

人身保险投 保单

人身保险投保单 Life Insurance Application Form

银行代理保险专用

在本投保单中，如英文表述与中文表述不一致，以中文表述为准。If the English wording is not consistent with the Chinese wording, the Chinese wording prevails.

保险合同领取形式 Insurance Contract Drawing Method: ☐ 电子合同 Electronic Contract

投保须知 Preliminary Instructions

感谢您投保中德安联人寿保险有限公司（以下简称中德安联）的保险产品。为了便于您了解所投保的产品，维护您自己的合法权益，填写投保单前请认真阅读本投保须知。Thank you for choosing Allianz China Life Insurance Company Limited (AZCL). To better understand the applied products, and to protect your legitimate interest, please read the Preliminary Instructions carefully before filling the application form.

1. 请认真阅读保险条款，特别是关于保险责任、责任免除、犹豫期、退保等关键信息的条款，并全面理解所要投保的产品。您可以在中德安联网站(www.allianz.com.cn)下载所投保产品的条款。Please read the insurance clauses carefully, especially the clauses about insurance benefit, exclusions, free-look period and surrender. Please understand the products that you applied comprehensively. You can download the insurance clauses from AZCL website (www.allianz.com.cn).
2. 投保人、被保险人应当如实填写投保单的各项内容，信息不完整或不真实将直接影响投保人和被保险人的权益。The policyholder and the insured should fill the application form faithfully. Incomplete or unreal info will damage the interest of policyholder and insured.
3. 投保人、被保险人在投保单上所提供的个人及受益人信息（包括联系方式），将被用于保费计算、核保、保单递送、客户回访、续期服务等事项，因此请务必提供真实、准确、完整的信息。如您希望了解与个人信息相关的政策，请进入以下链接查询：https://www.allianz.com.cn/privacy-announcement.php. Personal info provided in the application form (including contacts) will be used for premium calculation, underwriting, policy delivery, return call, renewal service and etc. Please provide real, accurate and complete info. If you want to know detailed policy about personal info, please inquire on following link: https://www.allianz.com.cn/privacy-announcement.php.
4. 中德安联承诺，未经客户同意，不会将客户信息用于中德安联及第三方机构的销售活动。AZCL promises not to use client data for sales activity by AZCL or 3rd party without client consent.
5. 为未成年人投保的人身保险，因被保险人身故给付的保险金总和不得超过国务院保险监督管理机构规定的限额（对于被保险人不满10周岁的，不得超过人民币20万元；对于被保险人已满10周岁但未满18周岁的，不得超过人民币50万元），各保险合同约定的身故给付的保险金总和也不得超过该限额。本公司可以承保的身故给付保险金总和为（前述限额-被保险人已经参保的身故给付保险金额）。The total amount of death benefit applied for minor and the promissory total amount of death benefit should not exceed the limit as prescribed by CIRC (RMB200,000 for insured below 10 years old and, RMB500,000 for insured age between 10 to 18 years old).
6. 中德安联核保通过后出具正式保单，但中德安联可能要求对被保险人进行体检，或要求补充其他材料。根据核保情况，中德安联可能会做出加费或者拒绝承保等决定。AZCL will issue formal policy after acceptance. AZCL may request for physical examination or other documents before approval. Based on the acquired information, AZCL may give decisions as rating up, rejection, etc.
7. 投保人对被保险人应当具有保险利益，若无保险利益，则合同无效。以死亡为给付保险金条件的，未经被保险人书面同意并认可保险金额的，合同无效。父母为其未成年子女投保的人身保险不受此限制。The policyholder must have insurable interest on the insured, otherwise the insurance contract will be void. If the insured does not signed the application form, the insurance contract that stipulates death as the prerequisite for the payment of the insurance benefits will be void, except that parents apply life insurance for minor child.
8. 投保单为保险合同的重要组成部分，请用黑色或蓝色墨水笔认真填写，且请勿涂改；投保人、被保险人签名处需由投保人、被保险人本人亲笔签署，不得由他人代签（18岁以下未成年人由监护人签名）。The application form is an important part of insurance contract, please complete it with black or blue-black water pen, and please do not alter. Policyholder and insured should duly sign the application form. Guardian of insured under 18 shall sign on behalf of the insured.
9. 在保险合同效力中止后二年内，经协商一致，自您补交保单欠款之日起，合同效力恢复。具体内容以保险合同为准。You may apply for reinstatement within 2 years from the date of lapse. Reinstatement will take place after we reach an agreement with you and you pay off the policy debt. Please refer to the insurance clause for details.
10. 中德安联未授权任何个人或机构作出与本投保单各事项及保险条款不相符的解释、说明、承诺或保证，除经中德安联正式程序修改或批注的内容外，与本投保单各事项及保险条款不相符的任何书面或口头的解释、说明、承诺或保证均无效。AZCL has not authorised any individual and/or institution to give explanation, illustration, promise or guarantee which is different from insurance clauses or the detailed information on this application form. All the aforesaid explanation, illustration, promise or guarantee will be void except that it has been modified or endorsed by AZCL through official procedure.

主被保险人 Primary Insured (请注明您所使用的联系电话的国家及地区号码。Please indicate country and area code of your telephone and mobile number.)

姓名: Full Name	性别 Gender: <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期: Date of Birth (YYYY/MM/DD)	年龄: Age
证件类型 ID Type:		证件号码 ID No.:	
证件有效期至: Date of ID Expiry (YYYY/MM/DD)	国籍/地区: Nationality	出生地所属国家/地区: Place of Birth	个人年收入约: Annual Income (Ten Thousand RMB)
当地社会医疗保险参保人员 Covered by Local Sociomedical Insurance: <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No			
工作单位: Name of Employer		行业类型: Type of Business	具体工作: Occupation
经常居住(通讯)地址 Residential (Contact) Address:			邮编 Postal Code:
固定电话(区号) Tel: (+)-()-		移动电话 Mobile: (+)	Email:

其他被保险人一 First Other Insured (只能投保附加险 Other insured can apply for riders only)

