



請掃二維碼登入
客戶專頁，即時
辦理保單更改或
查閱進度。

https://cs.chinalife.com.hk

更改保單保障申請表 Request For Change of Policy Coverage

更改保單保障申請表



02070040100101

保單持有人姓名 Name of Policyholder	受保人姓名 Name of Insured	保單號碼 Policy No.
<input type="text"/>	<input type="text"/>	<input type="text"/>

保險中介人資料 Insurance Intermediary's Information	
保險中介人姓名 Name of Insurance Intermediary <input type="text"/>	
保險中介人編號 Insurance Intermediary's Code <input type="text"/>	聯絡電話 Contact No. <input type="text"/>

重要須知 Important Notes	
<p>1. 如申請增加附加保障，此表格必須於澳門簽署。The form MUST be signed in Macau if addition of rider(s) is applied.</p> <p>2. 本表格中所用之「本公司」或「貴公司」之表述指中國人壽保險（海外）股份有限公司。The expression “the Company” used in this form refers to China Life Insurance (Overseas) Company Limited.</p> <p>3. 只接受正本表格及本表格應以正楷填寫及由保單持有人簽名，簽名式樣須與本公司的記錄相符。保單持有人亦必須於本表格內任何曾修改的地方簽署作實。Only original form is accepted and this form is to be completed in BLOCK LETTERS and signed by the Policyholder with the signature correspond with the Company's record. Any amendments in this form must be countersigned by the Policyholder in full signature.</p> <p>4. 本公司有權隨時更新此申請表，並接受或拒絕未符合本公司要求的申請表。請登入本公司網站 www.chinalife.com.mo 瀏覽及下載最新版本。The Company reserves the right to update this form from time to time, accept or reject the form if the Company's requirements are not fulfilled. Please visit our website www.chinalife.com.mo to view and download the latest version of the form.</p> <p>5. 如申請未能符合本公司的有關規定，本公司有權拒絕有關申請。The Company shall have right to reject the application if the application fails to fulfill Company's requirement(s).</p> <p>6. 經保險中介人/分銷銀行遞交的申請，以本公司收悉有關申請文件為準。Requests submitted via insurance intermediaries/ distribution banks are subject to the Company's receipt of the relevant documents.</p>	

第一部份 更改保單保障 Part 1 Change of Policy Benefit

1.1 <input type="checkbox"/> 更改基本計劃 / 附加保障 Change of Basic Plan / Riders							
冷靜期內申請 Application Within Cooling-off Period				<input type="checkbox"/> 是 Yes	<input type="checkbox"/> 否 No		
基本計劃 / 附加保障 Basic Plan / Riders	計劃編號 Plan Code	增加附加 保障 ^a Addition of Riders ^a	刪除 ^b Deletion ^b	減低保額 / 基本 金額 ^{b, c} Reduction of Sum Assured / Basic Amount ^{b, c}	新保額 / 基本金額 (保單貨幣) ^d New Sum Assured / Basic Amount (Policy / Currency) ^d	生效時間 Effective time	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	即時 Immediate	週年日 On Anniversary Date
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

更改基本計劃/附加保障注意事項 Notes for Change of Basic Plan/Riders :

a. 申請增加附加保障必須同時填寫第三至七部分。Must complete Part 3 to Part 7 for addition of riders.

b. 在申請獲批核後，閣下將會減少 / 失去相關保障及閣下於將來或未能以相同條款獲得相若的保障。You will reduce/lose the relevant coverage of the benefit concerned after approval of the request and you may not be able to reapply for the same benefit on the same terms/conditions in future.

c. 如在冷靜期後申請減少保單基本計劃保額 / 基本金額，必須同時填寫第八部份「轉保聲明」。Must complete Part 8“Policy Replacement Declaration” if apply for Reduction of Sum Assured/Basic Amount of basic plan after the cooling-off period.

d. 新保額 / 基本金額不可少於本公司要求的最低保額 / 基本金額。如申請獲批後有任何退款，將自動存放於本保單的「暫收賬戶」內，需另行填寫「保單財務調配申請表」申請提取。The new sum assured/basic amount should not be less than the minimum sum assured/basic amount required by the Company. If any refund after approved the application, the refund will be deposited into the Pending Account and the “Request for Financial Service Form” is required to apply for withdrawal.

