

**注释:** 填写本申请表前, 请阅读下列条款。请酌情使用正楷或复选框。

**Explanatory Notes:** Please read the following before completing this application. Please use BLOCK CAPITALS or check boxes as appropriate.

**告知义务提示:** 所有可能影响我们对本申请表的评估和考虑的所有事实(例如: 既往疾病或参与危险活动的情况), 均应予以告知, 否则将影响该保险单的有效性。如果您遇到您无法判断其重要与否的事实, 亦请一并告知。

**Terms and Conditions:** All material facts (e.g. a pre-existing health condition or involvement in a hazardous activity), which may affect Our assessment and consideration of this application, should be declared. Failure to do so may invalidate Your Cover under a Group plan. If You are in doubt as to whether a fact is material, then it should be disclosed.

若您之前有了类似的保险保障, 请附上您现有保险凭证的副本以便投保人要求连续保险单转移申请。

If You were covered under a similar Policy immediately prior to Your application for inclusion under this Group plan, please include a copy of Your current Certificate of Insurance, as Your Plan Sponsor may have requested Continuous Transfer Terms.

若仍有其他的补充信息, 请用另外的纸提供详细资料。您提供的所有信息都将严格保密。

If You run out of space please use a separate sheet of paper where necessary to provide full details. All information supplied will be treated in strict confidence.

申请投保时, 请回答所有问题并代表此申请表下的所有人签署声明。您可以在提交申请的三个月内向我们提出索取本申请表的副本。您应保存一份提供所有信息的记录。

As the applicant, You should answer all the questions and sign the declaration on behalf of all persons included in this application. A copy of this application can be supplied to You on request within three months of completion. You should keep a record of all information provided.

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请将填妥的申请表返回**我们**或**您的**代理人。  
Please return this completed form to **Us** or **Your agent**.

安态（上海）企业服务有限公司

电话: +400 881 1291

中国上海黄浦区西藏中路18号港陆广场1302室

传真: +8621 6326 8525

邮编: 200001

邮箱: [HuataiEnquiriesPSSShanghai@aetna.com](mailto:HuataiEnquiriesPSSShanghai@aetna.com)

Aetna (Shanghai) Enterprise Services Co., Ltd  
Suite 1302  
Harbour Ring Plaza  
18 Middle Xi Zang Rd  
HuangPu District, Shanghai, China, 200001

T: + 400 881 1291

F: + 8621 6326 8525

E: [HuataiEnquiriesPSSShanghai@aetna.com](mailto:HuataiEnquiriesPSSShanghai@aetna.com)

为了帮助您理解您的**保险保障**，**保险单**中大写和加粗的用词用句均有特殊意义，详情请参阅华泰全球至尊健康团体医疗保险计划《会员手册》及保单**条款**（另附）。**中文表述与英文表述不一致的，以中文表述为准。**

To help **You** understand **Your Cover**, the words and phrases that are capitalised and in bold in **Your Policy Documentation** have specific meanings, and are defined in the HuaTai Global Group Health Insurance Plan Member Handbook and **Policy Wording**. **Should there be any discrepancy, Chinese shall prevail.**

### 栏目1——投保人详细资料

#### Section 1 – Plan Sponsor's Details

投保人名称 <b>Plan Sponsor Name</b>		保险单号码 <b>Policy Number</b>	
地址 <b>Address</b>			邮编 <b>Postal Code</b>
电话 <b>Telephone</b>	传真 <b>Fax</b>	电邮地址 <b>E-mail Address</b>	

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栏目 2——申请人资料（员工）

**Section 2 – Applicant Details (Employee)**

姓 Family Name				称呼 Title		
名 First Name(s)						
婚姻状况 Marital Status		出生日期（年/月/日） Date of Birth (Day/Month/Year)		性别 Gender <input type="checkbox"/> 男 M <input type="checkbox"/> 女 F	身高（厘米/英寸） Height (cms/ins)	体重（千克/磅） Weight (kgs/lbs)
行业 Industry			职业/职称 Occupation/Job Title			
到职日期（年/月/日） Date of Employment (Day/Month/Year)		资格类别 Eligibility Category		参保日期（年/月/日） Date First Eligible to Join Plan (Day/Month/Year)		
国籍 Country of Nationality		护照号码/身份证号码 Passport No./ID Card No.		居住国 Country of Residence		
居住地址 Residential Address			通讯地址 Correspondence Address			
市/镇 Town/City			市/镇 Town/City			
国/州 Country/State			国/州 Country/State			
邮编 Postal Code			邮编 Postal Code			
住宅电话 Home Telephone			工作电话 Business Telephone			
手机 Mobile			传真 Fax			
住宅电邮地址 Home E-mail			工作电邮地址 Business E-mail			