姓名: Full Name	性别 Gender: <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期: Date of Birth (YYYY/MM/DD)	年龄: Age
证件类型 ID Type:		证件号码 ID No.:	
证件有效期至: Date of ID Expiry (YYYY/MM/DD)	国籍/地区: Nationality	出生地所属国家/地区: Place of Birth	个人年收入约: Annual Income (Ten Thousand RMB)
当地社会医疗保险参保人员 Covered by Local Sociomedical Insurance: <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No 与主被保险人关系 Relationship to Primary Insured:			
工作单位: Name of Employer		行业类型: Type of Business	具体工作: Occupation
经常居住(通讯)地址 Residential (Contact) Address:			邮编 Postal Code:
固定电话(区号) Tel: (+)-()-		移动电话 Mobile: (+)	Email:

其他被保险人二 Second Other Insured (只能投保附加险 Other insured can apply for riders only)

姓名: Full Name	性别 Gender: <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期: Date of Birth (YYYY/MM/DD)	年龄: Age
证件类型 ID Type:		证件号码 ID No.:	
证件有效期至: Date of ID Expiry (YYYY/MM/DD)	国籍/地区: Nationality	出生地所属国家/地区: Place of Birth	个人年收入约: Annual Income (Ten Thousand RMB)
当地社会医疗保险参保人员 Covered by Local Sociomedical Insurance: <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No 与主被保险人关系 Relationship to Primary Insured:			
工作单位: Name of Employer		行业类型: Type of Business	具体工作: Occupation
经常居住(通讯)地址 Residential (Contact) Address:			邮编 Postal Code:
固定电话(区号) Tel: (+)-()-		移动电话 Mobile: (+)	Email:

其他被保险人三 Third Other Insured (只能投保附加险 Other insured can apply for riders only)

姓名: Full Name	性别 Gender: <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期: Date of Birth (YYYY/MM/DD)	年龄: Age
证件类型 ID Type:		证件号码 ID No.:	
证件有效期至: Date of ID Expiry (YYYY/MM/DD)	国籍/地区: Nationality	出生地所属国家/地区: Place of Birth	个人年收入约: Annual Income (Ten Thousand RMB)
当地社会医疗保险参保人员 Covered by Local Sociomedical Insurance: <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No 与主被保险人关系 Relationship to Primary Insured:			
工作单位: Name of Employer		行业类型: Type of Business	具体工作: Occupation
经常居住(通讯)地址 Residential (Contact) Address:			邮编 Postal Code:
固定电话(区号) Tel: (+)-()-		移动电话 Mobile: (+)	Email:

其他被保险人四 Fourth Other Insured（只能投保附加险 Other insured can apply for riders only）

姓名: Full Name	性别 Gender: <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期: Date of Birth(YYYY/MM/DD)	年龄: Age
证件类型 ID Type:		证件号码 ID No.:	
证件有效期至: Date of ID Expiry(YYYY/MM/DD)	国籍/地区: Nationality	出生地所属国家/地区: Place of Birth	个人年收入约: Annual Income (Ten Thousand RMB)
当地社会医疗保险参保人员 Covered by Local Sociomedical Insurance: <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No		与主被保险人关系 Relationship to Primary Insured:	
工作单位: Name of Employer	行业类型: Type of Business	具体工作: Occupation	
经常居住（通讯）地址 Residential (Contact) Address:			邮编 Postal Code:
固定电话（区号）Tel: (+)-()-		移动电话 Mobile: (+)	Email:

其他被保险人五 Fifth Other Insured（只能投保附加险 Other insured can apply for riders only）

姓名: Full Name	性别 Gender: <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期: Date of Birth(YYYY/MM/DD)	年龄: Age
证件类型 ID Type:		证件号码 ID No.:	
证件有效期至: Date of ID Expiry(YYYY/MM/DD)	国籍/地区: Nationality	出生地所属国家/地区: Place of Birth	个人年收入约: Annual Income (Ten Thousand RMB)
当地社会医疗保险参保人员 Covered by Local Sociomedical Insurance: <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No		与主被保险人关系 Relationship to Primary Insured:	
工作单位: Name of Employer	行业类型: Type of Business	具体工作: Occupation	
经常居住（通讯）地址 Residential (Contact) Address:			邮编 Postal Code:
固定电话（区号）Tel: (+)-()-		移动电话 Mobile: (+)	Email:

投保人 Policyholder（请注明您所使用的联系电话的国家及地区号码。Please indicate country and area code of your telephone and mobile number.）

姓名: Full Name	性别 Gender: <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期: Date of Birth(YYYY/MM/DD)	年龄: Age
证件类型 ID Type:		证件号码 ID No.:	
证件有效期至: Date of ID Expiry(YYYY/MM/DD)	国籍/地区: Nationality	出生地所属国家/地区: Place of Birth	
与主被保险人关系 Relationship to Primary Insured:		个人年收入约 Annual Income:	万元(Ten Thousand RMB)
工作单位: Name of Employer	行业类型: Type of Business	具体工作: Occupation	
经常居住（通讯）地址 Resident (Contact) Address:			邮编 Postal Code:
固定电话（区号）Tel: (+)-()-		移动电话 Mobile: (+)	Email:

身故受益人 Death Beneficiary（身故受益人仅适用于有身故利益的险种，每种情况下的受益率之和应为 100%。Death Beneficiary is only applicable to insurance product with death benefit, the sum of proportion must be 100%. ）

(1)主被保险人身故受益人 Death Beneficiary of Primary Insured						
姓名 Full Name	出生日期 Date of Birth (YYYY/MM/DD)	性别 Gender	证件类型 ID Type	证件号码 ID No.	与主被保险人关系 Relationship to Primary Insured	受益率 Proportion
						.00%
						.00%
(2)其他被保险人身故受益人 Death Beneficiary of First Other Insured						
姓名 Full Name	出生日期 Date of Birth (YYYY/MM/DD)	性别 Gender	证件类型 ID Type	证件号码 ID No.	与其他被保险人一关系 Relationship to First Other Insured	受益率 Proportion
						.00%
						.00%
(3)其他被保险人身故受益人 Death Beneficiary of Second Other Insured						
姓名 Full Name	出生日期 Date of Birth (YYYY/MM/DD)	性别 Gender	证件类型 ID Type	证件号码 ID No.	与其他被保险人二关系 Relationship to Second Other Insured	受益率 Proportion
						.00%
						.00%
(4)其他被保险人身故受益人 Death Beneficiary of Third Other Insured						
姓名 Full Name	出生日期 Date of Birth (YYYY/MM/DD)	性别 Gender	证件类型 ID Type	证件号码 ID No.	与其他被保险人三关系 Relationship to Third Other Insured	受益率 Proportion
						.00%
						.00%
(5)其他被保险人身故受益人 Death Beneficiary of Fourth Other Insured						
姓名 Full Name	出生日期 Date of Birth (YYYY/MM/DD)	性别 Gender	证件类型 ID Type	证件号码 ID No.	与其他被保险人四关系 Relationship to Fourth Other Insured	受益率 Proportion
						.00%
						.00%
(6)其他被保险人身故受益人 Death Beneficiary of Fifth Other Insured						
姓名 Full Name	出生日期 Date of Birth (YYYY/MM/DD)	性别 Gender	证件类型 ID Type	证件号码 ID No.	与其他被保险人五关系 Relationship to Fifth Other Insured	受益率 Proportion
						.00%
						.00%