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第一部份更改保單保障 (續) Part 1 Change of Policy Benefit (Continued)
1.2 指定轉換醫療計劃 Designated Medical Benefit Conversion Program

 舊醫療險種代號及名稱
Old Rider Code and Name

 新醫療險種代號及名稱
New Rider Code and Name

 保單週年日期
Policy Anniversary Date

指定轉換醫療計劃注意事項 Notes for Designated Medical Benefit Conversion Program:

-必須於保單週年日前一個月內提出及遞交申請,更新保障將於下一個保單週年日生效。 Must be applied within 1 month before Policy Anniversary. The revised protection will be effective from the next Policy Anniversary Date.

1.3 刪除或減免職業額外保費/除外責任 Deletion / Reduction of Occupation Rating / Exclusions
 < 必須同時填寫及提交《更改持有人及受保人資料/職業/簽名申請表》有關更新職業的部份及遞交受僱證明。 Must complete & submit "Change of Policyholder/ Insured Personal Information/ Occupation/ Signature Form" the part relates to occupation updates and provide employment proof > .

1.4 刪除或減免健康額外保費/除外責任 Deletion / Reduction of Medical Rating / Exclusions
 < 必須填寫第七部份「健康聲明」。 Must complete Part 7 "Health Declaration">

1.5 重新申報健康狀況 Re-declaration of health information (適用於在保單 / 附加保障 / 恢復保單效力前的遺漏申報的健康狀況)
Applicable to report pre-existing health condition which was missed to declare before effective of the policy/rider(s)/policy reinstatement)
 < 必須在第七部份「健康聲明」的「詳情補充」中註明有關情況。 Must provide the details in the "Supplementary Details" of Part 7 "Health Declaration">.

第二部份 其他指示 Part 2 Other Instructions
第三部份 每月淨收入及教育程度 Part 3 Monthly Net Income and Education

 保單持有人每月淨收入
Monthly Net Income of Policyholder

MOP _____

 保單持有人教育程度
Education Level of Policyholder

 小學或以下 Primary or below
 大學或以上 University or above

 中學 Secondary
 其他 Others _____

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第四部份 職業詳情 Part 4 Occupation Details

如增加附加保障供款者免繳保費利益，必須在此部份提供受保人及保單持有人的有關資料。Must provide the information on Insured and Policyholder in this part if Payor Benefit Rider is applied.

	受保人 Insured	保單持有人 Policyholder
職業 Occupation		
業務性質 Nature of Business		
高空工作 Work at Height	<input type="checkbox"/> 否 No <input type="checkbox"/> 是 Yes 最高 maximum height _____ 米 M	<input type="checkbox"/> 否 No <input type="checkbox"/> 是 Yes 最高 maximum height _____ 米 M
重型機械操作 Heavy Machine Operation	<input type="checkbox"/> 否 No <input type="checkbox"/> 是 Yes _____ 請註明(Please specify)	<input type="checkbox"/> 否 No <input type="checkbox"/> 是 Yes _____ 請註明(Please specify)

第五部份 投保履歷 Part 5 Insurance History

如僅增加附加保障供款者免繳保費利益或免繳保費利益，無需填寫此部份問題。This part is not required to complete if only Payor Benefit Rider or Waiver of Premium Benefit is applied.

受保人是否持有或正在申請任何保險公司的人壽、危疾、醫療或意外保障？若是，請填妥下表。Does the Insured have in force or currently applying for life, critical illness, medical or accident insurance with any insurance company? If Yes, please complete the table below. 是 Yes 否 No

承保公司名稱 Name of Insurance Company	簽發年份 Year Issued	保障額 Sum Assured (澳門元 MOP)			
		人壽保障 Life Insurance	危疾保障 Critical Illness	住院入息保障 Hospital Income	意外保障 Accident Coverage
總保障額 Total Sum Assured					

第六部份 家庭狀況 Part 6 Family Details

必須在此部份提供受保人的有關資料，如申請增加附加保障供款者免繳保費利益，則必須同時提供保單持有人的有關資料。Must provide the information on Insured in this part. If Payor Benefit Rider is applied, the information on Policyholder is also required.