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栏目 3——连带被保险人 – 家属详细资料

Section 3 – Dependant's Details

连带被保险人-家属与申请人的居住国相同时才能包括在内。本保险计划下的子女连带被保险人必须在18周岁以下，在全日制学校就学并依赖被保险人供养者放宽到26周岁以下。若您还有其他连带被保险人-家属，请用另外的纸提供详细资料。

**Dependants** can only be included if their **Country of Residence** is the same as the Applicant's. Children to be included under this plan must be under 18 years of age, or 26 years or under if they are in full-time education and are fully dependent upon **You**. If **You** have any further **Dependants**, please provide details on a separate sheet.

连带被保险人-家属 1 Dependant 1	姓 Family Name			名 First Name(s)	
	其他缩写 Other Initials	称呼 Title	性别 Gender <input type="checkbox"/> 男 M <input type="checkbox"/> 女 F	身高 (厘米/英寸) Height (cms/ins)	体重 (千克/磅) Weight (kgs/lbs)
	与申请人关系 Relationship to Applicant			出生日期 (年/月/日) Date of Birth (Day/Month/Year)	
	职业/职称 Occupation/Job Title			国籍 Country of Nationality	护照编号/身份证号 Passport No./ID Card No.
连带被保险人-家属 2 Dependant 2	姓 Family Name			名 First Name(s)	
	其他缩写 Other Initials	称呼 Title	性别 Gender <input type="checkbox"/> 男 M <input type="checkbox"/> 女 F	身高 (厘米/英寸) Height (cms/ins)	体重 (千克/磅) Weight (kgs/lbs)
	与申请人关系 Relationship to Applicant			出生日期 (年/月/日) Date of Birth (Day/Month/Year)	
	职业/职称 Occupation/Job Title			国籍 Country of Nationality	护照编号/身份证号 Passport No./ID Card No.
连带被保险人-家属 3 Dependant 3	姓 Family Name			名 First Name(s)	
	其他缩写 Other Initials	称呼 Title	性别 Gender <input type="checkbox"/> 男 M <input type="checkbox"/> 女 F	身高 (厘米/英寸) Height (cms/ins)	体重 (千克/磅) Weight (kgs/lbs)
	与申请人关系 Relationship to Applicant			出生日期 (年/月/日) Date of Birth (Day/Month/Year)	
	职业/职称 Occupation/Job Title			国籍 Country of Nationality	护照编号/身份证号 Passport No./ID Card No.

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栏目 4——既往疾病

Section 4 – Pre-existing Condition(s)

您或您的连带被保险人-家属因投保前已知的既往疾病或相关症状就医的，均不在本保险单的保障范围内，投保后连续 2 年内未因既往疾病或相关症状诊疗的情况除外。

Benefits will not be available for any Medical Condition or Related Condition for which You, or anyone included in this application, have sought medical Advice or received medical Treatment for, had symptoms of, or to the best of Your knowledge existed, 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 with respect to that Medical Condition or any Related Condition.

申请连续保险单转移:

Members applying for Continuous Transfer Terms:

当您的连续保险单转移申请获得我们的同意后，您原有保险的承保条款将继续适用，同时我们保留附加条款的权利。请您附上原有保险凭证、载有详细批注内容及原有保险单起始生效日的文件副本。

Where Continuous Transfer Terms are accepted by Us, the previous underwriting applied in respect of Your existing Cover will apply. We reserve the right to apply additional terms. You should attach a copy of Your existing Certificate of Insurance, detailing any endorsements and the original Commencement Date of the expiring plan (or Cover).