主险 Main Product	险种名称 Plan Name	基本保险金额/基本年金金额 (元) Basic Sum Assured/Basic Annuity Payable (RMB)	类型 SA Type	保险期间 (年) Benefit term (Year)	保险费支付期 (年) Premium Term (Year)	期交/趸交保险费 (元) Regular/Single Premium (RMB)	首期追加保险费 (元)Initial Additional Premium (RMB)
附加险 Riders							
被保险人 Insured	险种名称 Plan Name	基本保险金额 (元) Basic Sum Assured (RMB)	类型 SA Type	保险期间 (年) Benefit Term (Year)	保险费支付期 (年) Premium Term (Year)	保险费(元) Premium (RMB)	
投保人 Policyholder							
主被保险人 Primary Insured							
其他被保险人 一 First Other Insured							
其他被保险人 二 Second Other Insure							
其他被保险人 三 Third Other Insure							
其他被保险人 四 Fourth Other Insure							
其他被保险人 五 Fifth Other Insure							
红利分配形式 Dividend Distribution Method: <input type="checkbox"/> 累积生息 Cash Accumulation <input type="checkbox"/> 抵交保费 Premium Deduction <input type="checkbox"/> 现金领取 Cash Payment <input type="checkbox"/> 其它 (请注明) Others(Please Specify): _____(若保险合同无需选择红利分配形式, 请勿填写, 误填者视作无效。如保险合同需要选择红利分配形式而未选择, 按保险合同约定处理。Please do not fill in if this option does not apply to this policy, or it will be considered as invalid. If the dividend distribution method is applicable for this policy but not filled, it will be treated according to the clause.)							
适用于年金产品 Applicable To Annuity Products Only (如保险合同中无此栏内容, 请勿填写; 误填者视作无效。Please do not fill in if the option does not apply to this policy, or it will be considered as invalid.)							
年金领取方式 Annuity Payment Method: <input type="checkbox"/> 月度领取 Monthly <input type="checkbox"/> 年度领取 Annually <input type="checkbox"/> 累积生息 Accumulated in AZCL <input type="checkbox"/> 其它 Other:_____							
起始年金/生存金领取年龄 Vesting Age: ____周岁 Years Old 年金领取年限 Annuity Term: ____年 Years							
交费方式(频次) Payment Frequency: <input type="checkbox"/> 一次交清 Single <input type="checkbox"/> 年交 Annually <input type="checkbox"/> 半年交 Bi-annually <input type="checkbox"/> 季度交 Quarterly <input type="checkbox"/> 月交 Monthly(如选择月交方式, 首期需交3个月保险费 If you choose monthly payment, AZCL will collect 3 months' premium as the first payment.)							
交费方法 Payment Method: <input type="checkbox"/> 自动转账 DDA <input type="checkbox"/> 现金 Cash <input type="checkbox"/> 支票 Cheque							
一年期主险是否自动申请续保 Whether to applying for renewal automatically for one year term main product: <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No (如保险合同为一年期主险而未选择此选项, 视作自动申请续保 If the main product is one year term product and this item is not filled, it will be regarded as applying for renewal automatically.)							
<input type="checkbox"/> 申请适用优选体费率 Preferred Risk Premium Rate If Qualified (被保险人是否适用优选体费率以中德安联核保结果为准。若保险合同中无此内容, 请勿填写; 误填者视作无效。Whether the insured is qualified for preferred risk premium rate depends on the underwriting decision of AZCL. Please do not tick if the option does not apply to this policy, or it will be considered as invalid)							
<input type="checkbox"/> 保险费自动垫交选择 Automatic Premium Loan (如勾选, 且保险合同的现金价值扣除保单欠款后足以垫交到期未交保险费及其利息的, 我们将自动为您垫交保险费并视作保单贷款, 适用保单贷款利率。若保险合同中无此内容, 请勿填写; 误填者视作无效。If APL is chosen and the policy's cash value, after deducting policy debt, is enough to cover the premium, an automatic policy loan will be made against the cash value to pay due premium. Please do not tick if the option does not apply to this policy, or it will be considered as invalid)							
首期保险费合计 First Premium In Total: _____元 RMB							
本投保人同意采用银行自动转账方式交纳首期和续期/追加保险费, 并授权中德安联及本人指定的银行自本人的授权账户自动扣取当期应交的保险费。今后如有与本合同有关的退还金额或投保人的领取金额, 本人也授权中德安联将相关款项转到授权账户。I agree to pay initial, renewal and top-up premiums through bank direct debit and authorize AZCL and designated bank to collect due premiums from the authorized account. In case of any refund or receivable, I also authorize AZCL to credit to my account.							
授权账户持有人 Account Holder: 投保人 Policyholder 授权银行 Name of Bank: _____分行/支行 Branch/Sub-branch_____							
开户地 Account Area: _____省/直辖市 Province _____市 (地级市) City							
授权账户号码 Account No. _____							
年金、满期及生存保险金给付账户 Annuity, Maturity and Surviving Benefit Payment Account (用于向主被保险人支付年金、满期或生存给付保险金。This account is used for paying annuity, maturity and surviving benefit to the Primary insured.)							
本被保险人同意中德安联采用银行自动转账方式支付年金、满期或生存给付保险金, 并同意中德安联将相应保险金转入本人指定的授权账户, 且中德安联不承担因本人指定的授权账户不真实、不准确、不完整等错误而导致中德安联不能及时给付相应保险金的责任。 I (Primary insured) agree AZCL to pay annuity, maturity and surviving benefit through bank direct credit and authorize AZCL to credit above benefit to my designated account. If the designated account was incorrect or incomplete, AZCL is not liable for delaying of the benefit payment.							
账户持有人 Account Holder: 主被保险人 Primary Insured 授权银行 Name of Bank: _____分行/支行 Branch/Sub-branch_____							
开户地 Account Area: _____省/直辖市 Province _____市 (地级市) City							
授权账户号码 Account No.: _____							
投资产品栏 Blanks for Investment Products (若保险合同中无下列内容, 请勿填写; 误填者视作无效。Please do not fill in the blanks if the items do not apply to this policy, or the information will be considered as invalid.)							
投资/理财账户名称 Investment Account							
分配比例 Proportion of Allocation							
<input type="checkbox"/> 投资账户自动转换 Investment Account Auto-rebalance							
投资时间选择 Investment Time: <input type="checkbox"/> 保单生效后立即进行投资 After Policy Issuance <input type="checkbox"/> 保单犹豫期满后投资 After Free-look Period							

