



 中國人壽 | 海外
CHINA LIFE

保單編號 Policy No.

[illegible]

受保人身份證/ 護照號碼 I.D. / Passport No. of Insured

保險中介名稱 Name of Insurance Intermediary

保險中介編號 Insurance Intermediary Code

聯絡電話 Contact No.

- 請以正楷填寫本申請表。任何資料如有更改，保單受益人/索償人必須在更改的位置簽署作實。Please complete this form in BLOCK LETTERS. All amendments should be endorsed by the Beneficiary / Claimant in full signature.
- 本申請表中所用之「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 expressions “the Company” or “our Company” used in this form refers to China Life Insurance (Overseas) Company Limited.
- 本申請表第一部分和第二部分必須由保單受益人/索償人填寫。Part I and Part II of this form must be completed by Beneficiary/Claimant
- 除簡易投保的保單外，若受保人身故時，自保單生效日或保單最後恢復效力當日起計不足兩年(以較後的日期為準)，則必須由受保人的主診醫生填寫本申請表第三部分-「主診醫生報告書」。Apart from simplified underwriting policy, if the death of Insured occurs within 2 years after the policy is issued or reinstated (whichever is later), Part III of this form - Attending Physician's Statement must be completed by the Attending doctor of Insured.
- 如保單受益人/索償人領取賠償款項時尚未達到法定的成人年齡，則需要受益人/索償人的監護人或信託人簽署收據領取身故賠償款項。Where a Beneficiary/Claimant is a minor in law at the time when receiving the death benefit, the guardian or trustee of the Beneficiary/Claimant must collect the death benefit and sign the receipt thereof.
- 如保單受益人/索償人為十八歲或以上，保單受益人/索償人必須親自填寫及簽署本申請表。若保單受益人/索償人為十八歲以下，本申請表應由受益人/索償人之家長或合法監護人填寫及簽署。如保單受益人/索償人因傷殘不能書寫，其直系親屬可代為填寫本申請表及簽字，並提供醫生證明。If the Beneficiary/Claimant is at or above age 18, the Beneficiary/Claimant must complete and sign this form by his or her good self. If the Beneficiary/Claimant is under age 18, this form should be completed and signed by the Beneficiary/Claimants' parent or legal guardian. In the event that the Beneficiary/Claimant is physically incapacitated and prevented from signing, this form may be completed and signed by an immediate family member with relevant physician's statement provided.
- 若保單受益人/索償人以圖章蓋印簽署，必須由一位見證人予以見證。見證人之個人資料只會用於處理本索償申請及核實和確認本申請表簽署人的身份之用。If the Beneficiary/Claimant uses a signature stamp, it must be witnessed by a witness. The personal particulars of the witness will only be used for the purpose of processing this claim and verifying and confirming the identity of the signatory of this form.
- 若保單受益人/索償人多於一位，則每位保單受益人/索償人必須分別填寫及簽署一份本申請表。If there is more than one Beneficiary / Claimant, a separate Death Claim Form must be completed and signed by each Beneficiary/Claimant.
- 保險中介人或銀行營業員收到本申請表並不代表本公司已收到。Receipt of this form by your Insurance Intermediary or bank officer does not constitute receipt by the Company.
- 如有任何查詢，請與 閣下的保險中介人聯絡或致電本公司客戶服務熱線(853) 2859 5519 查詢。填妥的表格及所需文件請寄往澳門新口岸宋玉生廣場 263 號中土大廈 22 樓 A、B、K-P 座。If you have any queries, please feel free to contact your insurance intermediary or our Customer Service Hotline at (853) 2859 5519 for details. Completed form(s) and required document(s) should be sent to China Life Insurance (Overseas) Co. Ltd., Alameda Dr. Carlos D' Assumpção No. 263, 22 Andar A, B, K-P, Edif. China Civil Plaza, Macau.
- 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 has the right to update this form from time to time and to accept or to 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.
- 如中英文版本有任何抵觸或不符之處，概以中文版本為準。If there is any discrepancy or inconsistency between the English version and the Chinese version of this form, the Chinese version shall prevail.



