

# Sales representative report 業務代表報告

Please provide the additional information on this page to help us process the application

請提供本頁之額外資訊以協助我們進行申請

## About the person being insured 關於被保險人資料

Did you meet the person being insured?/是否與被保險人見面? <input type="checkbox"/> Yes/ 是/ <input type="checkbox"/> No/否	How long have you known this person? 你已認識被保險人多久時? ----- years/年 ----- mths/月	Estimate his or her annual income from salary, bonuses and dividends (net of business expenses)被保險人之預估年薪、獎金、紅利(營業支出淨利)等收入:US\$
Income from other sources /其他來源之收入: US\$	Sources of other income / 其他收入來源	
Country of citizenship /國籍	Length of time in current country of residence / 在目前居住國家之居住時間:	
Does the proposed insured appear to be unhealthy in any way? / 建議之被保險人是否在任何部分看起來不健康? <input type="checkbox"/> No/否 <input type="checkbox"/> Yes/是(如為是, 請說明)		
Are you aware of anything about the proposed insured that might affect their insurability? / 你是否知悉可能影響被保險人保險能力之任何事宜? <input type="checkbox"/> No/否 <input type="checkbox"/> Yes/是(如為是, 請說明)		
Is the owner or beneficiary someone other than the proposed insured's parent, spouse, or child? /所有人或受益人是否為被保險人之父母、配偶或小孩以外之其他人? <input type="checkbox"/> No/否 <input type="checkbox"/> Yes/是(如為是, 請說明保險能力之利益為何)		

## Reason for taking out life insurance (check one) / 排除人壽保險的原因(勾選)

<input type="checkbox"/> Stock repurchase 股票買回	<input type="checkbox"/> Buy-sell agreement 買入-賣出協議	<input type="checkbox"/> Creditor protection 債權人保障	<input type="checkbox"/> Income replacement 所得替代
<input type="checkbox"/> Key person insurance 主要人員保險	<input type="checkbox"/> Tax or estate planning 稅務或資產規劃	<input type="checkbox"/> Deferred compensation 延遲補償	
<input type="checkbox"/> Other, please provide details/其他, 請說明			

## Business finances of the person being insured / 被保險人之公司財務

If coverage is for business-related needs, please tell us about the business finances

若保險範圍主要作為公司相關需求, 請告知公司財務狀況

Percentage of business owned by the person being insured 被保險人持有之公司比例 %	Are other partners or owners also applying? 其他合夥人或所有人是否也同時申請?	<input type="checkbox"/> Yes / 是 <i>Amount of insurance</i> 保險金額	<input type="checkbox"/> No / 否 <i>Please give details</i> 請說明
Net worth of the business/ 公司淨值 US\$	Fair market value of the business 公司市場價值 US\$	Net after-tax business income 公司稅後淨利	Last fiscal year 最近財務年度 -----US\$
			Previous fiscal year 先前財務年度 -----US\$

## Payment Information 付款資訊

Payment made with this application	Future payment frequency 後續付款頻率 <input type="checkbox"/> Monthly/每月 <input type="checkbox"/> Quarterly/每季 <input type="checkbox"/> Semi-Annually/每半年 <input type="checkbox"/> Annually /每年	Amount of schedule 預定付款總額 US\$
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The policy owner's identity is required for universal life insurance applications

終身人壽保險申請均須要填寫保單所有人身分

**Verifying the policy owner's identity 查核保單所有人身分**

<input type="checkbox"/> Birth certificate / 出生證明 <input type="checkbox"/> Passport / 護照	Document identification number / 身分證號碼
<input type="checkbox"/> Other / 其他	

**Sales Representative Information 業務代表資訊**

Name 姓名	Code 代碼	Agency 經銷處	Rep. Code 代表編號
Signature 簽名			

## Personal Fact Sheet 個人資料表

In this application you and your refer to the person being insured and the policy owner. We, us, our, and the Company refer to Capital Life Insurance Company of The Bahamas, a member of Sagicor Financial Corporation.

本份申請表中，你們及你們的是指被保險人及保單所有人，我們、我們的、及公司是指 Capital Life Insurance Company of The Bahamas，為 Sagicor Financial Corporation 之成員。

Please PRINT Clearly / 請清楚地以印刷字體填寫

### 1. General Information / 一般資料

If the mailing address differs from the residence address, please provide details in the sales representative's report / 若通訊地址與居住地址不同，影於業務代表報告中說明。

#### Information about the person being insured / 被保險人資料

Name (first, middle initial, last) / 姓名(姓氏)		<input type="checkbox"/> Male / 男 <input type="checkbox"/> Female/女	Date of birth/出生日期 (mm月/dd日/yy年)
Residence address (street number and name, apartment or suite) 居住地址(街道名稱與號碼，公寓或套房)		City / 城市	Province - State/省-州
Country / 國家	Postal Zip code / 郵遞區號	Place of birth (province / state and country) / 出生地(省/州與國家)	
Social insurance number/ 社會保險號碼		Other ID Information/ 其他身分證號碼	Province / State/ 省/州
Occupation (please specify job title and duties) / 職業(請說明職稱與職務)			Home phone# / 家裡電話號碼
Name and address of employer / 雇主姓名與地址			Business phone # / 公司電話號碼

#### Information about the policy owner

僅當保單所有人不為被保險人時才須填寫本部分，所有產品均需要填寫所有人之社會保險號碼

#### Individual owner / 保單所有人資訊

Name (first, middle initial, last) / 姓名		<input type="checkbox"/> Male / 男 <input type="checkbox"/> Female / 女	Relationship to the person being insured / 與被保險人關係
Residence address (street number and name, apartment or suite) 居住地址(街道名稱與號碼，公寓或套房)		City / 城市	Province – State 省-州
Country / 國家	Postal Zip code / 郵遞區號	Social insurance number/社會保險號碼	
Occupation (please specify job title and duties) / 職業(請說明職稱與職務)			Home phone# 家裡電話號碼
Name and address of employer / 雇主姓名與地址			Business phone # / 公司電話號碼