栏目 5——医疗问卷

Section 5 – Medical Questionnaire

请选择“是”或“否”来回答下列问题。

Please reply to the following questions by checking Yes or No.

若选择“是”，请在问题下方的相应空白处写明详细信息。

Where You have checked Yes, please provide all relevant details in the space below.

Table with 2 columns: Question, Yes/No. Contains 4 questions (a-d) regarding hospitalization, medication, medical practitioner consultation, and disabilities.

(续) continued

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栏目 5——医疗问卷 (续)

Section 5 – Medical Questionnaire (continued)

<p>请使用本栏提供附加信息，必要时另用纸张提供资料。 Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space.</p>
<p>请提供通常为<b>您</b>或本表所列的连带被保险人_家属看诊<b>医生</b>的详细资料。 Please give details of <b>Your</b> usual <b>Medical Practitioner</b>, and in respect of anyone else included in this application.</p>
<p>医生姓名 <b>Medical Practitioner Name</b></p>
<p>医生所在地址 <b>Medical Practitioner Address</b></p>
<p>其他信息 <b>Additional Information</b></p>

栏目6——生效日期 (注意: 保险生效日期自您填写本申请之日起不得超过30天。任何情况下, 本保险单之保障不得向前追溯。)

Section 6 – Commencement Date (Note: The commencement date can be no more than 30 days from the completion of this application by you. Under no circumstances will policies/coverage be backdated.)

<p>生效日期 (年/月/日) Commencement Date (Day/Month/Year):</p>
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栏目7—— 申请人声明

Section 7 – Applicant’s Declaration

本人 (本申请下申请保险之人) 以及配偶、具有完全行为能力的成年和/或未成年连带**被保险人-家属**授权医师、医疗保健专家、**医院**以及其他医疗保健机构 (“医疗机构”) 以及本人雇主在适用法律许可范围内向华泰财产保险有限公司和安态 (上海) 企业服务有限公司及其关联机构透露本申请书上列出的关于病史、医疗服务、医疗机构或**治疗**的信息, 包括牙齿、滥用药物以及人体免疫缺陷病毒/艾滋病服务 (“医疗保健信息”)。本人已经就此条款与配偶和有完全行为能力的成年连带**被保险人-家属**讨论, 并得到他们提供/使用其个人/健康信息的授权。

My spouse, competent adult and/or minor **Dependants**, and I (who are applying for **Cover** under this application) authorise any physician, health care professional, **Hospital**, other health care institution (“Providers”), and my employer to disclose, to the extent allowed by applicable law, to Huatai Property & Casualty Insurance Co., Ltd. and Aetna (Shanghai) Enterprise Services Co., Ltd. or an affiliated entity (“Aetna”), information concerning the medical history, services, supplies, or **Treatment** provided to anyone listed on this application, including dental, substance abuse and HIV/AIDS services (“health care information”). I have discussed the terms of the authorisation with my spouse and competent adult **Dependants** and have obtained their authorisation to release/process their personal/health information

本人确定并同意, 在保健或**治疗**、服务付款、以及与本人健康计划运行相关的活动需要时, 华泰财产保险有限公司和安态 (上海) 企业服务有限公司可以将相关个人信息和/或医疗保健信息 (包括在本表中填写的信息和其它途径收集到的信息) 透露给全球范围内华泰财产保险有限公司和安态 (上海) 企业服务有限公司及其关联机构、医疗机构, 付费人、其他保险公司、第三方管理员、服务供应商、顾问以及具有相关司法权的政府机构。

I confirm and agree that personal information and/or health care information collected or held by Huatai Property & Casualty Insurance Co., Ltd. and Aetna (Shanghai) Enterprise Services Co., Ltd., whether contained in this application form or otherwise obtained, may be disclosed worldwide to Aetna affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants, governmental authorities with appropriate jurisdiction, when necessary for care or **Treatment**, payment for services, and activities related to the operation of my health plan.