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第一部份 – 索償資料 (由受益人/索償人填寫)

PART I – PARTICULARS OF CLAIM (To be completed by Beneficiary/Claimant)

A. 受保人資料 INFORMATION OF THE INSURED

1	年齡及性別 Age and Sex							
2	身故時職業 Occupation at death							
3	出生日期 Date of Birth	年 Year			月 Month		日 Day	
	出生地點 Place of Birth							
4	身故日期 Date of Death	年 Year			月 Month		日 Day	
	身故地點 Place of Death							

B. 如因病身故，請提供下列資料: IF DEATH WAS DUE TO AN ILLNESS, PLEASE STATE:

1	請描述症狀 Please describe symptoms & abnormalities			
2	受保人何時最先發現或表示有該致死疾病 When did the Insured first appear or give indications of his/her fatal illness?			
3	受保人何時因相關疾病開始求診? When did the Insured first consult physician for the related illness?			
4	請列出受保人在身故前五年內曾經求診之醫院或醫務人員之姓名及地址 Name and address of all physicians who had treated the Insured or all hospitals or institutions where he had treated during the last five years preceding death.			
醫生名稱 Name of physician	地址 Address	日期 Date 年 Year 月 Month 日 Day	求診原因 Reasons for consultation	

C. 如因意外或其他事故導致身故，請提供下列資料: IF DEATH WAS DUE TO ACCIDENT OR OTHER CAUSE, PLEASE STATE:

1	意外或事故發生日期及時間 Date and time of the accident or incident	年 Year		月 Month		日 Day		時 Hour		分 Minute		上/下午 AM/PM
	意外或事故發生地點 Location of the accident or incident											
2	事發原因及經過和結果(如有新聞剪報，請附上)。Circumstances of the accident. (Please attach newspaper clippings if available)											
3	閣下有否報警？如有，請提供以下資料 Did you report to the police? If yes, please provide the following information											
		警署地點 Police Station				檔案編號 Case Reference No.						
<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No												

註：請附上警察報告/交通意外報告/口供紙/酒精測試報告影印本。

Remarks: Please attach a photocopy of the Police Report / Traffic Accident Report / Police Statement / Alcohol Test Report.

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D. 其他資料 OTHER INFORMATION

- 1 閣下有否因同一事故曾/將會向其他保險公司索償？如是，請提供該保險公司名稱及保單號碼。 Did/Will you make a claim against any other insurance company for the same incident? If yes, ☐ 是 Yes ☐ 否 No
please indicate the name of insurance company and policy no..

保險公司名稱 Name of Insurance Company

保單號碼 Policy No.

E. 領款方式(請選擇一種理賠支付方式) PAYMENT METHOD (Please select only one of the settlement options)

1. 自動入賬申請 Direct Credit Application

請提供賬戶證明文件，如印有賬戶持有人姓名/名稱及賬戶號碼的銀行卡/月結單/存摺。倘未有足夠資料顯示銀行賬戶持有人為保單受益人/索償人或因故未能成功自動入賬，有關款項將以劃線支票形式發出。 Please provide bank account document(s), such as bank card/monthly statement/ passbook with account holder name and account no. If there is insufficient information to identify the ownership of bank account belongs to Beneficiary/Claimant or direct credit is failed for any reason, the payment will be issued by cheque.

本人/我們現申請以上理賠匯款方式領取金額，並同意銀行於匯款中扣除相關手續費 (如有)

I/We agree to apply the captioned Claims Remittance Service and bank charge would be deducted from the payment amount. (If applicable)

- ☐ 至保單保單受益人/索償人於本公司指定的澳門開立銀行戶口 To a bank account set up in Macau designated by the company held by the Beneficiary/Claimant

銀行名稱 Name of Bank

銀行編號 Bank

分行編號 Branch No.

銀行賬戶號碼 Account No.

No.

賬戶持有人姓名(中文) (必須為保單受益人/索償人)

Name of bank account holder (Chinese) (Beneficiary/Claimant Only)

賬戶持有人姓名(英文) (必須為保單受益人/索償人)

Name of bank account holder (English) (Beneficiary/Claimant Only)

2 本地銀行劃線支票 MACAU LOCAL CROSSED CHEQUE

賠款貨幣選擇 Preferred Settlement Currency

- ☐ 保單貨幣 Policy Currency ☐ 港幣(按中國人壽保險(海外)股份有限公司每月之固定兌換率計算)
Hong Kong Dollar (at monthly fixed rate of China Life Insurance (Overseas) Company)
- ☐ 親自到客戶服務中心提取 Collect Cheque at Customer Service Centre in person
(請保單受益人/索償人帶同身份證明文件親臨本公司的澳門客戶服務中心收取支票。) (The Beneficiary/Claimant should collect the cheque at our Macau Customer Service Centre by presenting the identity document.)