简单产品告知事项 Declaration for Simple Products

若被保险人为未成年人，则请被保险人的父母代为回答。If the insured is a minor below 18 years old, the blank should be filled in by his/her parents.					主被保险人 投保人 Policyholder	其他被保险人一 Primary Insured	其他被保险人二 2nd Other Insured	其他被保险人三 3rd Other Insured	其他被保险人四 4th Other Insured	其他被保险人五 5th Other Insured
主被保险人身高 Primary Insured's Height: 厘米 cm, 体重 weight: 公斤 kg										
其他被保险人身高 First Other Insured's Height: 厘米 cm, 体重 weight: 公斤 kg										
其他被保险人身高 Second Other Insured's Height: 厘米 cm, 体重 weight: 公斤 kg										
其他被保险人身高 Third Other Insured's Height: 厘米 cm, 体重 weight: 公斤 kg										
其他被保险人身高 Fourth Other Insured's Height: 厘米 cm, 体重 weight: 公斤 kg										
其他被保险人身高 Fifth Other Insured's Height: 厘米 cm, 体重 weight: 公斤 kg										
投保人身高 Policyholder's Height: 厘米 cm, 体重 weight: 公斤 kg										
1. 在过去 5 年内，您是否曾因疾病或意外而接受手术或住院，或接受持续超过 1 个月的门诊治疗？在最近 6 个月内，您是否曾就诊，或服用处方药物，或被医生建议进行任何检查或治疗（一般感冒除外）？In last 5 years, have you ever got any disease or injury which led to surgery, inpatient treatment, more than 1 month of outpatient treatment or more than 1 month off work/study? In last 6 months have you ever consulted with doctor, taken any prescription drug, or been advised by doctor to take any examination or treatment(excluding common cold)?										
2. 您是否有以下情况：因饮酒或吸烟而接受医生治疗；使用药物成瘾或使用毒品？Have you ever been treated for drinking or smoking? Do you use any addictive drug?										
3. 您是否曾或正患有下列疾病或症状：a.心脏病、高血压、中风等心脑血管病；b.肺部疾病；c.胃肠肝胆胰疾病；d.糖尿病、甲状腺疾病等内分泌疾病；e.肾脏疾病、血尿、蛋白尿；f.血液疾病；g.红斑狼疮等结缔组织疾病；h.神经系统疾病、肢体感觉运动异常、痴呆或精神异常；i.癌症、肿瘤、肿块、囊肿、淋巴肿大、结肠息肉；j.严重视力或听力障碍；k. 身体残缺、先天性疾病；l. 性病、艾滋病或 HIV 感染；m. 在过去 12 个月内持续 3 周以上出现下列不明原因的 症状或不适：头痛、皮肤溃烂，或体重减轻超过 5 公斤（非健身或减肥原因）？Have you ever suffered/Are you currently suffering from any of the following diseases or symptoms: a. cardio-cerebral vascular diseases such as heart disease, hypertension, stroke; b. pulmonary disease; c. gastric diseases, intestinal diseases, hepatic diseases, cystic diseases or pancreatic diseases; d. endocrine diseases: such as diabetes mellitus, thyroid diseases; e. renal diseases, haematuria or proteinuria; f. blood diseases; g.connective tissue diseases: such as lupus erythematosus; h. nervous system diseases, paraesthesia, dyskinesia, dementia or psychosis; i. cancer, tumour, lump, cyst, lymph node enlargement or colonic polyp; j. severe vision or hearing disorder; k. disability or congenital diseases; l. AIDS, HIV infection, or any sexually transmitted disease; m. suffering from any of the following unknown cause symptoms or discomforts for three weeks or more in last 12 months: headache, skin ulcer or weight loss by more than 5kg (not caused by exercise or obesity control)?										
4. 您是否已有超过 300 万元身故责任的保险（航空意外身故除外），或曾被保险公司拒保、延期、限制保障范围或提高保费？Have you had more than 3 million RMB death benefit insurance (excluding aviation accident death benefit), or have you had any proposals to any insurance company rejected, postponed or accepted with exclusions or at special rate?										
5. 连同本次申请，您的身故保险责任（航空意外身故除外）是否超过 20 万元（小于 10 岁）或超过 50 万元（10-17 岁）？（18 周岁以下未成年人适用）Including this application, does your death benefit insurance (excluding aviation accident death benefit) exceed 200,000 RMB (for insured below 10 years old) or exceed 500,000 RMB (for insured age between 10 and 17 years old)? (Applicable to minors below 18 years old)										
6. 仅适用于 15 周岁及以上女性被保险人 Applicable to female insured older than 15y only: 是否怀孕超过 16 周？Are you currently pregnant more than 16 weeks?										
7. 仅适用于年龄在 2 周岁及以下的被保险人 Applicable to insured younger than 2 years old only: a) 出生时体重是否低于 2.5 公斤？Whether the insured's weight at birth less than 2.5kg? b) 有无早产、难产、窒息、出生时住院天数超过 7 天、先天性/遗传性疾病或畸形、智能低下或发育迟缓？Has the insured ever suffered/Is the insured currently suffering from premature birth, dystocia, suffocation, hospitalized for more than 7 days when he/she was born, congenital/hereditary disease or deformity, hypophrenia, growth retarded?										
若健康告知内容中回答“是”，请在下栏中详细说明。If any answer to the above questions is “Yes”, please give detail information in following blank.										
序号 No.	说明对象 Who	日期 Date	原因 Reason	就诊医院 Hospital	接受的检查和治疗 Examination and Treatment	诊断 Diagnosis	最近一次治疗时间 Time of Latest Treatment	目前状况 Current Status		

