三井住友海上火灾保险（中国）有限公司
MITSUI SUMITOMO INSURANCE (CHINA) CO.,LTD.
34F,Shanghai World Financial Center,100 Century Avenue,Pudong New Area,Shanghai 200120, P.R.China
PHONE: (021) 6877-7899 FAX: (021) 6877-7500

Questionnaire for Group Accident Insurance
团 体 人 身 意 外 伤 害 保 险 调 查 表

1. Applicant 投保人

Ownership(Please tick) ☐Japanese ☐Non-Japanese Foreign ☐State-owned ☐Collective ☐Private ☐Individual ☐Others
企业性质(请选择) 日资 非日资外企 国有 集体 私营 个体 其他

English Name
英文名称
Chinese Name
中文名称

Correspondence Address
通讯地址

Telephone 电话 | Fax 传真 | Post Code 邮编

Date and Time of Establishment
成立时间

Nature of Business
业务范围

2. Business Locations
业务地址

3. Period of Insurance
保险期限
From _____to_____
由 至

4. Territorial Limits
地域范围

5. Additional Coverage, please tick as per your needs.
额外保障, 请按照需要选择.

☐ 附加自然灾害风险特约条款（主要为地震及火山） Including Natural Hazard Cover (Earthquake & Volcano)

☐ 不附加自然灾害风险特约条款 Excluding Natural Hazard Cover

☐ 24小时意外保障 24-hour Accident Cover

☐ 只承保工作中发生的危险特约条款 Working hours Accident Cover ONLY

☐ 不承保工作中发生的危险特约条款 Non-working hours Accident Cover

责任范围 Benefits	**最高责任限额/每人 Maximum Limits/per person**				
	Plan1)	**Plan2)**	**Plan3)**	**Plan4)**	**Plan5)**
意外死亡及残疾 Accidental Death & Disablement	RMB 500,000	RMB 200,000	RMB 100,000	RMB 50,000	RMB 20,000
意外医疗费用 Accidental Medical Reimbursement	RMB 50,000	RMB 20,000	RMB 10,000	RMB 5,000	RMB 2,000
每日住院津贴 Daily Hospitalization Allowance	RMB 150	RMB 120	RMB 100	RMB 75	RMB 30
交通事故加倍给付 Traffic Accident Double Payment	RMB 500,000	RMB 200,000	RMB 100,000	RMB 50,000	RMB 20,000

Occupation 具体工种： Insurance Plan( ) 选择方案 Plan ( )	Estimated Number of the Insured 估计被保险人人数:
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Occupation 具体工种： Insurance Plan( ) 选择方案 Plan ( )	Estimated Number of the Insured 估计被保险人人数:

Please fill in the amount different from the Plans prescribed above, but in no case exceeding the limits set out in above Plan1).
若有不同于上述保险方案的要求，请在下栏记载, 但各项担保最高金额以Plan1）所载为限。

Occupation
职业种类：

Estimated Number of the Insured
估计被保险人人数:

Accidental Death & Disablement, Amount:
意外死亡及残疾保险金额：

Accidental Medical Reimbursement, Amount:
意外伤害医疗费用保险金额：

Daily Hospitalization Allowance, Amount:
每日住院津贴：

Traffic Accident Double Payment Rider 附加交通意外伤害加倍给付保险	YES	NO
	□	□

Occupation
职业种类：

Estimated Number of the Insured
估计被保险人人数:

Accidental Death & Disablement, Amount:
意外死亡及残疾保险金额：

Accidental Medical Reimbursement, Amount:
意外伤害医疗费用保险金额：

Daily Hospitalization Allowance, Amount:
每日住院津贴：

Traffic Accident Double Payment Rider 附加交通意外伤害加倍给付保险	YES	NO
	□	□

Occupation
职业种类：

Estimated Number of the Insured
估计被保险人人数:

Accidental Death & Disablement, Amount:
意外死亡及残疾保险金额：

Accidental Medical Reimbursement, Amount:
意外伤害医疗费用保险金额：

Daily Hospitalization Allowance, Amount:
每日住院津贴：

Traffic Accident Double Payment Rider 附加交通意外伤害加倍给付保险	YES	NO
	□	□

Occupation
职业种类：

Estimated Number of the Insured
估计被保险人人数:

