

更改保單資料申請書
Request for Policy Change Form



保單編號 Policy No.		保單權益人姓名 Name of Policyowner		被保人姓名 Name of Insured	
代理人編號 Agent Code		代理人姓名 Agent Name		代理銀行 Servicing Bank	

甲部 - 更改個人資料/保單權益人 Part A - Change of Personal Particulars/Change of Policyowner

	被保人 Insured	<input type="checkbox"/> 保單權益人 Policyowner <input type="checkbox"/> 次被保人(只適用於聯保) Second Insured (for joint life only)
1. 姓名/名稱 Name		
2. 身份證明文件號碼 Document No.	<input type="checkbox"/> 香港身份證號碼 HKID No. <input type="checkbox"/> 出生證書號碼 Birth Cert. No. <input type="checkbox"/> 護照號碼 Passport No.	<input type="checkbox"/> 香港身份證號碼 HKID No. <input type="checkbox"/> 商業登記號碼 B.R. No. <input type="checkbox"/> 護照號碼 Passport No.
3. 出生日期 Date of Birth	_____ / _____ / _____ Day 日 Month 月 Year 年	_____ / _____ / _____ Day 日 Month 月 Year 年
4. 性別/其他 Sex/Others	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female <input type="checkbox"/> 公司 Company
5. 與被保人關係 Relationship to the Insured	不適用 Not Applicable	
6. 聯絡電話號碼 Contact Phone No.	_____ / _____ / _____ 住宅 Home 流動電話 Mobile 辦公室 Office	_____ / _____ / _____ 住宅 Home 流動電話 Mobile 辦公室 Office
7. 新簽署 (如適用) New Signature (if applicable)		
8. 通訊地址 Mailing Address		
9. 其他 Others		

乙部 - 更改保單內容 Part B - Change of Policy Details

1. 繳費方式 Payment Mode	<input type="checkbox"/> 年繳 Annually <input type="checkbox"/> 半年繳 Semi-Annually <input type="checkbox"/> 季繳* Quarterly* <input type="checkbox"/> 月繳 (經自動轉帳) Monthly (By Autopay)				
2. 繳費辦法 Payment Method	<input type="checkbox"/> 郵寄帳單 Direct Billing				
	<input type="checkbox"/> 信用卡* (經自動轉帳) Credit Card* (By Autopay)		<input type="checkbox"/> 銀行戶口 (經自動轉帳) Bank Account (By Autopay)		
授權書須一併簽回 Authorization Form must be signed and returned 如付款人並非被保人或保單權益人，請申報關係並附上身份證明文件副本 If Payer is not the Insured or Policyowner, please declare the relationship and attach I.D. copy					
3. 自動轉帳日期* Autopay Day*	<input type="checkbox"/> 2 nd	<input type="checkbox"/> 16 th	<input type="checkbox"/> 5 th	<input type="checkbox"/> 20 th	
只適用於都市錦囊保健計劃 (for Citypack Outpatient Plan only)					
4. 保單幣值* Policy Currency*	<input type="checkbox"/> 港元 HKD <input type="checkbox"/> 美元 USD <small>請退回保單正本及繳交港元 150 之行政費用 Please return original policy and administrative charge of HKD150.00 is required</small>				
5. 受益人資料 Beneficiary Information	姓名/名稱 Name	香港身份證/護照/商業登記號碼 HKID/Passport/B.R. No.	年齡 Age	與被保人關係 Relationship to the Insured	百分比 (合共 100%) Percentage (Total 100%)
	所有曾指定之受益人均被自動撤銷 All previously named beneficiaries will be automatically revoked 倘無特別指示，利益將由所有受益人平均分配 Unless otherwise specified, multiple beneficiaries will share the proceeds evenly 如非被保人直系親屬，請提供其身份證明文件副本、通訊地址及更改原因 If no direct relationship to the Insured, please provide I.D. copy, mailing address and changing reasons				

*不適用於投資相連產品 Not applicable to Investment-Linked Products

取消轉讓 6. Release of Assignment	_____ 受讓人簽名 Signature of Assignee	_____ 生效日期 (日/月/年) Effective Date (dd/mm/yyyy)
	如受讓人在此簽署，即表示同意放棄於此保單的轉讓權益，並於上述所示日期生效 The assignment benefit of this policy will be abandoned if assignee signs here and it will be effective on the date indicated above	

重發保單 7. Re-issue Policy	<input type="checkbox"/>	本人/我們謹此聲明上述保單號碼之保單正本已經遺失，故要求補發一份保單副本並在有法律效力約束下代替已遺失的保單。本人/我們同意償付香港人壽保險有限公司（以下簡稱「貴公司」）在履行本人/我們所要求補發保單副本後可能引致之損失、索償及追討。本人/我們亦答應如日後尋回正本保單，定會歸還貴公司。本人/我們在法律的條約下謹以此聲明上述內容全為屬實。 本人/我們聲明上述保單並無權益轉讓（除非受讓人於下列簽署），亦無進行或仍未了結之破產或無力償債的訴訟。 I/We hereby declare that the original copy of the above-mentioned policy has been lost thus request for a duplicated copy which will by law replace the lost policy. In consideration therefore, I/We hereby undertake and agree to indemnify and hold harmless HONG KONG LIFE INSURANCE LIMITED ("the Company") against all losses, claims and demands which may be suffered by or made against the Company in consequence of the Company acceding to my/our request. I/We further undertake in the event of the said lost policy ever being discovered to return it to the Company. I/We make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Ordinance. I/We certify that the above-mentioned policy is not now assigned (except as indicated below by the signature of the assignee), if any, and that no proceedings in bankruptcy or insolvency have been instituted or are pending against me/us.
	須繳交港元 150 之行政費用 Administrative charge of HKD150.00 is required	