- ☐ 授權第三者(代領人)領取 Pick up cheque in person by authorized person

代領人姓名

Name of authorized person

代領人聯絡電話

Contact no. of authorized person

代領人身份證明文件號碼

I.D. no. of authorized person

- ☐ 支票寄往本人於本申請表第二部份問題 9 填寫之地址 Mail cheque to the address filled in question 9 of Part II in this form

- ☐ 經保險中介轉遞 Deliver via Insurance Intermediary

- ☐ 經銀行營業員轉送 (請指定銀行分行及經辦人員) Deliver by bank officer (Please state the branch and bank officer)

銀行分行 Branch

經辦人員 Bank Officer

3 其他方式 Other Methods

- ☐ 其他(請列明) Others (Please specify)

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第二部份 – 索償人資料 (由受益人/索償人填寫)

PART II – INFORMATION OF THE CLAIMANT (to be completed by the Beneficiary/Claimant)

1 稱謂 (先生/太太/女士/小姐) Title (Mr/ Mrs/ Ms/ Miss)

性別 Gender

2 中文姓名 Name in Chinese

3 英文姓名 Name in English

姓氏 Last Name

名字 First Name

4 a 職業 (必須填寫)
Occupation (Compulsory)4 b 行業 (必須填寫)
Business (Compulsory)

5 出生日期 Date of Birth

年 Year

月 Month

日 Day

出生國家 Country of Birth

6 國籍 / 地區 Nationality / Region

☐ 中國 Chinese☐

美國 U.S.

☐

其他 Others(請註明 please specify)

7 與受保人關係 Relationship to the Insured

8 ☐ 澳門永久居民身份證/香港身份證號碼 Macau Permanent ID Card/HKID Card No.☐ 非澳門永久居民身份證：身份證/護照號碼 Non-Macau ID Card: ID Card / Passport No.

簽發國家/地區 Issue Country/Region

☐ 商業組織註冊編號 Business association Registration No.

簽發國家/地區 Issue Country/Region

9 目前居住地址(個人) / 目前營業地址(商業組織)*Current Residential Address(Individual) / Current Business Address(Business association)*

城市 City

國家 Country

10 目前永久地址(個人) / 於成立地方之註冊辦事處地址(商業組織)* (如與目前居住地址(個人)/目前營業地址(商業組織)不同) Current Permanent Address (Individual)/Registered Office Address in the Place of Incorporation (Business association)* (if different from Current Residential Address (Individual)/Current Business Address (Business association))

城市 City

國家 Country

國家號 Country Code

電話號碼 Telephone No.

11 電話號碼 Telephone No.

12 手電號碼 Telephone No.

13 電郵地址 Email Address

14 閣下是否有委任合法之代表或律師? Have you appointed a legal representative/solicitor? 如有, 請註明代表人之姓名地址及電話。 If so, please provide the full name, address and contact no of the representative.

☐ 有 Yes☐ 沒有 No

姓名 Full Name

地址 Address

電話 Contact No.

15 閣下以何名義索償? In what capacity or title are you claiming this insurance?

☐ 指定受益人 Designated Beneficiary☐

受托人 Trustee

☐

遺產承辦人 Estate Administrator

☐

受讓人 Assignee

16 閣下是否美國公民或美國稅務居民(見備註)? Are you a U.S. Citizen or a U.S. tax resident (See Note)?

