**, during which no **Treatment** or **Advice** was given in respect of that **Medical Condition** or any **Related Medical Condition**.

**请保留本表副本作为记录**

## 第八部分 – 医疗调查问卷
## Section 8 – Medical Questionnaire

**请以是/否回答以下问题，若回答是，请提供详细信息。**

**Please reply to the following questions by checking Yes or No. Where You have checked Yes, please provide details.**

| | 是 Yes | 否 No |
|---|---|---|
| a. 最近 5 年中，您或本申请表所列的连带被保险人，是否接受过住院或类似治疗？<br>Have **You**, or anyone included in this application, been admitted to **Hospital** or other similar establishment in the last five years? | ☐ | ☐ |
| b. 最近 2 年中，医生是否为您或本申请表所列的连带被保险人开过服用 7 天以上的处方药或建议过进行其他治疗？<br>Have **You**, or anyone included in this application, been prescribed with a course of any drugs or medication, or **Treatments** for a period in excess of seven days in the last two years? | ☐ | ☐ |
| c. 就您所知，您或本申请表所列的连带被保险人是否存在已知的或已预见的症状需要就医，或服用处方药，或接受住院治疗？<br>Have **You**, or anyone included in this application, any known or foreseeable need to consult with a **Medical Practitioner** or any other health care professional and/or to be required to be prescribed any drugs or medication and/or to be admitted to a **Hospital** or other similar establishment? | ☐ | ☐ |
| d. 您或本申请表所列的连带被保险人是否有上述未提及的残疾、身体异常、复发疾病或重大疾病伤害？<br>Are **You**, or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above? | ☐ | ☐ |

上述问题中，若有答复为“是”的，请在此处提供详细信息，必要时另用纸张提供详细资料。
Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space.

**请保留本表副本作为记录**

**第九部分 – 保险经纪人姓名/签章**
**Section 9– Broker's Name/Stamp**

**第十部分 – 申请人申明**
**Section 10 – Applicant's Declaration**

本人的配偶、具有完全行为能力的成年附属被保险人，以及投保人本人（即申请该保障的被保险人），授权所有医师、医疗保障专家、医院以及其他健康诊疗机构（医疗服务提供商），向大众及代理机构安态或安态附属企业（"安态"）或可扩展至法律允许的机构，提供本保险单中的所列被保险人有关医疗病史、医疗服务、补给以及治疗的信息，包括牙科诊疗、精神性药物滥用以及人体免疫缺损病毒/艾滋等医疗护理信息。

My spouse, competent adult **Dependants**, and I (those who are applying for Cover under this Application) authorise any physician, healthcare professional, **Hospital**, and other healthcare institution ("Providers"), to disclose, to the extent allowed by applicable law, to Dazhong and its servicing agents, Aetna or its affiliated entity ("ASES") information concerning the medical history, services, supplies, or **Treatment** provided to anyone listed on this Application, including those services involving dental, substance abuse and HIV/AIDS ("healthcare information").

我确认并同意大众及代理机构对本人在申请表上或其他给予的资料上的私人信息及医疗资料信息的收集和保留，并确认及同意可在有必要时向全球范围内大众及代理机构安态附属企业、医疗服务供应商、付款人、其他保险人、第三方管理商、中间机构、医师和具有一定仲裁权的政府权威机构提供，如：治疗、支付服务费用以及与本人健康计划有关的信息。

I confirm and agree that personal information and/or healthcare information collected or held by Aetna, whether contained in this Application form or otherwise obtained, may be disclosed worldwide to Dazhong and its servicing agent, Aetna or its affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants, and governmental authorities with appropriate jurisdiction, when necessary for care or **Treatment**, payment for services, and activities related to the operation of my health plan.

本人明白大众及代理机构安态会基于以下目的使用如上信息：1）核保保险责任范围的申请书、核准参保条件、风险评估、确认所有被保险人的保险责任范围并决定是否同意承保；2）管理理赔，决定是否承担所有责任范围及补充福利 3）管理保险责任范围；4）根据适用法律及规定进行其他方面的保险运营，如：开拓市场、宣传等。

I understand that Dazhong or its servicing agent, Aetna, may rely on such information to: 1) underwrite this application for Cover, review eligibility, risk rating, cover confirmation and enrolment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for Cover and provisions of **Benefits**; 3) administer Cover; and 4) conduct other insurance operations, like marketing and publicity, according to applicable laws and regulations.

本人已与配偶和本申请表中其他有完全行为能力的成年附属被保险人讨论过该授权，并取得他们对于关于同意公开其健康信息的授权。本人明白可以拒绝透露个人健康信息，然而，这可能会导致拒保。

I have discussed the terms of this authorization with my spouse and competent adult **Dependants**, and I have obtained their consent to the release of their healthcare information pursuant to this authorization. I understand that I may decline to provide the Insurer and its servicing agents with consent to process my personal or healthcare information; however, this may result in declination of Cover.

本人明白可在适用法律允许的范围内，修改本人基本信息和健康信息，并有权要求获得授权书副本，其与原件具有同等法律效力。不限于安态或其他方，本人可随时撤销此项授权。同样，本人也有权选择不参与任何直接的营销活动。

I understand that I may review and offer corrections to my personal or healthcare information, to the extent allowed by law, receive a copy of this authorisation upon request, and that a photocopy is as valid as the original; and I may revoke this authorisation at any time, to the extent it has not been relied upon by Aetna or other party. I also have the right to opt out of any direct marketing campaigns.

本授权在法律允许范围内、在保险合同生效期间始终有效。

This authorization shall remain valid for the term of this Cover or for so long as allowed by law.