Complete this section only if the policy owner is not the person being insured. The owner's Social Insurance Number is required information for all products

僅當本保單為公司或其中任一合夥人未投保時才須填寫本部分，關於合夥人部分，請提供期社會保險號碼及與被保險人關係

Is there a contingent policy owner? 是否有附帶保單所有人

Name (first, middle initial, last) / 姓名	Relationship to the person being insured / 與被保險人關係
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**Corporate or joint owner / 公司或合夥人**

Name / 姓名			
Mailing address (street number and name, apartment or suite) / 通訊地址(街道名稱與號碼, 公寓或套房)			
City / 城市	Province - State / 省-州	Country / 國家	Zip code / 郵遞區號

**1. Your beneficiaries / 你的受益人**

Primary Beneficiaries (share of benefits must add up to 100%)

主要受益人(受益之比例加總後須為 100%)

Name (first, middle initial, last) 姓名	Relationship to the person being insured 與被保險人關係	Percentage share of benefits to be paid 支付之受益比例
		%
		%
		%

Contingent beneficiaries (share of benefits must add up to 100%)

連帶受益人(受益之比例加總後須為 100%)

Name (first, middle initial, last) 姓名	Relationship to the person being insured 與被保險人關係	Percentage share of benefits to be paid 支付之受益比例
		%
		%

**2 Your basic benefit / 你的基本受益**

For **term insurance**, complete Sections 2,3 and 5. / 期間保險, 請填寫第2、3及5部分。

For **universal life insurance**, complete Sections 2,3, 4 and 5. / 終身人壽保險, 請填寫第2、3、4及5部分。

**Your insurance coverage 你的保險範圍**

What type of insurance Policy are you applying for? 申請之保單種類	Sum insured (amount of coverage) 保額(保險項目之總額)
<input type="checkbox"/> Universal life/終身 <input type="checkbox"/> Term insurance/期間保險   \$	
If this application is for joint or multiple-life coverage, please give us the names of the others being insured / 若該申請為聯合或複合人壽保險, 請提供其他被保險人姓名	
Name (first, middle initial, last) / 姓名	
Name (first, middle initial, last) / 姓名	

If this new policy will replace an existing insurance policy, please complete a replacement form.

若本保單將取代現有保單, 請填寫替代表格。

**Other life insurance policies / 其他人壽保險保單**

Do you have other life insurance policies in effect or pending with us or another insurance company? / 你是否尚有其他有效之人壽保險保單或是向我們或其他保險公司申請中之人壽保單?

Yes / 是    No / 否 (If yes, please provide details below / 如為是, 請說明如下)

Insurance company 保險公司	Policy number 保單號碼	Year issued 發行年度	Type of coverage 保險範圍種類	Amount of coverage 保險金額	Is policy being replaced or onverted? 保單將被取帶或轉換?
			<input type="checkbox"/> Personal/個人	US\$	<input type="checkbox"/> Replacement / 替代

			<input type="checkbox"/> Business/公司		<input type="checkbox"/> Conversion / 轉換 <input type="checkbox"/> Not applicable/不適用
			<input type="checkbox"/> Personal/個人 <input type="checkbox"/> Business/公司	US\$	<input type="checkbox"/> Replacement / 替代 <input type="checkbox"/> Conversion / 轉換 <input type="checkbox"/> Not applicable/不適用
			<input type="checkbox"/> Personal/個人 <input type="checkbox"/> Business/公司	US\$	<input type="checkbox"/> Replacement / 替代 <input type="checkbox"/> Conversion / 轉換 <input type="checkbox"/> Not applicable/不適用

### 3. Additional benefits 附加受益

You may add certain benefits to the policy you're applying for. Check the box next to each benefit you're adding. 你得於申請之保單增加特定之受益，請於每個方格勾選你欲增加之受益

Accidental Death & Dismemberment Benefit 意外死亡&殘障受益

Total Disability Waiver of Premium Benefit 肢障之保險費全額豁免

### 4. Universal life insurance – additional information 終身人壽保險-額外資訊

#### Choosing a death benefit option 選擇死亡受益方式

Choose one of the following: 自下列選擇一種:

Level death benefit 相同之死亡受益

Increasing death benefit 漸增之死亡受益

### 5. Temporary life insurance questions 暫時性人壽保險問題

To apply for temporary insurance, these questions must be answered **No** by the person being insured  
為申請暫時性保險，所有問題須由被保險人回答為否

1) Within the last 12 months, have you consulted a doctor for chest pain, any known or suspected heart attack, stroke, cancer or AIDS? 在過去 12 個月內，你是否曾因胸部疼痛、任何其他已知或疑似心臟病、中風、癌症或 AIDS 就醫?	<input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否
2) Within the last 2 years, have you applied for life or health insurance and been refused coverage or received a rated or modified offer? 過去 2 年內，你是否曾申請人壽或健康保險，但被拒絕承保或收到修改之保單?	<input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否
3) Within the past 45 days, have you been admitted or advised to be admitted to a hospital or clinic as an in-patient, except for pregnancy or childbirth? 過去 45 天內，除懷孕或生產外，你是否曾經住院或被告之到醫院或診所住院?	<input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否

### 6. Medical and personal history 醫藥及個人歷史

To apply for temporary insurance, these questions must be answered **No** by the person being insured  
下列問題須由被保險人回答。

#### 6.1 Required information 要求資料

a) Within the last 12 months, have you used any product containing marijuana, tobacco or nicotine, including tobacco cessation products? 過去12個月內，你是否曾使用任何含有大麻、煙草、或尼古丁之產品，包含煙草中止產品?  Yes / 是  No / 否

If yes, what product did you consume, how much and how frequently?  
如為是，你使用何種產品? 使用份量與頻率?

b) Within the last 3 years, have you been convicted of more than three driving violations, been involved as a driver in a motor vehicle accident, or has your driver's license been suspended or revoked?  
過去 3 年內，你是否曾因違規駕駛被判刑超過 3 次以上，曾因身為駕駛涉及汽車意外，或讓你的駕駛執照被吊扣或撤銷?  Yes / 是  No / 否

If yes, please provide details including license number and licensing country/

如為是，請說明細節，包含駕照號碼與發照國家

c) Have you at any time been convicted of any offence by any court whether civil, military or criminal in any jurisdiction? Are any charges pending?