☐ 是 Yes TIN No.☐ 否 No

索償所需文件清單 CLAIM DOCUMENT CHECKLIST

✓ 基本文件 Basic Documents ; ● 附加文件 Additional Documents	
索償所需文件(文件的核實副本可於本公司的客戶服務中心辦理) Claim Document (Documents can be certified at our Company's Customer Service Centre)	身故賠償 Death claim
<input type="checkbox"/> 保單正本 / 保單遺失聲明書 (如未能提供保單正本) Original Policy / Policy Lost Declaration (if unable to provide original policy)	✓
<input type="checkbox"/> 由受益人/索償人填妥並簽署之本申請表第一及第二部分 Part I & Part II of this form completed and signed by Beneficiary / Claimant	✓
<input type="checkbox"/> 由受保人之主診醫生填寫並且簽署及蓋印之本申請表第三部分# Part III of this form completed and signed by the attending physician of Insured with chop#	●
<input type="checkbox"/> 死亡登記之敘述證明(核實副本) Registration of Death (Certified True Copy)	✓
<input type="checkbox"/> 死亡證明書(核實副本) Death Certificate (Certified True Copy)	✓
<input type="checkbox"/> 死亡簡報(核實副本) Death Report (Certified True Copy)	●
<input type="checkbox"/> 受保人之身份證明文件(Copy) ID of Insured (Copy)	✓
<input type="checkbox"/> 受益人之身份證明文件(核實副本) ID of Beneficiary (Certified True Copy)	✓
<input type="checkbox"/> 受保人之澳門身份證註銷證明文件(核實副本)^ Cancellation of Macau ID confirmation note from Immigration Department (Certified True Copy) ^	●
<input type="checkbox"/> 受保人與受益人之關係證明(核實副本) Relationship Proof between the Insured and Beneficiary (Certified True Copy)	✓
<input type="checkbox"/> 受益人之地址證明(核實副本) Address Proof of Beneficiary (Certified True Copy)	✓
<input type="checkbox"/> 稅務信息交換之自我證明表格(理賠適用) Self Certification Form(For Claims) for Automatic Exchange of Financial Account Information (CRS)	✓
<input type="checkbox"/> 死亡公證書(核實副本)* Notarial Certificate of Death (Certified True Copy)*	✓
<input type="checkbox"/> 戶籍註銷證明(核實副本)* Household Certificate Cancelled (Certified True Copy)*	✓
<input type="checkbox"/> 死亡醫學證明書(核實副本)* Medical Certificate for Cause of Death (Certified True Copy)*	✓
<input type="checkbox"/> 喪葬證明(核實副本)* Funeral and Cremation Proof (Certified True Copy)*	✓
<input type="checkbox"/> 意外事故/警察調查報告 Accident / Police Investigation Report (意外身故適用 For accidental death)	✓
<input type="checkbox"/> 信托文件(核實副本) (如監護人紙) Trustee Documents (Certified True Copy) (e.g. certificate of guardianship)	●
<input type="checkbox"/> 遺產管理書 / 遺囑認證書(核實副本) Letters of Administration / Grant of Probate (Certified True Copy)	●
<input type="checkbox"/> 驗屍/解剖報告 Autopsy Report	●
<input type="checkbox"/> 門診及住院病史 Clinical or Hospital Records	●
<input type="checkbox"/> 公安報告 Police Report	●

#適用於非簡易投保的保單 或 生效或復效不足兩年的個案 #For death occurs within 2 years after the policy is issued or reinstated or non-simplified underwriting policy

^適用於澳門居民在境外出險個案 ^For HK resident but event occurred overseas

*適用於中國內地出險個案 *For event occurred in Mainland

聲明、授權及簽署 DECLARATION, AUTHORIZATION AND SIGNATURE

A. 客戶確認符合《外國帳戶稅收遵從法案》和其他適用法律 CUSTOMER ACKNOWLEDGE REGARDING COMPLIANCE WITH FOREIGN ACCOUNT TAX COMPLIANCE ACT AND OTHER APPLICABLE LAWS

閣下認知本公司須遵從，遵守或履行法律、法規、命令、指引、守則和包括《海外帳戶稅收合規法案》適用規定的要求，或任何公眾、司法、稅務、政府和 / 或其他監管機構等協定的要求，包括但不限於美國國稅局 (以下簡稱「監管機構」) 在不同的司法管轄區不時頒布及修訂的協定 (以下簡稱「適用規定」)。在這方面，閣下同意本公司可以在任何時候完全酌情採取任何相關行動，包括但不限於向任何監管機構透露閣下的個人資料，以確保本公司遵行適用規定。

You acknowledge that the Company shall be obliged to comply with, observe or fulfill the requirements of the laws, regulations, orders, guidelines, codes, and requirements including the applicable requirements under the Foreign Account Tax Compliance Act or agreements with any public, judicial, taxation, governmental and/or other regulatory authorities, including without limitation, the U.S. Internal Revenue Service (the "Authorities" and each an "Authority") in various jurisdictions as promulgated and amended from time to time (the "Applicable Requirements"). In this connection, you agree that the Company may at any time take any relevant actions as may be determined by the Company in its sole and absolute discretion which including but not limited to disclose your particulars to any Authority for the purpose of ensuring the Company's compliance or adherence with the Applicable Requirements.

客戶同意向第三方披露資料

Customer consent to disclose information to third parties

A. 客戶確認符合《海外帳戶稅收合規法案》和其他適用法律(續)CUSTOMER ACKNOWLEDGEMENT REGARDING COMPLIANCE WITH FOREIGN ACCOUNT TAX COMPLIANCE ACT AND OTHER APPLICABLE LAWS(Continued)

閣下同意本公司可能將根據適用規定的要求，向任何監管機關披露閣下的個人資料或任何資料。此等披露可以由本公司直接或通過中國人壽保險（集團）公司或中國人壽保險（集團）公司的其他成員進行。基於前述的原因，以及儘管在本表格或我們之間的任何其他協議所載的任何內容，本公司可能需要閣下向本公司提供進一步資料，以便向任何監管機關透露，而閣下必須在合理要求的時間（由提出申請或知會變更資料的 90 日期天）內，向本公司提供相關的資料。

You agree that the Company may disclose your particulars or any information to any Authority in connection or adherence with the Applicable Requirements. Such disclosure may be effected directly or sent through any of the China Life Insurance (Group) Company or other affiliates of the China Life Insurance (Group) Company. For the purposes of the foregoing and notwithstanding anything contained in this form or any other agreements between us, the Company may need you to provide the Company with further information as may be required for disclosure to any Authority and you shall provide the same to the Company within such time as may be reasonably required (Within 90 calendar days from the date of the application or information change).

