保單資料更改申請表 (III) Request for Change of Policy Information Form (III)
(適用於更改繳費方式 / 給付方式 / 保單保障 / 恢復保單效力)
(Applicable for Change of Payment Mode / Payment Options / Policy Coverage / Reinstatement)

CSM-CHG03

7032000301

保單號碼 Policy No. | | | | | | | | | | |

請以**正楷**填寫本表。任何資料如有更改，保單持有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 Policyholder in full signature.
本表中所用之「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 expression "the Company" used in this form refers to China Life Insurance (Overseas) Company Limited

第一部份 保單資料 Part 1 Policy Information

受保人姓名 Name of Insured (選擇性填寫 Optional)

姓 Last name　　名 First name

保單持有人姓名 Name of Policyholder

姓 Last name　　名 First name

請選擇適當之空格☑ Please tick the relevant box(es)

第二部份 更改繳費方式 Part 2 Change of Payment Mode

☐ 年繳 Annual
*於下一週年日起生效,
Effective from the next Anniversary Date

☐ 半年繳 Semi-Annual
*於週年日或週年日後第七個月起生效,
Effective from the seventh or the Anniversary Date

☐ 季繳 Quarterly
*於週年日或週年日後第四、七或十個月起生效,
Effective from the Anniversary Date, the fourth, the seventh or the tenth month

☐ 月繳* Monthly
* 請遞交自動轉賬授權書及2 個月保費一併遞交
Please submit a Direct Debit Authorization Form with 2 months premium payment

Please submit the original policy

☐ 預繳保費***Pre-paid Premium
*** 請連同預繳保費計劃書及銀行入數紙一併遞交
Please submit a pre-paid premium proposal together with bank-in payment receipt

第三部份 自動轉賬指示# Part 3 Autopay Instruction#

☐ 取消自動轉賬指示 Cancel Autopay Instruction　　☐ 恢復自動轉賬指示 Reactivate Autopay Instruction

自動轉賬指示會於本公司收到及接受申請後生效。在本公司收到及接受申請前所繳交的保費將不獲退還。
Autopay instruction will be effective only after your request is accepted and completed successfully by the Company. Any premium paid prior to the Company's approval of the request will not be refunded.

第四部份 更改給付方式 Part 4 Change of Payment Options

紅利 Dividend	可支取現金 Cash Coupon	年金 Annuity
☐ 提取現金 Cash payment	☐ 提取現金 Cash payment	☐ 提取現金 Cash payment
☐ 積存生息 Accumulation with Interest	☐ 積存生息 Accumulation with Interest	☐ 積存生息 Accumulation with Interest
☐ 抵付保費 Premium Payment	☐ 抵付保費 Premium Payment	☐ 抵付保費 Premium Payment

*當「提取現金」申請生效後,該/該等保單賬戶內的所有累積款項會即時被全數領取
ALL accumulated amount in the related policy account/accounts will be withdrawal immediately when the change of Cash Payment

保單號碼 **Policy No.** | | | | | | | | | | |

第五部份 更改保單保障 Part 5 Change of Policy Benefit

☐ **更改保額 / 附加保障## Change of Sum Assured / Riders##**
如申請增加附加保障，請填寫"第七部份 健康聲明"。
Please fill in "Part 4 Health Declaration", if you apply for new riders.

生效日期^ Effective Date^
^如申請即時生效，請連同銀行入數紙一併遞交
Please submit bank-in payment receipt if you apply for rider addition with immediate effect.

基本計劃 / 附加保障 Basic Plan / Riders	計劃編號 Plan Code	增加* Addition	刪除 Deletion	減額 Reduction	新保額 / 保費 New Sum Assured / Premium	即時生效 With Immediate Effective	週年日生效 Effective on Anniversary Date
1.		☐	☐	☐		☐	☐
2.		☐	☐	☐		☐	☐
3.		☐	☐	☐		☐	☐
4.		☐	☐	☐		☐	☐
*教育程度 Education Level	☐ 小學或以下 Primary or below ☐ 中學 Secondary ☐ 大學或以上 University or above ☐ 其他 Others _____						
*每月淨收入 Monthly Net Income	MOP						

☐ **刪除或減免因健康所附加的額外保費 / 除外責任### Deletion / Reduction of Medical Rating / Exclusions**
☐ **重新申報資料 / 健康狀況### (請詳細說明) Declaration of information / Health (Please state in details)**
請填寫"第七部份 健康聲明"。Please fill in "Part 7 Health Declaration".
☐ **恢復保單效力 Policy Reinstatement (須補繳逾期保費及利息 Please submit sufficient arrears premiums plus interest)**

注意：Notes:
1. 保單持有人可於保單失效兩年內申請恢復保單效力，若保單失效超過兩年，則即告終止。
Policyholder can apply for policy reinstatement for those policy(ies) lapsed within two years. Policy(ies) shall be terminated if lapsed more than two years.
2. 請填寫 "第七部份 健康聲明"。
Please fill in "Part 7 Health Declaration"

第六部份 其他指示 Part 6 Other Instruction

第七部份 健康聲明 Part 7 Health Declaration

+ 如申請恢復保單效力而保單內附有「供款者免繳保費利益保障」(PB)，或申請增加所述之附加險，保單持有人須填寫此部份。
Policyholder should complete this section if PB is attached for reinstatement or if PB is applied.

