# 更改保單申請書
# REQUEST FOR CHANGE OF POLICY PARTICULARS

| 保單號碼 **Policy Number** | 持有人姓名 **Name of Owner** | 受保人姓名 **Name of Insured** |
|---|---|---|
| 保險中介人姓名<br>**Insurance Intermediary's Name** | 保險中介人編號<br>**Insurance Intermediary's Code** | 中介人聯絡電話<br>**Insurance Intermediary's Tel. No.** |

**注意事項 Important Notes**

1. 本申請表應由保單持有人及/或受保人或受抵人以正楷填寫及簽名，簽名式樣須與保單上的記錄相符。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。
   This form is to be completed by the Policyholder and/or Insured or Assignee in BLOCK LETTERS and signed with the signature same as recorded in the policy file. All amendments should be endorsed by the Policyholder in full signature.

2. 如閣下未能符合本公司的有關規定，本公司有權拒絕閣下的申請。
   We shall have right to reject your application if you fail to fulfill Company's requirement(s).

3. 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 a signature chop, a 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.

4. 本申請將於(1)本公司收到此申請並記錄在案和(2)本公司發出批單或書面的確認函後才生效。
   This application shall take effect upon (1) this request is received and recorded by the Company and (2) the Company confirms in writing by issuing an endorsement or a letter.

5. 請勿在空白表格或尚未填妥的表格上簽署。
   Please do not sign on blank or incomplete form.

6. 請簽署本申請表後30 天內交回中國太平人壽保險(香港)有限公司處理。
   Please return to China Taiping Life Insurance (Hong Kong) Company Limited within 30 days after signing this form.

7. 甲部及乙部之條款 ： 申請需於受保人及持有人在生期間提出並獲本公司接受。
   In respect of Part A & Part B: This request may only be made and accepted by the Company during the life time of BOTH the Insured and the Owner

8. 已付款並不保證此申請可即時生效。申請復效/增加附加契約/更改基本保險計劃/增加保額/刪除不保事項/刪除額外保費(以適用者為準)，需於本公司收妥相關文件，包括但不限於健康證明書及全數保費，並獲本公司接納及批准受保人的健康現況證明，及其他所需要求後，方為正式生效。本公司保留權利撤銷任何申請。
   Payment does not guarantee immediate approval of the application. The reinstatement/addition of rider/change of plan /increasing sum assured/removal of exclusion/removal of medical rating, whichever is applicable, will only become effective when we receive the relevant documents, including but not limited to the health certificate and the full premium, and provided that we accept and approve the satisfactory proof of the insured's current health condition and other necessary requirements. We reserve the right to void any application.



香港銅鑼灣新寧道 8 號中國太平大廈 2 期 7 樓
7/F, China Taiping Tower Phase II, 8 Sunning Road, Causeway Bay, Hong Kong
電話(Tel): 852-28536333 傳真(Fax): 852-28536323 網址(Website): tplhk.cntaiping.com

保單號碼 **Policy Number**

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每一份保單請填寫一份申請表
**PLEASE USE A SEPARATE FORM FOR EACH POLICY NUMBER**

請 √ 所需項目
**Please tick where appropriate**

甲部
**PART A**

**更改付款形式 Change Mode of Payment**

☐ 年繳 Annually ☐ 半年繳 Semi-annually ☐ 季繳 Quarterly ☐ 月繳 Monthly*

*月繳保費必需經由自動轉賬繳交。請連同「直接付款授權書」遞交。
*Payment must be via direct debit arrangement. Please submit together with the Direct Debit Authorization Form.

**取消自動轉賬 Cancel Autopay**

☐ 取消自動轉帳 Cancel Autopay

**更改月繳保費自動轉賬之週期 Change Autopay Cycle for Monthly Premium**

☐ 月初轉賬 First Cycle ☐ 月中轉賬 Second Cycle

**更改個人資料 Correction of Personal Particulars**
(請提交身份證明文件副本 Please submit together with proof of identity)

☐ 受保人 Insured ☐ 持有人 Owner

姓名 Name : _____
出生日期 Date of birth : _____
(MM 月/DD 日/YYYY 年)
身分證或護照號碼 ID/ Passport No. : _____
國籍 Nationality : _____
性別 Gender : _____

**其他 Others :**

乙部 (除減低投保額及取消附加契約外,請提交健康証明書)
**PART B** (Health Certificate is required except for reduction of face amount or deletion of rider(s))