你是否曾因民事、軍事、或刑事案件被法院判刑？是否有任何懸而未決之費用？  Yes / 是  No / 否

If yes, please provide full details 如為是，請說明全部細節

d) Were you ever declared bankrupt or is bankruptcy pending? If yes, provide full details and discharged date. 你是否曾宣告破產或宣告破產中？若是，請說明全部細節及撤銷日期。  Yes / 是  No / 否

If yes, please provide details 如為是，請說明全部細節

e) Have you lived outside your current country of residence within the last 12 months? If yes, provide location, duration and frequency. 在最近12個月內，你是否曾在居住國以外之國家居住？若是，請提供地點、期間、及頻率。  Yes / 是  No / 否

If yes, please provide details 如為是，請說明全部細節

f) Do you plan to live or travel outside your current country of residence (excluding vacations) in the next two years? If yes, provide location, duration and frequency. 未來2年，你是否計劃要到居住國以外之地區居住或旅行？若是，請提供地點、期間、及頻率。  Yes / 是  No / 否

If yes, please provide details 如為是，請說明全部細節

If you answer yes to questions "g), h), i) or j)" you must complete the appropriate questionnaire and submit it with your application.

若問題 g)、h)、i)、或 j) 的答案為是，你必須填寫適當之問卷並連同申請書一起提出。

g) Have you ever been advised to stop drinking alcohol or to drink less?

你是否曾被告知停止喝酒或喝少一點？

Yes / 是  No / 否

h) Do you presently drink alcoholic beverages? If yes, indicate usual weekly quantity and type of beverage (e.g. wine, beer, spirits). If no, indicate date last used?

你目前是否有喝含酒精之飲料？若是，說明通常每週數量與飲料種類(例如葡萄酒、啤酒、烈酒)，若否，說明最後使用的日期？  Yes / 是  No / 否

i) Within the last 10 years, have you used cocaine, LSD, speed, heroin, barbiturates or other non-prescribed narcotics? 在過去10年內，你是否曾使用古柯鹼、麥角酸二乙、安非他命、海洛因、巴必妥酸鹽、或其他未經醫生處方許可之毒品？  Yes / 是  No / 否

j) Within the last 24 months, have you engaged in any hazardous activities such as flying, scuba or skydiving, racing or climbing or do you intend to in the future? 在過去24個月內，你是否曾從事任何冒險性活動，如飛行、潛水、或特技跳傘，或是你未來企圖進行？  Yes / 是  No / 否

Applicants who do not require a medical or paramedical exam **must** answer these additional questions.

For all other applicants, answering these questions may help us process your application faster.

不須進行健康或醫療輔助檢查之申請人必須回答這些額外問題，而其他回答下列問題之申請人，可能會有助我們加速進行你的申請。

## 6.2 Additional information 額外資料

Your height 身高 Ft. In. m. cm. 呎 吋 尺 公分	Your current weight 目前體重	<input type="checkbox"/> lbs. 磅 <input type="checkbox"/> kgs. 公斤	Change in weight in the last year 去年更動之體重 <input type="checkbox"/> Gain 增加 <input type="checkbox"/> Loss 減少 <input type="checkbox"/> No change 沒變	<input type="checkbox"/> lbs. 磅 <input type="checkbox"/> kgs. 公斤
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Name of your regular doctor 固定醫師姓名		
Date last visited, reason seen, diagnosis and treatment or advice provided 最近看醫生之日期、原因、診斷與治療或其提供建議		
Address (street name and number) 地址(街名與號碼)		
City 城市	Province-State 省-州	Postal-Zip Code 郵遞區號

If you answer "yes" to any questions, please provide further details on the next page. Please complete the appropriate questionnaire if you answer "yes" to any question from a) through f)  
若你有任何問題回答是，請在下一頁提供細節，若問題 a)至 f)中有任何問題的答案為是，請填寫適當之問卷。

**Have you ever had or sought medical advice for, any of the following?**

**你是否曾因下列之任何原因持有或尋求醫療協助?**

- |  |   |
|--|---|
| <p>a) Diabetes, thyroid or other endocrine disorder<br/>糖尿病、甲狀腺或其他內分泌失調<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> <p>b) Respiratory disorder<br/>呼吸疾病<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> <p>c) Mental or psychiatric disorder<br/>精神或精神疾病<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> <p>d) Epilepsy<br/>癲癇<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> <p>e) Digestive, pancreas or bowel disorder<br/>消化、胰臟、或腸疾病<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> <p>f) Chest pain<br/>胸痛<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> <p>g) Heart attack or heart condition<br/>心臟病或心臟問題<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> <p>h) High blood pressure<br/>高血壓<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> <p>i) Stroke or TIA (transient ischemic attack)<br/>中風或暫時性局部缺血發作<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> | <p>j) Blood or lymph gland disorder<br/>血液或淋巴腺疾病<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> <p>k) Hepatitis, test indicating a hepatitis carrier state or liver disorder<br/>肝炎、經測試為肝炎帶原者、或肝臟疾病<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> <p>l) Cancer or tumor<br/>癌症或腫瘤<br/><input type="checkbox"/> Yes / 是 <input type="checkbox"/> No / 否</p> |
|--|---|

