太平养老保险股份有限公司
TAIPING PENSION CO., LTD.

团体被保险人告知声明书
Health Declaration

投保团体：Insurance Applicant:		投保单号：Application Form No:	
姓名： Full Name	性别 Gender： ☐男 Male ☐女 Female	出生日期：年 月 日 Date of Birth(YYYY/MM/DD)	年龄：周岁 Age:
证件类型 ID Type: ☐身份证 ID Card ☐护照 Passport ☐其它 Others:_____		证件号码 ID No.	
国籍 Nationality:	职业 Occupation:	职务 Position:	
个人年收入约 Annual Income: 万元(Ten Thousand RMB)	身高 Height: 厘米 cm	体重 Weight: 公斤 kg	
当地社会医疗保险参保人 Covered by Local Sociomedical Insurance:☐是 Yes☐否 No	当地社会医疗生育保险参保人 Covered by Local Social Maternity Insurance:☐是 Yes☐否 No		

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 below 18 years old, the blank should be filled in by his/her parents.	是 Yes	否 No
1.您目前是否能正常从事全职工作？Are you currently active at work on a full-time basis?	☐	☐
2. 您是否曾/正患有下列症状、疾病或残疾：Have you ever suffered/Are you currently suffering from the following symptoms, diseases and/or disabilities:		
（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, pleural effusion, asthma, bronchiectasis, chronic bronchitis, emphysema, lung tuberculosis, etc?	☐	☐
（3）心慌、胸闷、胸痛、心律失常、心绞痛、心肌炎、心肌病、先天性心脏病、风湿性心脏病、冠心病、高血压、高血脂、动脉瘤等心脏血管疾病？Cardiovascular disorder: Palpitation, chest distress, chest pain, arrhythmia, angina, myocarditis, cardiomyopathy, congenital heart disease, rheumatic heart disease, coronary artery disease, hypertension, hyperlipidemia, aneurysm, etc?	☐	☐
（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、胃切除、肠切除、胰腺切除、肝切除、脾切除等消化系统疾病或残疾？Digestive system disorder and/or disabilities: 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, gastrectomy, enterectomy, pancreatectomy, hepatectomy, splenectomy, etc?	☐	☐
（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、肾切除、输尿管闭锁等泌尿系统疾病？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, nephrectomy, ureteral atresia, etc?	☐	☐
（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, etc?	☐	☐
（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、脑脊液鼻漏（耳漏）等神经系统或精神疾患？Nervous system or mental disorder: dizziness, headache, faint, convulsion, stroke, epilepsy, partial or total loss of sensation or motion, Parkinsonism, hypophrenia, abnormal mental state, depression, cerebrospinal rhinorrhea(cerebrospinal otorrhea), etc?	☐	☐
（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、腰椎或颈椎椎间盘疾患、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, neck vertebra or lumbar disc diseases, hyperosteogeny，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, etc. 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、牙齿缺失（4 颗及以上）等眼耳鼻喉、口腔疾病或残疾？Eye, ear, nose, throat and oral disorder or disabilities: eyesight or hearing deteriorated, hoarseness, high myopia (8.0D or over), cataract, glaucoma, retina detachment, meniere's disease, loss of teeth(more than three teeth), etc?	☐	☐
（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?	☐	☐
3. 在最近五年内，您是否曾有下列情况：Have you ever suffered/Are you currently suffering from following conditions in the last 5 years:		
（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 个月的治疗，或持续病假超过 10 天？Undergone a surgery operation, hospitalized, or had continuous medical treatment for more than one month, or had continuous sick leave for more than 10 days due to any disease or injury?	☐	☐

4. 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.)	☐	☐
5. 仅适用于15周岁及以上的女性被保险人：Only for female insured of 15 years old and older :		
（1）是否正在怀孕？若“是”，请告知怀孕_____月。Are you pregnant? If ‘Yes’, pregnant for ___ months.	☐	☐
（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, hysteromyoma, 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？Have you ever been hospitalized or had surgery due to abnormal pregnancy?	☐	☐
6. 仅适用于年龄在3周岁以下的被保险人:Only for insured of age under 3 years old:		
（1）出生时体重_____公斤，出生时住院天数是否超过7天？若“是”，请说明原因：_____。Weight of birth:___kg. Whether the insured was hospitalized more than 7 days when he/she was born? If ‘Yes’, please specify the reason:_____.	☐	☐
（2）有无早产、难产、窒息、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, congenital/hereditary disease or deformity, hypophrenia, growth retarded?	☐	☐
其他告知 Other Declaration:		
7. 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、飞行、滑雪、潜水、滑翔、跳伞、攀岩、探险活动、赛马、赛车等）？Have you ever taken or do you expected to take endangered sports or jobs, such as mountaineering, flying, skiing, diving, gliding, parachute jumping, rock climbing, exploring, horse racing, car racing, etc.?	☐	☐
8. 保险经历：Experience of insurance application: （1）您是否曾向其它公司申请过人身保险？若“是”，请说明：Have you ever applied for insurance to other insurer? If ‘Yes’, please specify: 累计重大疾病类保险保额:_____万元,累计住院补贴类保险保额:_____元/天,累计寿险保额:_____万元,累计意外险保额:_____万元,其它:_____。 Total sum assured of critical illness cover: _____ ×10 thousand RMB, total sum assured of hospital income cover: _____RMB/day, total sum assured of life insurance cover: _____ ×10 thousand RMB, total sum assured of accident cover: _____ ×10 thousand RMB, others: _____ （2）您是否曾被拒保、延期、限制保障范围或提高保费？Have your application of insurance ever been declined, postponed or accepted with exclusions or special rated?	☐ ☐ ☐	☐ ☐ ☐

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 specify in following blanks.

序号 No.	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

若其它告知为“是”，请在下栏中详细说明。If any answer to the above questions other than health declaration is “Yes”, please specify in following blanks.

被保险人声明 Applicant’s declaration

1. 本人确认上述陈述是完整、属实的，与保单条款等相关资料一起作为保险责任的基础。
   I declare that to the best of my knowledge and belief that the statements made above are complete and true, together with the policy terms and conditions, shall form the basis of the coverage.
2. 我知道任何健康上得变化应在保单生效前通知贵公司，由于未如实告知重要情况将会导致拒赔。
   I understand that any change to my health must be notified to Taiping Pension prior to the commencement date of the contract and that failure to disclose all material facts may result in the rejection of claims.
3. 我授权所有拥有本人健康信息的执照医师、医疗从业者、医院、诊所或其它医疗机构、保险机构或个人，可提供给贵公司有关该保险责任的相关信息。
   I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medical related facility, insurance company, institution or person that has any records or knowledge of me, my dependants or my health to provide Taiping Pension with any information they may require in respect of this coverage.

被保险人/监护人签章 Applicant’s signature: 日期 Date:

与被保险人关系 Relationship to the insured:

（当被保险人为未成年人时需填写 Please fill out if the insured is a minor.）