(续) continued

请保留副本以作记录 Please Retain a Copy for Your Records

保险单由华泰财产保险有限公司上海分公司签发并由安态 (上海) 企业服务有限公司提供管理服务。安态 (上海) 企业服务有限公司是Aetna Inc. 的全资控股子公司。安态 (上海) 企业服务有限公司隶属于Aetna Inc. 国际业务部 Aetna International. Aetna®是Aetna Inc. 的注册商标并在全球范围内受商标注册条约的保护。

在此未对本文件包含信息的完整性和/ 或准确性作出任何明示或暗示的保证或陈述, 且所给信息仅用于指导。在根据上述信息采取行动前, 请核实该信息。您不应依赖此类信息, 应当寻求自己独立的法律意见。对该使用信息以及其中包含的资料而引起的任何直接或间接的损失、损害, 我们概不负责。

Aetna 不提供护理, 也不保证获得健康服务。并非所有健康服务都会承保。健康信息计划提供一般性健康信息, 不作为健康护理专家诊断或治疗的替代品。请参看计划文档获得有关利益、除外、限制和承保条件等完整说明。信息在制作时是准确的, 但也会发生变化。有关 Aetna International 的更多信息, 敬请登录 www.aetnainternational.com。

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No warranty or representation is given, whether expressed or implied, as to the completeness and/or accuracy of the information contained in this document and accordingly the information given is for guidance purposes only. You are requested to verify the above information before you act upon it. You should not rely on such information and should seek your own independent legal advice. We will not be liable for any loss and damage, whether direct or indirect, from your use of the information and the materials contained therein.

Aetna does not provide care or guarantee access to health services. Not all health services are covered. Health information programmes provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of cover. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna International plans, refer to www.aetnainternational.com.

**Section 7 – Applicant's Declaration (continued)**

本人明白华泰财产保险有限公司和安态（上海）企业服务有限公司及其关联机构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 Huatai 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.

本人已与本人配偶及有完全行为能力的成年和/或未成年**连带被保险人-家属**讨论过该授权条款，本人已取得任何必要的同意，可以根据本授权协议透露他们的医疗保健信息。本人了解，本人可以拒绝授权华泰财产保险有限公司和安态（上海）企业服务有限公司及其关联机构处理上述个人或医疗保健信息，但这有可能会导导致保险公司拒绝承保。

I have discussed the terms of this authorisation with my spouse and competent adult and/or minor **Dependants**, and I have obtained any necessary consent to the release of their health care information pursuant to this authorisation. I understand that I may decline to provide Huatai Property & Casualty Insurance Co., Ltd. and Aetna (Shanghai) Enterprise Services Co., Ltd. or an affiliated Aetna entity with consent to process the aforementioned personal or health care information; however, this may result in declination of **Cover**.

本人可在法律许可范围内，审查或修正本人个人或医疗保健信息，经本人要求，可收到该授权协议的一个副本，且该复印件与原件具有同等效力；且在未依靠华泰财产保险有限公司和安态（上海）企业服务有限公司或第三方的情况下，本人可在任何时候撤销该授权。本人也具有退出任何直接营销活动的权利。

I understand that I may review and offer corrections to my personal or health care 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 Huatai Property & Casualty Insurance Co., Ltd. and Aetna (Shanghai) Enterprise Services Co., Ltd. or other party. I also have the right to opt out of any direct marketing campaigns.

本授权应对本保险条款或法律许可期限内持续有效。

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

本人了解，若本人或本人的**连带被保险人-家属**故意向华泰财产保险有限公司和安态（上海）企业服务有限公司提供虚假、不完整或误导性的事实或信息，以欺诈或试图诈骗华泰财产保险有限公司和安态（上海）企业服务有限公司或其关联机构，则这是违法的。处罚包括监禁、罚款、拒绝承保、保障取消以及法定损害赔偿金。

I understand it is unlawful for me or my **Dependants** to knowingly provide false, incomplete or misleading facts or information to Huatai Property & Casualty Insurance Co., Ltd. and Aetna (Shanghai) Enterprise Services Co., Ltd. for the purpose of defrauding or attempting to defraud Huatai Property & Casualty Insurance Co., Ltd. and Aetna (Shanghai) Enterprise Services Co., Ltd or any affiliated Aetna entity. Penalties may include imprisonment, fines, denial of **Cover**, rescission of **Benefits**, and legal damages.

