

供公司使用 — 保险中介详情及印章

For company use – intermediary details and stamp

保险中介公司：
Intermediary company:

传真号码：
Fax number:

联络姓名：
Contact name:

电邮地址：
Email address:

电话号码：
Telephone number:

官方印章：
Official stamp:

连带被保险人是指在保单生效日期或随后的任何续保日期与被保险人居住在一起的配偶、成年伴侣和/或18岁以下的未婚子女、或接受全日制教育的28岁以下的子女(需要提供其注册教育机构出具的书面证明)。术语“伴侣”可能指丈夫、妻子、民事伴侣或以类似关系和您永久居住在一起的人士。所有连带被保险人均应在保险凭证中被称为被保险人。

要在您的保险计划中新增连带被保险人，则请采用正楷字体填写本申请表。

如未告知所有的重要事实，可能会导致本公司解除保险合同及/或日后的理赔申请不被受理。重要事实指可能会影响本保险公司是否同意承保或提高保险费率的事实。如投保人不确定某事实是否属重要，投保人应披露该事实。

请保留一份投保人向本保险公司提供有关本申请的所有数据的记录。

如有的话，请在申请人的申请中附上医疗报告或检验结果。如果本保险公司需要更多数据，本保险公司可能要求申请人填写其他医疗问卷。投保人提供的所有数据均会被严格保密。

本保险公司会以申请人在本表格中所提供的数据为依据，决定是否接受申请人的投保申请，及是否需要适用特别条款。特别条款指适用于投保人的保险的责任免除事项或条件。如申请人就任何既往症的治疗提出理赔申请，而申请人未在本投保单中向本保险公司告知或未能详尽告知该医疗状况，本保险公司可拒绝支付该理赔申请。本保险公司有权解除保险合同，或对申请人的保险合同订立特别条款，而该等条款将具有追溯效力。请务必留意并确保完全及正确地填写本投保单。

如在申请人的投保单填妥后及在本保险公司的书面接受日期、支付保费日期或申请人的生效日期/参保日期(以最迟者为准)前，发生任何会影响申请人在本投保单所提供数据的事情(如申请人的健康状况或连带被保险人的健康状况发生变化)，投保人须书面告知本保险公司该等变化。

保险人有权拒绝或接受被保险人的投保申请，或在订立特殊条款的前提下接受被保险人的投保单。

请透过您的保险中介向时康管理顾问(上海)有限公司寄送您填妥的申请表格，然后连同政府颁发的身份证/护照复印件转交：亚太财产保险有限公司，中国上海市虹口区吴淞路218号宝矿国际大厦11楼1105室，邮编：200080。

您亦可将其扫描及电邮至ChinaSales@now-health.com或
传真至+(86) 400 077 7900。

A dependant is one spouse or adult partner and/or unmarried children who are no more than 18 years old and residing with the insured member, no more than 28 years old if in full-time education (written proof may be required from the educational institute where they are enrolled), at the start date or any subsequent renewal date. The term 'partner' shall mean husband, wife, civil partner or the person permanently living with the insured member in a similar relationship. All dependants must be named as insured persons in the certificate of insurance.

To add a dependant to the insured member's plan, please complete this form in BLOCK CAPITALS.

Failure to disclose all material facts may lead to cancellation of the insurance policy by the insurer and/or non-acceptance of future claims. A material fact is one which is likely to influence the insurer to accept the application or to increase the premium rate. If the applicant is unsure whether a fact is material, the applicant should disclose it.

Please keep a record of all information the applicant supplies to the insurer in connection with this application.

Please enclose any medical reports or test results with the application if they are available.

The insurer may ask the applicant to complete a further medical questionnaire if the insurer needs more information. All the information the applicant provides will be treated in strict confidence. The insurer relies on the information that the applicant provides in this form to decide whether or not to accept the application, and whether or not the insurer needs to apply special terms. Special terms are exclusions or conditions that the insurer may apply to the applicant's cover. If the applicant submits a claim for the treatment of any pre-existing condition which the applicant did not tell the insurer about here or did not tell the insurer everything about, the insurer may refuse to pay that claim. The insurer also has the right to terminate the insurance contract, or the insurer may impose special terms on the applicant's policy which the insurer will apply retrospectively. Please take the greatest care to ensure that this application form is completed fully and accurately.

