AIA International Limited
(Incorporated in Bermuda
with limited liability)

GENERAL HEALTH QUESTIONNAIRE 健康問卷

Policy Number 保單號碼

Agent/Broker Code 營業員/經紀號碼 **Area Code** 區域編號

Agency/Broker Name 營業員/經紀組別

Agent/Broker's Name 營業員/經紀姓名

Agent/Broker's Tel. No. 營業員/經紀聯絡電話

Operations
營運部

VIP (V)

Name of Proposed Insured / Insured
準受保人/受保人姓名

I. D. Card Number / Passport Number
身分證號碼/護照號碼

Please give full and accurate answer to each question, use additional sheet, if necessary.
請詳細答覆以下之問題，如有需要，可加附頁作答。

Please complete this questionnaire by answering the following questions in connection to _____.

請提供有關 _____ 的所有正確資料。

1.

(a) Date of first occurrence 首次出現病徵	Date 日期： (MM月 / DD日 / YYYY年)
(b) What was the date you first consulted the doctor? 首次求診醫生是何時？	Date 日期： (MM月 / DD日 / YYYY年)
(c) What was the reason for the consultation? 求診之原因？	

2.

(a) Date of last symptom 最後一次出現徵狀日期	Date 日期： (MM月 / DD日 / YYYY年)
(b) Duration of each symptom 每次徵狀為期多久	
(c) Please state how frequent do you suffer from these symptoms 請註明曾患有相關徵狀之次數	☐ Occasionally 偶爾 ☐ Daily 每天 ☐ Weekly 每星期 ☐ Others, please state 其他，請註明 _____

3. Has there been surgery performed or planned to perform for this condition?
閣下是否曾接受或打算接受上述問題的手術治療？

☐ No 否 ☐ Yes 是 Please provide details 請詳細說明 _____

4. Please provide full name, address of your regular doctor for your condition and date(s) of consultation in last 12 months.
請閣下提供慣常求診醫生之姓名、地址及過去十二個月內曾求診的日期。

Name of Doctor 醫生之姓名：	
Address 地址：	
Date 日期： (MM月/ DD日/YYYY年)	

5. Is / Are there any other doctor(s) that you also consult in relation to your condition?
除以上醫生外，閣下有沒有就上述問題諮詢其他醫生?

☐ No 否 ☐ Yes 是 please provide full name, address and date of consultation in last 12 months.
請註明就診醫生之姓名、地址及日期。

Name of Doctor 醫生之姓名：	
Address 地址：	
Date 日期： (MM月/ DD日/YYYY年)	

6. Please provide details of all your treatments, including doctor consultation, name(s) of medications, hospitalization, surgery or physiotherapy, etc.
請註明閣下的治療詳情，包括醫療諮詢、藥物名稱、住院治療、手術或物理治療等。

Type of Treatment 治療詳情：	
Date from and to 開始及停止日期： (MM月/ DD日/YYYY年)	

7. Are you still on follow up and / or treatment?
閣下是否仍在覆診及/或接受治療?

☐ No, please state date of last follow up: 否，最後覆診日期：	Date 日期： (MM月 / DD日 / YYYY年)
☐ Yes, please state date of next follow up: 是，下次覆診日期：	Date 日期： (MM月 / DD日 / YYYY年)

8. Have you ever been off work or your normal daily activities restricted in any way due to your condition for 7 consecutive days or more ?
閣下是否因上述問題而無法工作或如常活動連續七日或以上?

☐ No 否 ☐ Yes 是 please provide date and duration 請註明日期及持續多久

_____

9. Please provide copies of any medical report you may have.
請提供有關報告副本以作參考。

I hereby declare and agree that the above particulars and answers are complete and true, and this questionnaire will form part of the contract for the desired insurance on my life. I also authorize the Company to obtain, if necessary, confidential reports from any doctor / clinic / hospital that I have referred above.
本人在此聲明及同意以上所填報之資料及答案均為正確及事實之全部，並構成要保書合約的一部份。本人亦授權貴公司，如有需要，可向上述醫生／診所／醫院索取有關資料。

Date
日期 _____
(MM月 / DD日 / YYYY年)

Signature of the Proposed Insured / Insured
準受保人/受保人簽署 _____
(Please do not sign on blank form 請勿在空白表格上簽署)
(If the Proposed Insured / Insured is under age 18, signature of the Applicant / Owner is required)
（若準受保人/受保人年齡在十八歲以下，請由申請人/持有人簽署）