

**更改保單利益申請書**  
**Request for Benefits 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	

<b>甲部 Part A</b>					
更改基本計劃/ 附加保障 Change of Basic Plan/ Supplementary Benefit	基本計劃/附加保障 Basic Plan/Supplementary Benefit	增加 <sup>#</sup> Add <sup>#</sup>	刪除 Delete	更改 <sup>#</sup> Change <sup>#</sup>	新投保額/保障級別 New Sum Insured/Benefit Class
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
保單復效 Policy Reinstatement	<input type="checkbox"/> 復效 <sup>#</sup> Reinstatement <sup>#</sup> 請支付所需之保費及利息 Please settle the premium and interest required 如失效前的自動轉帳戶口已取消，請填寫「直接付款/信用卡付款授權書」。“DDA/CCPA Form” is required if autopay account has been cancelled before lapsation				
其他 <sup>#</sup> Others <sup>#</sup>					

<sup>#</sup> 如有關申請需要重新核保，請填妥乙部 If re-underwriting for the request is needed, please complete Part B

<b>乙部 Part B</b>					
<b>I. 個人資料 Personal Particulars</b>					
	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)			
	身高 Height _____ <input type="checkbox"/> 呎 feet <input type="checkbox"/> 厘米 cm 體重 Weight _____ <input type="checkbox"/> 磅 lbs <input type="checkbox"/> 公斤 kgs	身高 Height _____ <input type="checkbox"/> 呎 feet <input type="checkbox"/> 厘米 cm 體重 Weight _____ <input type="checkbox"/> 磅 lbs <input type="checkbox"/> 公斤 kgs			
公司名稱及業務性質 Name of Company & Nature of Business					
職業 Occupation					
確實職務 Exact Duties	<input type="checkbox"/> 體力勞動 Manual Work <input type="checkbox"/> 高空工作 Work at Height <input type="checkbox"/> 離港工作 Travel Overseas 如牽涉上述職務，請述詳情 Please give details if involved in the above job duties		<input type="checkbox"/> 體力勞動 Manual Work <input type="checkbox"/> 高空工作 Work at Height <input type="checkbox"/> 離港工作 Travel Overseas 如牽涉上述職務，請述詳情 Please give details if involved in the above job duties		

<b>II. 健康資料 Health Information</b>			
被保人 / 保單權益人 / 次被保人 (只適用於聯保) Do the Insured / Policyowner / Second Insured (for joint life only)		是 Yes	否 No
1. (及其直系親屬中)，曾否有人患過肺結核、糖尿病*、腎病、心臟病、中風、高血壓*、冠狀動脈病、血科疾病、精神病(例如：抑壓、焦慮、抑鬱症)、遺傳病、癌症、腫瘤*、肝炎、肝炎帶菌者、後天免疫能力缺乏症或其有關病況? (and any of the immediate family) have or ever had Tuberculosis, Diabetes*, Kidney Disease, Heart Disease, Stroke, High Blood Pressure*, Coronary Artery Disease, Blood Disorder, Mental Disease (e.g. Stress, Anxiety, Depression), Hereditary Disease, Cancer, Tumour*, Hepatitis, Hepatitis Carrier, AIDS or AIDS related conditions?		<input type="checkbox"/>	<input type="checkbox"/>
2. 曾否患有或獲被告知患有任何疾病、身體機能失調、身體上的缺陷、嚴重受傷*、嚴重流鼻血、背脊或頸部疼痛*、癲癇症*或哮喘*；或曾否為任何疾病或就上述任何情況接受或打算接受治療？ have ever had or been told to have, or intend to be treated or have been treated for any Disease, Disorder, Physical Impairment or Deformity, Severe Injury*, Severe Nose Bleeding, Back or Neck Pain*, Epilepsy* or Asthma*?		<input type="checkbox"/>	<input type="checkbox"/>
3a. 在過去五年內，曾否接受或被建議接受 X 光檢查、電腦掃描、超聲波、心電圖、活體檢驗、尿液檢驗、血液檢驗(例如：膽固醇、後天免疫能力缺乏症、肝炎包括乙型肝炎、貧血等)、其他的診查或診斷檢驗？ have had or have been advised to have X-ray, CT Scan, Ultra-sonogram, ECG, Biopsy, Urine Test, Blood Test (e.g. Cholesterol, AIDS, Hepatitis including Hepatitis B, Anemia, etc.), any other investigatory or diagnostic tests in the past five years?		<input type="checkbox"/>	<input type="checkbox"/>
b. 在過去五年內，曾患有上文並未提及的任何疾病、接受過的手術、醫生之建議或曾留醫治療？ have had any illness, operation, medical advice or hospital treatment not mentioned above in the past five years?		<input type="checkbox"/>	<input type="checkbox"/>
4. 只適用於女性 For Female Only			
a. 現時是否懷孕？如「是」者，請標明預產期。 now in pregnant? If "yes", please state the expected delivery date.		<input type="checkbox"/>	<input type="checkbox"/>
b. 閣下曾否患有任何乳房或生殖器官的疾病，包括不正常之塗片細胞檢查及月經失調？ have ever had any disorder of the Breast or Reproductive Organs including abnormal smear tests and irregular menses?		<input type="checkbox"/>	<input type="checkbox"/>
如上述問題的答案為「是」，請標明題號、何人及有關詳情包括患病日期、診斷、持續時間、治療、檢驗結果及所有主診醫生姓名和醫療機構名稱(請附上有關之覆診卡副本，如有)。並請詳述閣下私人醫生之姓名及地址，及最後診症之日期、原因和結果。若過去十二個月內體重之增減多於十磅，請標明何人及詳述原因。 If any answers to the above questions is "yes", please indicate the question number, the person affected and provide full details including onset dates, diagnosis, duration, treatment, result and name of all attending physicians and medical institutions (please provide patient card copy, if any). Please also provide name & address of your personal physician, and date, reason and result of last consultation. If there has been any weight changes over 10 lbs in the past 12 months, please indicate the person affected and give reasons.			
<input type="checkbox"/> 被保人 Insured <input type="checkbox"/> 保單權益人 Policyowner <input type="checkbox"/> 次被保人 Second Insured (只適用於聯保) (for joint life only)			
<b>*請填妥有關之問卷 Please complete the corresponding questionnaire(s)</b>			