If, after completing the application form and before the latest of either the insurer's written acceptance, payment of premium or the applicant's start date/entry date, anything occurs which affects the information the applicant provided in this form, such as a change in the applicant's state of health or the state of health of any of the applicant's dependants, the applicant must tell the insurer in writing about the change.

We reserve the right to decline or accept Your application or to accept Your application form with special terms.

Please send the completed application form along with a copy of Your government issued identity document to the insurer via the applicant's intermediary to Asia-Pacific Property & Casualty Insurance Co., Ltd., c/o: Now Health International (Shanghai) Limited, Room 1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China. The applicant can also scan and email it to ChinaSales@now-health.com or fax it to +(86) 400 077 7900.

第一部分：投保人详情

Section 1: Policyholder information

投保人姓名：
Policyholder name:

保险单编号：
Policy number:

第二部分：新增连带被保险人的详情

Section 2: Add Dependant details

名：
First name(s):

姓：
Family name:

我们应如何称呼他/她？
What does he/she like to be called?

(如投保人的全名为John Andrew Smith, 投保人可能希望我们称他为John或Smith先生或Andy。保险人将在所有通讯中以这种方式称呼他。)
(If the applicant's full name is John Andrew Smith, the applicant might like to be called John or Mr Smith or Andy. The insurer will address all correspondence to the applicant in this way.)

性别： Gender:	男性 <input type="checkbox"/> 女性 <input type="checkbox"/>	出生日期(日/月/年)： Date of birth (dd/mm/yyyy):	/	/
居住国家： Country of Residence:	国籍(护照签发国家)： Nationality (Country of passport issuance):			
身份证件/护照号码： ID/Passport number:				
身高(厘米/英尺)： Height (cm/ft):	体重(公斤/磅)： Weight (kg/lbs):			
职业： Occupation:	行业： Occupation industry:			
您或本投保单的任何预定成员, 或其家庭成员或紧密联系人有否涉及政治风险? (如是, 请提供进一步的细节) Are You or any intended member of this policy, or any family member or close associate a politically exposed person? (If yes please provide further details)				
			是 <input type="checkbox"/> Yes	否 <input type="checkbox"/> No

第三部分：参保日期

Section 3: Entry Date

您希望您的连带被保险人保险的生效日期为(日/月/年)：
Date the applicant wishes cover to start (dd/mm/yyyy): / /

在本公司收到本投保单及正确保费, 且投保人接受本公司的全部条款及条件后, 保险方可生效。

您可要求保险在本保单填妥后的60日内开始生效。

Cover cannot start until the applicant has accepted all of the insurer's terms and conditions following the insurer's receipt of this application form and the insurer has received the correct premium.

The applicant can apply for cover to start on a future date that is within 60 days of completion of this application form.

第四部分：保费的支付方式

Section 4: Frequency of premium payment

请注意, 如投保人现根据指示性报价作出付款, 在本公司审核本投保单后, 应付金额可能会发生变动。

投保人须在保险期开始前, 同意并支付修改后的保费。连带被保险人的保费支付方式应按直接被保险人的保单付款方式。请选择投保人支付保费的频率。

Please note that if the payment the applicant is makes now is based on an indicative quote, the amount due may change once the insurer has reviewed this application. The applicant must agree and pay the revised premium before cover can start. The additional premium for this dependant should be paid by the same method as the direct insured policy.

保单首期保费需在保险合同起保30天内支付, 超期未支付, 本保险合同自始无效。若投保时约定分期缴纳保费, 则投保人应按约定按时交纳各期保费。若在约定缴费日30天后还未缴付续期保费, 则本保险合同效力自动终止。

The initial premium for this insurance contract should be paid within 30 days of the effective date of the coverage. The insurance contract will be void if the premium is not paid on time. If the premium is agreed to be paid by installment during policy application, the policyholder should make the installment premium payment on time and as per its respective schedule. If there is an overdue payment of the insurance installment premium payment, the insurance contract will be terminated automatically.