复杂产品告知事项 Declaration for Complicated Products

健康告知 Health Declaration 若被保险人为未成年人，则请被保险人的父母代为回答。If the insured is a minor below 18 years old, the blank should be filled in by his/her parents. 主被保险人身高 Primary Insured's Height: 厘米 cm, 体重 weight: 公斤 kg 其他被保险人一身高 First Other Insured's Height: 厘米 cm, 体重 weight: 公斤 kg 其他被保险人二身高 Second Other Insured's Height: 厘米 cm, 体重 weight: 公斤 kg 其他被保险人三身高 Third Other Insured's Height: 厘米 cm, 体重 weight: 公斤 kg 其他被保险人四身高 Fourth Other Insured's Height: 厘米 cm, 体重 weight: 公斤 kg 其他被保险人五身高 Fifth Other Insured's Height: 厘米 cm, 体重 weight: 公斤 kg 投保人身高 Policyholder's Height: 厘米 cm, 体重 weight: 公斤 kg	投保人 Policyholder	主被保险人 Primary Insured	其他被保险人一 1st Other Insured	其他被保险人二 2nd Other Insured	其他被保险人三 3rd Other Insured	其他被保险人四 4th Other Insured	其他被保险人五 5th Other Insured
1. 您是否曾/正患有下列症状或疾病: Have you ever suffered/Are you currently suffering from the following symptoms and/or diseases:							
(1) 癌症、肿瘤、肿块、囊肿、息肉、淋巴结肿大、消瘦（体重一年内下降超过 5 公斤,不包括健身或减肥原因）? Cancer, tumor, lump, cyst, polyp, lymph node enlargement, weight loss (more than 5kg in one year, not caused by exercise and/or obesity control)							
(2) 咳嗽或咯痰（一年中超过三个月）、咯血、呼吸困难、气胸、胸腔积液、哮喘、支气管扩张、慢性支气管炎、肺气肿、肺结核等呼吸系统疾病? Respiratory system disorder: cough or expectoration (more than 3 months in a year), emptysis, dyspnoea, pneumothorax, thorax hydrops, asthma, bronchiectasis, chronic bronchitis, emphysema, lung tuberculous?							
(3) 心慌、胸闷、胸痛、心律失常、心绞痛、心肌炎、心肌梗、先天性心脏病、风湿性心脏病、冠心病、高血压、高血脂、动脉瘤等心脑血管疾病? Cardiovascular disorder: Palpitation, chest distress, chest pain, arrhythmia, angina, myocarditis, cardiomyopathy, congenital heart disease, rheumatic heart disease, coronary artery disease, hypertension, hyperlipidemia, aneurysm?							
(4) 反复腹痛或腹泻、呕血、便血、黄疸、吞咽困难、肝脾肿大、胃或十二指肠溃疡、慢性或溃疡性结肠炎、肝炎、肝炎病毒携带、肝硬化、脂肪肝、胆囊炎、肝胆结石、胰腺炎、痔疮、疝气等消化系统疾病? Digestive system disorder: frequent bellyache or diarrhea, hematemesis, hematochezia, jaundice, dysphagia, liver/spleen enlargement, gastric or duodenal ulcer, chronic or ulcerative colitis, hepatitis, hepatitis virus carrier, liver cirrhosis, fatty liver, cholecystitis, gallbladder stone, pancreatitis, haemorrhoids, hernia?							
(5) 血尿、蛋白尿、肾炎、肾病综合症、肾功能异常、尿毒症、肾囊肿、尿路结石、尿路畸形、尿路感染、前列腺肥大、前列腺炎等泌尿系统疾病? Urinary system disease: haematuria, proteinuria, nephritis, nephrotic syndrome, abnormal renal function, uremia, kidney cyst, urinary tract stone, urinary tract deformity, urinary tract infection, prostate enlargement, prostatitis?							
(6) 多饮、多食、多尿、尿糖或血糖异常、糖尿病、甲状腺疾病等内分泌系统疾病? Endocrine disorder: polydipsia, frequent hunger, polyuria, abnormal urine/blood sugar, diabetes mellitus, thyroid disease?							
(7) 反复头痛或头晕、晕厥、抽搐、中风、癫痫、感觉或运动障碍、帕金森氏症、智能障碍、精神状态异常、抑郁症等神经系统或精神疾患? Nervous system disorder: dizziness, headache, faint, convulsion, stroke, epilepsy, partial or total loss of sensation or motion, Parkinsonism, hypophrenia, depression or mental disorder?							
(8) 关节肿痛、痛风、类风湿性关节炎、强直性脊柱炎、肌无力、红斑狼疮、椎间盘突出、骨质增生、骨折、关节损伤或脱位、骨骼或关节畸形、肢体残缺或活动障碍、下肢静脉曲张? joint swelling or pain, gout, rheumatoid arthritis, ankylosing spondylitis, myasthenia, lupus erythematosus, prolapsed intervertebral disk, hyperosteoegny, fracture, joint injury or dislocation, skeleton or joint deformity, mutilation or malfunction of any limb, varicosity?							
(9) 不明原因的皮下出血、反复鼻或齿龈出血、贫血、紫癜、血友病、白血病等血液疾病，接受输血，或被医生建议做骨髓检查? Blood disorder: noncausal subcutaneous hemorrhagic spot, repeated nasal or gingival hemorrhage, anaemia, purpura, haemophilia, leukemia, ever received a blood transfusion, or requested by doctor to take bone marrow examination?							
(10) 视力或听力明显下降、不明原因声嘶、高度近视(800 度以上)、白内障、青光眼、视网膜剥离、美尼尔症等眼耳鼻喉或口腔疾病? Eye, ear, nose, throat and oral disorder: eyesight or hearing deteriorated, hoarseness, high myopia (8.0D or over), cataract, glaucoma, retina detachment, meniere's disease?							