1	閣下的親生父母、兄弟姊妹中曾否有死於或患有心臟病、中風、高血壓、糖尿病、腎病、多發性硬化症、精神病、肝炎(或肝炎帶菌)、癌症或任何遺傳疾病？如有，請在下表註明患病或死亡年齡、關係及原因。Have any of your natural parents, brother(s) or sister(s) died or suffered from heart disease, stroke, high blood pressure, diabetes mellitus, kidney disease, multiple sclerosis, mental disease, hepatitis (or is a hepatitis carrier), cancer or any other hereditary diseases? If Yes, please provide details of onset/death age(s), relationship and cause of death or condition(s) in the table below.	受保人 Insured	保單持有人 Policyholder																								
		<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No																								
		<table border="1"> <thead> <tr> <th rowspan="2">關係 Relationship</th> <th colspan="2">受保人 Insured</th> <th colspan="2">保單持有人 Policyholder</th> </tr> <tr> <th>疾病 Disease</th> <th>病發 / 死亡年齡 Onset/Death Age</th> <th>疾病 Disease</th> <th>病發 / 死亡年齡 Onset/Death Age</th> </tr> </thead> <tbody> <tr> <td>父親 Father</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>母親 Mother</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>兄弟姊妹 Sibling(s)</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		關係 Relationship	受保人 Insured		保單持有人 Policyholder		疾病 Disease	病發 / 死亡年齡 Onset/Death Age	疾病 Disease	病發 / 死亡年齡 Onset/Death Age	父親 Father					母親 Mother					兄弟姊妹 Sibling(s)				
關係 Relationship	受保人 Insured		保單持有人 Policyholder																								
	疾病 Disease	病發 / 死亡年齡 Onset/Death Age	疾病 Disease	病發 / 死亡年齡 Onset/Death Age																							
父親 Father																											
母親 Mother																											
兄弟姊妹 Sibling(s)																											
2	(a) 受保人的父母是否擁有人壽或危疾保險(適用於17歲或以下)？如是，請在下表註明。Does the Insured's parent(s) have in force life or critical illness insurance (for age 17 or below)? If Yes, please complete the table below.	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No																									
	(b) 受保人的配偶是否擁有人壽或危疾保險(適用於家庭主婦)？如是，請在下表註明。Does the Insured's spouse have in force life or critical illness insurance (for homemaker)? If Yes, please complete the table below.	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No																									
		2(a) 父 Father	2(b) 母 Mother																								
		2(c) 配偶 Spouse																									
	人壽保險金額 Life Insurance Amount (MOP)																										
	危疾保險金額(HK\$) Critical Illness Insurance Amount (MOP)																										

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第六部份 家庭狀況 (續) Part 6 Family Details (CONTINUED)

3	閣下曾否於過去十二個月內或打算在未來十二個月內在澳門以外居留超過六個月 (旅遊除外)? 如是, 請在下表註明國家、城市、原因及時間。Have you resided or intended to reside outside Macau for more than 6 months during the last 12 months or in the coming 12 months (except for Holiday)? If Yes, please state the country, city, reason(s) and duration in the table below.		受保人 Insured	保單持有人 Policyholder
			<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
		受保人 Insured	保單持有人 Policyholder	
	國家及城市 Name of Country and City (請列出所有 Please state all)	<input type="checkbox"/> 中國城市 City in China (不包西藏自治區 / 新疆維吾爾自治區 / 青海省 excluding Tibet Autonomous Region/Xinjiang Uygur Autonomous Region/Qinghai) <input type="checkbox"/> 澳門 Macau <input type="checkbox"/> 其他 Others _____	<input type="checkbox"/> 中國城市 City in China (不包西藏自治區 / 新疆維吾爾自治區 / 青海省 excluding Tibet Autonomous Region/Xinjiang Uygur Autonomous Region/Qinghai) <input type="checkbox"/> 澳門 Macau <input type="checkbox"/> 其他 Others _____	
	逗留原因 Reason of Stay			
	時間(月數) Duration Month(s)			