- m) Muscular or nervous system disorder  
肌肉或神經系統疾病  
 Yes / 是  No / 否
- n) Kidney or bladder disorder  
腎臟或膀胱疾病  
 Yes / 是  No / 否
- o) Arthritis  
關節炎  
 Yes / 是  No / 否
- p) AIDS, or a positive HIV test  
AIDS、或 HIV 測試呈陽性反應  
 Yes / 是  No / 否
- t) Have you, other than already disclosed, been treated by a doctor or admitted to a hospital in the last 5 years (excluding minor injuries, cold, seasonal allergies, tonsillectomy, appendectomy, gallbladder removal, herniotomy and childbirth)?  
除前述已揭露外，在過去五年內，你是否曾接受醫生治療或住院(除小傷害、感冒、季節性過敏、扁桃腺切除、闌尾切除、膽囊移除、疝切開術、及生產外)?  Yes / 是  No / 否
- u) Within the past 5 years, have you had any x-rays, electrocardiograms, blood tests or any other medical tests?  
過去五年內，你是否曾接受 X 光照射、心電圖、血液測試、或其他醫療機檢驗?  Yes / 是  No / 否
- V) Have you ever been advised to have further medical investigations, tests, or surgery which have either not been completed, or where you have yet to be advised of the results?  
你是否曾被告知進行進一步的醫療檢查、測試或手術，無論是否尚未完成或是結果尚未被告知?  
 Yes / 是  No / 否
- w) Are you aware of any symptoms or complaints for which you have not yet consulted a physician?  
你是否有發現任何症狀或不適，但尚未請教醫生?  Yes / 是  No / 否
- x) Are you currently taking any medication?  
你目前是否有服用任何藥物?  Yes / 是  No / 否
- y) Has any parent, brother or sister had a history of cancer (specify type), heart or polycystic kidney disease, stroke, diabetes, Huntington's Chorea or any hereditary disease, mental illness or attempted suicide?  
是否有父母、兄弟姊妹曾經罹患癌症(說明種類)、心臟或腎臟疾病、中風、糖尿病、Huntington's Chorea、或其他遺傳疾病、心理異常、或企圖自殺?  Yes / 是  No / 否

Please provide details below for any yes answers under section 6.2. Use a separate sheet of paper if necessary.

在6.2部分如有任何問題回答是，請提供明細如下。如有必要，請填寫單獨之表格報告。

Question 問題	Doctor's name and address 醫生姓名與地址	Date seen 就醫日期	Reason for visit or diagnosis 就醫或診療原因	Advice or treatment received 報告或接受之治療


### 7. Pre-authorized monthly payments 預先授權每月付款

Complete this section if you want us to collect your monthly payments directly from your bank account.

如果你希望我們每個月直接由你的銀行帳戶中安排扣款，請填寫本部分。

Please, attach a voided check with your application

請隨本申請表附上一張空白支票

#### Banking information 銀行資料

Please supply the following information 請提供下列資料

Name of account holder (first, middle initial, last) 帳戶所有人姓名	
Name and address of your financial institutions (street number and name) 金融機構之名稱與地址	
Branch transit number 分行代碼	Your account number 帳號

#### Terms and conditions for pre-authorized monthly payments

##### 預先授權每月付款之期間與條件

If you've chosen to make your payments directly from your bank account, you agree that:

如果你已選擇直接由銀行帳號進行付款，則你已同意如下：

- your bank or financial institution is authorized to treat any withdrawal by Capital Life Insurance Company of The Bahamas ("the Company") as though it was made by you personally  
你的銀行或金融機構被授權信任任何由 Capital Life Insurance Company of The Bahamas(稱“公司”)所進行之提款，視同你個人進行之提款。
- you or "the Company" may cancel this pre-authorized payment agreement at any time by giving notice in writing  
你或公司得在發出書面通知後，隨時終止本項事先授權付款協議。
- the agreement is cancelled automatically if we are unable to make a withdrawal from your account, and  
若我們未能於你的帳戶中提款，則本協議自動終止。
- If the agreement ends, payments will be due twice a year, on the policy anniversary date and again 6 months later.  
當本協議書結束時，到期款項將分一年兩期支付，分別於保單年度日期及後續六個月後到期。

Signature of account holder 帳戶所有人簽名

X

## 8. Signatures 簽名

This section must be signed by the person being insured.

本部分須經被保險人簽名。

The policy owner must also sign, if he or she is not the person being insured.

若保單所有人並非被保險人，則保單所有人亦須簽名。

For corporate-owned policies, the signature and title of a signing officer is required.

對於公司持有之保單，須有授權簽署人之簽名與職稱。

By signing below, I understand and agree that:

經簽署如下，我了解並同意：

- The answers and statement I've made in this application, and in any other document forming part of this application (collectively called this application) are complete and true and will form the basis of any new Insurance policy the Company issues.

本人於本申請書及連同本申請書之其他文件(總稱為本申請書)所做之回答與聲明均完整且屬實，將為公司發出之所有新保單之基礎。

- Sales representatives or medical examiners do not have the authority to make or modify a Company policy; to decide whether anyone proposed for insurance is an acceptable risk, or to waive any of the Company's rights or requirements.

業務代表或醫療檢驗者無權進行或修改公司之保單；決定是否申請保險之當事人為可接受之風險，或放棄任何公司之任何權利或要求。

- The Company has no liability related to this application unless and until it has approved the issue of a policy; received the required minimum payment; and received complete and true answers and statements for all questions and information on the application at the time the required minimum payment is received.

僅當公司許可並發出保單後；收到要求之最低保費；並在收到保費的同時，也收到完整並屬實關於申請書上所有問題與聲明之答案與資料，否則公司對與本申請之相關事宜不具義務。

I've asked to receive this and all related documents in English. 我已收到所有相關之英文文件。

Signature of the person being insured 被保險人簽名 X	Signature of the policy owner (if other than person being insured) 保單所有人簽名(若為被保險人以外之其他人) X	
Location signed 簽署地點	Date 日期 (MM/DD/YY)	Title (corporate policy owners only) 職稱(僅適用公司保單所有人)

## Authorization to disclose information 授權揭露資訊

By signing below, you authorize that your personal information may be provided to Capital Life Insurance Company of The Bahamas ("the Company") by any of the following:

經簽署如下，你授權同意下列單位得提供個人資料給 Capital Life Insurance Company of The Bahamas ("公司"):

- Medical practitioners, hospitals and clinics 醫療人員、醫院、及診所
- The Medical Information Bureau 醫療資訊機構
- Investigation agencies 調查單位
- Motor vehicle bureau 汽車機構
- Other insurers or reinsurers, and 其他保險業者或在保險業者，及
- Your sales representative and the local sales agency or life insurer with whom he or she has a contract 你的業務代表及當地業務代理，或持有契約之人壽保險業者

This information is required to evaluate the risk associated with your application for life insurance, administer this insurance policy, pay insurance claims and benefits, and provide you with continuing service. You agree that we may disclose your personal information to the persons or organizations named above. In the case of sales representatives or sales agencies, disclosure will be restricted to non-medical information. You also consent to a personal investigation as part of your application.