**申請更改基本保險計劃 Application for Change of Basic Plan**

☐ 減少基本保額至
Reduce Basic Face Amount to _____

**申請取消附加契約 Application for Deletion of Supplementary Contract**

_____
_____
_____
_____

**申請增加附加契約 Application for Addition of Supplementary Benefit**

_____
_____
_____
_____

**申請刪除或減少因健康所附加的額外保費/不保事項 Application for Remove / Reduce Medical Rating / Exclusion**

☐ 額外保費 Medical Rating ☐ 不保事項 Exclusion

**申請復效 Application for Reinstatement**

☐ 申請復效 Apply for reinstatement

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**聲明及授權**
**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「打擊洗錢及恐怖分子資金籌集(金融機構) 條例」第 615 章所載，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。
6. 本人/我們完全明白，若本保單表明若本人/我們的配偶或子女受益或擬以賦予利益予本人/我們的配偶/子女，或本保單上將本人/吾等的配偶或子女列爲受益人，本保單可能須符合香港法例第 182 章《已婚者地位條例》的規定所監管。在該等情況下，保單下應付的款項可能不可用於償還本人/我們的債項。因此，本人/我們可能不可使用或轉讓本保單作爲本人/我們債項的抵押品。

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記錄者，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 China Taiping Life Insurance (Hong Kong) Company Limited (hereinafter called “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 Anti-money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance, Cap. 615
6. We fully understand that if the Policy is expressed to be for the benefit of or purporting to confer a benefit upon my/our spouse or child(ren), or if my/our spouse or child(ren) is named as the beneficiary(ies) of the Policy, the Policy may be subject to application of the Married Persons Status Ordinance (Chapter 182 of the Laws of Hong Kong) (“MPSO”). In such circumstances, the money payable under the Policy may not be able to be used to repay my/our debts. As a result, I/we may not be able to use or effect any assignment of the Policy as collateral for any of my/our debts

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.

保單號碼 **Policy Number**

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By signing below, I / we represent that I am / we are not a U.S. person for purposes of U.S. federal income tax and that I am /we are not acting for, or on behalf of, a U.S. person. I / We understand that the Company, believing this statement to be true, will rely on it and act on it. In the event this statement is incorrect / false, the Company reserves the right and shall be entitled to cancel the policy. Any policy issued may accordingly be considered void in which case the Company shall notify me / us and repay any premiums less reasonable charges and policy withdrawals / loans.

Note: A false statement or misrepresentation of tax status by a U.S. person could lead to penalties under U.S. law. If your tax status changes and you become a U.S. citizen or resident, you must notify us within 30 days. (This Clause is not applicable to U.S. citizens or residents, who must complete IRS Form W- 9.)

於下方簽署作實，本人/我們聲明，就美國聯邦薪俸稅之有關事項而言，本人/我們並非美國人，及並不代表美國人行事。本人/我們明白貴公司相信此陳述是真實的，並以此為依據及代為行事。倘若此陳述是不正確/虛假的，貴公司保留權利，並有權取消保單。任何依據此陳述而繕發的保單可視作無效。在這情況下，貴公司將通知我/我們償還扣除合理的費用及保單提款/貸款後的保費。

備注：根據美國法律，任何美國人就其稅務狀況有虛假或失實陳述，將會受到刑罰。若閣下的稅務狀況有更改，並且成為美國公民或居民，請於三十日內通知本公司。（美國公民或居民必須填寫 IRS 之 W-9 表格，而以上之有關條款並不適用。）

_____ 於 On _____

保單持有人 / 信託人簽署(如非受保人)
Signature of Owner / Trustee (if other than insured)

月 MM / 日 DD / 年 YYYY

_____ 於 On _____

受讓人簽署
Signature of Assignee
(if applicable 如適用)

月 MM / 日 DD / 年 YYYY

_____ 於 On _____

見證人簽署
Signature of witness
(if applicable 如適用)

月 MM / 日 DD / 年 YYYY

見證人姓名(身分證明文件上的英文/中文全名):
Name of Witness(English/Chinese Name in Full as per identity document): _____

見證人之首四個位香港/澳門身分證編號或護照首五個位之編號:
First 4 characters of HK ID Card Number of Witness or First 5 characters of Passport No.: _____

見證人之聯絡電話號碼:
Contact Phone No. of Witness: _____