TRANSAMERICA®
LIFE BERMUDA LTD

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PARAMEDICAL EXAMINATION
體格檢查（護士）

IMPORTANT INFORMATION

Please complete in ENGLISH and BLOCK CAPITALS.

The Chinese text is for reference only. If there is any conflict between the meaning of the words or terms of the English and Chinese text of this application form, the English version shall prevail.

If you make a mistake completing this form, simply cross out the error, note the correct details and initial each correction.

Capitalised terms in this form have the same meaning as defined in the policy.

重要資料

請以英文正楷填寫。

中文譯本僅供參考用途。如中文譯本與英文原文有歧義，概以英文原文為準。

如表格內所填寫的資料有任何錯誤，請予以修正並在旁邊簡簽作實。

本表格所用的大寫詞彙，與保單定義者具相同涵義。

PART 1 第一部

☑ Select the box that applies 請選擇合適空格

(To be completed by the patient 由受保人填寫)

Name 姓名			
Gender 性別	☐ Male 男 ☐ Female 女	Date of Birth 出生日期	(dd/mm/yyyy) (日 / 月 / 年)
ID Type 身份證明文件類型		ID Number 身份證號碼	

Please provide the following details 請提供以下資料:

a) Name and Address of Personal or Attending Physician
私家醫生或主診醫生之姓名及地址

b) Phone Number 電話號碼	Country Code 國家號碼 – Area Code 地區號碼 – Phone Number 電話號碼
c) Date last consulted 上一次求診日期	(dd/mm/yyyy) (日 / 月 / 年)
Reason for consultation 求診原因	
Diagnosis/Result of visit 診斷/求診結果	

d) List any medications (prescription or non prescription) you are taking currently
請列出現時服用的藥物（處方或非處方藥物）

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PART 1 第一部 (Continued) (續)

☑ Select the box that applies 請選擇合適空格

Smoking Status 吸煙習慣

1. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)? ☐ Yes 有 ☐ No 沒有
閣下曾否使用任何形式的煙草或尼古丁產品（包括香煙、雪茄、小雪茄、煙斗、嚼煙、戒煙貼或戒煙香口膠)?

If 'Yes', provide details below.
如有，請提供以下資料。

Product 產品	Freqyency 次數	Current 現在	Past 過去	Date Last Used 最後一次使用日期
Cigarettes 香煙	pack(s) 包/day 日	☐	☐	(dd/mm/yyyy) (日 / 月 / 年)
Cigars 雪茄	/day 日	☐	☐	(dd/mm/yyyy) (日 / 月 / 年)
Other 其他	/day 日	☐	☐	(dd/mm/yyyy) (日 / 月 / 年)

Family Questions 家族資料

2. Has any member of your immediate family (parents, brothers, sisters) died of Coronary Artery Disease or Cancer prior to age 60? ☐ Yes 是 ☐ No 否
閣下是否有任何直系親屬（父母、兄弟、姊妹）於60歲前因冠心病或癌症死亡?

3. Please provide the following details:
請提供以下資料:

Living 健在			Deceased 已故		
	Age 年齡	Present Health 現時健康情況		Age 年齡	Cause of Death 死因
Father 父親			Father 父親		
Mother 母親			Mother 母親		
Siblings 兄弟姊妹			Siblings 兄弟姊妹		

Health Questions 健康情況

Please provide details for 'Yes' answers in the "Supplementary Information" section below.
如答案為「是」，請於「補充資料」部分提供詳情。

4. Within the last 10 years have you had symptoms of, or been told by a physician that you have had or have:
過去10年閣下是否有出現以下症狀，或獲醫生告知有以下疾病:

a) Chest pain, angina, congestive heart failure, heart attack, shortness of breath, heart murmur, high blood pressure, irregular heart beat, heart valve disease or any other disease or disorder of the heart or arteries? ☐ Yes 是 ☐ No 否
胸痛、心絞痛、充血性心臟衰竭、心臟病發作、氣促、心臟雜音、高血壓、心律不齊、心臟瓣膜疾病或任何其他心臟或血管疾病？

b) Aneurysm, transient ischemic attack (TIA), stroke, or peripheral vascular disease? ☐ Yes 是 ☐ No 否
動脈瘤、短暫腦缺血、中風或周邊血管疾病?

c) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands? ☐ Yes 是 ☐ No 否
糖尿病、高血糖、血糖耐量異常或任何腺體疾病?

d) Seizures, fainting, dizziness, epilepsy, convulsions or paralysis? ☐ Yes 是 ☐ No 否
痙攣、發昏、頭暈、癲癇、抽搐或癱瘓?

e) Any nervous, mental or emotional disorder, or received counselling for anxiety, depression, stress, or any other emotional condition? ☐ Yes 是 ☐ No 否
任何神經、精神或情緒失調，或因焦慮、抑鬱、壓力過大或任何其他情緒問題並接受輔導?

