

Name of Policy Owner / Employer: 保單持有人或僱主名稱 Policy No.: 保單編號

A. PARTICULARS OF PROPOSED INSURED 投保人之個人資料

1. Name of Proposed Insured: 受保人姓名 HKID Card No.: 香港身份證號碼 Date of Birth: 出生日期

Sex: 性別 Occupation: 職業 Exact Job Duties: 職位 Marital Status: 婚姻狀況 Height: 身高 (m) Weight: (kg) (米) 體重 (千克)

Telephone No.: (H) (O) Home Address: 電話號碼 住宅 公司 住址

2. Name & address of your usual medical attendant 閣下慣常就診的醫生姓名及地址

3. Are you applying for, or being covered by any other insurers? 你現時是否在美國萬通保險亞洲有限公司或其它保險公司申請或購有任何保單? Yes ☐ No ☐
If yes, please state the name of insurer, type of policy and the issue date. 如「有」, 請列明該保險公司名稱、保單類別及保單生效日期。 是 否

4. If the proposed insured is a dependant of an employee, please fill in the following: 倘受保人是僱員家屬, 請填妥以下資料:

Employee Name: 僱員姓名 HKID Card No.: 香港身份證號碼 Relationship: 與僱員之關係

B. PERSONAL STATEMENT BY PROPOSED INSURED 投保人之健康聲明

*Please tick (✓) the appropriate box 請於適當空格內劃上 (✓) 號

1. Do you smoke, take drugs, narcotics or alcohol? If “Yes”, please indicate type and quantity. 閣下有否吸煙、服用藥物、毒品或含酒精飲品? 如「有」, 請列明種類及份量。 Yes ☐ No ☐

2. Have you: 閣下曾否: a. EVER been refused insurance or been offered insurance with restricted benefits or at other than standard rates? 被保險公司拒絕接受投保或向閣下提供有限制條款的保障或提高保費? ☐ ☐ b. engaged in or planned to engage in any hazardous sports or activities? 參與或打算參與任何危險活動或運動? ☐ ☐

3. Have you EVER suffered from or been treated for any of the following disorders or diseases? 閣下曾否感染或接受有關下列疾病之治療? (If yes, please tick the following box where applicable and give full details in the space provided below.) (若有, 請在適當之方格內加✓號, 並於以下空位內詳述。)

<input type="checkbox"/> a. Any impairment in physical condition 任何身體上的缺陷	<input type="checkbox"/> e. Stone or kidney disease 腎石或腎病	<input type="checkbox"/> i. Ulcer of any kind, stomach, bowel, liver or gall bladder disease 各類潰瘍症、胃、腸、肝或膽臟疾病	<input type="checkbox"/> l. Sexually transmitted disease 性病
<input type="checkbox"/> b. Asthma or respiratory or lungs disease 哮喘病或呼吸疾病	<input type="checkbox"/> f. Diabetes 糖尿病	<input type="checkbox"/> j. Arthritis, gout, spinal or muscular skeletal disease or disorder 關節炎、痛風、脊柱、肌肉或骨骼病	<input type="checkbox"/> m. AIDS or AIDS related conditions 後天免疫力缺乏症或相關病況
<input type="checkbox"/> c. Anxiety, epilepsy or mental disorder 精神抑鬱、癲癇或精神病	<input type="checkbox"/> g. Thyroid gland disease or disorder 甲狀腺病或失調	<input type="checkbox"/> k. Cancer, tumour or cyst of any kind 癌症、腫瘤或各類囊腫	<input type="checkbox"/> n. Alcoholism or drug addiction 酗酒或藥癮
<input type="checkbox"/> d. High blood pressure, pain in the chest, heart or cardiovascular disease or disorder 高血壓、胸口痛、心臟或血管循環系統病	<input type="checkbox"/> h. Disease or disorder of nose, eye or ear 鼻、眼或耳疾病或失常		FEMALE ONLY <input type="checkbox"/> o. Gynaecological disease or complications/ conditions associated with pregnancy 婦科病或與妊娠相關之疾病及其併發症

4. In the past 5 years, have you: 過去五年內, 閣下曾否: a. had, or been advised to have blood tests, electrocardiograms or X-rays? (e.g. Cholesterol, AIDS or Hepatitis etc.) 接受或被建議接受驗血、心電圖或 X-光檢查? (如檢查膽脂素、愛滋病或肝炎等) ☐ ☐ b. had any illness requiring regular medical treatment or advice, operation or hospitalization not mentioned in B3 above? 患有上文 B3 並未提及的任何疾病、接受手術或定期診斷或留醫治療? ☐ ☐

5. Are you now receiving or contemplating any operation or medical treatment? 閣下現正接受手術或打算接受任何手術或治療? ☐ ☐

6. If your answer to any of the questions from B2 to B5 above is "Yes", please give full details below. 如 B2 至 B5 的答案為“是”, 請詳列資料。

Question No. 問題編號	Duration 治療期間	Type of Illness, Treatment & Condition 疾病、治療及病情說明	Current Condition 現時情況	Name/Address of Attending Doctor/Hospital 主診醫生/醫院名稱及地址

IMPORTANT NOTE: All answers to this application will form the basis and become part of the Policy between you and MassMutual Asia. You are required to disclose in this application everything you know or could reasonably be expected to know because MassMutual Asia will accept the risks and the terms of insurance based on what you disclose in this application. If you are in doubt whether a fact is material, please disclose it in this application. Your failure to comply with this requirement may cause the policy issued be null and void.