III. 個人嗜好 Personal Behaviour		
被保人 / 保單權益人 / 次被保人(只適用於聯保) Do the Insured / Policyowner / Second Insured (for joint life only)	是 Yes	否 No
1a. 曾否在過往十二個月內吸食煙草產品?如「是」者,請列明類別、平均每天吸食數量及吸食年期。 smoke or have ever smoked any form of tobacco products during the past 12 months? If "yes", please state type, average daily consumption and duration. <input type="checkbox"/> 被保人 Insured 類別 Type _____ 每日用量 Daily consumption _____ 服用年期 Duration _____ <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) 類別 Type _____ 每日用量 Daily consumption _____ 服用年期 Duration _____	<input type="checkbox"/>	<input type="checkbox"/>
b. 是否曾因醫生建議而停止吸食煙草產品?如「是」者,請詳述原因。 have stopped smoking on medical advice? If "yes", please give reasons <input type="checkbox"/> 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) 原因 Reason: _____	<input type="checkbox"/>	<input type="checkbox"/>

2. 是否有飲酒、服食藥物或吸毒習慣?如「是」者,請列明類別、平均份量及年期。 drink alcohol, take drugs or narcotics? If "yes", please state type, average daily consumption and duration. <input type="checkbox"/> 被保人 Insured 類別 Type _____ 每日用量 Daily consumption _____ 服用年期 Duration _____ <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) 類別 Type _____ 每日用量 Daily consumption _____ 服用年期 Duration _____	<input type="checkbox"/>	<input type="checkbox"/>
3. 曾否參與或意圖參與任何危險運動,如潛水,跳傘,賽車及攀山?如「是」者,請填寫有關問卷。 engage in or intend to engage in any hazardous sports such as diving, parachuting, automobile & car racing and mountaineering? If "yes", please complete the corresponding questionnaire(s).	<input type="checkbox"/>	<input type="checkbox"/>

IV. 個人投保紀錄 Personal Insurance History		
被保人 / 保單權益人 / 次被保人(只適用於聯保)(1)是否擁有已生效及/或審核中之其他保險;或(2)在過去投保人壽、意外或醫療保險時,或要求恢復此類保單效力時,曾否被拒絕、延期、加費或更改受保條款;或(3)曾否就意外、醫療或任何類型的保險提出索償?如「是」者,請標明何人並於下面詳述。 Do the Insured / Policyowner / Second Insured (for joint life only) have (1) any other insurance in force and/or pending; OR (2) any application for or reinstatement of life, accident or health insurance which have ever been declined, postponed, rated or in any way modified; OR (3) any claim for accident, health or any sort of benefits? If "yes", please indicate the person affected and give details below.	是 Yes	否 No
	<input type="checkbox"/>	<input type="checkbox"/>

	承保公司 Insurance Company	投保日期 Date of Application	保險類別 Type of Insurance	投保金額 Amount of Coverage	生效 In force	處理中 In progress	拒保 Declined	延期 Postponed	非標準保費 Sub-Standard rate	曾索償 Claimed
被保人 Insured										
<input type="checkbox"/> 保單權益人 Policyowner <input type="checkbox"/> 次被保人 Second Insured										

**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、處理理賠或具有關分析、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
香港 Hong Kong	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)
簽署地 Signature Place	日期(日/月/年) Date (dd/mm/yyyy)	

S.V.