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☑ Select the box that applies 請選擇合適空格

f) Alzheimer's disease, dementia, memory loss or organic brain syndrome? ☐ Yes 是 ☐ No 否
阿爾茲海默病、失智症、失憶或器質性腦綜合症?

g) Multiple sclerosis (MS), muscular dystrophy, Parkinson's disease or tremors? ☐ Yes 是 ☐ No 否
多發性硬化症、肌肉萎縮症、帕金遜症或震顫?

h) Arthritis, gout, chronic fatigue, fibromyalgia, myalgia, osteoporosis, or any other bone, joint or muscle disorder? ☐ Yes 是 ☐ No 否
關節炎、痛風、慢性疲勞、纖維肌痛症、肌肉痛、骨質疏鬆，或任何其他骨骼、關節或肌肉疾病?

i) Asthma, sleep apnoea, bronchitis, pneumonia, emphysema, chronic obstructive lung disease or any other lung disorder? ☐ Yes 是 ☐ No 否
哮喘、 睡眠窒息症、支氣管炎、肺炎、肺氣腫、慢性阻塞性肺病或任何其他肺病?

j) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, Crohn's disease, or other disease of the liver, gall bladder, pancreas, stomach or intestines? ☐ Yes 是 ☐ No 否
肝硬化、肝炎、潰瘍、結腸炎、憩室炎、克隆氏病，或其他肝臟、膽囊、胰臟、胃或腸疾病?

k) Disease of the prostate, testicles, uterus, cervix, ovaries or breasts? ☐ Yes 是 ☐ No 否
前列腺、睪丸、子宮、子宮頸、卵巢或乳房疾病？

l) Anaemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells or bone marrow or any lymph node disorders? ☐ Yes 是 ☐ No 否
貧血、出血或凝血障礙疾病、復發性感染，或任何免疫系統、血液或血細胞或骨髓問題或疾病，或任何淋巴結疾病?

m) Disease of the urinary tract, bladder or kidneys, sugar, protein or blood in the urine? ☐ Yes 是 ☐ No 否
尿道、膀胱或腎臟疾病，或糖尿、蛋白尿或血尿?

n) Cancer, leukaemia, lymphoma, malignant melanoma or tumours of any kind, malignant or benign? ☐ Yes 是 ☐ No 否
癌症、白血病、淋巴瘤、惡性黑色素瘤或任何類型的腫瘤（不論惡性或良性)?

o) Any other health impairment or medically treated condition? ☐ Yes 是 ☐ No 否
任何其他健康問題或接受醫藥治療的病症?

5. **Within the last 10 years have you had:**
過去10年閣下有否曾經:

a) An operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness, disease or accident? ☐ Yes 是 ☐ No 否
接受手術或因任何不適、疾病或意外入住醫院或於其他醫療護理機構作觀察及／或治療?

b) Any diagnostic tests (e.g. blood, urine, ECGs, x-rays etc), whether conducted on an in-patient or out-patient basis (other than for regular health screening, visa or employment medicals which were confirmed as normal results)? ☐ Yes 是 ☐ No 否
進行任何住院或門診診斷檢測 (例如:血液、尿液、心電圖、 X光等)(檢查結果正常的一般健康檢查、簽證或入職身體檢查除外)?

6. Within the last 10 years have you been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes 是 ☐ No 否
過去10年曾否經醫生確診患有愛滋病或接受有關治療，或於HIV病毒測試中呈陽性反應?

7. Do you:
閣下是否:

a) Have any symptom or medical concern for which you have not consulted a physician or had any consultation, testing or investigation recommended by a physician which has not yet been completed? ☐ Yes 是 ☐ No 否
患有任何徵狀或健康問題而未向醫生求診，或由醫生建議之測試或檢驗尚未完成?

b) Consume alcoholic beverages?
飲用酒精飲品?

