請掃二維碼登入客戶專頁，即時辦理**保單更改**或**查閱進度**。
https://cs.chinalife.com.hk

中國人壽 CHINA LIFE | 海外

恢復保單效力申請表
Request for Policy Reinstatement

保單持有人姓名 Name of Policyholder	受保人姓名 Name of Insured	保單號碼 Policy No.

保險中介人資料 Insurance Intermediary's Information

保險中介人姓名 Name of Insurance Intermediary

保險中介人編號 Insurance Intermediary's Code

聯絡電話 Contact No.

重要須知 Important Notes

1. 本表格中所用之「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.
2. 請以正楷填寫本表格，任何資料如有更改，保單持有人必須在更改的地方簽署作實。Please complete this form in BLOCK LETTERS. All amendments should be endorsed by the Policyholder in full signature.
3. 保單持有人之簽署必須與本公司之記錄相符。The signature of the Policyholder must correspond with the Company's record.
4. 保險中介人或銀行職員收到此表格並不代表本公司亦已收妥。Receipt of this form by Insurance Intermediary or Bank Staff does not constitute receipt by the Company.
5. 本公司有權隨時更新此申請表，並接受或拒絕未符合本公司要求的申請表。請登入本公司網站 www.chinalife.com.hk 瀏覽及下載最新版本。The Company has the right to update this form from time to time and to accept or to reject the form if the Company's requirements are not fulfilled. Please visit our website www.chinalife.com.hk to view and download the latest version of the form.
6. 如申請未能符合本公司的有關規定，本公司有權拒絕有關申請。The Company shall have right to reject the application if the application fails to fulfill Company's requirement(s).
7. 每份申請表只可填寫一份保單號碼 (副本表格，恕不接受)。
   Please use a separate form for each policy number (Copies of this form are not accepted).

第一部份 恢復保單效力注意事項 Part 1 Important Notes of Policy Reinstatement

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**第三部份**『健康聲明』。 Please fill in **Part 3** "Health Declaration".
3. 若此申請能獲批後，須繳全數逾期保費及利息。If this application is approved, please submit sufficient full arrears premiums plus interest.

第二部份 其他指示 Part 2 Other Instruction

保單號碼 Policy No.