第七部份 健康聲明 Part 7 Health Declaration

必須在此部份提供受保人的有關資料, 如申請增加附加保障供款者免繳保費利益, 則必須同時提供保單持有人的有關資料。Must provide the information on Insured in this part. If Payor Benefit Rider is applied, the information on Policyholder is also required.		受保人 Insured	保單持有人 Policyholder
1	(a) 閣下的身高? Your height?	_____ 公分 cm	_____ 公分 cm
	(b) 閣下的體重? Your weight?	_____ 公斤 kg	_____ 公斤 kg
	(c) 過去一年內, 閣下的體重曾否有 5 公斤或 11 磅以上的增減? 若有, 請說明原因。Has your weight changed more than 5kgs/11 lbs in the past year? If Yes, please state the reason.	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(d) 閣下曾否在過去三個月的任何時間內持續超過一星期有下列病徵: 疲倦、體重下降、腹瀉、淋巴核腫大或不尋常的皮膚潰瘍? Have you at any time in the past 3 months had any of the following symptoms for more than 1 week continuously: fatigue, weight loss, diarrhea, enlarged lymph nodes or unusual skin lesions?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
2	在過去 12 個月內閣下曾否吸煙? 若有, 請填寫下列問題。 In the past 12 months, have you ever smoked? If Yes, please complete below questions	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(a) 每日平均吸煙多少支? Average number of pieces daily?	_____ 支 Piece(s)	_____ 支 Piece(s)
	(b) 吸煙已有多少年? For how many years have you smoked?	_____ 年 Year(s)	_____ 年 Year(s)
3	閣下曾否服用成癮藥物, 或慣常飲啤酒、餐酒、烈酒或曾接受與服用藥物或飲酒相關的治療或輔導? 如有, 請註明種類及用量。Have you ever taken any habit forming drugs or used beer, wine or spirits regularly or been treated or advised in connection with your alcohol consumption or taking of drugs? If Yes, please state the type and quantity.	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
4	閣下曾否患有, 或獲告知患有, 或曾接受下列疾病之治療 Have you ever had or been told you had, or been treated for the following diseases?		
	(a) 肺結核病、哮喘、吐血、呼吸困難、或任何呼吸系統或肺部疾病? Tuberculosis, asthma, blood spitting, shortness of breath, or any respiratory or lung disease?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(b) 心悸、胸痛、高血壓病、貧血、任何心臟、血液或血管疾病? Palpitation, chest pain, high blood pressure, anaemia, any disease of the heart, blood or blood vessels?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(c) 腸胃潰瘍、經常消化不良、疝氣、癰管、痔瘡、胃、胰、腸、黃疸、或任何肝病 (包括肝炎帶菌)、膽囊、消化系統之疾病? Gastro intestinal ulcer, recurrent indigestion, hernia, fistula, piles, stomach, pancreas, intestine, jaundice or any disease of liver (including hepatitis carrier), gall bladder or digestive system?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(d) 尿糖、尿蛋白、泌尿系統結石、性病、腎臟或前列腺疾病、或其他生殖泌尿系統之病症? Urinary sugar/albumin/stones, venereal disease, or diseases of the kidney, prostate, reproductive or urinary system?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(e) 腦癇症、抽搐、昏暈、嚴重頭痛、精神病或精神不安、任何腦部或神經系統不正常或疾病? Epilepsy, seizure, fainting spells, severe headache, mental or nervous condition, any disease or abnormality of the brain or nervous system?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(f) 癌症、腫瘤/不正常的生長物、囊腫、任何透過性接觸傳染的疾病、糖尿病、甲狀腺腫大、其他內分泌疾病或嚴重受傷? Cancer, tumor /abnormal growth, cyst, any sexually transmitted disease, diabetes, goitre, any endocrine disease or severe injury?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No