		受保人 Insured	+ 保單持有人 Policyholder
1.	身高及體重 Height and Weight	公分 cm 公斤 kg	公分 cm 公斤 kg
2.	過去 12 個月內，閣下的體重是否曾經增加/減少？請注明原因。 Any gain or loss of your weight in the past 12 months? Please specify the reason(s). 原因 Reason(s)：_____	增 / 減 Gain / Loss 公斤 kg	增 / 減 Gain / Loss 公斤 kg
3.	職業 Occupation		
4.	業務性質 Nature of Business		
5.	(a) 高空作業 Work at Height (請註明 please specify) ： 最高 max height _____米/m	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
	(b) 重型機械操作 Heavy Machinery Operation： (請註明 please specify) _____	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
6.	在過去 12 個月內閣下有否吸煙？如「有」，請填寫下列問題： In the past 12 months, have you ever smoked? If "yes", please complete below questions：	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
	(a) 每日平均吸煙多少支 Average number of pieces daily?	_____ 支/天 pieces/day	_____ 支/天 pieces/day
	(b) 吸煙已有多少年 How many years have you smoked?	_____ 年 years	_____ 年 years
7.	閣下的家屬中曾否有人患癌症、精神病、糖尿病、心血管病或任何遺傳疾病？ Have your family members ever had cancer, mental disease, diabetes mellitus, cardiovascular diseases and any other inherited diseases?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No

保單號碼 **Policy No.** | | | | | | | | | | |

8.	閣下曾否使用任何可成癮藥物、吸毒、酗酒或曾接受戒毒或戒酒治療？ Have you ever used habit forming drugs or narcotics or alcohol excessively or been treated for drug or alcoholism?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
9.	閣下是否患有先天性缺陷疾病，例如先天性心臟病、腦發育不全等？ Have you ever had congenital disease such as congenital heart disease, abnormal brain development, etc?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
10.	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：		
	(a) 肺結核病、呼吸系統或肺部疾病？ Tuberculosis, respiratory or lung disease?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
	(b) 風濕性心臟病、血壓病、胸痛、心臟、血液或血管疾病？ Rheumatic heart disease, high blood pressure, chest pain, any disease of the heart, blood or blood vessels?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
	(c) 腸胃潰瘍、肝或膽囊或消化器官之疾病？ Gastro-intestinal ulcer, disease of liver, gall-bladder or digestive organs?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
	(d) 腎石或任何生殖泌尿系統病症？ Renal stones or any reproductive urinary disease?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
	(e) 癲癇或任何精神病或神經不正常？ Epilepsy, or any mental or nervous disorder?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
	(f) 癌症、腫瘤、任何透過性接觸傳染的疾病、糖尿病、其他內分泌疾病或嚴重受傷？ Cancer, tumor, any sexually transmitted disease, diabetes, any endocrine disease or severe injury?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No

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

11.	在過去五年內，閣下曾否 In the past 5 years, have you ever：		
	(a) 接受過或被建議進行診斷檢驗，如 X 光、心電圖、特殊血液檢驗及健康檢查？Had or been advised to take any diagnostic test(s), such as X-Ray, ECG, special blood test or body check-up?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 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?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
12.	閣下目前是否正接受藥物治療或醫療護理？ Are you currently receiving medical treatment or under medical care of any kind?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
13.	閣下是否有可預見或打算進行之醫生囑咐、診症或治療？ Do you have any expected need or intention of receiving medical advice, consultation, or treatment?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
14.	閣下曾否接受或打算接受任可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？ 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?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
15.	閣下曾否被通知在愛滋病毒抗體測驗中呈陽性反應？ Have you ever been told you had positive reaction in AIDS test?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
16.	閣下曾否在過去三個月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 anytime 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?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
17.	閣下曾否被通知因身體不適而接受任何檢查或治療未在上述各項提及？ Have you ever received any medical check-up or treatment due to illness which is not mentioned in the above?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
18.	只適同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.	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 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？ Have you had any disorder of the breast or reproductive organs, or prenatal or postnatal complication?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No
19.	閣下過去有否因疾病、意外、受傷而提出或獲得過任何賠償？ Have you ever made a claim or received any compensation for illness, accident or injury?	☐ 有 Yes ☐ 無 No	☐ 有 Yes ☐ 無 No

若上方任何問題答案為“是”或“有”者，請註明題號，並詳述診治醫生，醫院名稱、地址，求診日期，檢查項目，診斷結果及接受何種治療及檢驗結果。
For each “Yes” answer in the above questions, please indicate the question number and provide details including name and addresses of all attending physicians or hospitals, dates and duration, diagnosis, treatment and result.