第三部份 健康聲明 Part 3 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	(a) 閣下的身高? Your height?	公分 cm	公分 cm
	(b) 閣下的體重? Your weight?	公斤 kg	公斤 kg
	(c) 過去一年內，閣下的體重曾否有 5 公斤或 11 磅以上的增減？若有，請說明原因。Has your weight changed more than 5kgs/11 lbs in the past year? If Yes, please state the reason.	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
	(d) 閣下曾否在過去三個月的任何時間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?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
2	在過去 12 個月內閣下曾否吸煙? 若有，請填寫下列問題 In the past 12 months, have you ever smoked? If Yes, please complete below questions	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
	(a) 每日平均吸煙多少支？Average number of pieces daily?	______支 Piece(s)	______支 Piece(s)
	(b) 吸煙已有多少年？For how many years have you smoked?	______年 Year(s)	______年 Year(s)
3	閣下曾否服用成癮藥物，或慣常飲啤酒、餐酒、烈酒或曾接受與服用藥物或飲酒相關的治療或輔導？如有，請註明種類及用量。Have you ever taken any habit forming drugs or used beer, wine or spirits regularly or been treated or advised in connection with your alcohol consumption or taking of drugs? If Yes, please state the type and quantity.	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
4	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 the following diseases		
	(a) 肺結核病、哮喘*、吐血、呼吸困難、或任何呼吸系統或肺部疾病*？Tuberculosis, asthma*, blood-spitting, shortness of breath, or any respiratory or lung disease*?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
	(b) 心悸、胸痛、高血壓病*、貧血、任何心臟*、血液或血管疾病？ Palpitation, chest pain, high blood pressure*, anaemia, any disease of the heart*, blood or blood vessels?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
	(c) 腸胃潰瘍、經常消化不良、疝氣、瘻管、痔瘡、胃、胰、腸、黃疸、或任何肝病* (包括肝炎帶菌)、膽囊、消化系統之疾病*？Gastro-intestinal ulcer, recurrent indigestion, hernia, fistula, piles, stomach, pancreas, intestine, jaundice or any disease of liver* (including hepatitis carrier), gall-bladder or digestive system*?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
	(d) 尿糖、尿蛋白、泌尿系統結石、性病、腎臟或前列腺疾病、或其他生殖泌尿系統之病症*？Urinary sugar/albumin/stones, venereal disease, or diseases of the kidney, prostate, reproductive or urinary system*?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
	(e) 癲癇*、抽搐、暈厥、嚴重頭痛、精神健康狀況異常*、任何腦部或神經系統不正常或疾病？ Epilepsy*,seizure ,fainting spells ,severe headache, any disease or abnormality mental health condition*, any disease or abnormality of the brain or nervous system?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
	(f) 癌症、腫瘤/不正常的生長物、囊腫*、任何透過性接觸傳染的疾病、糖尿病*、甲狀腺疾病*、其他內分泌疾病或嚴重受傷？Cancer, tumor/abnormal growth, cyst*, any sexually transmitted disease, diabetes*, any thyroid disease*, any endocrine disease or severe injury?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
	(g) 感官疾病或功能失常(如眼、鼻、喉、耳或口腔之疾病)？Disease or disorder of the sense organ(s) (e.g. disorder of the eyes, nose, throat, ears or oral cavity)?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
	(h) 風濕性發熱、關節炎、痛風或肌肉及骨骼疾病* (如關節或骨骼疾病)、結締組織或皮膚疾病或任何未在上述各項提及之疾病或治療？Rheumatic fever, arthritis, gout or disorder of musculoskeletal system* (e.g. joint or bone), connective tissues or skin disorder, or any other disorder or treatment not mentioned?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
5	在過去五年內，閣下曾否 In the past five years, have you ever		
	(a) 接受過或被建議進行診斷檢驗，如 X 光、心電圖、電腦掃描、超聲波、尿液、特殊血液檢驗及健康檢查？(例行身體檢查超過一年且結果正常除外)had or had been advised to take any diagnostic test(s), such as X-Ray, ECG, CT scan, ultrasound, urine, special blood test or physical check-up?(Except routine physical examinations over one year with normal results.)	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 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?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
	(c) 其他健康狀況或病徵及症狀（例如腫塊、頭痛、持續咳嗽、胸痛或上腹痛）而正在或打算尋求醫療意見 Other medical conditions or sign and symptom (such as lump, headache, persistent coughing, chest pain or epigastric pain) that you are seeking or intend to seek medical advice	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No

* 如是，請填有關之問卷 If Yes, please complete the appropriate questionnaire

保單號碼 Policy No.

第三部份 健康聲明(續) Part 3 Health Declaration (Continued)

+ 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
6	閣下目前是否正接受藥物治療或醫療護理或是否有可預見或打算進行之醫生囑咐、診症或治療？或閣下是否有慣常求診的醫生/家庭醫生？若是，請註明醫生姓名及地址。Are you currently receiving medical treatment or under medical care of any kind or do you have any expected need or intention of receiving medical advice, consultation or treatment? Or do you have regular doctor or family doctor? If Yes, please state the name and address of the doctor and reason(s) of medical consultation(s).	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
7	閣下曾否接受或打算接受任何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？或閣下的配偶是否曾患有愛滋病或其綜合病徵？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? Or has your spouse suffered from any AIDS related condition?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
8	閣下是否曾或有此意圖參與任何攀山、跳傘、潛水、危險性運動、賽事或並非以乘客身份乘搭固定班次的民航客機？如有，請填寫有關之問卷。Have you ever engaged in any mountaineering, sky diving, scuba diving, hazardous sports, racing or flying other than as a fare-paying passenger on a regularly scheduled airline or do you have any intention to do so? If Yes, please complete the appropriate questionnaire.	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
9	閣下在過去投保或申請復效人壽、危疾、意外或醫療保險時，曾否被拒絕、延期、加費或被修改？如有，請填寫原因、投保公司名稱、投保日期及保單號碼。Has any application for or reinstatement of life, critical illness, accident or medical insurance on you been declined, postponed, rated-up or accepted with modified terms? If Yes, please provide the reason, name of insurance company, application date and policy number.	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
10	只適用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、月經失調或柏氏宮頸抹片不正常？ Have you had any disorder of the breast or reproductive organs, or prenatal or postnatal complication, menstrual disorders or abnormal pap smears?	☐ 是 Yes ☐ 否 No	☐ 是 Yes ☐ 否 No
11	只適用於十七歲或以下之未成年人士 For Juvenile aged 17or below only		
	(a) 閣下是否早產(37 週或以下)或過期出生? 出生後有否接受特別護理？Was your birth premature (37 weeks or below) or post-mature? Any special care needed after birth?	☐ 是 Yes ☐ 否 No	不適用 Not Applicable
	(b) 閣下是否有身體缺陷、生理上或心智發育緩慢的跡象？Have you had any physical defects or shown any sign of slow physical or mental development?	☐ 是 Yes ☐ 否 No	