重要事項: 閣下在本申請書內提供的資料將作為閣下與美國萬通保險制定保單的基礎。該等資料亦會成為保單的一部份。閣下必須提供一切知悉或據常理知悉的資料, 因美國萬通保險會按照閣下所提供的資料評核受投保申請及決定保險條款。如閣下不清楚某一事項是否重要, 請閣下將該事項填寫於申請書內。

DECLARATION & AGREEMENT 聲明及同意 I declare and agree that: (1) I have read the above Important Note and understand my responsibility to disclose all facts to MassMutual Asia Ltd (The Company); and (2) All statements and answers made in all parts of the Application are full, complete and true to the best of my knowledge and belief regardless of whether or not they are in my handwriting.

本人謹此聲明: (1) 本人已閱讀了上述的「重要事項」, 並理解本人有責任確實提供一切事實予美國萬通保險亞洲有限公司 (貴公司); 及 (2) 本人在申請書內提供的資料及聲明, 無論是否由本人親筆作答, 均為完整、正確及真實。本人同意貴公司或其代理人持有或收存, 藉此申請書或其他途徑之個人資料, 可供貴公司儲存、使用或披露, 以促貴公司可: - 提供任何貴公司相信他人可能有興趣或必須知道的意見或產品/服務資料; 或因其他原因需與本人聯絡。 I authorize any medical, insurance company or other organization, institution or person, who has any records or knowledge of me or my health or who has been or may in the future be consulted by me, to divulge to The Company or its reinsurers or any legal tribunal any information he or she may have acquired with regard to me for the purpose of evaluating the insurance risk of my application. The photostated copies of this authorization shall be as effective and valid as the original. 本人謹此授權任何註冊西醫、醫院、診所、保險公司或機構、其他組織或人士, 凡知道或擁有有關本人之資料者, 均可將該等資料提供給貴公司及有關機構以作評核本保險申請之用。本授權書的影印本與正本有同等效力。

Personal Data 有關個人資料 I understand that information provided in respect of this application, policy to be issued or financial related product or service or alterations, variations or cancellation of them and any claims of whatsoever nature made hereunder may be held, used or disclosed in connection with this or any other insurance related product or any claim of whatsoever nature made thereunder by this company or any related company or by any other company carrying on insurance related business in or from Hong Kong or any association of federation of insurance companies that exists or is formed from time to time.

本人明白, 就本投保申請/保單或財務產品/服務或其更改、取消、或任何性質的索償而提供的資料, 可供貴公司 (或其關連公司) 或任何經營與保險有關之業務 (在香港經營或自香港帶往外地經營) 或任何現存 (或將來成) 的保險公司組成的聯會或保險業行會, 因為任何保險產品或任何性質的索償而持有、使用或披露。 I understand that, according to the Personal Data (Privacy) Ordinance, I have the right to obtain access to and to request correction of any personal information concerning myself held by The Company. Request should be made to the Employee Benefits Department, The Company (address as shown on this form).

本人明白根據個人資料 (私隱) 條例, 本人有權要求讀取及修正貴公司所持有本人的個人資料, 惟此等要求須致函貴公司 (地址詳見本表格) 僱員福利部。 In accordance with the provisions of the Personal Data (Privacy) Ordinance of Hong Kong, by signing below, I consent that the personal information collected or held by The Company or its agents / brokers (whether contained in this application or otherwise obtained) is provided and may be held, used and disclosed to enable the Company to: - refer to individuals or organizations within or outside of Hong Kong.

- provide to me or have provided to me advice or information concerning other products or services The Company believes may be of interest to me or communicate with me for any purpose. 本人同意貴公司或其代理人持有或收存, 藉此申請書或其他途徑之個人資料, 可供貴公司儲存、使用或披露, 以促貴公司可: - 提供任何貴公司相信他人可能有興趣或必須知道的意見或產品/服務資料; 或因其他原因需與本人聯絡。

I also agree that MassMutual Asia Limited may release all information regarding myself including but not limited to my medical condition for the purpose of modifying the terms of the policy or the benefit coverage to my Employer. 本人亦同意美國萬通保險亞洲有限公司向本人之僱主提供有關本人之所有資料 (包括但不限於本人之身體健康狀況), 用以修訂保單之條款及保障範圍。

Proposed Insured Signature 受保人簽署 Date 月 日 年

If there is any conflict in wordings between the English version and the Chinese translation, the former shall prevail.
如中文譯本與英文譯本有異, 概以英文原本為準。