	年缴 Annually
银行转账 Bank transfer	<input type="checkbox"/>

开具发票的相关注意事项, 请参见 — “付款人及发票抬头要求”。
The matters related to fapiao issuance, please refer to — “The Payor and the Issuance of Fapiao Request”.

第五部分：保险详情

Section 5: Insurance details

请回答几个有关保险计划下新增连带被保险人的问题。

Please answer these questions in respect of the dependant the insured member wishes to add to his/her policy.

5.1 您的连带被保险人目前是否在另一家公司投有健康保险？

Does your dependant currently have health insurance with another company?

是 Yes 否 No

如果是, 请提供详情。
If yes, please give details:

5.2 您的连带被保险人打算继续维持现有保险吗？

Does your dependant intend to continue with the existing insurance?

是 Yes 否 No

5.3 您的连带被保险人是否曾经在亚太财产保险有限公司投有健康保险？

Has your dependant (s) insured previously with health insurance provided by Asia-Pacific Property & Casualty Insurance Company Limited?

是 Yes 否 No

如果是, 请提供投保日期及保单号码。

If yes, please give details of when insured and previous policy number:

5.4 您的连带被保险人曾否被健康保险或其他保险拒绝投保或被要求附加特别承保条件及/或额外保费？

Has your dependant (s) ever had an application or health Insurance declined or had special terms imposed?

是 Yes 否 No

如果是, 请提供详情。
If yes, please give details:

第六部分：健康声明

Section 6: Health declaration

您的连带被保险人无需披露有关普通感冒、疫苗接种或花粉过敏的事宜。

The applicant does not need to disclose matters related to common colds, vaccinations or hayfever.

		连带被保险人 Dependant
6.1	在近五年来连带被保险人是否曾经接受任何外科手术或在医院、诊所、疗养院、护理院或其他医疗机构看病或接受治疗, 而因此停止工作超过一周, 及/或接受超过10 天的治疗 ? Has the applicant in the last five years ever undergone any surgical procedure, been a patient or been treated in a hospital, clinic, sanatorium, nursing home or other medical institution where he/she was off work for more than one week, and/or received more than 10 days' treatment?	是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>
6.2	连带被保险人目前是否正在接受任何类型的药物(除口服避孕药外)或接受或计划接受任何治疗或测试, 或预先安排任何日间留院或住院治疗 ? Is the applicant currently taking any kind of medication (other than oral contraceptives), or is any treatment or tests currently being performed or planned, or any day or in-patient hospitalisation scheduled?	是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>

连带被保险人曾否罹患过以下疾病, 或接受过以下疾病的治疗、测试或调查, 或被诊断为患有以下疾病或因以下疾病而住院 :

Has the applicant ever suffered from, received treatment, tests or investigation for, been diagnosed with, or been hospitalised for:

6.3	哮喘、支气管炎、肺结核、肺炎或任何其他呼吸系统疾病 ? Asthma, bronchitis, tuberculosis, pneumonia or any other respiratory conditions?	是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>
6.4	焦虑、抑郁、心理疾病、精神疾病、精神状况、毒品或酒精成瘾或滥用 ? Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>
6.5	血液失调、贫血、血友病、地中海贫血或其他血液测试异常 ? 连带被保险人是否曾经被检测出艾滋病或乙型或丙型肝炎呈阳性 ? Blood disorders, anaemia, haemophilia, thalassaemia or other abnormal blood tests? Has the applicant ever been tested positive for HIV, Hepatitis B or C?	是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>
6.6	癌症、囊肿、息肉或任何恶性或良性的异常增生 ? Cancer, cyst, polyp, or any abnormal growth whether cancerous or benign?	是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>
6.7	消化系统疾病或功能异常, 包括胃部、结肠、直肠、疝气或任何其他肠道疾病 ? Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>
6.8	肾脏、脾脏、肝脏、胰脏、膀胱、前列腺, 及其它泌尿、生殖系统的疾病或功能异常 ? Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, and urinary or reproductive conditions?	是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>