詳情補充 Supplementary Details

若「健康聲明」問題答案為「是」或需任何補充，請在此欄提供詳細資料並註明所屬部份及題號。如下列空位不夠使用，請填寫「要保補充陳述書」。如閣下曾進行身體檢查、化驗或入院接受治療，請提供相關之覆診預約紙、身體檢查及化驗報告之副本作參考。

If any answer to "Health Declaration" is Yes or any supplementary information is needed, please give full particulars below and quote the relevant section and question number. If space given is insufficient, please complete a "Supplementary Information Form". Please provide copies of appointment slip and investigation reports for review if there are any physical check-up, laboratory test or hospitalization history.

題號 Question No.	詳情Details 包括患病/受傷日期、患病/受傷持續時間、發病次數及病情、診斷結果、曾接受的治療、檢查種類及其結果、最後覆診日期等Including dates of illness/injury, duration, number of attacks, severity of illness / injury, diagnosis, type of treatment or investigation received and their results, last follow-up date etc	康復程度 (如適用) Degree of Recovery (If applicable)	主診醫生/醫院名稱及地址 (如適用) Name & Address of Attending Doctor/Hospital (If applicable)

保單號碼 Policy No.

第四部份 聲明及授權 Part 4 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。本授書影印本與正本均有同等效力。

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.

第五部份 收取個人壽險保費徵費 Part 5 Collection of Premium Levy on Individual Life Insurance Policy

本人/我們謹已收悉：

貴公司就保險業監管局要求並授權向每位保單持有人所持有的有效保單徵收「保費徵費」(下稱「徵費」)，及將收取的保費徵費將會全數轉交予該局。保險業監管局亦可以根據相關條例，將有關的欠付款作為民事債項及向相關的保單持有人追討欠款並有機會徵收罰款。有關收取徵費的詳情，請瀏覽中國人壽(海外)股份有限公司的網頁 www.chinalife.com.hk/levy。

I/We hereby notified that:

China Life Insurance (Overseas) Company Limited, as an authorized insurer, is statutorily required to collect Premium Levy ("Levy") from policyholder on behalf of the Insurance Authority ("IA") and report to IA. IA may take legal proceedings against policyholder in respect of any outstanding Levy as civil debt and may impose pecuniary penalty. For details of the collection of Levy, please refer to the website at www.chinalife.com.hk/levy.

第六部份 個人資料收集聲明 Part 6 Personal Information Collection Statement

本人/我們確認已閱讀及明白「中國人壽保險（海外）股份有限公司」的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於 www.chinalife.com.hk 下載或向中國人壽保險（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.

第七部份 簽署 Part 7 Signature

1. 此表格必須於保單持有人簽署日起計 30 天內交至本公司辦理手續。This form must be received by the Company within 30 days from the sign date of Policyholder.
2. 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，見證人必須為年滿 18 歲或以上的第三者。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 witness must be an individual third party aged 18 or above. 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.
3. 請勿在空白表格上簽署。Please DO NOT sign on BLANK form.

	保單持有人 Policyholder			受保人簽署 (倘非保單持有人及18歲或上) Signature of Insured (if different from the Policyholder & aged 18 or above)			抵押轉讓之承讓人 (如適用) Signature of Collateral Assignee (if applicable)			見證人 Witness		
簽署或公司印鑑 Signature and/or Company Chop												
日期 Date												
	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day