☐ Never 從不

☐ Currently 現時 — Type of beverage 飲品類型 ________ Frequency 次數 ________ Quantity 飲用量 ________

☐ In the past 過去 — Date stopped 停止飲酒日期 |_|_|_|_|_|_|_|_| (dd/mm/yyyy) (日/ 月/ 年) Reason stopped 原因 ________

中文譯本僅供參考用途。如中文譯本與英文原文有歧義，概以英文原文為準。

☑ Select the box that applies 請選擇合適空格

8.	**Within the last 10 years have you:** **過去10年閣下曾否:**	
a)	Been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment counselling or participated in a support group? 被勸籲限制或停止飲酒或服食藥物、接受治療輔導或參加互助小組?	☐ Yes 是 ☐ No 否
b)	Used or tested positive for marijuana, cocaine, heroin, amphetamines, or hallucinogens? 服用大麻、可卡因、海洛英、安非他命或迷幻劑，或對有關測試呈陽性反應?	☐ Yes 是 ☐ No 否
c)	Used any tranquilizers, sedatives or narcotic drugs or any prescription drug except in accordance with physician's instructions? 服用任何鎮定劑、鎮靜劑、麻醉藥或任何處方藥物（由醫生處方除外)?	☐ Yes 是 ☐ No 否

Supplementary Information 補充資料

Question Number 問題編號	Details (include dates, diagnosis, duration, outcome, treatment and the names of all attending physicians, clinics and hospitals) 詳情（包括日期、診斷、時期、結果、治療及所有主診醫生姓名與診所及醫院名稱)

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Authorisation To Obtain Information 索取資料授權

I, ____ (the "patient") hereby consent to and authorise:

1. any registered medical physician, medical practitioner, medical care provider, hospital, clinic, medical laboratory, government organisation or any other medical or medical related facility that has record or knowledge of my health and medical history or treatments to provide such information about me; (including diagnosis, examination and test results, medical reports, treatments and prognosis) with respect to any of my physical or mental conditions and/or treatments to such insurance provider (or its legal representatives) as I may designate from time to time; and
2. the insurance provider (who I have designated) to disclose such medical or other information about me which has been provided to the insurance provider or which the insurance provider develops during its evaluation of any application for life insurance to:
   a) its reinsurers;
   b) any other insurance company that I may designate;
   c) me;
   d) my financial representative, when that financial representative is seeking insurance coverage through the insurance provider on my behalf;
   e) any medical professional that I may designate; and
   f) any person or entity entitled to receive such information by law.

I acknowledge and agree that:

1. the above authorisation will be valid for two years from the date shown below. A photocopy of the authorisation will be as valid as the original;
2. the above authorisation shall bind my successors and assigns and remain valid notwithstanding my death or incapacity as far as legally possible;
3. information collected under the authorisation may be used by the insurance provider to evaluate my application for insurance, to evaluate a claim for benefits, for reinsurance or for other insurance related purposes; and
4. I and my authorised representative are entitled to a copy of this authorisation.

本人 ____ （「受保人」）謹此同意及授權:

1. 任何擁有本人健康及病歷或治療紀錄之註冊醫生、醫護人員、醫療服務供應商、醫院、診所、醫學化驗所、政府組織或任何其他醫療或醫療相關組織，可不時向本人指定的保險公司（或其法定代表）提供有關本人身體或精神狀況及／或治療之資料（包括診斷、檢查及測試結果、醫療報告、治療及疾病預後); 及
2. (本人指定之) 保險公司可將其獲得有關本人的醫療或其他資料或其評估壽險申請時發現有關本人之醫療或其他資料，披露予:
   a) 其再保商；
   b) 本人指定之任何其他保險公司;
   c) 本人;
   d) 本人的財務代表（如財務代表代表本人透過保險公司申請保險)；
   e) 本人指定之任何專業醫護人員；及
   f) 根據法例有權收取該等資料之任何人士或實體。

本人確認及同意:

1. 以上授權將由以下所示日期起計兩年有效，授權影印本將與正本具同等效力；
2. 以上授權將對本人之繼承人及權益轉讓人具約束力，即使本人身故或無行為能力，仍在法律許可的情況下有效；
3. 保險公司可使用根據授權收集的資料評估本人的保險申請、索償、再保安排或其他保險相關用途；及
4. 本人及本人之授權代表有權取得本授權書副本。

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Signatures 簽署

I have read the statements and answers in this form and they are complete and true to the best of my knowledge and belief.

I hereby agree that they shall form part of any application for life insurance for which this medical information was required.