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第七部份 健康聲明 (續) Part 7 Health Declaration (Continued)			
必須在此部份提供受保人的有關資料。如申請增加附加保障供款者免繳保費利益，則必須同時提供保單持有人的有關資料。Must provide the information on Insured in this part. If Payor Benefit Rider is applied, the information on Policyholder is also required.		受保人 Insured	保單持有人 Policyholder
4.	(g) 感官疾病或功能失常(如眼、鼻、喉、耳或口腔之疾病) Disease or disorder of the sense organ(s) (e.g. disorder of the eyes, nose, throat, ears or oral cavity)?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(h) 風濕性發熱、關節炎、痛風或肌肉及骨骼疾病 (如關節或骨骼疾病)、結締組織或皮膚疾病或任何未在上述各項提及之疾病? Rheumatic fever, arthritis, gout or disorder of musculoskeletal system (e.g. joint or bone), connective tissues or skin disorder, or any other disorder not mentioned?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
5	在過去五年內，閣下曾否 In the past five years, have you ever		
	(a) 接受過或被建議進行診斷檢驗，如 X 光、心電圖、電腦掃描、超聲波、尿液、特殊血液檢驗及健康檢查? Had or had been advised to take any diagnostic test(s), such as X Ray, ECG, CT scan, ultrasound, urine, special blood test or physical check-up?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(b) 患有疾病、接受過手術、就診/治療或留醫等而未在上述各項提及者? Had any illness, operation, medical consultation/treatment or hospitalization not mentioned above?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(c) 其他健康狀況或病徵及症狀(例如腫塊、頭痛、持續咳嗽、胸痛或上腹痛) 而正在或打算尋求醫療意見。Other medical conditions or sign and symptom (such as lump, headache, persistent coughing, chest pain or epigastric pain) that you are seeking or intend to seek medical advice	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
6	閣下目前是否正接受藥物治療或醫療護理或是否有可預見或打算進行之醫生囑咐、診症或治療? 或閣下是否有慣常求診的醫生/家庭醫生? 若是，請註明醫生姓名及地址。 Are you currently receiving medical treatment or under medical care of any kind or do you have any expected need or intention of receiving medical advice, consultation or treatment? Or do you have regular doctor or family doctor? If Yes, please state the name and address of the doctor and reason(s) of medical consultation(s).	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
7	閣下曾否接受或打算接受任何有關愛滋病或愛滋病綜合病徵之醫生囑咐、輔導或治療，或曾被通知患有上述提及之疾病? 或閣下的配偶是否曾患有愛滋病或其綜合病徵? Have you ever received or do you intend to receive any medical advice, counseling or treatment in connection with AIDS, or any AIDS related conditions, or been told you had the above-mentioned disease? Or has your spouse suffered from any AIDS related condition?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
8	閣下是否曾或有此意圖參與任何攀山、跳傘、潛水、危險性運動、賽事或並非以乘客身份乘搭固定班次的民航客機? 如有，請填寫有關之問卷。 Have you ever engaged in any mountaineering, sky diving, scuba diving, hazardous sports, racing or flying other than as a fare-paying passenger on a regularly scheduled airline or do you have any intention to do so? If Yes, please complete the appropriate questionnaire.	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
9	閣下在過去投保或申請復效人壽、危疾、意外或醫療保險時，曾否被拒絕、延期、加費或被修改? 如有，請填寫原因、投保公司名稱、投保日期及保單號碼。 Has any application for or reinstatement of life, critical illness, accident or medical insurance on you been declined, postponed, rated-up or accepted with modified terms? If Yes, please provide the reason, name of insurance company, application date and policy number.	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
10	只適用於十二歲或以上之女性 For Female aged 12 or above only		
	(a) 閣下現在是否懷孕? 如是，請告知懷孕週數。 Are you pregnant now? If Yes, please state pregnancy duration.	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
	(b) 閣下曾否有乳房或生殖器官疾病或產前產後之併發症、月經失調或柏氏宮頸抹片不正常? Have you had any disorder of the breast or reproductive organs, or prenatal or postnatal complication, menstrual disorders or abnormal pap smears?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
11	只適用於十七歲或以下之未成年人士 For Juvenile aged 17 or below only		
	(a) 閣下是否早產 37 週或以下 或過期出生? 出生後有否接受特別護理? Was your birth premature (37 weeks or below) or post mature? Any special care needed after birth?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	不適用 Not Applicable
	(b) 閣下是否有身體缺陷、生理上或心智發育緩慢的跡象? Have you had any physical defects or shown any sign of slow physical or mental development?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	

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第七部份 健康聲明 (續) Part 7 Health Declaration (Continued)

詳情補充 Supplementary Details

若「健康聲明」問題答案為「是」或有任何補充，請在此欄提供詳細資料並註明所屬部份及題號。如下列空位不夠使用，請填寫「要保補充陳述書」。如閣下曾進行身體檢查、化驗或入院接受治療，請提供相關之覆診預約紙、身體檢查及化驗報告之副本作參考。

If any answer to "Health Declaration" is Yes or any supplementary information, please give full particulars below and quote the relevant section and question number. If space given is insufficient, please complete a "Supplementary Information Form". Please provide copies of appointment slip and investigation reports for review if there are any physical check-up, laboratory test or hospitalization history.