本資訊作為評估你對人壽保險申請之相關風險、管理保單、支付保險理賠與收益、並提供你持續之服務，

你同意我們得揭露你的個人資料給上列之人員或組織，在業務代表或業務代理方面，將僅限揭露非醫療資料，你也同意就你的申請進行個人調查。

A photocopy of this authorization will be as valid as the original. 本授權之副本將與正本具相同之效力。

Signature of the person being insured 被保險人簽名 X	Signature of the policy owner (if other than person being insured) 保單所有人簽名(若為被保險人以外之其他人) X
Date (MM/DD/YY) 日期(月/日/年)	

## 9. Notice regarding Medical Information Bureau 關於醫療資料機構之通知

### **DETACH AND LEAVE WITH APPLICANT 申請人之分遣與離開**

Information regarding your insurability will be treated as confidential. Capital Life Insurance Company of the Bahamas or their reinsurer(s) may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of the life insurance companies, which operates as information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Capital Life Insurance Company of The Bahamas or their reinsurer(s) may also make information in its file available to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits. It is our understanding that upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file.

關於你可保險能力之相關資料將被視為機密資料，然而，Capital Life Insurance Company of the Bahamas 或其再保險公司得提報一份簡單的報告給醫療資訊機構，為人壽保險公司之非營利會員組織，代表其會員進行資料交換，若你向其他隸屬機構之會員保險公司提出人壽或健康保險申請，或向公司提出保險理賠或受益，則該機構，根據要求，將提供公司其所持有之檔案，Capital Life Insurance Company of the Bahamas 或其再保險公司亦得提供該資料檔案給其他你申請人壽或健康保險之人壽公司，或是你提出理賠或受益申請之公司，就我們的理解，一旦收到你的要求，該機構將得揭露你個人檔案中之任何資料。

The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112 USA.

該機構之資料辦公室地址為 Post Office 105, Essex Station, Boston, Massachusetts 02112 USA。

## Certificate of Temporary Life Insurance 暫時性人壽保險證書

We, us, our and the Company refer to Capital Life Insurance Company of The Bahamas, a member of Sagicor Financial Corporation.

我們及公司，指 Capital Life Insurance Company of the Bahamas，為 Sagicor Financial Corporation 之成員。

Capital Life Insurance Company of The Bahamas agrees to provide temporary insurance beginning on the date of signature on part 8 of the application bearing the same serial number as this certificate for the person or persons being insured in the application if:

在下列情況下，Capital Life Insurance Company of the Bahamas 同意自本申請書第 8 部分之日期起，提供暫時性保險，其保單證書序號同被保險人在申請書中之序號：

- The temporary life insurance questions in the application have been truthfully answered “no”  
本申請書中關於暫時性人壽保險問題已完全回答為否。
- All other required questions in the application have been truthfully and completely answered, and  
本申請書之所有其他問題已誠實且完全回答，且
- A payment has been made with the application.  
費用已連同本申請書繳付。

The beneficiary for temporary life insurance is the person or persons named as beneficiary in the policy being applied for.

暫時性人壽保險的受益人將為申請保單所指定之受益人。

### What we'll pay under this temporary insurance

#### 根據本暫時性保險，我們擬支付之金額

The amount we'll pay on the death of the person or persons insured under this certificate is the amount we would have paid if we had issued the policy being applied for. In no event will we pay more than \$500,000 in total under all temporary life insurance certificates in effect for this person. This limitation includes any accidental death benefit covering the person insured. Any amount payable will be distributed proportionally among all Certificate of Temporary Life Insurance in effect.

根據本證書，我們將支付之被保險人死亡金額為我們擬支付給申請中保單之金額，在任何情況下，所有有效之暫時性人壽保險證書之理賠總額將不超過\$500,000。這項限制包含被保險人涵括之任何意外死亡理賠。所以支付金額將依照所有有效之暫時性人壽保險保單依照比例分配。

### When we won't pay a death benefit

#### 我們不給付死亡理賠之情況

- Commits suicide.  
自殺
- Dies as a result of self-inflicted injuries.  
因本身造成之傷害而死亡
- In these events, we will refund the amount paid with this application.  
在這些情況下，我們將歸還連同本申請書支付之金額

### When this temporary insurance ends

#### 本暫時性保險終止之時間

Insurance coverage on any insured person under this temporary agreement ends on the earliest of the following dates:

任何根據本暫時性協議之被保險人保險範圍將於下列日期終止，以先到之日期為準：

- 2 days after we send notice telling the policy owner that the insurance has been cancelled.  
我們寄出通知告知保單所有人本保險已終止後 2 天。
- The date that a policy we issue as a result of the application takes effect.

本申請書生效且發出保單之日期。

- The date the policy owner asks us to cancel the insurance, or  
保單所有人提出要求我們中止本保險之日期，或
- The date the insured person dies.  
被保險人死亡之日期。

### Receipt of payment 付款收迄

We acknowledge receiving payment with this application for insurance.

我們承認款項已連同本保險申請書同時收到。

### How your universal life funds will be invested 如何投資終身保險之基金

Any money paid with this application will be invested in the Capital Life Segregated Insurance Fund from the date we have approved the issue of a policy, until the date that our Head Office receives any paperwork that may be required on delivery of the policy to the policy owner. Once that paperwork has been received, any money paid with the application will be invested in the Fund, subject to the normal account minimums.