儘管載於本表格或我們之間任何其他協議所包含的任何內容，閣下同意向本公司提供協助，使本公司能夠就閣下遵行適用規定下的義務。

就閣下任何在申請時或其他時間向本公司提供的任何資料，閣下同意及時（30 日期天之內）向本公司提供更新資料。尤其重要的是閣下立即通知本公司下列的更新：若閣下是個人，閣下的個人身份號碼、地址、電話、國籍、稅務狀況或稅籍所在地的變動；閣下擁有多於一個國家的稅籍；若閣下是法團法人或任何其他類型的實體，閣下的註冊地址、業務營運地址、主要股東、法定及實際受益人或管理人（擁有或控制 10% 或以上股份或所有權或管理權的人士）、稅務狀況、稅籍所在地的變動，或若閣下擁有多於一個國家的稅籍。若發生這些變動，或任何其他資料顯示發生了變動，本公司可能會要求閣下提供額外文件或資料。此等資料和文件包括但不限於正式完成及 / 或簽署（並且如有需要，由公證人作出公證）的稅務申報或表格。

如果閣下未能及時向本公司提供資料或文件，或閣下所提供所需的資料或文件並非最新、準確或完整，為確定本公司持續遵從適用規定，閣下同意本公司可以完全酌情決定隨時採取任何相關行動以確保本公司遵從適用法律及法規的要求。

Notwithstanding anything contained in this form or any other agreements between us, you agree to provide the Company with such assistance as may be necessary to enable the Company to comply with the Company's obligations under all Applicable Requirements concerning you or your policies with the Company. You agree to update the Company in a timely manner (within 30 calendar days) of any change of any of the details previously provided to the Company whether at time of application or at any other times. In particular, it is very important that you notify the Company immediately if, where you are an individual, your personal identification numbers, addresses, telephone numbers, nationality, tax status or tax residency changes or if you become tax resident in more than one country, or, where you are a corporation or any other type of entity, your registered address, address of your place of business, substantial shareholders, legal and beneficial owners or controllers (who own or control 10% or more of your shares or ownership interest or control), tax status, tax residency changes or if you become tax resident in more than one country. If any of these changes occurs or if any other information comes to light concerning such changes, the Company may need to request additional documents or information from you. Such information and documents include but are not limited to duly completed and/or executed (and, if necessary, notarized) tax declarations or forms. If you do not provide the Company with the information or documents requested in a timely manner or if any information or documents provided are not up-to-date, accurate or complete you agree that the Company may take any relevant actions at any time as may be determined by the Company in its sole and absolute discretion to be required to ensure compliance with the applicable Laws and Regulations on the part of Company.

備註：如上述第二部份資料顯示受益人可能是美國公民或美國稅務居民 1 及/或可能與美國有關聯 2，受益人需填妥將由本公司發出的確認書，連同所需的美國稅務自我聲明書（如：W-9、W-8BEN 或同等文件）及相關證明文件（如適用）一併呈交予本公司。如受益人為組織機構，除前述文件之外，受益人另需填妥並遞交「補充陳述書 - 適用於要保人/受益人/索償人/受託人為組織機構」及「補充陳述書 - 適用於個人股東」（如適用）。

1 美國稅務居民指的是美國綠卡持有人（即美國合法永久居民）或滿足實質居住測試（即他/她於本納稅年內已在美國逗留至少 31 天和三年內在美國逗留至少 183 天在(含本納稅年度及過往兩年))。

- 三年內在美國逗留日數計算方法 = 本年實際居住在美國日數 + 1/3 去年居住在美國的日數 + 1/6 前年居住在美國的日數 2 與美國有關聯的資料包括但不限於：出生國家為美國 3、電話號碼為美國號碼、郵寄或永久地址為美國地址、客戶提供美國郵政信箱或轉交地址或代存地址、客戶授予擁有美國地址的人代理權或簽名權、常設指示將資金轉入位於美國的帳戶、任何與美國相關的資訊等。