第六部分：健康声明

Section 6: Health declaration

连带被保险人曾否罹患过以下疾病, 或接受过以下疾病的治疗、测试或调查, 或被诊断为患有以下疾病或因以下疾病而住院 :
Has the applicant ever suffered from, received treatment, tests or investigation for, been diagnosed with, or been hospitalised for:

6.9 糖尿病、甲状腺疾病或功能异常或体重异常 ? Diabetes, thyroid disorders or weight management problems?	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
6.10 癫痫、多发性硬化症或其他神经系统疾病 ? Epilepsy, multiple sclerosis or other neurological conditions?	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
6.11 高血压、心脏或循环系统疾病、中风或胆固醇水平过高 ? High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level?	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
6.12 膝部不适、背痛、皮肤疾病、风湿、痛风、关节炎或骨、脊柱、关节、肌肉或皮肤等相关联的疾病 ? Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscles and skin related disease?	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
6.13 在过去五年, 有以下不适症状、曾经被诊断有或治疗过以下情况 : 反复咽痛、慢性咳嗽、咯痰、咯血、呼吸困难或其他呼吸系统症状、腰痛、尿频、尿急、尿痛、排尿困难、血尿、蛋白尿、尿量异常、夜尿增多、面部浮肿、食欲减退、腹胀、腹痛、呕血、黑便、便血、黄疸、吞咽困难、心悸、活动后气促、下肢水肿或静脉曲张、胸部不适或胸闷、晕厥、风湿热或心脏杂音、心律不齐、乏力、头昏、牙龈出血、皮下出血、紫癜、骨痛、腰痛、食欲异常、多汗、多饮、多尿、双手震颤、肥胖、色素沉着、眩晕、晕厥、记忆力减退、视力障碍、震颤、抽搐、惊厥、瘫痪、感觉异常、白内障、青光眼或其他眼疾患、听力损失、任何身体障碍、先天性或遗传性障碍、残疾、复发性疾病、目前怀孕、任何形式的中止妊娠、任何妊娠并发症或胎儿有任何异常、重大损伤或医疗状况 ? Any health problems or complaints, been diagnosed with, or had treatment for any of the following in the past 5 years: Repeated pharyngalgia, chronic cough, expectoration, hemoptysis, difficulty breathing or other symptoms of the respiratory system, back pain, frequent urination, urgency of urination, pain in urination, difficulty urinating, blood or protein in the urine, abnormal amount of urine, nocturia, swelling in the face, chronic loss of appetite, abdominal distention, abdominal pain, hematemesis, melena, hematchezia, jaundice, difficulty swallowing, palpitation, tachypnea after exercise, edema or varicose veins of lower extremity, chest discomfort or pressure, syncope, rheumatic fever or heart murmur, arrhythmia, fatigue, dizziness, subcutaneous, hemorrhage, purpura, pain in bone, neck pain and lumbar pain, abnormal appetite, hyperhidrosis, polydipsia, polyuria, tremor on hands, obesity pigmentation, vertigo, syncope, hypomnesia, disturbance of vision, tremor, convulsions, seizure, paralysis, sensory abnormality, cataracts, glaucoma, or any eye disorder, hearing loss, or any physical impairment, congenital or hereditary disorder, disability, recurrent illness, currently pregnant, termination of pregnancy, any complications of pregnancy or abnormal of the fetus, major injury or medical condition.	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
6.14 如为女性, 连带被保险人是否曾罹患任何乳房或妇科疾病 ? Females only. Has the applicant ever suffered from any breast or gynaecological disorders?	是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

附加资料

Additional information

如您在第6.1题至6.14 题中的任何一条问题的回答为「是」, 请在以下方框内提供详情。
请提供最详尽细节, 包括诊断日期及性质、症状出现频率及严重程度、最近发作日期以及任何过往、目前或已知的日后治疗的详情。

If You answered 'Yes' to any of questions 6.1 to 6.14, please provide details in the box below.