連同本申請支付之任何金額都將自我們核准發出保單日起投資於 Capital Life Segregated Insurance Fund，並於我們總部收到任何書面要求寄送保單給保單所有人時中止，一旦收到通知，連同申請書所支付之金額將投資於基金，根據一般帳戶最低金額。

### All checks must be payable to Capital Life Insurance Company.

所有支票必須支付給 Capital Life Insurance Company。

Amount of payment 付款金額 \$	Name of person being Insured (first, middle initial, last) 被保險人姓名	Date /(MM/DD/YY) 日期(月/日/年)
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Sales representative name (first, middle initial, last) 業務代表姓名 X
Signature of sales representative 業務代表簽名 X





**CAPITAL  
LIFE**

Every question must be asked by the Medical Examiner and the answers recorded in ink in the Examiner's own handwriting. Please print names and addresses. The Proposed Insured must sign in the Examiner's presence. Examinations must be made in private.

每個問題都必須由醫療檢查人員詢問並親自紀錄答案，請以印刷體書明姓名與地址，申請保險人必須在檢查人員面前簽署，檢驗必須私下進行。

**Application Part II 申請書第II部分**

1. Name of Proposed Insured 被保險人名字		MI 中間姓氏	Last Name 姓	2.a. Date of Birth 生日	b. Age 年齡
3. Name and address of your personal physician 個人醫生姓名與地址		Date of last visit 最後就診日期	Reason & results 原因&結果	Treatment-Medication prescribed 治療-藥物	
4. Have you ever been treated for or ever had any known indication of: 你是否曾接受治療或具下列任何已知症狀:			Yes 是/ No 否	Details of "Yes" answers. (Identify question number, circle applicable items: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities). 回答是，請說明細節(說明問題編號，圈選合適項目：包含診斷、日期、期間、及所有參與醫生與醫療機構之名稱與地址)	
a. Disorder of eyes, ears, nose, throat or skin disorder? 眼、耳、鼻、喉嚨或皮膚疾病?					
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, Transient Ischemic Attack (TIA), epilepsy, depression, multiple sclerosis, Alzheimer's disease, Parkinson's, tremor, motor neuron disease, mental or nervous system disorder? 頭昏、頭暈、抽搐、頭痛、語言缺陷、癱瘓或中風、暫時性局部缺血、癲癇、低血壓、多重硬化、阿耳滋海默氏病、帕金森氏、顫抖、運動神經疾病、心理或神經系統疾病?					
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, sleep apnea or chronic respiratory disorder? 呼吸缺氧、持續性嘶啞或感冒、血液不良、支氣管炎、肋膜炎、氣喘、肺癰腫、肺結核、睡眠呼吸窒礙或長期性呼吸疾病?					
d. Chest pain, palpitation, angina, irregular pulse, cholesterol elevation, abnormal ECG, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? 胸痛、心悸、心絞痛、不規律心跳、膽固醇過高、心電圖異常、高血壓、風濕熱、心臟雜音、心臟病或其他心臟或血管疾病?					
e. Jaundice, hepatitis, hepatitis B carrier, intestinal bleeding, ulcer, intestinal polyps, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver, gallbladder or pancreas? 黃疸、肝炎、B型肝炎帶原者、腸出血、潰瘍、腸息肉、疝氣、結腸炎、痔核、長期消化不良、或其他胃、腸、肝、膽囊或胰臟疾病?					
f. Sugar, albumin, blood or pus in urine, sexually transmitted disease, stones, cysts or any other disorder of the kidney, bladder, prostate or reproductive organs? 血糖、蛋白、血液、或尿液濃度、性傳染病、結石、囊腫、或任何腎臟、膀胱、前列腺、或生殖器官疾病?					
g. Diabetes; thyroid or other endocrine disorders? 糖尿病、甲狀腺、或其他內分泌疾病?					
h. Neuritis, sciatica, rheumatism, arthritis, lupus, fibromyalgia, gout, or disorder of muscles or bones, including the spine, back or joints? 神經炎、坐骨神經痛、風濕、關節炎、狼瘡、痛風、纖維痛、或肌肉或骨骼疾病，包含脊椎、背或關節?					
i. Deformity, lameness or amputation? 畸形、跛足、或截肢?					
j. AIDS (Acquired Immunity Deficiency Syndrome), ARC (AIDS - Related Complex), HIV positive test or any immunological disorder? AIDS(後天免疫不全症候群)、ARC、HIV 測試陽性反應、或其他免疫疾病?					
k. Allergies, lymph gland disorder, anemia or other disorder of the blood? 過敏、淋巴腺疾病、貧血或其他血液疾病?					