3 若受益人的出生國家為美國，但聲明為非美國公民或美國稅務居民，除 W-8BEN 之外，受益人需提供美國以外國家或地區簽發的護照副本，或政府簽發可證明非美國公民或美國稅務居民身份的任何身份證明文件的副本，及喪失/放棄美國籍之證明文件副本。

Notes: If the information provided in Part II indicates that the Beneficiary may have become a U.S. Citizen or a U.S. tax resident¹ and/or the Beneficiary may have links to the U.S.², the Beneficiary is required to complete and return a confirmation letter which shall be posted by the Company, along with a U.S. tax self-certification form (e.g. W-9, W-8BEN or an equivalent form) and relevant supporting documents (if applicable) to the Company. If the Beneficiary is an Entity, the Beneficiary is required to complete and submit the "Supplementary Information Form – Applicable to Entity Applicant/Beneficiary/Claimant/Assignee" and "Supplementary Information Form – Applicable to Individual Shareholder" (if applicable) in addition to the aforementioned documents.

1 U.S. tax resident refers to U.S. Green Card holder (i.e. U.S. lawful permanent resident) or individual who meets the substantial presence test (i.e. he/she has been present in the U.S. for at least 31 actual days in the current tax year and 183 equivalent days during a three year period (including current year and the two prior years)). - Equivalent days = Actual days in the U.S. in the current year + 1/3 of his days in the U.S. in the immediately preceding year + 1/6 of his days in the U.S. in the second preceding year.

2 Information that has a U.S. link, included but not limited to: a U.S. place of birth³, a U.S. telephone number, a U.S. correspondence or permanent address, a U.S. P.O. box address, a U.S. "in-care-of" or "hold mail" address, a power of attorney or signatory authority granted to a person with a U.S. address, standing instructions to make payments to accounts maintained in the U.S., any U.S. related information, etc.

3 If the Beneficiary's place of birth is U.S., but declared that he/she is not a U.S. Citizen or a U.S. tax resident, apart from filing in W-8BEN, the Beneficiary is required to provide a copy of non-U.S. passport or government issued identification document evidencing non-U.S. citizenship or Tax resident, AND a Certificate of Loss of Nationality of U.S.

為遵循 FATCA 及相關的本地法規，本人/我們同意貴公司提供本人/我們的個人資料予美國或相關的本地司法、稅務或其他監管機構，以確保貴公司遵行 FATCA 或適用規定。亦明白本人/我們需回答本申請表的所有問題及於 90 日期天內將所需的稅務自我聲明書及相關證明文件（如適用）一併交予貴公司，否則貴公司須按規定將本人/我們列為不合規帳戶，並可能向美國國稅局彙報。

Pursuant to FATCA or applicable local laws, I/we hereby consent to the Company to report my/our personal data to the U.S. or applicable local regulators or tax authorities where necessary in order to comply with FATCA or applicable local laws and understand that I/we need to answer all questions in this form and return the required tax self-certification form and relevant supporting documents (if applicable) to the Company within 90 calendar days. Otherwise, the Company may report my/our account to the IRS as a Non-Consenting U.S. Account in compliance with the FATCA regulations.

B. 個人資料收集聲明 PERSONAL INFORMATION COLLECTION STATEMENT

聲明和授權：本人 / 我們確認本人/我們已閱讀並明白中國人壽 (海外)股份有限公司的收集個人資料聲明。本人 / 我們特此確認並同意公司根據本聲明使用和移轉本人/我們的個人資料，包括為直接促銷之目的使用和提供本人 / 我們的個人資料。本人/我們已取得在此申請提供第三方資料 (如有) 所需的同意。本人 / 我們確認並同意為本聲明中所述之目的將本人 / 我們的個人資料移轉至澳門境外給本聲明所述的承轉人的類別。有關最新版本的收集個人資料聲明，可於 <https://www.chinalife.com.mo/zh-hant/personal-information-collection-statement> 下載或向中國人壽 (海外) 股份有限公司索取。

重要提示：請於以下簽署部份簽名，以示閣下同意。若閣下不同意根據“為直接促銷目的而使用個人資料”部份所述為直接促銷之目的而使用和提供閣下的個人資料，請在以下方格劃上 ☒ 號。

Declaration and authorization: I/We acknowledge and confirm that I/we have read and understood the Personal Information Collection Statement of China Life Insurance (Overseas) Company Limited. I/We hereby give my/our acknowledgement and agree to the use and transfer of my/our personal data by the Company in accordance with the PICS, including the use and provision of my/our personal data for the purpose of direct marketing. I/We have obtained the consent to provide the third party information (if any) in this application. I/We acknowledge and consent to the transfer of my/our personal data outside of Macau for the purposes and to the types of transferee as set out in the PICS. For the latest version of the personal information collection statement, it can be downloaded from <https://www.chinalife.com.mo/zh-hant/personal-information-collection-statement> or is made available upon request.

