百年人寿 AEON LIFE
创新百年 关爱永恒

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百年尊贵无忧高端团体医疗投保单

AEON Honorable & Easy High-end Group Medical Insurance Application Form

条形码粘贴处
Paste bar code here

A.投保须知 Application Notice

1. 为使贵单位充分了解投保内容并维护贵单位的权益，投保前请贵单位仔细阅读本保险相关内容和条款，确认已充分理解保险责任、责任免除、如实告知、合同解除等重要事项后做出投保决定。

In order for you to fully understand the insurance applied for and so as to protect your rights and interests, please make a decision about applying for the group health plan after you carefully read relevant insurance contents and policy wording and you fully understand important issues like benefits, exclusions, honest disclosure and contract cancellation.

2. 投保单、被保险人清单及其它保险人认为有必要的资料（以下简称“投保资料”）是本公司签发保险单的依据，将成为保险合同的重要组成部分，对于本公司提出的各项询问，投保人、被保险人须如实告知，本公司承诺对投保资料内容保密。

The Application Form, List of Insured Members and other files deemed necessary by the Insurer (hereinafter “application files”) are basis for the Insurer to issue the Insurance Contract and will be an important part of the Insurance Contract. For all inquires of the Insurer, the Policyholder and Insured should disclose honestly, the Insurer guarantee to keep confidential of the application files.

3. 本投保单须加盖投保人公章并由投保单位法定代表人或授权经办人签名（章）确认。所有投保资料须加盖骑缝章。授权经办人的所有行为将全权代表投保人的意愿。

The Application Form should be sealed by the Policyholder and signed by the legal representative or authorized person of the Policyholder. All the application files should be sealed on the perforation. All the acts of the authorized person are fully representing the Policyholder’s will.

4. 若贵单位已填写投保资料并签章，将视为投保人已充分理解保险条款并同意遵守。

If you fill in and sign/seal the application files, it should be regard that the Policyholder is fully understand the policy wording and agree to abide by it.

5. 中英文内容不一致以中文为准

In case there is any discrepancy between the Chinese and English texts, the Chinese text shall prevail.

B.投保单位资料 Details Of Policyholder

单位名称 Company Name				单位总人数 Number of Staff	
通讯地址 Address				邮政编码 Postcode	
组织机构代码 Certificate of Organization Code		工商注册号 Registration No.		税务登记号 Tax register No.	
机构分布区域 Distribution of Company	☐当地 Local ☐全省/直辖市 Province-wide/Municipality ☐全国 Country-wide ☐跨国 Worldwide				
单位性质 Nature of Company	☐国有 State-owned ☐集体 Collective ☐私营 Private ☐股份制 Stock company ☐个体 Self-employed ☐中外合资 Sino-foreign joint venture ☐外商独资 Wholly foreign-owned ☐机关事业单位 Public institution ☐社会团体 Social organization ☐其他 Other				

开户银行 Name of Bank		账户号码 Account umber		行业类别 Industrial Classification	
法定代表人 Legal Representative		单位联系电话 Unit telephone		单位传真号码 Unit Fax number	
保险联系人 Contact Person	女士/先生 Ms/Mr	部门 Department		职务 Job Title	
电子邮箱 E-Mail		办公电话 Tel (Office)		手 机 Mobile	

C.投保基本信息 Basic Information of the Insurance

投保日期 Application Date	年 月 日	保险合同生效日期：从载于保险单上的生效日零时开始 Effective date of the insurance contract：From 0:00 of the effective date of the policy			
投保总人数 Total number of the people insured		主被保险人数 Number of the primary insured		连带被保险人数 Number of the additional insured	
保险期间 Duration of the insurance	1 年 1 year		交费方式 Type of payment	一次性交费 Lump-sum	
付款方式 Payment Method	☐现金 Cash ☐现金支票 Draft ☐转帐支票 Transfer Check ☐转帐 Transfer ☐其它 Other				

D. 保障信息 Information of the Insurance

单位：人民币元 Unit: RMB (yuan)

险种责任 Liabilities of the insurance	层级Ⅰ： Level Ⅰ:	层级Ⅱ： Level Ⅱ:	层级Ⅲ： Level Ⅲ:	层级Ⅳ： Level Ⅴ:
	人数： Number of people:	人数： Number of people:	人数： Number of people:	人数： Number of people:
必选责任 Mandatory liability				
以下为可选责任，如选择该责任，请在表格中用“√”填充。 The following are optional. Please tick “√” the appropriate box below.				
牙科医疗保险金 Dental insurance				
体检和疫苗保险金 Physical examination and vaccination insurance				
眼科及视力保险金 Vision insurance				
特殊疾病及特殊项目保险金 Specific disease and specific purpose insurance				
险种责任 Liabilities of the insurance	层级Ⅴ： Level Ⅴ:	层级Ⅵ： Level Ⅵ:	层级Ⅶ： Level Ⅶ:	层级Ⅷ： Level Ⅷ:
	人数： Number of people:	人数： Number of people:	人数： Number of people:	人数： Number of people:
必选责任 Mandatory liability				
以下为可选责任，如选择该责任，请在表格中用“√”填充。 The following are optional. Please tick “√” the appropriate box below.				
牙科医疗保险金 Dental insurance				
体检和疫苗保险金 Physical examination and vaccination insurance				
眼科及视力保险金 Vision insurance				
特殊疾病及特殊项目保险金 Specific disease and specific purpose insurance				
保险费合计 Total premium：（大写 In Words）			（小写 In Figure）￥	
特别约定 Special Agreement：				

E.团体健康告知 Group Health Questionnaire

请如实填写团体健康告知。既往症是指在保险人对其保险责任生效前被保险人已就此接受诊断、医学咨询或治疗，或服用药物，或显现症状的疾病或损伤。

The purpose of the Health Questionnaire is to evaluate the health conditions for all the primary insured and each of his/her dependents if any and to determine the underwriting conditions, please answer the questions below truthfully. Pre-existing conditions: means any Illness or Injury, physical or mental condition, for which an Insured Person received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident prior to the effective date.