8. 其他指示 Other Instructions	
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丙部 - 定期壽險轉換 Part C - Term Conversion

原有保單 Existing Policy	<input type="checkbox"/> 定期壽險計劃 Term Plan <input type="checkbox"/> 定期壽險附加保障 Term Rider	剩餘投保額 Remaining Sum Insured	<input type="checkbox"/> 港元 HKD <input type="checkbox"/> 美元 USD	\$ _____
	如選擇全部轉換定期壽險計劃，請退回保單正本，而所有餘下保費將會轉移至新保單 Please return original policy and any unearned premium will be transferred to the new policy if full conversion of the Term Plan is selected			

新保單 New Policy	保單編號 Policy No.	基本計劃 Basic Plan		
	保單日期 Policy Date	投保額 Sum Insured	<input type="checkbox"/> 港元 HKD <input type="checkbox"/> 美元 USD	\$ _____
	請支付所需之首期保費 Please settle the initial premium required 如增加投保額，請填寫客戶所需保險分析表及新投保申請書 Please complete Needs Analysis Form and new Application Form if increasing Sum Insured 如採用月繳為繳費方式或自動轉帳為繳費辦法，請填寫「直接付款 / 信用咭付款授權書」"DDA / CCPA Form" is required if monthly mode or autopay is adopted			

聲明與授權 Declaration and Authorization

根據個人資料(私隱)條例，本人/我們清楚明白及完全同意以下各項：(1) 貴公司為進行保險業務而收集或持有任何由本人/我們提供有關於本人/我們或其他在本申請書提及人士之個人資料(不論是否從本申請書或其他途徑所得)。貴公司並可將該等資料儲存、使用、透露、發放及轉交予(不論在本港或海外)任何與貴公司有關之人士/機構或任何貴公司認為有需要之人等(包括其他從事與保險或再保險業務有關之公司、中介人、理賠調查員、有關提供保險業務服務之公司、專業顧問、政府機關、或任何保險業組織或聯會)，以用作處理本投保或其他保險或財務產品/服務之申請，及提供所有關於該等申請之繼續服務、處理理賠或其有關分析、統計或精算研究用途、直接銷售及資料核對、與本人/我們或貴公司認為有關之機構/人士溝通；(2) 本人/我們有權知悉貴公司是否持有本人的資料及有權查閱該等資料，若認為有關本人/我們的資料不準確，本人/我們有權要求貴公司給予更正，同時有權查悉貴公司對於資料的政策與實務做法，及獲告知貴公司持有本人/我們資料的類別。任何關於查閱或更正資料申請，或欲查悉貴公司對於個人資料的政策與實務做法或所持有的資料類別，可以書面向貴公司資料保護主任提出；(3) 貴公司有權就處理任何查詢資料的要求收取合理費用。
 本人/我們謹此授權：(1) 任何僱主、醫生、醫院、診所、保險公司、政府部門、其他機構或人士，凡曾已或將會知悉或持有本人/我們的個人資料(不論是醫療或其他資料)，均可向貴公司或其代表透露、發放或轉交該等資料，以作為處理本申請及其後之保單復效和理賠事宜；(2) 貴公司或任何其指定之醫護人員或化驗所，可就本申請及其後之保單復效和理賠事宜，替本人/我們進行所需之醫療評估及測試以審核本人/我們之健康狀況。即使本人/我們死亡或喪失能力，此授權書仍具效力，而本人/我們之繼承人及受讓人亦會受此授權書約束。本授權書之影印本與正本均有同等效力。
 Under the Personal Data (Privacy) Ordinance, I/We hereby declare, understand and agree that: (1) Any personal information provided by me/us whether relating to me/us or other persons named herein (whether contained herein or otherwise obtained) is collected or held by the Company to enable the Company to carry on insurance business and may be stored, used, disclosed, released and transferred (whether within or outside Hong Kong) by the Company to any individuals/organizations associated with the Company or any selected party as the Company may consider necessary (including any other company carrying on insurance or reinsurance related business or any intermediary or claims investigator or other service provider providing services relevant to insurance business or professional advisor or government authority or any association or federation of insurance companies) for the purpose of processing this application or any other application for insurance or financial related product/service and providing all on-going services related to such application, claim processing or any analysis of it, statistical or actuarial research, direct marketing and data matching, and communication with me/us or any relevant organization/person as the Company may consider necessary; (2) I/We have the right to check whether the Company holds data about me/us and the right of access to such data and require the Company to correct any data relating to me/us which are inaccurate. I/We also have the right to ascertain the Company's policies and practices in relation to data and to be kept informed of the kind of data held by the Company. Such request can be made in writing and addressed to the Data Protection Officer of the Company; (3) The Company has the right to charge a reasonable fee for the processing of any data access request.
 I/We hereby authorize: (1) any employer, doctor, hospital, clinic, insurance company, government office or any organization or person who has or may hereafter have any record, knowledge or information of me/us (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to this application and any reinstatement or claim arising therefrom; (2) the Company or any of its appointed medical/paramedical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of me/us in relation to this application for insurance and any reinstatement or claim arising therefrom. This authorization shall bind the successors and assignees of me/us and remain valid notwithstanding death or incapacity. A photocopy of this authorization shall be valid as the original.

被保人簽署 Signature of Insured	保單權益人簽署 (如非被保人) Signature of Policyowner (If other than Insured)	次被保人簽署 Signature of Second Insured
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香港 Hong Kong 簽署地 Signature Place	日期 (日/月/年) Date (dd/mm/yyyy)	代理人/見證人簽署 Signature of Agent/Witness	受讓人/不可撤換受益人(如有)簽署 Signature of Assignee/Irrevocable Beneficiary (if any)
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