Important: Please indicate your agreement by signing on the space provided below. If you do not agree to the use and provision of your personal data for direct marketing as set out in the section “Use of personal data in direct marketing”, please tick the box below.

☐ 本人 / 我們不同意根據以上收集個人資料聲明 (參閱 “為直接促銷目的而使用個人資料” 部份) 為直接促銷之目的而使用和提供本人 / 我們的個人資料，亦不希望接收任何推廣及直接促銷材料。

I / We do not agree with the use and provision of my / our personal data for direct marketing purposes as set out above in the Personal Information Collection Statement (see “Use of personal data in direct marketing”) and do not wish to receive any promotional and direct marketing materials.

D. 聲明及授權 DECLARATION AND AUTHORIZATION**授權 Authorization**

本人，保單受益人/索償人，代表本人及尚未成年之受益人/索償人(如有)及受保人謹此授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、政府部門，或其他機構、組織或人士、凡知道或持有任何有關本人/我們/受保人之紀錄、認識或資料者，均可將該等資料提供、發放及轉交給貴公司； (2) 貴公司或任何其指定之醫療/輔助醫療檢查員或化驗所，可就本索償申請替本人/我們/受保人進行所需之醫療評估及測試，作為審核本人/我們/受保人之健康狀況。此授權對本人/我們/受保人之繼承人及授讓人具有約束力；即使本人/我們/受保人死亡或無行為能力時，此授權書仍具效力。此授權書的影印本與正本均有同等效力。I, the Beneficiary/Claimant, represent me/the Beneficiary/Claimant under 18 years old (if any)/the Insured HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that is aware of or has any records, knowledge or information of me/us/the Insured to disclose, release and transfer such information to the Company; ; (2) the Company or any of its appointed medical / para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ourselves/the Insured in relation to this claim. This authorization shall bind the successors and assignees of me/us/the Insured and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

聲明 Declaration

本人，保單受益人/索償人，謹此聲明及同意(1)上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所信，均為事實之全部並確實無訛； 本人明白倘未知任何一項是否重要，本人均須將其事實在本申請表上說明；(2)本人對任何人所作出之任何聲明，除在本申請表上填寫或印出及經 貴公司發表和批准外，貴公司不須受其約束。若相關人士不能提供任何本申請表所需的資料，貴公司可能因此不能審核及處理本償申請。I, the Beneficiary/Claimant, HEREBY DECLARE and AGREE that (1) all the foregoing statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true; I also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. (2) The Company is not bound by any statement which I may have made to any person unless it is written or printed here and is presented and approved by the Company. If any relevant persons fail to provide any information requested in this claim form, it may result in the Company's inability to process and deal with this claim.

E. 簽署(請勿在空白表格上簽署) SIGNATURE (Please DO NOT sign on BLANK form)

	受益人/索償人 Beneficiary/Claimant			見證人 Witness		
簽署 Signature						
姓名 Name						
身份證/護照號碼 I.D. Card / Passport No.						
日期 Date	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day

保單編號 Policy No.

第三部份 – 主診醫生報告書 (由主診醫生填寫, 所有費用由索償人自行承擔)

PART III – ATTENDING PHYSICIAN'S STATEMENT (To be completed by attending physician at the Claimant's own expenses)

A. 死者資料 PARTICULARS OF DECEASED

死者姓名 Name of Deceased	身份證/護照號碼 I.D / Passport No.		
身故時報稱住址 Deceased's Address at time of death			
身故時報稱職業 Occupation at the time of death	最後工作日期 Last date of working	年 Year	月 Month
		/	/
			日 Day
身故地點 Place of death	身故日期 Date of death	年 Year	月 Month
		/	/
			日 Day
身故原因 Cause of death			

是否已經或將會進行驗屍？如有，請提供解剖驗屍日期和報告副本。Whether an autopsy report will be or has been done? If so, please provide the date and a copy of autopsy report.