(11) 性病、艾滋病或 HIV 感染、使用毒品、使用药物成瘾? Sexually transmitted disease, AIDS or HIV infection, use any addictive drug?							
2. 在最近五年内，您是否曾有下列情况: In last 5 years, have you ever suffered/Are you currently suffering from following conditions:							
(1) 任何异常检查结果，如验血、验便、心电图、X 光、穿刺、造影、核磁共振、CT、B 超等? Any abnormal medical check results, such as blood test, feces examination, urine analysis, electrocardiogram, X-ray, puncture biopsy, contrast examination, MRI, CT, ultrasonography, etc.?							
(2) 因疾病或意外而接受手术或住院，或接受持续超过 1 个月的门诊治疗，或停工、停课超过 1 个月? Have you ever got any disease or injury which led to surgery, inpatient treatment, more than 1 month of outpatient treatment or more than 1 month off work/study?							
3. 在最近 6 个月内，您是否曾就诊，或服用处方药物，或被医生建议进行任何检查或治疗（一般感冒除外）? In last 6 months have you ever consulted with doctor, taken any prescription drug, or been advised by doctor to take any examination or treatment (excluding common cold)?							
4. (1) 您是否吸烟超过每天 20 支? Do you smoke more than 20 cigarettes per day?							
(2) 您是否饮酒或曾饮酒超过每天 100 毫升，或每周 500 毫升? 若“是”，已/曾饮酒____年，种类____，平均每周____次，每次____两或____毫升。Have you ever drunk/Are you currently drinking alcohol? If ‘Yes’, please specify: drinking____year(s), type of drink:____, ____times per week, ____g or ____ml each time.							
(3) 您是否曾因为饮酒或吸烟而接受医生治疗? Have you ever been treated for drinking alcohol or smoking?							
5. 您的父母或兄弟姐妹中是否有两人或以上在 60 岁之前因疾病身故或患恶性肿瘤、心肌梗塞或中风? 若“是”，请提供关于疾病诊断、诊断年龄、身故年龄等细节。Do you have 2 or more family members (parents or siblings) who passed away before 60y due to any disease or have malignant tumor, heart attack or stroke? If "Yes", please give detailed information including diagnosis, age at diagnosis, age at death.)							
6. 仅适用于 15 周岁及以上的女性被保险人: For female older than 15y only:							
(1) 是否怀孕超过 16 周? Are you currently pregnant more than 16 weeks?							
(2) 是否曾/正患有乳房肿块、阴道不规则流血、子宫肌瘤、子宫内膜异位症、卵巢囊肿、盆腔炎、宫颈涂片检查异常等乳房或女性生殖系统症状或疾病? Have you ever suffered/Are you currently suffering from mammary lump, irregular vaginal hemorrhage, hysteroymoma, endometriosis, ovarian cyst, pelvic inflammation, abnormal Pap smear and other mammary or female reproductive system symptom or disease?							
(3) 是否曾因异常妊娠而住院治疗或手术，或因医生要求而剖腹生产? Have you ever been admitted to hospital or had surgery due to abnormal pregnancy, or taken caesarean operation requested by doctor?							
7. 仅适用于年龄在 2 周岁及以下的被保险人:For insured younger than 2y only:							
(1) 出生时体重是否低于 2.5 公斤? Whether the insured's weight at birth less than 2.5kg?							
(2) 有无早产、难产、窒息、出生时住院天数超过 7 天、先天性/遗传性疾病或畸形、智能低下或发育迟缓? Has the insured ever suffered/Is the insured currently suffering from premature birth, dystocia, suffocation, hospitalized more than 7 days, congenital/hereditary disease or deformity, hypophrenia, growth retarded?							
其他告知 Other Declaration:							
8. 您是否正在从事或正打算从事有危险的体育爱好或工作（如登山、赛车等）? Have you ever taken or do you expected to take endangered sports or jobs, such as mountaineering, car racing, etc.?							
9. 您是否在国外连续居住过 3 个月或正计划去国外居住 3 个月以上? Have you ever lived or do you expect to live abroad for more than 3 months?							
10. 您是否已有超过 300 万元身故责任的保险（航空意外身故除外），或曾被保险公司拒保、延期、限制保障范围或提高保费? Have you had more than 3 million RMB death benefit insurance (excluding aviation accident death benefit), or have you had any proposals to any insurance company rejected, postponed or accepted with exclusions or at special rate?							
11. 连同本次申请，您的身故保险责任（航空意外身故除外）是否超过 20 万元（小于 10 岁）或超过 50 万元（10-17 岁）?（18 周岁以下未成年人适用）Including this application, does your death benefit insurance (excluding aviation accident death benefit) exceed 200,000 RMB (for insured below 10 years old) or exceed 500,000 RMB (for insured age between 10 and 17 years old)? (Applicable to minors below 18 years old)							