Please provide as much detail as possible, including the date and nature of diagnosis, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future Treatment.

会员姓名 Member name				
诊断 (如果没有提供, 请描述 症状的确切性质) Diagnosis (If none made please describe the exact nature of symptoms suffered)				

附加资料

Additional information

如您在第6.1题至6.14题中的任何一条问题的回答为「是」，请在以下方框内提供详情。

请提供最详尽细节，包括诊断日期及性质、症状出现频率及严重程度、最近发作日期以及任何过往、目前或已知的日后治疗的详情。

If **You** answered 'Yes' to any of questions 6.1 to 6.14, please provide details in the box below.

Please provide as much detail as possible, including the date and nature of diagnosis, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future Treatment.

就诊日期 Date of consultation				
接受治疗 Treatment received				
最近治疗日期/症状 Date of last treatment/ symptoms				
任何潜在的原因 Any underlying cause				
身体上的具体位置， 包括左侧或右侧 Specific location on body including left or right				
结果 (例如: 正在进行治疗， 完全康复, 可能会复发)或 需要随访宫颈涂片的频率 (每年一次或每6个月一次) Outcome (e.g. on-going complete recovery, likely to recur) or for smears, frequency (annually, 6-monthly)				

第七部分：医生的联络资料

Section 7: Doctor's contact details

请提供您现时平常就诊的医生或对您的病历最熟悉的医生的详情。

Please give details of the applicant's current usual doctor or the one who is most familiar with his/her medical history.

医生详情

Medical practitioner's details

姓名： Name:	电话号码： Telephone number:
地址： Address:	
最近就诊的日期及原因： Date of last attendance and reason:	

第八部分：重要备注

Section 8: Important notes

注意：

- 请注意您的保险计划不承保投保前疾病及其相关疾病(不包括事先得到保险人书面同意承保的投保前疾病)
投保前疾病的定义为任何疾病或损伤在保单起始日期或者批单签发日前：
 - 曾接受过治疗、测试或检查; 或曾被确诊; 或曾接受过住院治疗; 或者
 - 曾出现过症状, 无论是否有过确切诊断
- 在上述详情维持不变的条件下, 报价将在30天内有效, 且报价按照亚太财产保险有限公司的全球保个人与家庭医疗保险计划的条款、条件及责任免除事项发出。
- 所报保费是根据每人在报价日期的年龄计算。如在您于亚太财产保险有限公司的个人与家庭医疗保险计划的实际生效日期前, 任何人士的年龄出现增长, 保费可能会因此而改变。在本保险公司收到本投保单及正确保费, 且您接受本保险公司的全部条款及条件后, 保险方可生效。
- 所报保费是根据您的身体质量指数在正常限度内厘定。
- 关于亚太财产保险有限公司偿付能力说明
亚太财产保险有限公司核心及综合偿付能力充足率均达到监管要求, 如您需详细了解亚太财产保险有限公司最新季度的偿付能力信息及风险综合评级结果等有关情况, 请登录亚太财产保险有限公司官方网站 (<http://www.apins.com>) 「信息披露-专项信息-偿付能力」专栏查询。

信息保护

保险人会在考虑投保人的保单申请过程中和向被保险人签发保单以及处理保险人与会员的关系时, 收集有关投保人或投保人的员工(即被保险人包括保单持有人和家属, 如适用)的某些个人和敏感信息。处理这些信息的目的是核保被保险人的保险保障范围、管理签发的任何保单以及管理理赔。被保险人的信息可能被转交至时康集团公司、保险人、核保人、你的保险中介、再保险公司、医疗服务和医疗网络提供者、医疗援助公司、第三方管理人员、理赔管理人员、相关人员以履行职责所需的保单各方面的义务。

