中國人壽保險(海外)股份有限公司
China Life Insurance (Overseas) Company Limited

(於中華人民共和國註冊成立之股份有限公司)
(incorporated in the People's Republic of China with limited liability)

中國人壽 CHINA LIFE | 海外

保單資料更改申請表 (IX) Request for Change of Policy Information Form (IX)
(適用於取消自動轉賬指示)
(Applicable for Cancel Autopay Instruction)

CS-CHG09

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 自動轉賬指示# Part 2 Autopay Instruction#

☑ 取消自動轉賬指示 Cancel 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.

第三部份 聲明及授權 Part 3 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。

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 Anti-money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance, Cap. 615.

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.

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

第四部份 個人資料收集聲明 Part 4 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.hk 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.hk or is made available upon request.

第五部份 簽署 Part 5 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

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