若健康告知内容中回答“是”，请注明对象（投保人、被保险人），并在下栏中详细说明。If any answer to the above questions is “Yes”, please give detail information in following blank.

序号 No.	说明对象 Who	日期 Date	原因 Reason	就诊医院 Hospital	接受的检查和治疗 Examination and Treatment	诊断 Diagnosis	最近一次治疗时间 Time of Latest Treatment	目前状况 Current Status
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若其它告知为“是”，请注明对象（投保人、被保险人），并在下栏中详细说明。If any answer to the above questions other than health declaration is “Yes”, please give detailed information in following blank.

个人税收居民身份声明 Individual Tax Residency Declaration

1. 本人声明为（以下 A-C 为单选）I am (single choice from A-C):

☐ A 中国税收居民 tax resident of China

☐ B 非中国税收居民 not tax resident of China

☐ C 既是中国税收居民，又是其他税收管辖区居民 tax resident of both China and other place

说明 Note:

中国税收居民个人是指在中国境内有住所，或者无住所而在一个纳税年度内在中国境内居住累计满一百八十三天的个人。在中国境内无住所又不居住，或者无住所而一个纳税年度内在中国境内居住累计不满一百八十三天的个人，为非居民个人。纳税年度，自公历一月一日起至十二月三十一日止。在中国境内有住所是指因户籍、家庭、经济利益关系而在中国境内习惯性居住。

Individual tax resident of China refers to an individual who has domicile in China, or though without domicile but has resided for more than 183 days in a tax year in total in China. An individual who has no domicile and does not reside in China, or has no domicile and resided in China for less than 183 days in a tax year is a non-resident individual. Tax year is the calendar year from January 1st to December 31th. Domicile refers to habitual residence in China on account of domiciliary registration, family ties, economic interests.

若第 1 项选择 B 或 C，或为外籍或港澳台人士，请继续填写以下 2 至 4 内容 If you choose B or C in question 1, or if you are foreigner or people from HongKong, Macao or Taiwan, please go on to answer the following questions from 2 to 4.

2. 本人在中国大陆以外的税收居民国（地区）及纳税人识别号如下 My tax residency and Tax Identification Number (TIN) is as bellow:

税收居民国（地区）Country (area) of tax residency _____, 纳税人识别号 TIN: _____

如果不能提供纳税人识别号，请说明原因（单选）If you can not provide TIN, please give the reason (single choice):

☐ 居民国（地区）不发放纳税人识别号 The country (area) does not issue TIN.

☐ 未能取得纳税人识别号，原因 I do not get TIN because: _____

税收居民国（地区）Country (area) of tax residency _____, 纳税人识别号 TIN: _____

如果不能提供纳税人识别号，请说明原因（单选）If you can not provide TIN, please give the reason (single choice):

☐ 居民国（地区）不发放纳税人识别号 The country (area) does not issue TIN.

☐ 未能取得纳税人识别号，原因 I do not get TIN because: _____

3. 本人持有美国绿卡或美国永久居留权 I am holding US Green Card/US Permanent Residence

☐ 是 Yes ☐ 否 No

4. 本人持有双重/多重国籍，且其中包括美国国籍 I am holding dual/multiple nationalities, and one of them is US.

☐ 是 Yes ☐ 否 No

本人确认上述信息的真实、准确和完整，且当这些信息发生变更时，将在 30 日内通知中德安联人寿保险有限公司。I confirm that the information above is factual, accurate and complete. I shall inform Allianz China Life Insurance Company Limited of any change to the information within 30 days.

个人税收居民身份声明 Individual Tax Residency Declaration

1. 本人声明为（以下 A-C 为单选）I am (single choice from A-C):

☐ A 中国税收居民 tax resident of China

☐ B 非中国税收居民 not tax resident of China

☐ C 既是中国税收居民，又是其他税收管辖区居民 tax resident of both China and other place

说明 Note:

中国税收居民个人是指在中国境内有住所，或者无住所而在一个纳税年度内在中国境内居住累计满一百八十三天的个人。在中国境内无住所又不居住，或者无住所而一个纳税年度内在中国境内居住累计不满一百八十三天的个人，为非居民个人。纳税年度，自公历一月一日起至十二月三十一日止。在中国境内有住所是指因户籍、家庭、经济利益关系而在中国境内习惯性居住。

Individual tax resident of China refers to an individual who has domicile in China, or though without domicile but has resided for more than 183 days in a tax year in total in China. An individual who has no domicile and does not reside in China, or has no domicile and resided in China for less than 183 days in a tax year is a non-resident individual. Tax year is the calendar year from January 1st to December 31th. Domicile refers to habitual residence in China on account of domiciliary registration, family ties, economic interests.

若第 1 项选择 B 或 C，或为外籍或港澳台人士，请继续填写以下 2 至 4 内容 If you choose B or C in question 1, or if you are foreigner or people from HongKong, Macao or Taiwan, please go on to answer the following questions from 2 to 4.

2. 本人在中国大陆以外的税收居民国（地区）及纳税人识别号如下 My tax residency and Tax Identification Number (TIN) is as bellow:

税收居民国（地区）Country (area) of tax residency _____, 纳税人识别号 TIN: _____

如果不能提供纳税人识别号，请说明原因（单选）If you can not provide TIN, please give the reason (single choice):

☐ 居民国（地区）不发放纳税人识别号 The country (area) does not issue TIN.

☐ 未能取得纳税人识别号，原因 I do not get TIN because: _____

税收居民国（地区）Country (area) of tax residency _____, 纳税人识别号 TIN: _____

如果不能提供纳税人识别号，请说明原因（单选）If you can not provide TIN, please give the reason (single choice):

☐ 居民国（地区）不发放纳税人识别号 The country (area) does not issue TIN.

☐ 未能取得纳税人识别号，原因 I do not get TIN because: _____

3. 本人持有美国绿卡或美国永久居留权 I am holding US Green Card/US Permanent Residence

☐ 是 Yes ☐ 否 No

4. 本人持有双重/多重国籍，且其中包括美国国籍 I am holding dual/multiple nationalities, and one of them is US.

☐ 是 Yes ☐ 否 No

本人确认上述信息的真实、准确和完整，且当这些信息发生变更时，将在 30 日内通知中德安联人寿保险有限公司。I confirm that the information above is factual, accurate and complete. I shall inform Allianz China Life Insurance Company Limited of any change to the information within 30 days.