☐ 沒有 No ☐ 不確定 Uncertain ☐ 有,日期 Yes, date

年 Year 月 Month 日 Day

/ /

B. 診治信息 CONSULTATION INFORMATION

1 閣下為死者診症多久了？ How long have you been the medical physician for the Deceased?	
2 首次診治診斷結果及日期 Diagnosis and Date of your first visit	診斷 Diagnosis
	年 Year 月 Month 日 Day
	/ /
3 閣下有否替死者診治與其身故原因相關之最後疾病？ Had you attend the deceased during his/her last illness related to the cause of death?	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No

C. 由意外導致身故 DEATH CAUSED BY ACCIDENT

1 意外日期和時間 Date and time of accident	年 Year	月 Month	日 Day	時 Hr	分 Min	上/下午 AM/PM
	/	/		:		
2 意外地點及詳情 Place and Details of accident						

D. 由疾病導致身故 DEATH CAUSED BY ILLNESS

1 死者最後疾病的診斷結果及首次求診日期 The first treatment date of the for the last illness	診斷 Diagnosis	年 Year	月 Month	日 Day
		/	/	
2 死者最後疾病在求診前已存在多久？ How long did the deceased suffer from the last illness before seeking medical treatment?				
3 治療摘要 Medical Treatment Summary				
4 死者是否經由其他醫生或醫院轉介？如有，請說明詳情。 Had the Deceased been previously referred by other Physician / Hospital? If so, please specify details.	<input type="checkbox"/> 沒有 No <input type="checkbox"/> 有, 醫生姓名/醫院名稱 Yes, Name of Physician / Hospital			

5 身故原因是否與舊病復發或其他慢性/嚴重疾病有關？如有，請說明詳情。Was the cause of death secondary to a recurrent or other chronic / critical condition? If so, please specify details.

☐ 沒有 No ☐ 有 Yes 首次求診 First consultation 年 Year 月 Month 日 Day
首次徵狀出現 Symptom onset 年 Year 月 Month 日 Day

疾病 Disease

治療/住院詳情 Details of Treatment / Hospitalization

醫生姓名/醫院名稱 Name of Physician/Hospital

6 死者是否因以下原因，直接或間接引致或加劇死亡？Was the Deceased's death directly or indirectly due to or aggravated by the following?

☐ 不是 No ☐ 是，請在適當的位置上剔號及提供詳情 Yes, please tick where it is appropriate and give details

☐ 家族病史 unfavorable family health history

☐ 先天 / 遺傳性情況 congenital / inherited condition

☐ 酗酒 / 酒精 / 毒品 / 藥物
alcoholism / alcohol / narcotics / drugs

☐ 後天免疫力缺乏症 / 與後天免疫力缺乏症相關的綜合症
AIDS / AIDS related complex disease

☐ 精神紊亂 mental disorders

☐ 妊娠 / 分娩 pregnancy / childbirth

☐ 參與危險性運動 / 活動 / 職業
engaging in hazardous sport / activity / occupation

☐ 自殺 / 自我傷害 suicide / self-inflicted

☐ 中毒 / 氣體 / 濃煙 (自願或非自願) poison / gas / fumes (voluntarily or involuntarily)

☐ 如有其他，請說明: others, please specify:

E. 其他醫療病史 OTHER MEDICAL HISTORY

1 死者的飲酒/吸煙習慣 Details of drinking & smoking habit of the deceased

每日用量 (支/包/樽/罐) Daily consumption (piece/ pack/ bottle/ can)

習慣始自 Drinking/ Smoking start date since 年 Year 月 Month 日 Day

2 死者之死亡是否由飲酒之習慣促成？Did the drinking habit contribute to the death of the Deceased?

是 Yes 否 No

☐ ☐

3 死者之死亡是否由吸煙之習慣促成？Did the smoking habit contribute to the death of the Deceased?

☐ ☐

4 死者是否有使用藥物之習慣？如有，請陳述藥物之類別，每日用量及以維持多少年。Did the Deceased use of any drugs? If yes, please state the type of drugs used and also the no. of years of this habit.

☐ ☐

每日用量 Daily consumption

藥物類別 Type of drugs

用藥始自 Using drugs start date since

年 Year 月 Month 日 Day

5 請詳述其他直接或間接導致死者身故之特殊因素，包括死者之其他習慣及其職業。Please state any other special cause, direct or indirect, for the death in the habits or occupation of the Deceased.

6 其他閣下認為可幫助我們審理此賠償之資料。Any further information which, in your opinion, will assist us in assessing this claim.

F. 主診醫生資料 PARTICULARS OF ATTENDING PHYSICIAN

主診醫生姓名 Name of Attending Physician		資歷 Qualification	
地址 Address		聯絡電話 Contact No.	
主診醫生簽署/醫院蓋章 Signature & Stamp of Attending Physician/ Hospital		日期 Date	年 Year 月 Month 日 Day