**请保留本表副本作为记录**

本人明白在事先知晓的情况下，以诈骗或企图欺骗大众及代理机构为目的，向大众及代理机构安态提供错误的、不完整的或具有误导性的事实信息是非法的。惩罚可包括关押监禁、罚款、拒保、保障终止和法律赔偿。

I understand it is unlawful for me or my **Dependants** to knowingly provide false, incomplete or misleading facts or information to Dazhong or its servicing agent, Aetna, for the purpose of defrauding or attempting to defraud them. Penalties may include imprisonment, fines, denial of Cover, rescission of **Benefits**, and legal damages.

本人知悉安态的医疗服务供应商是独立签约人，并非安态代理机构、安态附属企业或安态员工。

I acknowledge that Aetna's participating providers are independent contractors and are not agents or employees of Aetna or any affiliated Aetna Entity.

本人明白并接受第七部分中关于既往病史的定义。

I understand and accept **Section 7** on Pre-existing Condition(s).

本人声明我的答案是基于自己最全面的认知所提供的最完整、真实的信息，申请表中非本人亲自手写的信息也已确认为正确。

I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.

本人已提供与本申请相关的所有事实。

I have declared all material facts which relate to this application.

本人声明并确认在填写本申请表时，保险人已就保险条款及福利保障计划，特别是责任免除、责任减轻及投保人和被保险人义务的内容向本人作了明确说明。本人及被保险人对本保险合同的条款及福利保障计划已没有任何异议并完全予以接受，同意签订本保险合同并愿意接受本保险合同的约束。

本人明白自保单生效之日起 15 天内，若被保险人未申请任何索赔，直接被保险人可书面通知保险人解除保险合同。

I declare that I have read and understand the documents '***Policy Wording***' and '***Benefit Schedule***', specially exclusion and other benefit limit and agree to accept and conform to the terms of the **Policy**, unless I cancel this **Policy** within 15 days from the **Commencement Date and there is no claims submitted**. I am satisfied that the product selected meets my requirements at this time.

本人同意在医疗网络服务供应商求诊时，对于保单条款中规定不承保的医疗状况或治疗，本人和连带被保险人有义务在收到不允以理赔的通知后的 14 日内向 **Aetna** 全数支付该些项目诊疗费用。

I agree that where **Medical Treatment** is received within the **Provider Network** by myself or any of my **Dependants** and it is substantiated that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Policy**, that I, as the **Member**, shall be fully responsible for reimbursement to Aetna within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such medical **Treatment**.

本人明白并同意当我没有及时向 **Aetna** 归还承保范围外诊疗项目的费用时，**Aetna** 可以使用一切可用的手段追讨欠款并且在费用结算后继续履约保险责任。保险责任暂停期间不进行任何理赔手续。

I understand and confirm that where I have not made repayment of funds disbursed by Aetna in respect of such medical **Treatment** not covered by the **Policy**, Aetna Global Benefits shall use all available means to recover owed funds and will suspend **Cover** for the **Member** until the date of full settlement of all outstanding amounts due from the **Member** to Aetna. **Cover** shall be reinstated on the same basis as immediately prior to the suspension. In no event shall any claim for **Treatment** received during any period of suspension be made or met.

**请保留本表副本作为记录**

申请持续转保的被保险人补充条款：

**Additional Provisions for Members applying for Continuous Transfer Terms**

我明白若故意虚假陈述上述声明或事实，本人的承保资格将被取消，诚如从未参保，并且丧失获得保障的资格，大众及代理机构安态或安态附属企业（“安态”）有权追回期间支付的保障费用。

I understand that if any statement made above or, if accepted for **Cover**, if any subsequent claims made are found to be fraudulent or unfounded my **Cover** will be cancelled as if I had no **Cover** in place from the start, and any **Benefits** shall be forfeited and recoverable by Dazhong and its servicing agents, Aetna or its affiliated entity ("ASES").

从目前的保险计划转保至环球尊耀健康个人医疗保险计划 或正在参保环球尊耀健康个人医疗保险计划 另外获得更宽的承保范围（如在续期时增加保障选项，则过去曾就医、问诊的转保前的既往病症不适用新的环球尊耀健康个人医疗保险计划下的保险金额和/或新增的保险责任。

Where **You** transfer to the Dazhong Worldwide Health Individual Insurance Plan from any other of **Our** existing plans or, whilst covered under the Dazhong Worldwide Health Individual Insurance Plan **You** receive any enhanced **Cover** (such as inclusion of an option at any **Renewal Date**), any enhanced **Cover** or maximum refundable amounts are restricted to new **Medical Conditions** which have not been previously suffered from, whether or not diagnosed, after the date of transfer.

从团体保险转保至个人保险时，保单以保险人书面同意书为准。保险责任范围的条款将会相应作出调整。

Transfer from a **Group** to an individual **Policy** is subject to written approval from **Us**. Terms of **Cover** may be subject to variation.

从类似其他保险人所提供的的私人医疗保险转保时，被保险人须提供上一年度保单，并且保证在两份保障期间没有中断。保险人随时保留无条件拒保或提供其他可选方案的权利。

Transfer of any similar private medical **Cover** provided by any other insurer is subject to submission of a copy of the expiring **Policy** and subject to there being no break in **Cover**. **We** reserve the right at all times to decline an application without giving any reason and/or to offer alternative terms.

| 申请人签名 Applicant’s Signature | 日期 (日/月/年)<br>Date (Day/Month/Year) |
|---|---|

**请保留本表副本作为记录**

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