请就所有主被保险人与附属被保险人的健康状况如实回答下列问题。若答案为“是”，请详细说明。所有主被保险人和附属被保险人中是否有人：Please truthfully answer YES or NO to each of the following questions for the primary insured and each of his/her dependents if any. For each YES answer, please explain and provide details:

目前尚在病假中？Currently in sick leave?	☐是 YES ☐否 NO

近一年内有无因患病而不能全勤工作或减轻工作量的员工？Unable to be fully active in work, or reduce work load due to sickness during the last year?	☐是 YES ☐否 NO
曾经被诊断有或治疗过任何以下重大疾病的情况之一：Been diagnosed with, treated for any of the following of catastrophic illness:	☐是 YES ☐否 NO
1).心血管疾病-包括冠心病、先天性心脏病、心肌梗塞、主动脉瘤。Cardiovascular disease - includes coronary artery disease, congenital heart disease, chronic pulmonary heart disease, myocardial infarction, aortic aneurysm.	
2).神经疾病-包括脑卒中、脑动脉瘤、阿尔茨海默病、帕金森病、脊髓空洞症、多发性硬化症。Neurological conditions - includes stroke, brain aneurysm, Alzheimer's disease, Parkinson's disease, Syringomyelia, Multiple Sclerosis.	
3).血液疾病-包括白血病、淋巴瘤、再生障碍性贫血、血小板减少性紫癜、血友病。Hematologic disease - includes leukemia, lymphoma, aplastic anemia, ITP, hemophilia.	
4).肺部疾病-慢性阻塞性肺病、原发性肺动脉高压。Pulmonary diseases - includes chronic obstructive pulmonary disease, primary pulmonary hypertension.	
5).消化疾病-肝硬化、重症肝炎。Digestive diseases - includes liver cirrhosis, severe hepatitis.	
6). 自身免疫性疾病-包括系统性红斑狼疮、系统性硬皮病、获得性免疫缺陷综合症（艾滋病）、艾滋相关综合征和其他与 HIV 病毒相关的性传染病或者症状。Autoimmune diseases - includes systemic lupus erythematosus, systemic scleroderma, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS), and all diseases caused by and/or related to the HIV virus.	
7).其他-包括所有肿瘤、主要器官衰竭或移植、囊性纤维化、黑斑息肉病、Ⅲ度烧伤。Others - includes all cancer, major organ failure /transplant, cystic fibrosis, Peutz-Jeghers syndrome, Ⅲ-degree burns.	
上述健康告知若有任一被保险人回答“是”，请该被保险人如实、仔细填写全球医疗团体保险个人调查表。For any answers YES, the corresponding insured need fill in Group Health Plan Member Health Statement as truthfully and thoroughly as possible.	

F.投保人声明 Policyholder Declaration

在本投保人投保该保单的保险年度内，投保人申请投保的所有员工及其申请与该员工同时投保的该员工配偶、子女都未曾被诊断有或治疗过任何以上团体健康告知中的七项重大疾病之一。在申请投保时，投保人、拟投保员工及与该员工同时投保的该员工配偶、子女对上述重大疾病有如实告知义务。投保人或拟投保员工及与该员工同时投保的该员工配偶、子女若因故意或重大过失等未能履行上述如实告知义务，保险人有权调查重大疾病是否属于保前疾病，并进行重新核保或不承担该部分未如实告知的投保员工（包括该员工配偶、子女）上述疾病的保险责任，由此产生的保险人和该部分未如实告知的投保员工（包括该员工配偶、子女）之间的纠纷或责任由投保人承担。

The Policyholder declares that during the policy period, none of the Primary Insured or their dependents have been diagnosed with, treated for any of the above 7 catastrophic conditions. During the Effective Period of the Policy, the Policyholder, all Primary Insured and/or their dependents undertake the liability of informing above mentioned catastrophic conditions according to the facts. If due to any reasons such as intention or gross negligence, etc. the Policyholder and/or any Primary Insured and/or their dependents fails to undertake the liability of informing according to the facts, the Insurer reserves the right to further investigate whether catastrophic conditions fall in pre-existing conditions or not, and my re-underwrite or not cover the conditions stated above of the Primary Insured and/or their dependents for whom the Policyholder does not inform the Insurer according to the facts. The Policyholder will undertake the liabilities for any disputes arising hereto between the Insurer and the Primary Insured and/or their dependents.

保险有效期内，本投保人确认以投保单上载明的传真电话或电子邮件提出的加人、减人、退保等保全变更申请有效，投保人不再就同一变更事项另行提供经投保人签章的书面申请，由此产生的相关法律责任由本投保人承担。如传真电话或电子邮件发生变化，投保人将以书面形式提交授权变更通知。

During the policy period, the Policyholder certifies that the applications of policy changes such as addition, deletion, cancellation, etc. made from the fax or email stated in the Application are valid. For the same changes, the Policyholder will not provide additional written application with chop. The Policyholder will undertake relevant legal liabilities. If the fax or email stated in the Application changed, the Policyholder will provide written Authorization Change Notice.

我确认上述所有信息及后附的被保险人清单真实有效。

I hereby acknowledge the reality and validity of the above information and the attached enrollment form.

投保人签名 Signature：　　投保单位盖章 Chop：

签章日期 Date：　　年　　月　　日