Accidental Death & Disablement, Amount:
意外死亡及残疾保险金额：

Accidental Medical Reimbursement, Amount:
意外伤害医疗费用保险金额：

Daily Hospitalization Allowance, Amount:
每日住院津贴：

Traffic Accident Double Payment Rider 附加交通意外伤害加倍给付保险	YES	NO
	□	□

Remarks: the application would not be effective until the applicant complied with conditions hereunder:
投保人需遵循下列几点方可达成有效投保

a. This insurance is void unless the applicant has obtained permission from the Insureds to this Coverage and Sums Insured under this insurance.
由于本保险是包含以死亡为给付条件的保险内容的合同，因此未经被保险人同意并认可保险金额的，本保险无效。
Please tick 请选择
☐ have signed agreement with each Insured 已经与每位被保险人签定同意书
☐ have notified each Insured by Announcement 已经以公告形式通知所有被保险人
☐ have obtained consent from each Insured by other means 已经以其他形式取得被保险人同意

b. All persons should be insured while the Group is less than or equal to 5 persons.
投保时被保险人数不少于5人。

c. The insured, whose age is between 16 and 60 both ages inclusive, on the sheet under this coverage shall be fulltime employees of the Group and hold ability to perform normal work .
本保险所附被保险人名册中所载人员，且被保险人的年龄在16周岁（含16周岁）至60周岁之间，能正常工作或正常劳动的投保单位全职在职工作人员。

d. The applicant shall have employment relationship with the insured.
投保人与被保险人之间应具备雇佣关系。

e. If Blank Form insurance is selected, the applicant must have the permission from the Insureds to indemnity payment method stipulated in this insurance.
若投保人以准记名方式投保，则需就该保险金给付方式取得被保险人同意。
Please tick 请选择
☐ have signed agreement with each Insured 已经与每位被保险人签定同意书
☐ have notified each Insured by Announcement 已经以公告形式通知所有被保险人
☐ have obtained consent from each Insured by other means 已经以其他形式取得被保险人同意

NOTE:
Provision of written documents stated in the above a. & e. is prerequisite condition for insurance company to accept the Applicant's proposal.
如投保人决定投保, 必须提供上述a. 和 e. 的书面证明文件作为本保险的有效附件.

The following questions must be answered by the Applicant (Please tick appropriate box):
投保人必须回答以下问题（请选择适当空格加√号）

		YES	NO
1.	Is there any other insurance effected upon your liability to your group currently or previously? 目前或以前是否有其他团体意外人身伤害保险？ If "YES", please give details (name of the company and the sum insured) 如果"是"，请说明保险公司并注明保险金额。	□	□
2.	Has any Company or Underwriter at any time ⑴declined to accept or continue any insurance of yours, ⑵required an increased premium or⑶ imposed special conditions? 是否曾有其他保险公司⑴拒绝接受或延续贵公司的保险，⑵加收保费或⑶附加特别条件 If any of the above answer is "YES", please give details. 如上述任何一项为"是"，请详细说明	□	□
3.	Does all the declared staff attend the social medical insurance scheme? 是否参加了基本医疗保险计划 If yes, please advise the effective date. 如是，请提供参加日期	□	□

4. State hereunder all accidents to your group insured incidental to their occupation during the past three years in details. Please attach a list if necessary. If you have enjoyed a clean loss record, state "NO".
请列明过去三年中贵公司雇员因职务所发生的意外事故的详细情况。如有必要，请另页详述。如无损失记录，请说明"无"

Year 年份	Brief description of accidents 事故起因简述	Amount of Settled Claims 已决索赔金额	Amount of Outstanding Claim 未决索赔金额	Insured With 保险公司

5. In addition to Hospitals classified as Level 2 Class 1 or Level 3, the Insured requests any other hospital/clinic or other medical establishment to be added as the accepted/appointed medical service establishment, please state the details hereunder, and Please note that the request will not be accepted only upon written approval by the insurer.
除指定二级甲等医院及其以上（三级）医院外，若投保人需向保险人要求将其他医院或医疗机构列入保险人指定或认可医疗机构范围，请在下栏列出。下记医院/医疗机构唯经保险人书面认可后，方可列入保险人的本保险及附加险中指定或认可医疗机构范围。

I/We declare the information given above to be correct and agree that this questionnaire shall form the basis of the contract between me/us and the Insurer.
我/我们就此宣告以上所填报资料真实无误并同意此调查表将成为我/我们和保险公司之合约的基础

Applicant's Signature: Date:
投保人签名 日期: