ZURICH
蘇黎世

Zurich HealthTotal Critical Illness Insurance Plan Medical Questionnaire
蘇黎世「全護之選」危疾保險計劃醫療問卷

For more than one insured person apply use only.
只供多於一位受保人申請時使用。

Please note that this medical questionnaire will form part of the Zurich HealthTotal Critical Illness Insurance Plan Enrollment Form.
此醫療問卷為蘇黎世「全護之選」危疾保險計劃投保表格的一部分。

Enquiry no. 查詢電話：+852 2903 9391　Fax 傳真：+852 2968 0639

Please tick the appropriate box and * delete whichever is inappropriate. 請✔適用方格及於 * 號刪去不適用者。

Please complete in BLOCK LETTERS. 請以英文正楷大寫填報。

Name of Insured Person 受保人姓名	Name of Proposer 投保人姓名

Health question 醫療問卷

Part A - General medical information 甲部 – 一般醫療資料

1 Please provide details for your family doctor / treating medical practitioner 請提供家庭／主診醫生資料

Name 姓名

Address 地址

Telephone 電話

	Yes 是	No 否
2 Have you gained/lost weight of 10lb (4.5kg) or more in the last 12 months? If yes, please give reason and exact figure. 閣下的體重是否在過去十二個月內增加或減少10磅（4.5公斤）或以上。若「是」，請說明確實增加或減少之重量及原因。 Exact figure gained/lost* 確實增加／減少 * 之重量：_____kg公斤／ _____lb磅 Reason 原因 _____	◯	◯
3 Do you drink alcohol? If yes, please specify type of drink (e.g. beer, wine, spirit etc.) and your weekly consumption. 閣下是否會飲用酒精飲品？若「是」，請註明飲品種類（例如啤酒、葡萄酒、烈酒等）及每週飲用量。 Type of drink 飲品種類 _____Weekly consumption 每週飲用量_____ml 毫升	◯	◯
4 Do you smoke or have you ever smoked any cigarettes? If yes, please state details. 閣下是否曾吸煙？若「是」，請註明每日吸煙數量。 Consumption 吸煙數量 _____pieces/day 支／每天 for 達 _____years 年 If you have ceased smoking, please state when and for what reason 如閣下已停止吸煙，請註明戒煙日期。 Date ceased 戒煙日期_____(DD/MM/YY 日／月／年) and reason 及原因 _____	◯	◯