本人承认，华泰财产保险有限公司和安态（上海）企业服务有限公司的参与医疗机构都是独立承包商，而非代理人或华泰财产保险有限公司和安态（上海）企业服务有限公司或其关联机构的员工或任何附属于其的实体。

I acknowledge that Huatai Property & Casualty Insurance Co., Ltd. and Aetna (Shanghai) Enterprise Services Co., Ltd. participating providers are independent contractors and are not agents or employees of Huatai Property & Casualty Insurance Co., Ltd and Aetna (Shanghai) Enterprise Services Co., Ltd or any affiliated Aetna entity.

本人了解并接受本申请表栏目 4 中关于既往疾病的内容，本人关于此申请的所有材料均属实。

I understand and accept Section 4 on Pre-existing Condition(s) and I have declared all material facts which relate to this application.

本人所给予的回答均就本人所知是全面的、真实的、完整的；并且，本人经过审查此申请中非本人亲自书写的回答或陈述，确认该等信息均属实。

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.

*(续) continued*

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**Section 7 – Applicant’s Declaration (continued)**

本人同意，根据本保险单条款，若本人或本人连带被保险人-家属在**医疗提供商网络**内接受不在**保险单**保障范围内的**治疗**，作为**会员**，本人将在收到所有此类医疗服务相关的不可赔付费用通知的**14**天内，完全承担对华泰财产保险有限公司和/或安态（上海）企业服务有限公司及其关联机构的偿还责任。

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 Huatai Property & Casualty Insurance Co.,Ltd. and/or Aetna (Shanghai) Enterprise Services Co., Ltd. or any affiliated Aetna entity within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such medical **Treatment**.

本人了解并确认，若本人未偿还华泰财产保险有限公司和/或安态（上海）企业服务有限公司及其关联机构已经支付的不在本**保险单**保障范围内的医疗服务费用，华泰财产保险有限公司和/或安态（上海）企业服务有限公司或其关联机构将采取所有可行方法来收回费用，并且会暂停本人**会员保障**直至本人足额缴纳之日。会员保障暂停期间，任何情况下不能就**治疗**提出任何索赔。

I understand and confirm that where I have not made repayment of funds disbursed by Huatai Property & Casualty Insurance Co.,Ltd. and/or Aetna (Shanghai) Enterprise Services Co., Ltd or any affiliated Aetna entity in respect of such medical **Treatment** not covered by the **Policy**, Huatai Property & Casualty Insurance Co.,Ltd. and/ Aetna (Shanghai) Enterprise Services Co., Ltd. or any affiliated Aetna entity 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 Huatai Property & Casualty Insurance Co.,Ltd. and/or Aetna (Shanghai) Enterprise Services Co., Ltd or any affiliated Aetna entity at which point **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.

**关于会员申请连续转移的附加条款**

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

本人了解，若上述任何陈述或同意投保以及随后做出的任何索赔被发现是基于欺骗或不在本人保险保障范围内的，本人**保险保障**将会被撤销，并且保险人将剥夺和收回本人自投保日起的所有**保障**。

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 Huatai Property & Casualty Insurance Co.,Ltd..

若您从**我们**任何其他现有的计划转换到华泰全球至尊健康团体医疗保险计划中，且受本保险计划保护，您接受的保险将会扩大（如包括续约日期时，您可进行选择），该扩大的保险或最大可偿还金额在转换日后对以前未患过的（不论是否已诊断）新的**医疗状况**具有限制性。

Where **You** transfer to the HuaTai Global Group Health Insurance Plan from any other of **Our** existing plans or, whilst covered under the healthcare 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.

是否同意接受由其他保险公司提供的相类似的**医疗保险保障**转移，除需要提交**保险凭证**外，保险期不能有中断。我们保留在任何时候无理由拒绝该项申请和/或提供其他替代条款的权利。

Transfer of any similar private medical **Cover** provided by any other insurer is subject to submission of a copy of the **Certificate of Insurance** 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.

申请人姓名及签名： Applicant’s Name and Signature	日期（日/月/年） Date (Day/Month/Year)
连带被保险人（或其监护人）签名： Dependant/Guardian’s Name and Signature	日期（日/月/年） Date (Day/Month/Year)

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