1. Cancer, tumor, cyst, polyp or any other malignancy? 癌症、腫瘤、囊腫、息肉、或其他惡性腫瘤?							
m. Any breast disorder, including swelling, cysts, unusual changes or lesions or any abnormal mammogram? 任何乳房疾病, 包含腫瘤、囊腫、異常改變或器官損害、或乳房 X 光攝影片異常?							
5. Within the last 12 months, have you used any product containing marijuana, tobacco or nicotine, including tobacco cessation products? If yes, what product did you consume, how much and how frequently? 在過去 12 個月內, 你是否曾使用任何含有大麻、煙草、或尼古丁之產品, 包含煙草中止產品? 如為是, 你使用何種產品? 使用份量與頻率?							
6. Do you now, or have you ever used alcoholic beverages? If so, how much and how often? Provide dates and details. 你目前或你是否曾經使用酒精飲料? 如為是, 多少且多常? 提供日期與明細.							
7. In the past 10 years, have you used: 在過去 10 年, 你是否曾經使用:							
a. barbiturates, sedatives, or tranquilizers? 巴必妥酸鹽、鎮定劑或精神安定劑?							
b. L.S.D., marijuana, cocaine, stimulants or other amphetamine? L.S.D.、大麻、古柯鹼、興奮劑、或其他安非他命?							
c. heroin, morphine or other narcotic drug? 海洛因、嗎啡、或其他毒品?							
8. Have you, within the past 5 years had a blood transfusion, tattoos or multiple body piercings? 在過去 5 年內, 你是否曾經經輸血、刺青、或在身體打洞?							
9. In the past 10 years, have you been treated for alcoholism or any drug habit? If yes, are you taking treatment, medication or counseling? 在過去 10 年內, 你是否曾因酗酒或毒品接受治療?							
11. Are you now under observation or taking treatment from any medical professional? 你目前是否正接受任何醫療專業之觀察或治療?							
12. Have you had any unexplained change in weight (5-10 lbs) within the past year? 在過去 1 年內, 你的體重是否有無法解釋之改變(5~10 磅)?							
13. Other than above, have you within the past 5 years:							
a. Had any mental or physical disorder not listed above? 有上述以外之心理或生理疾病?							
b. Had a check up, consultation, illness, injury, surgery? 進行檢查、診療、疾病、傷害、手術?							
c. Been a patient in hospital, clinic, sanatorium, or other medical facility? 為醫院、診所、療養院、或其他醫療機構之病患?							
d. Had electrocardiogram, X-ray or other diagnostic test? 進行心電圖、X 光、或其他診斷檢驗?							
e. Been advised to have any diagnostic test, hospitalization or surgery which was NOT completed? 被告知進行任何尚未完成之診斷檢驗、住院治療或手術?							
14. Are you aware of any symptoms or complaints for which you have not yet consulted a physician? 你是否發現任何症狀或身體不適, 尚未詢問醫生?							
15. Have any of your immediately family (including spouse, parents, brothers or sisters) ever been treated for: tuberculosis, diabetes, cancer (specify type), growth or other malignancy (specify type), high blood pressure, stroke, heart or kidney disease, Multiple sclerosis, Parkinson's, Lou Gehrig's Disease, Motor Neuron Disease, Alzheimer's Disease or any mental or nervous disorder, AIDS or any inherited disease? 你的任何直接親屬(含配偶、父母、兄弟姊妹、曾因下列接受治療: 肺結核、糖尿病、癌症(說明種類)、腫瘤或其他惡性腫瘤(說明種類)、高血壓、中風、心臟病或腎臟病、多重細胞硬化、帕金森氏症、運動神經疾病、阿耳滋海默氏病、或任何其他心理或神經疾病、AIDS、或任何免疫疾病?							
If yes, state family member, if cancer, specify type of cancer, and age of onset. 如為是, 請說明家庭成員, 如為癌症, 說明癌症種類及發病年齡。							
Family History 家族歷史	生	歿				16. Females only 女性填寫 a. Have you ever had any disorder of menstruation, pregnancy or of	Yes / NO 是 / 否 ( ) ( )
	年齡	健康說明	發病年齡	死亡年齡	死亡原因		

Father 父						the female organs? 你是否曾經罹患月經、懷孕、或女性器官疾病? To the best of your knowledge and belief are you now pregnant? 就你目前所知，是否懷孕?	( ) ( )
Mother 母							
Brothers 兄弟							
Sisters 姊妹							
Spouse 配偶							

I hereby declare that the foregoing answers are true and they shall be held to form part of the proposal for my life insurance with the Capital Life Insurance Company Limited.

本人聲明前述回答均屬實且視為我個人向 Capital Life Insurance Company Limited 申請之個人壽保險之一部份。

Dated this      day of      Year  
 日期\_\_\_\_\_日\_\_\_\_\_月\_\_\_\_\_年

\_\_\_\_\_  
 M.D.  
 Medical Examiner 醫療檢驗人員

\_\_\_\_\_  
 Signature of Proposed Insured 申請之被保險人簽名  
 (Applicant if Proposed Insured is under 15)  
 (若被保險人小於15歲，則由申請人簽名)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, reinsurance company, the Medical Information Bureau or other organization, institute or person, that has any records or knowledge of me or my health, to give to the Capital Life Insurance Company Limited any such information. A photographic copy of this authorization shall be as valid as the original.

本人授權任何持有我個人或我的健康紀錄或知識之職業醫師、醫療人員、醫院、診所、或其他醫療或醫療相關機構、保險公司、在保險公司、醫療資訊機構或其他組織、機構、或人員，得將該資料提供給 Capital Life Insurance Company Limited。本授權之副本其效力同正本文件。

Date  
 日期\_\_\_\_\_

\_\_\_\_\_  
 Signature of Proposed Insured  
 申請之被保險人簽名  
 (Applicant if Proposed Insured is under 15)  
 (若被保險人小於 15 歲，則由申請人簽名)