任何协助管理您的保险计划的第三方亦需承担相同的保密责任。

被保险人的姓名及联络资料将不会向其他机构揭露(上述情况除外)。

请参阅我们的隐私政策, 以充分了解我们如何管理您的信息
<http://www.now-health.cn/en/privacy-policy/>。

通过选择电邮或其他可接受程序参与计划, 这代表您声明同意此处描述的数据处理做法。这也代表您同意时康集团公司收集、处理和使用个人数据(根据适用的数据保护法定义)以及将个人数据转移给此处提及的第三方, 以提供计划条款规定的服务。这些第三方可能不适用于适用的数据保护法管辖的国家。

未满十八(18)岁的会员应由父母或监护人填妥同意书。如果您接受上述条款, 请在下方签名、注明日期并勾选「我同意」框内, 以确认您已获得本申请表所涵盖的所有人员的事先明确同意, 并代表他们提交此申请。

我同意 我不同意

时康国际可能会联络您, 提供您可能感兴趣的其他产品和服务的详细资讯。如果合适, 我们可能会透过邮寄、电话或电子邮件与您联系。

我同意 我不同意

Remark:

- Pre-Existing Medical Conditions
Your policy does not cover you for treatment of Pre-Existing Medical Conditions and Related Conditions unless accepted by the insurer in writing.
A Pre-Existing Medical Condition means any disease, injury or illness for which:
 - You have received treatment, tests or investigations for, been diagnosed with or been hospitalised for; or
 - You have suffered from or experienced symptoms; whether the medical condition has been diagnosed or not, at any time before your start date/entry date into the plan.
- Quotations are valid for 30 days subject to the above details remaining the same and are issued in accordance with Asia-Pacific Property & Casualty Insurance Co., Ltd. medical insurance policy terms, conditions and exclusions.
- The premiums quoted have been calculated based on each person's age at the date of the quotation. Premiums may be subject to change if the age of any person increases prior to the actual start date of the applicant's Asia-Pacific Property & Casualty Insurance Co., Ltd. medical insurance policy. Cover cannot start until the applicant has accepted all of the insurer's terms and conditions following the receipt of this application form and the insurer has received the correct premium.
- The premiums quoted have been based on the applicant's body mass index being within normal limits.
- Solvency Notification for Asia-Pacific Property & Casualty Insurance Co., Ltd.
Our core and comprehensive solvency adequacy ratios both meet regulatory requirements. If you need detailed information about our company's latest quarterly solvency information and risk rating results, please visit our official website (<http://www.apins.com>) and check the "Information Disclosure - Special Information - Solvency" section.

Data protection

The insurer will collect certain personal and sensitive information about the applicant or applicant's employees (i.e. insured members include policy holder and dependents, if applicable), in the course of considering the applicant's application and if a policy is issued to the insured member, conducting the insurer's relationship with the members. This information will be processed for the purposes of underwriting the insured member's insurance coverage, managing any policy issued and administering claims. The insured members' information may be passed to Now Health group companies, the insurer of your policy, underwriters, your intermediary, reinsurers, medical providers and network providers, medical assistance companies, third-party administrators, claims administrators and parties required to the extent needed to fulfill the obligations of the policy.

The same duty of confidentiality is required of any third parties to whom the administration of your policy may be subcontracted.

The insured members' name and contact details will not be disclosed to other organisations (except as stated above).

To fully understand how we manage your information, please refer to our Privacy Policy at <http://www.now-health.cn/en/privacy-policy/>.

By electing to participate in the Plan via email or other acceptance procedure, You are declaring that You agree with the data processing practices described herein. You also consent to the collection, processing and use of Personal Data (as defined under the applicable data protection law) by the Now Health group companies as well as the transfer of Personal Data to the third parties mentioned herein for the purpose of providing the services set out under the terms of this Plan. These third parties may be located in countries which may not be designated jurisdictions for data transfer as per applicable Data Protection Laws.

A parent or guardian should complete the consent for any member that is under the age of eighteen (18). If you accept the above, please sign, date and check the "I consent" box below which confirms that you have the prior and express consent of all persons to be covered pursuant to this application form, to submit this application on their behalf.

I consent I do not consent

Now Health International may contact You with details of other products and services which may be of interest to You. You may be contacted by post, telephone or email if appropriate.