- 临时保障声明：本人（我们）已知晓，自中德安联收到足额首期保险费的次日起，至中德安联同意承保并签发保险单或不同意承保并签发延期或拒保通知书之日止，中德安联将承担投保单所载被保险人申请险种的由意外伤害事故导致的身故及残疾保险责任，且向同一被保险人给付的临时保障累计不超过人民币二十五万元，同时中德安联将在理赔时无息退还已支付保险费。如投保人和被保险人未履行如实告知义务，或导致被保险人身故或残疾的事件属于所申请险种责任免除条款范畴，则中德安联不承担上述意外身故及残疾保险责任。Temporary Insurance Agreement (TIA) Statement: I am (We are) aware that, if the Insured sustains accidental death or disability, Allianz China Life Insurance Co., Ltd (AZCL) will pay the benefit of death (and disability, if applicable) as applied by the Insured in the application form. The TIA commences from the next day when AZCL receives sufficient initial premium, to the day when AZCL accepts the application and issues policy, or to the day when AZCL issues postpone or decline letter. The accumulated benefit payable to the same Insured under TIA should not exceed RMB250,000. AZCL will refund premium without any interest when settling the claim. If the policyholder and/or the Insured is found fail to implement his/her duty of faithful disclosure or if the Insured's death and/or disability results from any prescribed exclusion clauses of the insurance applied, AZCL will not pay the above accidental death and disability benefit.
- 中德安联已向本人（我们）提供了保险条款和产品说明书（如有）且予以了说明，并就保险责任、免除保险责任及犹豫期等作了重点提示和明确解释说明，且本人（我们）亦已全部阅读并理解。本人（我们）通过本投保单提供的信息均完整、正确且真实。AZCL has provided me (us) with the insurance clauses and product brochures (if applicable), and has explained to me (us) clearly and emphasized on crucial clauses as insurance benefit, exclusions and cooling-off period, etc. I (We) have read completely and understood. The information provided here in this proposal by my (our) own is complete, accurate, factual.
- 本人（我们）已知晓，一年期主险的保险期间为一年。在本人（我们）选择自动申请续保方式时，须经中德安联审核同意续保并收取保险费后一年期主险方继续有效，直至本人（我们）书面申请终止续保；如经中德安联审核不同意续保，则一年期主险满期终止。I am (we are) aware that the benefit term of one year term main product is one year. When I (we) select applying for renewal automatically, the one year term main product will remain valid only after AZCL agree to accept renewal and receiving premium, until I (we) terminate renewal with written application. The one year term main product will be expired if AZCL disagree to accept renewal.
- 本人（我们）谨此授权任何注册医师、医院诊所、保险公司、或其他拥有本人（我们）资料、或了解本人（我们）的组织、机构或个人，均可在法律允许的范围内，向中德安联、其他保险人、有管辖权的司法部门以及中与中德安联合作的第三方机构（包括但不限于上海保险交易所股份有限公司及其合作伙伴）提供所了解的关于本人（我们）的资料和信息，亦同意中德安联或与中德安联合作的第三方机构向上述机构、组织或个人进行相关调查；并授权中德安联因拟提供其他相关销售、售后服务及资料处理等需要而以合法方式向中德安联的销售人员提供，以及与中德安联合作的第三方机构或其人员以合法方式相互提供或存储本人（我们）的相关信息及保险合同所载的信息。本授权文件的复印件与正本拥有同样的效力。I (we) hereby agree and authorise any physician, hospital and clinic, insurance company or any other organization or person who has my (our) materials or know about me (us), to release to AZCL, any other insurer, judicial department which has the jurisdiction and third-party institution co-operated with AZCL (including but not limited to Shanghai Insurance Exchange Co., Ltd. and its cooperation partners) any relevant information concerning me (us) within the permission of law at any time. I (we) also agree and authorise AZCL or third-party institution co-operated with AZCL to investigate related information from above organizations or persons. I (We) agree and authorise AZCL to release related information concerning me (us) and contained on my (our) policy to sales person of AZCL, provide and store related information with each other for third-party institution (and its staff) co-operated with AZCL within the law for the purpose of sales, or providing other related after-sale service and data processing. A photocopy of this authorization shall be as valid as the original.
- 本人（我们）同意，含“效力恢复”条款的产品，申请恢复合同效力时，中德安联有权要求本人（我们）提供本人（我们）的相关信息，并进行体检等。合同效力恢复须经中德安联审核同意并补交保单欠款之后方可实行。I (we) agree that in case of any application for policy reinstatement, I (we) shall follow the requirement of AZCL, including but not limited to submission of all related information, attending medical exams and etc. Upon acceptance of AZCL and all due premium paid, the policy shall be reinstated.
- 本人（我们）在本投保单上的签名即为对本投保单上所述全部事项的同意、确认和授权，特别是委托自动扣缴应交保费的授权。I (we) sign this application form as I (we) confirm all the conditions mentioned above, especially the authorization of DDA.
- 本人（我们）同意中德安联依据相关法律法规要求向政府机构或税务机构（包括中国境外）提供本人（我们）所持有的保险合同所载的信息。I (we) hereby agree to (and waive any otherwise applicable restrictions on) the disclosure by AZCL of my Policy Information to any government or tax authority (whether within or outside China) for the purposes of ensuring the Company's compliance with Applicable Laws and Regulations.
- 本人（我们）承诺将及时向中德安联更新本人（我们）的个人信息（姓名、地址、联系电话、国籍等），包括但不限于已获得或可能获得的国籍或居住地。I (we) hereby agree to promptly update AZCL of any changes or additions to the information of Name, Address, Contact Number, Nationality, and etc, including but not limited to any new citizenships or residencies that I (we) may acquire.
- 本人（我们）同意使用电子信函服务，并同意通过预留的电子邮箱接收本人（我们）名下所有保单的通知类信函（包括但不限于保费通知书，红利通知书等）。I (we) hereby agree to receive all the notices (including but not limited to renewal notice, dividend notice) via email.
- 本人（投保人）同意中德安联及其合作银行根据法律法规的要求对相应保单的销售过程进行录音录像。I (Policyholder) agree AZCL and cooperative bank to recording audio and video of the sales process in accordance with the requirements of laws and regulations.

[illegible]

I have understood the features of this product and uncertainty of the policy benefits, and I am willing to undertake the risk of uncertain benefits.

其他声明 Other Statement:

投保人签名: Signature of Policyholder	主被保险人/法定监护人签名: Signature of Primary Insured/Legal Guardian	其他被保险人一/法定监护人签名: Signature of First Other Insured/Legal Guardian
其他被保险人二/法定监护人签名: Signature of Second Other Insured/Legal Guardian	其他被保险人三/法定监护人签名: Signature of Third Other Insured/Legal Guardian	其他被保险人四/法定监护人签名: Signature of Fourth Other Insured/Legal Guardian
其他被保险人五/法定监护人签名: Signature of Fifth Other Insured/Legal Guardian		

本单投保方式 Application Type of This Policy:

代理销售机构 代码/签章:	银行经办人员/见证营销员 编号/签名:	安联营销人员 编号/签名:	地点: Signing venue	签署日期: 年 月 日 Signing date (YYYY/MM/DD)
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