<b>Part III 第III部份 MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE</b> <b>醫療檢查人員個人填寫</b>		Name of Agent 代理人姓名	
<p>Make a careful examination of heart and lungs with stethoscope against bare skin. With some histories, findings may have particular significance. Comments regarding relevant findings should be included under "Details" below.</p> <p>以聽診器隔著皮膚表層進行心臟與肺的詳細檢查，根據經驗，若發現可能具有特殊意義，請將相關發現之意見於細節中說明。</p>			
1. Height in shoes 含鞋之身高 _____ft.(英尺)_____in.(英寸)		3 At Rest 靜態 After Exercise 運動後 3 Minutes Later 3分鐘後	
Weight without coat 不穿外套體重? _____磅 Did you measure? 你是否曾測量? _____		Pulse 脈搏: Rate 次數 Irregularities per min 每分鐘不規則	
2. Measurement-on bared skin 測量-直接接觸皮膚 Chest 胸圍 Forced 強迫                      Forced 強迫 Inspiration 吸氣 _____in. Expiration 吐氣 _____in. Abdomen 腰圍 _____in. Hip waist ratio 臀圍 _____in.		4. Blood Pressure. <b>Please Record all readings.</b> With history of hypertension or if first reading is over 135 systolic or over 85 diastolic, take two additional readings at intervals 血壓. 請紀錄所有數據. 若有高血壓歷史或第一次收縮壓超過135或舒張壓超過85, 請間隔後另外進行兩次測量。 First Reading 第一次測量      Subsequent Readings 後續測量      Is diastolic at: Disappearance 心臟舒張 消失 _____                      _____                      _____ Systolic 收縮壓                      _____                      Of all sound (Phase V)? <input type="checkbox"/> Yes 是 _____                      _____                      可聽範圍(階段V)? <input type="checkbox"/> No 否 Diastolic 舒張壓                      _____                      Of Change of Sound (Phase IV)? <input type="checkbox"/> Yes 是 _____                      _____                      音調改變(階段IV)? <input type="checkbox"/> NO 否	
5. Heart 心臟 : Is there any 是否有下列: Enlargement 擴大 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否      yspnea 呼吸困難 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Murmur(s) 雜音 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否      Edema 水腫 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 (describe below - If more than one, describe separately 說明如下-如果有一個以上, 請分別說明) Location 位置                      Indicate 說明 Constant 連續                      ( ) ( )      Apex by 高點 Inconstant 不連續                      ( ) ( ) Transmitted 傳導                      ( ) ( ) Localized 局部化                      ( ) ( )      Murmur area by 雜音區域 Systolic 心臟收縮                      ( ) ( ) Presystolic 預先收縮                      ( ) ( ) Diastolic 心臟舒張                      ( ) ( )      Point of greatest 最高點 Soft 柔軟性(Gr.1-2)                      ( ) ( )      intensity by 程度 Mod 頻率(Gr.3-4)                      ( ) ( ) Loud 聲音(Gr.5-6)                      ( ) ( ) After Exercise 運動後 ( ) ( )      Transmission by 傳送 Increased 增加                      ( ) ( ) Absent 不存在                      ( ) ( ) Unchanged 未改變                      ( ) ( )      For your comments and your impression 你的意見與感想 Decreased 減少                      ( ) ( )		Details of "Yes" answers. (identify item) 回答為是之說明(說明項目編號)	

<p>6. Is there on examination any abnormality of the following: 檢查中是否發現任何下列異常? (Circle applicable items and give details 圈選適用項目並說明細節)      是      否</p> <p>a. Eyes, ears, nose, mouth, pharynx? 眼、耳、鼻、口、咽喉?      ( )      ( ) (If vision or hearing markedly impaired, indicate degree and correction 若視覺、聽覺明顯受損, 說明程度與矯正)</p> <p>b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? 皮膚(含傷疤)、淋巴管、靜脈血管、血管末梢?      ( )      ( )</p> <p>c. Nervous System (include reflexes, gait, paralysis)? 神經系統(含反射、步伐、麻痺)?      ( )      ( )</p> <p>d. Respiratory System? 呼吸系統?      ( )      ( )</p> <p>e. Abdomen (include scars)? 腹部(含咽喉)?      ( )      ( )</p> <p>f. Genitourinary System (include prostate)? 泌尿生殖系統(含前列腺)?      ( )      ( )</p> <p>g. Endocrine System (include thyroid and breasts)? 內分泌系統(含甲狀腺及乳房)?      ( )      ( )</p> <p>h. Musculoskeletal system (include spine, joints, amputations, deformities)? 肌肉與骨骼系統(含脊椎、關節、截肢、畸形)?      ( )      ( )</p> <p>7. a. a. Are there any hernias? 是否有疝氣?      ( )      ( )</p> <p>b. Any hemorrhoids? 是否有痔瘡?      ( )      ( )</p> <p>8. Are you in any way related to Proposed Insured or agents? 你與申請之被保險人或代理是否有任何關係?      ( )      ( )</p> <p>9. Are you aware of anything about the health, habits, environment or mode of life which might unfavorably affect the insurability of Proposed Insured? If "yes", give details. (A confidential report may be sent to the Medical Director). 你是否了解任何可能影響申請被保險人保險能力之相關健康、習慣、環境、或生活模式資訊? 如為是, 請說明細節。(可能會另外寄送一份機密報告給醫療經理人)      ( )      ( )</p> <p>10. How long and how well have you known the Proposed Insured? 你已認識被保險人多長時間? 認識程度為何? _____ years 年 _____ months 月</p>			
Urinalysis: Specific Gravity 驗尿: 重大危險	Albumin 血清蛋白	Sugar 血糖	Send Specimen to Laboratory if: 下列情況, 需提供檢體給實驗室:
<p>Are you sending a portion of the specimen to the Company's authorized laboratory for microscopic analysis? 你是否正寄送檢體的一部份至公司授權的實驗室進行顯微分析?</p> <p>Yes 是( )</p> <p>No 否( )</p>			<p>(1) the applicant is over age 60; 申請人超過60歲</p> <p>(2) you detect albumin or sugar or suspect recent disease of the urinary tract; 你發覺可能罹患血清蛋白、血糖、或懷疑尿液方面疾病</p> <p>(3) there is pronounced obesity, diabetes in the family or elevated blood pressure; or 明顯過胖、家族中有糖尿病患、或血壓過高; 或</p> <p>(4) advised by the agent 經代理人告知</p>

I have carefully examined \_\_\_\_\_ this \_\_\_\_\_ day \_\_\_\_\_, Year \_\_\_\_\_ at \_\_\_\_\_ o'clock  
本人已仔細檢驗 \_\_\_\_\_ 日期 \_\_\_\_\_ 日 \_\_\_\_\_ 月 \_\_\_\_\_ 年 \_\_\_\_\_ 時間 \_\_\_\_\_

Examination was made in private at 檢驗於下列場所已私下進行  
( ) my office 我的辦公室  
( ) residence of Proposed Insured 被保險人住所  
( ) place of business of Proposed Insured 被保險人營業場所

Examination was a 檢驗為:  
( ) Complete Medical 完整檢驗      ( ) Short Medical 簡要檢驗      ( ) Para Medical 部分檢驗

After completing above, please print in block letter's (rubber stamp or type writer will suffice) name and address:  
完成上述後, 請以粗體字母填寫姓名與地址(橡皮章或打字具相同效力)

Name 姓名:

Address 地址:

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Signature of Examiner 檢驗者簽名