Part B - Medical history 乙部 – 病歷

(I) For all insured persons 適用於所有受保人

	Yes 是	No 否
5 Have you ever been or are you currently taking any medication prescribed for more than 14 days or drugs such as stimulants, hallucinogens, narcotics or other controlled substance other than prescribed by a medical practitioner, or are you currently being or been counselled or treated for excessive use of alcohol or drugs? If yes, please state details. 閣下是否曾／正在服用任何由醫生處方超過十四天之藥物或其他並非由醫生處方的受管制藥物如興奮劑、迷幻藥、麻醉劑等，或是否曾／正在因酗酒或吸毒而接受輔導或治療？若「是」，請提供詳情。 Details 詳情 _____	◯	◯
6 Have any of your natural parents, brothers or sisters suffered from heart disease, stroke, hypertension, diabetes, kidney disease, mental disorder, hepatitis (or is a hepatitis carrier), cancer or any hereditary disease? If yes, please state details. 閣下的親生父母或兄弟姐妹是否曾患上任何心臟病、中風、高血壓、糖尿病、腎病、精神失常、肝炎（或肝炎帶菌者）、癌症或任何遺傳病？若「是」，請提供詳情。 Details 詳情 _____	◯	◯
7 Other than medical test(s) required by an employer or insurer, have you ever undergone or been recommended by a medical practitioner any medical test, such as blood test(s), x-ray, electrocardiogram, ultrasonogram, CT scan, biopsy or other investigations in the past 5 years? If yes, please provide details and reports. 除了僱主或保險公司指定之醫療檢查外，閣下是否曾在過去五年內進行或被醫生建議進行任何醫療檢查，包括血液測試、X光、心電圖、超聲波、電腦掃描、活組織檢驗或其他檢驗？若「是」，請提供詳情及報告。 Details 詳情 _____	◯	◯
8 Have you ever suffered from or been treated or do you foresee to consult with a medical practitioner for any of the following disorders or diseases? If yes, please provide details. 閣下是否曾患上、被診斷為或可預見就以下問題或疾病求診？若「是」，請提供詳情。		
(i) The muscular skeletal system (e.g. muscular or bone disorder, spinal problem, arthritis, gout) or other related symptoms/diseases? 骨骼及肌肉系統（如肌肉或骨骼不適、脊椎問題、關節炎、痛風）或其他有關的徵狀或疾病？	◯	◯
(ii) The respiratory system (e.g. tuberculosis, asthma, chronic bronchitis) or other related symptoms/diseases? 呼吸系統（如結核病、哮喘、慢性支氣管炎）或其他有關的徵狀或疾病？	◯	◯
(iii) The endocrine system (e.g. diabetes, thyroid disorder) or other related symptoms/diseases? 內分泌系統（如糖尿病、甲狀腺問題）或其他有關的徵狀或疾病？	◯	◯
(iv) The gastro-intestinal tract (e.g. any kind of hepatitis or liver disease, gastric or duodenal ulcer or ulcer of any kind, haemorrhoids, hernia, gall bladder, bowel) or other related symptoms/diseases? 腸胃管道（如任何肝炎或肝病、胃或十二指腸潰瘍、任何潰瘍、痔瘡、疝氣、膽囊、腸）或其他有關的徵狀或疾病？	◯	◯
(v) Breast or genitor-urinary organs (e.g. any disease of the kidneys or bladder) or other related symptoms/diseases? 乳房或泌尿生殖器官（如任何腎或膀胱疾病）或其他有關的徵狀或疾病？	◯	◯
(vi) The heart or cardiovascular or circulatory system (e.g. chest pain, any disorder of the heart or arteries, murmur, raised blood pressure, stroke, varicose veins, rheumatic fever) or blood (e.g. anaemia, haemophilia) or other related symptoms/diseases? 心臟、心血管、循環系統（如心絞痛、心臟或動脈問題、心漏症、高血壓、中風、靜脈曲張、風濕熱）或血液（如貧血、血友病）或其他有關的徵狀或疾病？	◯	◯
(vii) The nervous system, mental disorder or psychiatric problem or brain function disorder (e.g. dizziness, epilepsy, paralysis, anxiety) or other related symptoms/diseases? 神經系統、精神失常、精神病或腦功能問題（如暈眩、癲癇、癱瘓、焦慮）或其他有關的徵狀或疾病？	◯	◯
(viii) Impairment of the eyes / ears / nose (e.g. cataracts, ear infections, tonsillitis) or other related symptoms/diseases? 眼、耳、鼻的損傷（如白內障、耳道感染、扁桃腺炎）或其他有關的徵狀或疾病？	◯	◯
(ix) Tumor, cyst, lump, growth, cancer or malignant tumor or other related symptoms/diseases? 腫瘤、囊腫、腫塊、瘤、癌、惡性腫瘤或其他有關的徵狀或疾病？	◯	◯
(x) Venereal disease, AIDS, AIDS related conditions, any blood test for HIV virus? 性病、愛滋病、與愛滋病有關的疾病、或曾接受愛滋病病毒血液測試？	◯	◯
Details 詳情 _____		
9 Are there any health or physical conditions in the last 5 years not mentioned above which may affect your well being? If yes, please state details. 閣下於過去五年內是否曾有任何以上未提及的健康或身體狀況？若「是」，請提供詳情。 Details 詳情 _____	◯	◯

Part B - Medical history (continued) 乙部 – 病歷（續）

(II) For insured person under the age of 2 years 只適用於兩歲以下的受保人：

10 Weight at birth 出生體重_____ kg/公斤 / _____ lb/磅

	Yes 是	No 否
11 Has the proposed insured person been confined in hospital for more than 5 days? If yes, please state details. 自出生起計，如受保人留院超過五天，請提供詳情。 Details 詳情 _____	◯	◯
12 Were there any birth difficulties, congenital deformities, lack of physical or mental development or Down's syndrome? If yes, please state details. 是否曾出現難產、先天性肢體畸形、缺乏正常體格或心智發展或唐氏綜合症等徵狀？若「是」，請提供詳情。 Details 詳情 _____	◯	◯