I consent I do not consent

第九部分：声明及授权

Section 9: Declaration and authorisation

本人特此代表本投保单中列名的所有人士就上文指明的亚太财产保险有限公司全球保医疗保险计划申请保险。

本人已收取并阅读本计划的保障一览表、条款及条件、定义、保障和责任免除事项。本人明白投保单、保险凭证、保障一览表、全球保会员手册以及附有本计划条款和条件的保险条款, 将构成我们双方之间的合同以及本计划合同的所有部分。

本人知道保障覆盖范围将根据协议提供。

- 本人声明所填投保单各项及告知事项均属事实, 就本投保单的各名人士作出的披露乃属完整, 即便所提供的若干资料并非本人亲笔书写。本人明白, 本人或连带被保险人欺诈或企图欺诈亚太财产保险有限公司而向亚太财产保险有限公司提供错误、不完整或有误导性的事实或数据属违法。惩罚包括监禁、罚款、拒绝承保、取消赔偿及法定损害赔偿。
- 本人明白本人须在书面接受日期、支付保费日期或生效日期/参保日期(以最迟者为准)前, 通知亚太财产保险有限公司关于本投保单内所载事实的任何变动, 包括本投保单内列名的任何人士的健康状况的变化。
- 就本投保申请而言, 本人授权曾经对本投保单内列名的任何人士进行过治疗或作出过咨询的任何医生, 向亚太财产保险有限公司提供其可能需要的、与本计划下索赔相关的任何治疗数据。本人已与本人的伴侣及有足够能力的成年连带被保险人讨论本授权书的条款, 且本人已获取该等人士的同意以根据本授权书提供其医疗数据。

I hereby apply for cover on behalf of all the persons named in this application form for a Asia-Pacific Property & Casualty Insurance Co., Ltd. insurance policy as specified above.

I have received and read the benefit schedule, terms and conditions, definitions, benefits and exclusions of this policy. I understand that the application form, certificate of insurance, benefit schedule and WorldCare Member's handbook and the policy wording incorporating the policy terms and conditions make up the contract between the insurer and the policyholder and all form part of the policy agreement. I am aware that cover shall be provided in accordance with the agreement.

- I declare that the information given in this application is true and that disclosure in respect of each person included in this application is complete, even if some of the information provided is not in my own handwriting. I understand it is unlawful for me or my dependants to knowingly provide false, incomplete or misleading facts or information to Asia-Pacific Property & Casualty Insurance Co., Ltd. for the purpose of defrauding or attempting to defraud Asia-Pacific Property & Casualty Insurance Co., Ltd. Penalties may include imprisonment, fines, denial of coverage, rescission of benefits and legal damages.
- I understand that I must notify Asia-Pacific Property & Casualty Insurance Co., Ltd. of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it, before the latest of either written acceptance, payment of premium or the start date/entry date.
- For the purpose of this application I authorise any doctor who has ever treated or advised any of the persons named in this application to provide Asia-Pacific Property & Casualty Insurance Co., Ltd. with any information they may require in connection with treatment related to any claim under this policy. I have discussed the terms of this authorisation with my partner and competent adult dependants, and I have obtained their consent to the release of their healthcare information pursuant to this authorisation.