本人已閱讀本表格內的陳述及答案，據本人所知及所信皆為準確完整。

本人同意有關陳述及答案將會成為任何需要本醫療資料之壽險申請之一部分。

Signature of **Patient/Proposed Insured** **準受保人**簽署	Place 地點	(Country 國家)
X	Date 日期	(dd/mm/yyyy 日／月／年)

I certify that I have truly and accurately recorded on this form the information supplied by the patient/proposed insured.
本人證明已如實及準確地於本表格記錄準受保人提供之資料。

Signature of **Paramedical Examiner** as Witness **體格檢查護士** 簽署 (作為見證人)	Print Name of Paramedical Examiner 體格檢查護士姓名	
X	Name of Financial Representative 財務代表姓名	

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PART 2 第二部

Paramedical Examiner's Report
體格檢查報告（護士）

☑ Select the box that applies 請選擇合適空格

(To be completed by the paramedical examiner 由體格檢查護士填寫)

1. a) Height
身高 ____________________ m米/ ft呎
Did you measure? 是否有度高? ☐ Yes 是 ☐ No 否

b) Weight
體重 ____________________ kg公斤/ lbs磅
Did you weigh? 是否有磅重？ ☐ Yes 是 ☐ No 否

Males only: Abdomen
只適用於男性： 腰圍 ____________________ inches 吋/ cm 厘米

c) Any weight change in the past 12 months? ☐ Yes 是 ☐ No 否
過去12個月體重是否有任何變化?

If 'Yes', amount
如是，體重變化為 ____________________kg公斤/ lbs磅

☐ Loss 體重下降

☐ Gain 體重增加

d) Urine Dipstick Result:
尿液試紙結果:

Protein 蛋白	Sugar 糖	Blood 血液

☐ Urine sample sent to the laboratory (please tick)
尿液樣本已送往化驗所（請剔選）

2. Blood Pressure Readings:
血壓讀數:

	Standing 站立	Sitting 坐下	Lying 躺臥
Systolic 收縮壓			
Diastolic 舒張壓			

3. Pulse 脈搏

Pulse Rate 脈搏率 : ____________________ per minute 每分鐘

☐ Regular 規律正常

☐ Irregular 規律異常

Type of irregularity
異常類型 ____

If extra systoles, No. per minute
如錄得過早收縮，每分鐘 ____________________ 次

4. Have you examined the patient in the past year? ☐ Yes 是 ☐ No 否
過去一年閣下有否替受保人進行檢查?

Is the patient known or related to you and/or your private patient? ☐ Yes 是 ☐ No 否
閣下是否認識受保人或與受保人有關連?

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PART 2 第二部

Paramedical Examiner's Report (Continued)
體格檢查報告（護士）(續)

☑ Select the box that applies
請選擇合適空格

Paramedical Examiner's Certification And Signature 體格檢查護士證明及簽署

How did you identify the patient?
閣下如何識別受保人身份?

☐ Driver's License (with photo) 駕駛執照（附照片）
☐ Passport 護照
☐ Other photo ID – please provide details 其他附照片的身份證明文件 – 請註明

____

Examination location:
體格檢查地點:

☐ Examiner's Office 醫務所
☐ Residence of Proposed Insured 準受保人住所
☐ Business address of Proposed Insured 準受保人業務地址
☐ Other - please provide details 其他 – 請註明

____

Indicate requirements completed
請註明已完成的檢查項目

☐ Blood 血液
☐ Urine 尿液
☐ Other 其他

Indicate further instructions (if applicable)
請註明其他指引（如適用）

____

Indicate any requirements not completed and reason
請註明沒有完成的檢查項目及原因

____

Date provided to financial representative 通知予財務代表日期 (dd/mm/yyyy) (日 / 月 / 年)

Signatures 簽署

I hereby certify that I have personally examined the patient and have correctly and fully reported my findings.
本人謹此證明已親自替受保人進行身體檢查，並正確及完整地呈報檢查結果。

Signature of **Paramedical Examiner** **體格檢查護士**簽署	Clinic Stamp/Chop 醫務所蓋章
X	

Name of Paramedical Examiner 體格檢查護士姓名		Paramedical Firm Identification 醫務所名稱	
Place 地點	(Country 國家)	Date 日期	(dd/mm/yyyy 日／月／年)

Address 地址	Number/Street/Building 室／街道／大廈	
	City 城市	Province 省份
	Country 國家	Postal Code 郵政編號

Phone Number 電話號碼	Country Code 國家號碼 – Area Code 地區號碼 – Phone Number 電話號碼
Examination completed on (date and time) 完成檢查（日期及時間）	

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