題號 Question No.	詳情 Details 包括患病 / 受傷日期、患病 / 受傷持續時間、發病次數及病情、診斷結果、曾接受的治療、檢查種類及其結果、最後覆診日期等 Including dates of illness/injury, duration, number of attacks, severity of illness/injury, diagnosis, type of treatment or investigation received and their results, last follow-up date etc.	康復程度 (如適用) Degree of Recovery (If applicable)	主診醫生 / 醫院名稱及地址 (如適用) Name & Address of Attending Doctor/Hospital (If applicable)

第八部份 轉保聲明 Part 8 Policy Replacement Declaration

注意事項 Notes :

如在冷靜期後申請減少保單基本計劃保額 / 基本金額，請填寫此部分。Please complete this part if you apply for reducing the sum assured/basic amount of basic plan after the cooling-off period.

閣下是否使用或打算使用此人壽保險保單的部分或全部資金，或使用或打算使用通過減少此人壽保險保單的應付保費而節省的金額，以資助閣下於過去或其後 12 個月內新申請的人壽保險保單（如有）？例如，該等資金或金額可能來自從閣下將此人壽保險保單在冷靜期後通過減低此人壽保險保單基本計劃的保額 / 基本金額而節省的保費。如是，該等情況將被視為「轉保」。Are you using or do you intend to use some or all of the funds arising from the above-mentioned policy, or any savings made by reducing the premium payable under the above-mentioned policy, in order to fund the new life insurance policy (if any) which is purchased within 12 months prior or follow to the date of this application? For example, such funds or savings may arise from reducing the premium payable of the above-mentioned policy by reducing the basic plan sum assured/basic amount of the policy after the cooling-off period. If yes, such conditions will be considered as Policy Replacement.

是 Yes

否 No

註 Notes :

「轉保」可能令閣下帶來實質及潛在損失。為保障閣下的權益，請仔細比較現有保單與新保單的條款，衡量轉保是否符合本身的最佳利益。閣下應尋求專業意見以了解相關風險及轉保的不利後果。並細閱澳門金融管理局網站 www.amcm.gov.mo 瀏覽《人壽保險轉保指引》法則及指引以了解有關詳情。You may suffer loss in case of "Policy Replacement". To protect your interest, you should carefully consider your existing and the new insurance policies and assess whether the Policy Replacement is in your best interests before making a decision. You should seek professional advice to understand the associated risks and potential disadvantages of Policy Replacement. For details, please visit the AMCM website at www.amcm.gov.mo to read the guidelines titled, "GUIDELINES FOR LIFE INSURANCE REPLACEMENT".

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第九部份 聲明及授權 Part 9 Declaration and Authorization

本人 / 我們現申請辦理上述之更改事項，謹此聲明並確認所有提供之資料及細節是準確無誤，真實及為事實之全部，並且是盡本人 / 我們所知及所信而作答的。本人 / 我們並同意此等更改事項或服務必須符合下列所有條件及經貴公司批准，方能生效。I/We hereby request the above change(s) be effected and declare that all statement, information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief and no material information has been withheld in relation to this request. I/We agree that such change(s) or service(s) will not take effect unless all of the following conditions are met and approved by the Company:

1. 所有需要之款項及文件已提交予貴公司並由貴公司收受。All required payment and documents have been submitted to the Company and duly received by the Company.
2. 此項申請在受保人在生並仍然符合受保條件時，經貴公司接納及批准。The request is accepted and approved by the Company during the lifetime and continued insurability of the Insured.
3. 在此申請表及貴公司所須之其他文件上填報之一切資料及申報，將成為此保單之一部份（除非另有其他指示）。The information and statement made in this request and in other documents as required by the Company shall form the basis for this policy alteration request and form a part of the policy(ies) unless otherwise specified.
4. 貴公司將以書面或附註形式通知此申請被接納。Acceptance of the request for change shall be confirmed by the Company in writing or endorsement.
5. 本人 / 我們提供符合貴公司要求之有效證明文件（例如：身分證及地址證明）予貴公司，讓貴公司能按照於「預防及打擊透過保險活動清洗黑錢及資助恐怖主義的操作指引」法規所載，對本人/我們、保單之最終實益擁有人(如有)及本人/我們之授權簽署人士(如適用)進行客戶盡職審查。I/We provide valid documentation proofs (such as identity document and address proof) to the satisfaction of the Company for the Company to conduct due diligence on myself/ourselves, the ultimate beneficial owner of the policy (if any) and my/our authorized signatory(ies) (if applicable) pursuant to the "Guidelines on Prevention and Combating Money Laundering and Financing of Terrorism in Insurance" Ordinance.