(III) For female insured person only 只適用於女性受保人：

	Yes 是	No 否
13 Are you now pregnant? If yes, please state the expected delivery date. 閣下是否正在懷孕？若「是」，請註明預產期。 The expected delivery date 預產期為 _____	◯	◯
14 Have you ever had any complications during pregnancy or delivery (e.g. ectopic pregnancy, gestational diabetes, hypertension, protein in urine etc.)? If yes, please state details. 閣下是否曾因懷孕或生產而患上任何併發症（如宮外孕、妊娠糖尿、高血壓、蛋白尿等）？若「是」，請提供詳情。 Details 詳情 _____	◯	◯
15 Have you ever had or been told to have, or been treated for any disease/disorder of, or are you intending to have any tests/investigations/treatment of the breast (e.g. mammogram, an ultrasound or surgery, etc) or the cervix or uterus (e.g. a pap smear, cone biopsy, colposcopy or ultrasound, etc)? If yes, please state details. 閣下是否曾或被建議或打算就乳房疾病接受治療或檢查（例如乳房X光、超音波或手術等）或就子宮頸或子宮疾病接受治療或檢查（例如柏氏細胞塗片、錐型活體切片檢查、陰道鏡或超音波檢查等）？若「是」，請提供詳情。 Details 詳情 _____	◯	◯

Part C - Personal insurance information 丙部 – 個人保單資料

	Yes 是	No 否
16 Are you having any personal accident insurance, individual medical insurance, hospital cash insurance or critical illness insurance with Zurich Insurance Company Ltd or any other insurer(s)? If yes, please state the policy no., benefits type, the sum insured and the company name of the insurer (including Zurich Insurance Company Ltd). 閣下現時是否擁有蘇黎世保險有限公司或其他保險公司承保之個人意外、個人醫療、住院現金或危疾保單？若「是」，請提供保單號碼、保單項目、保額及保險公司名稱（包括蘇黎世保險有限公司）。 Details 詳情 _____	◯	◯
17 For policies stated in question 16, are you currently making a claim for accident, disability, or medical insurance benefit? If yes, please state details. 對於問題16列明的保單，閣下現時是否進行任何意外、傷殘或醫療保險之索償？若「是」，請提供詳情。 Details 詳情 _____	◯	◯
18 Have you ever been refused enrollment, renewal or reinstatement of life insurance, personal accident insurance, medical insurance, hospital income insurance, or critical illness insurance, or subject to special terms and conditions or additional premium? If yes, please state details. 閣下是否曾於投保、續保或復效任何人壽、個人意外、醫療、住院現金或危疾保險時被拒或需附加特別條款或增收保費始被接納？若「是」，請提供詳情。 Details 詳情 _____	◯	◯

I/We confirm that all the above information provided by me/us is true, correct and accurate. I/We authorize Zurich Insurance Company Ltd (the "Company") to obtain medical information from the insured person's medical practitioner(s) and I/we agree to supply additional information relevant to the policy of Zurich HealthTotal Critical Illness Insurance Plan at my/our own expense. I/We understand and agree that this medical questionnaire will form part of the Zurich HealthTotal Critical Illness Insurance Plan Enrollment Form which constitutes the basis of the contract between me/us and the Company.

本人/吾等確認以上提供之所有資料均為事實正確無誤。本人/吾等明白本人/吾等必須填妥授權蘇黎世保險有限公司(「貴公司」)有權向受保人之醫生索取有關病歷資料，本人/吾等亦同意提供任何進一步與蘇黎世「全護之選」危疾保險計劃有關之資料並自付所需費用。本人/吾等明白此醫療問卷為蘇黎世「全護之選」危疾保險計劃投保表格的一部分，而該投保表格將構成本人/吾等與 貴公司之間的合約依據。

Signature of proposer
投保人簽署：

Date
日期 Day 日 Month 月 Year 年

Zurich Insurance Company Ltd (a company incorporated in Switzerland)
蘇黎世保險有限公司(於瑞士註冊成立之公司)

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