PRE-EXISTING QUESTIONNAIRE

既往症问卷调查

Contact Us 热线服务
Tel 电话：400-816-9300

Please scan and submit completed form with appropriate signatures via e-mail to **chinaservice@gbg.com**
请扫描并邮件发送已完整填写且签名的表格至 **chinaservice@gbg.com**

A.PATIENT INFORMATION
就诊人/被保险人信息

Name (Last, First, MI)： 姓名：	Alias： 别名：
Date of Birth (MM/DD/YY)： 出生日期（月/日/年）：	Policy ID Number： 保单号码：
Policyholder Name： 主被保人姓名：	Diagnosis/ Symptom/ Complaint： 诊断/症状/主诉：

Date(s) first symptom was noticed by the patient/insured/被保险人首次发现该症状日期：

Date (Day/Month/Year) patient first took medicine for, or first consulted with a physician or other medical provider for this condition/被保险人针对该症状首次吃药，或看医生日期：

If delay between first symptoms and date treatment sought, please advise reason for waiting：
被保险人首次发现该症状之后，并未及时采取治疗，请解释原因：

History of Treatments (Include all medications, surgical procedures, etc. for the past 3 years)：
过去三年的治疗情况（包括药物治疗，手术治疗等等）：

*** For the insured employees and dependents covered under the previous group policy, if valid insurance transfer certifications can be provided, non-catastrophic-illness pre-existing can be covered without a waiting period after underwriting review and approval. 在原保险公司团险下的被保险员工及附属被保险人如能提供有效保险转换证明，非重大疾病的既往症经保险公司核保审核通过后可减免等待期。**

All fields are required. Do not leave any questions blank. Please provide as much detail as possible.
GBG to fill out first four lines (thru Diagnosis) above. 请务必填写以上所有必要信息。

B.PHYSICIAN INFORMATION (if more than one, please continue on back)
医生信息（如果超过一个医生，请使用背面）

Physician's Name (Print) 主治医生姓名: :	
Physician's Signature : 医生签名 :	Date Signed : 签名日期 :
Physician's Mailing Address/地址 :	
Physician's Email Address : 邮箱 :	Physician's Telephone Number : 电话 :

C. FRAUD WARNING
警告

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.
任何人提交载有虚假或欺骗性陈述的索赔申请而企图讹骗或促使对承保人讹骗的行为是保险诈骗犯罪行为。

Signature 就诊人签名: Date 日期:

PLEASE ATTACH THE INITIAL CONSULTATION EVALUATION/EXAMINATION AND ANY RELEVANT LAB, RADIOLOGY, PATHOLOGY RESULTS, CHART NOTES, ETC. AND SUBMIT TO THE ADDRESS ABOVE. RELATED SERVICES CANNOT BE PROCESSED WITHOUT THE SUBMISSION OF THIS FORM.
被保险人需将就诊时病例以及所有相关检查结果，如化验结果，放射学结果，病理结果等等，寄往表格上方的地址。如若被保险人没有提交以上表格及相关材料，保险公司将无法进行理赔。