本人 / 我們謹此代表本人及所有受保人同意及授權：I/We hereby agree and authorize on behalf of myself and/or the Insured that:

1. 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構，或其他機構、組織或人士、凡知道或持有任何有關本人及受保人或任何一位受保人之紀錄者，及 / 或曾診驗或可能將會診驗本人及任何一位受保人者，均可將該等資料提供給貴公司。Any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of me/the Insured and who has attended or may hereafter attend myself/the Insured to disclose such information to the Company.
2. 貴公司或任何其指定之醫生或化驗所，可就此保單更改申請替本人及任何受保人進行所需之醫療評估及測試，作為審核本人及任何受保人之健康狀況。此授權對本人之繼承人及受讓人具有約束力；即使本人死亡或無行為能力時，此授權仍具效力。本授權影印本與正本均有同等效力。The Company or any of its appointed medical examiners or laboratories may perform the necessary medical assessment and tests to evaluate the health status of myself/the Insured in relation to this Application. This authorization shall bind my successors and assignees and remain valid notwithstanding my death or incapacity. A photocopy of this authorization shall be as valid as the original.

第十部份 個人資料收集聲明 Part 10 Personal Information Collection Statement

本人/我們確認已閱讀及明白貴公司的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於 www.chinalife.com.mo 下載或向貴公司索取。I/We confirm that I/we have read and understood the Personal Information Collection Statement (" PICS") of the Company. For the latest version of the PICS, it can be downloaded from www.chinalife.com.mo or is made available upon request to the Company.

第十一部分聲明及簽署 (請勿在空白表格上簽署) Part 11 Declarations and Signature (Please DO NOT sign on BLANK form)

1. 本表格必須於保單持有人簽署日起計 30 天內交至本公司辦理手續。This form must be received by the Company within 30 days from the sign date of Policyholder.
2. 若保單持有人或受保人以圖章蓋印簽署，必須有一位見證人，見證人必須為年滿 18 歲或以上的第三者。見證人之個人資料只會用於處理本申請及確認本表格簽署人的身份之用。If the Policyholder or Insured uses a signature chop, a witness is required. The witness must be an individual third party aged 18 or above. The personal particulars of the witness will only be used for the purpose of verification and confirmation of the identity of the signatory of this form.

本人 / 我們謹此確認已閱讀及明白以上申請內的所有內容、條款及條件並同意受該等內容、條款及條件約束。本人 / 我們謹此同意作出以上協議及聲明。I/We hereby confirm that I/we have read and understood all the content, terms and conditions of the above request, and agree to be bound by those content, terms and conditions. I/We hereby agree to make the above agreements and declarations.

	保單持有人 Policyholder			受保人 (倘非保單持有人及 18 歲或以上) Insured (if different from the Policyholder & aged 18 or above)			受讓人 (如適用) Assignee (if applicable)			見證人 (如適用) Witness (if applicable)		
	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day
簽署及 / 或公司印鑑 Signature and/or Company Chop												
姓名 Name												
身份證明文件號碼 Identity Document No.												
日期 Date												

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所需文件指引 Documents Checklist

服務申請類別 Type of Service Request	所需文件(請✓閣下已提交的文件) Documents Required (Please ✓ against the documents you submitted)	
	保單持有人 Policyholder	
增加附加險 Addition of Riders	<input type="checkbox"/>	身份證明文件核實副本 Verified copy of identification document
	<input type="checkbox"/>	身體檢查或化驗報告之副本(如適用) Copy of physical examination report or laboratory report (if applicable)
指定轉換醫療計劃 Designated Medical Benefit Conversion Program	<input type="checkbox"/>	身份證明文件核實副本 Verified copy of identification document
刪除或減免職業額外保費/除外責任 Deletion / Reduction of Occupation Rating /	<input type="checkbox"/>	身份證明文件核實副本 Verified copy of identification document
	<input type="checkbox"/>	《更改持有人及受保人資料/職業/簽名申請表》“Change of Policyholder/ Insured Personal Information/ Occupation/ Signature Form”
	<input type="checkbox"/>	受僱證明 Employment proof
刪除或減免健康額外保費/除外責任 Deletion / Reduction of Medical Rating / Exclusions	<input type="checkbox"/>	身體檢查或化驗報告之副本(如適用) Copy of physical examination report or laboratory report (if applicable)
重新申報健康狀況 Re-declaration of health information	<input type="checkbox"/>	身體檢查或化驗報告之副本(如適用) Copy of physical examination report or laboratory report (if applicable)