- 本人声明,本人已阅读并明白保险条款的以下章节:
 - 取消和终止权利
 - 有关个人与家庭保单的法律及司法管辖区
 - 个人与家庭保单用字及我们的服务
 - 赔偿安排
 - 责任免除
 - 时康管理顾问(上海)有限公司代表亚太财产保险有限公司安排及管理保单及支付索赔
- 本人明白,如亚太财产保险有限公司因任何原因无法收取本人的保费,且本人未在亚太财产保险有限公司提出使用其他支付方法的要求后的七天内,向亚太财产保险有限公司提供其它支付方法,因而令本人的保险计划失效,亚太财产保险有限公司对此不承担责任亦因此无需支付理赔申请。
- 本人同意如本人或本人的任何连带被保险人在指定医疗网络内接受治疗,包括但不限于门诊直付,预先审核住院等等,而最后该治疗或医疗状况所涉及的费用,根据保险计划的条款及条件被确定为不予偿付的,本人同意负责向亚太财产保险有限公司偿还其已垫付的所有上述费用。
- 本人明白并确认,如本人未偿还亚太财产保险有限公司基于诚信而垫付的不在保障范围之内的治疗费用,则本人其它的有效理赔申请可被欠付亚太财产保险有限公司的款项所抵消及/或本人的保险计划可能被终止直至欠付款项被全数结清。
- 本人承认,如亚太财产保险有限公司确定一项理赔申请为欺诈,本人的医疗保险计划可能被终止,且该终止将立即生效。
- 本人已阅读重要备注。
- 本人同意上述声明并明白保险乃根据亚太财产保险有限公司全球保医疗保障的条款及条件提供。
- 本人同意如果投保单的中英文内容存在不一致时,以中文文本的内容为准。
- 本人已认真阅读并理解上述《投保须知》的内容,严格履行明确告知义务。
- 本人明白,如果本人能够向其他保险保单索赔任何治疗费用或其他保障,亚太财产保险有限公司仅负责理赔总额中相应比例的部分。
- 本人和本保险计划涵盖的人员或我所代表的机构了解时康国际集团公司提供的服务的其中一部分包括敏感信息的处理。因此,当我们申请保险单时,即表示同意时康国际集团公司出于保险单的目的处理我们和我们的家属或我们的员工和家属的敏感信息。如果没有所需的敏感信息,则无法根据保单协议提供服务。敏感信息包括但不限于健康和医疗相关信息、医疗报告、遗传数据等。
- 本人同意在管理我们保单时,收集和使用本人和我们的家属或我们的员工和家属的个人信息和敏感信息。本人同意(如需要)包括分享我们和我们的家属或我们的员工和家属的个人信息和敏感信息与其他时康国际集团公司办事处、保险人、再保险公司、核保人、医疗服务和医疗网络提供者、医疗援助公司、第三方保单管理人、理赔管理人、相关人员以履行职责所需的保单各方面的义务。
- 本人明白信息将得到安全保存并严格保密。
- 在保单申请和保单有效期内的任何时间,如出于保单的目的需要提供未成年人(18岁以下)的个人和敏感信息,本人确认我是未成年人的家长或法定监护人,如果我不是未成年人的家长或法定监护人,我确认我已获得其父母/法定监护人的同意,向时康国际集团公司提供其履行职责所需的保单各方面的义务的信息。
- 本人确认已阅读并理解时康国际集团公司的隐私政策和本人的权利:
<http://www.now-health.cn/en/privacy-policy/>
- 本人已经收到并仔细阅读保险条款,尤其是对责任免除、投保人义务、被保险人义务、赔偿限额、免赔额、自付比例等保险人用黑体字特别标明提醒本人特别注意的内容,保险人已经进行说明和解释,本人能够理解并知晓法律后果,对保险条款包括保险人用黑体字特别注明部分的内容没有异议,本人已经充分理解和清楚保险条款的全部内容。上述所填写内容均属事实,同意以此投保单作为订立保险合同的依据。

签署(被保险人/投保人):
Signature (Insured/main applicant):

日期(日/月/年):
Date (dd/mm/yyyy):

保险合同由亚太财产保险有限公司签发,并委托时康管理顾问(上海)有限公司进行保单管理。

亚太财产保险有限公司地址:中国深圳市福田区中心区福华一路免税商务大厦29-30楼,邮编:518048

时康管理顾问(上海)有限公司地址:中国上海市虹口区吴淞路218号宝矿国际大厦11楼1105室,邮编:200080

Policies are issued by Asia-Pacific Property & Casualty Insurance Co., Ltd.

Registered Office: 29-30F, Dutyfree Business Building, 1st Fuhua Road, Futian CBD, Shenzhen 518048, China.

Policies are administered by Now Health International (Shanghai) Limited.

Room 1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China.