保單號碼 **Policy No.** | | | | | | | | | | |

第八部份 聲明及授權 Part 8 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：

1. 所有需要之款項及文件提交予 貴公司並完整無缺。
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。
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)
4. 貴公司將以書面或附註形式通知此申請被接納。
5. 本人/我們提供符合 貴公司要求之有效証明文件(例如：身分證明及地址證明)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)進行客户盡職審查。

本人/我們謹此代表本人及所有受保人同意及授權：

1. 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構，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。
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。本授權書的影印本與正本均有同等效力。

本人/我們聲明及同意已獲所有受保人授權及同意本人作出上述授權。

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 approve by the Company.

1. All required payment and complete supporting documents have been submitted to the Company.
2. The request is accepted and approved by the Company during the lifetime and continued insurability of the Insured.
3. 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. Acceptance of the request for change shall be confirmed by the Company in writing or endorsement.
5. 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 Prevent ion and Combating Money Laundering and Financing of Terrorism in Insurance" Ordinance.

I/We hereby agree and authorize on behalf of myself and/or the Insured that:

1. 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. 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.

I/We declare and agree that I/we have the full authority from and consent of the Insured to make the above authorizations.

第九部份 簽署 Part 9 Signature

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。見證人之個人資料只會用於處理本申請及確認本申請表簽署人的身份之用。
If the Policyholder or Insured uses signature chop, the witness is required. 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.

受保人簽署 (倘非保單持有人及 18 歲或以上) Signature of Insured (if different from the Policyholder & aged 18 or above)	日期 _____ / _____ / _____ Date 日/DD 月/MM 年/YYYY
保單持有人簽署 Signature of Policyholder	日期 _____ / _____ / _____ Date 日/DD 月/MM 年/YYYY
受抵人簽署 (如適用) Signature of Assignee (if applicable)	日期 _____ / _____ / _____ Date 日/DD 月/MM 年/YYYY
見證人簽署 Signature of Witness 見證人姓名及身份證明文件號碼 Name and Identity Document Number of Witness	日期 _____ / _____ / _____ Date 日/DD 月/MM 年/YYYY

保單號碼 **Policy No.** | | | | | | | | | | |

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中國人壽（海外）股份有限公司的收集個人資料聲明("本聲明")。有關最新版本的收集個人資料聲明，可於 www.chinalife.com.mo 下載或向中國人壽（海外）股份有限公司索取。

I/We confirm that I/We have read and understood the Personal Information Collection Statement ("PICS") of China Life Insurance (Overseas) Company Limited. For the latest version of the PICS, it can be downloaded from www.chinalife.com.mo or is made available upon request.

重要提示：請於下文空白處簽名，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，請在下文空格處劃上「✓」號。

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 data in direct marketing", please tick the box below.

☐ 本人不同意根據以上**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的個人資料，亦不希望接收任何推廣及直接促銷材料。
I do not agree with the use and provision of my personal data for direct marketing purposes as set out above in the **Personal Information Collection Statement** (see "Use and provision of personal data in direct marketing") and do not wish to receive any promotional and direct marketing materials.

保單持有人簽署 Signature of Policyholder	日期 _____ / _____ / _____ Date 日/DD 月/MM 年/YYYY

註：Remarks:

1. 此表格必須於簽署後 30 天內交至本公司客戶服務中心辦理，方為有效。2. 請勿在空白表格上簽署。

1. The application form must be submitted to our Customer Service Centre within 30 days from the sign date. 2. Please do not sign on blank form.

只適用於保險中介人 For Insurance Intermediary Use Only

保險中介人姓名 Name of Insurance Intermediary	聯絡電話號碼 Contact Telephone Number	職場編號 Branch Code	保險中介人編號 Insurance Intermediary Code
只適用於銀行 For Bank Use Only			
銀行職員姓名 Name of Bank Staff	聯絡電話號碼 Contact Telephone Number	分行編號 Branch Code	保險中介人編號 Insurance Intermediary Code
只供內部使用 For Internal Use Only			
覆核員 Checked by	記錄員 Recorded by	簽名校對員 Signature Verified by	備註 Remarks

[此頁無其他內容]

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