

高端医疗保险合同变更申请书 Application for the Change of Cigna & CMB High-end Medical Insurance Contract



保险合同编号: Insurance Contract Number		申请人姓名: Applicant's Name	
申请人类型: Applicant Type	<input type="checkbox"/> 投保人 Policyholder	<input type="checkbox"/> 被保险人 Insured Person	<input type="checkbox"/> 其他(请写明关系) Other (please specify the relationship)
本人因: I hereby apply to make changes to the following	(请写明原因), 申请对以下 _____ 项进行变更, 合计 _____ 项。 (please specify the reason), with a total of _____ items to be amended.		
1. 请用正楷字和黑色或蓝黑色墨水笔填写申请书, 所需变更的事项请在申请书对应的勾选项中以“√”表示, 不变更的信息无需填写。 1. Please complete this application form in block letters using a black or blue-black ink pen. For any items to be changed, please mark the corresponding check box in the application form with a "√". Information that is not being changed does not need to be filled in. 2. 未成年被保险人的监护人代办业务时, 需提供监护人证件, 并在签名处填写监护人的手机号码。 2. When handling matters on behalf of a minor insured person, the guardian must provide identification documents and enter the guardian's mobile phone number in the signature section.			

A类-资料变更类 (如变更对象为多人, 请填写多份申请书。)

Category A - Information Change (If multiple individuals are subject to the change, please complete a separate application form for each person.)

<input type="checkbox"/> A1. 变更联系资料 Change of Contact Information	<input type="checkbox"/> A2. 变更客户资料 Change of Customer Information	<input type="checkbox"/> A3. 变更职业信息 Change of Occupational Information	<input type="checkbox"/> A4. 变更投保人 Change of Policyholder
变更对象 Change Target	<input type="checkbox"/> 投保人 Policyholder <input type="checkbox"/> 被保险人姓名 Insured Person's Name: _____		
提示: 1. 变更被保险人手机号码时需提供联系地址; 2. 若本次申请的是[A4. 变更投保人], 请同时填写【联系资料】、【客户资料】、【职业信息】、【A5. 变更签名】的投保人新签名样本以及【A6. 变更收/付费方式】; 3. 若申请变更投保、被保险人姓名, 请在【A5. 变更签名】处提供新的签名样本。4. 如您名下其他保单的相关资料发生了变更, 请同步提交申请。 Notice: 1. When changing the insured person's mobile phone number, the contact address must also be provided; 2. If this application involves [A4. Change of Policyholder], please also complete the sections for [Contact Information], [Customer Information], [Occupational Information], new signature specimen of the policyholder in [A5. Change of Signature], and [A6. Change of Payment/Receipt Method]; 3. If applying to change the name of the policyholder or the insured person, please provide a new signature specimen in [A5. Change of Signature]; 4. If any relevant information under other policies in your name has changed, please submit an application for those policies as well.			
联系资料 Contact Information	联系电话: Contact Number	电子邮箱: Email Address	邮编: Postal Code
联系地址: Contact Address (Must include detailed address down to the door/house number) _____ (须详至门牌号)			
客户资料 Customer Information	姓名: Name	性别: Gender <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期: Date of Birth (YYYY/MM/DD) _____ 年 ____ 月 ____ 日
	婚姻状况: Marital Status	国籍/地区: Nationality / Region	证件类型: ID Document Type <input type="checkbox"/> 身份证 Identity Card <input type="checkbox"/> 其他 Other _____
	证件号码: ID Number	证件有效期: ID Validity Period _____ 年 YYYY ____ 月 MM ____ 日 DD 至 _____ 年 YYYY ____ 月 MM ____ 日 DD <input type="checkbox"/> 长期 Permanent	
职业信息 Occupational Information	行业: Industry	职务: Title	工作内容: Job Duties
	工作单位/学校: Employer/School	年收入: Annual Income _____ 万元 (in RMB 10,000)	
如您本次申请的是[A4. 变更投保人], 则被保险人是新投保人的: <input type="checkbox"/> 本人 <input type="checkbox"/> 父母 <input type="checkbox"/> 配偶 <input type="checkbox"/> 子女 <input type="checkbox"/> 其他 _____ If you are applying for [A4. Change of Policyholder], the insured person is the new policyholder's <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			
<input type="checkbox"/> A5. 变更签名: Change of Signature	变更对象 Change Target: <input type="checkbox"/> 投保人 Policyholder <input type="checkbox"/> 被保险人姓名 Insured Person's Name _____	变更原因 Reason for Change: <input type="checkbox"/> 签名风格变化 Change in Signature Style <input type="checkbox"/> 其他原因 Other _____	
	投保人新签名样本: New Signature Specimen of Policyholder	被保险人新签名样本: New Signature Specimen of Insured Person	
<input type="checkbox"/> A6. 变更收/付费方式 Change of Payment/Receipt Method	<input type="checkbox"/> 自动转账 Automatic Transfer Initiated by Policyholder	<input type="checkbox"/> 银行代收 (仅限银保渠道) Bank Collection (applicable only to bancassurance channel)	
	<input type="checkbox"/> 自动扣款/退费 Automatic Debit/Refund	勾选此项需同时填写【A7. 变更银行账号】 (If this option is selected, please also complete [A7. Change of Bank Account Information])	
<input type="checkbox"/> A7. 变更银行账号 Change of Bank Account Information	<input type="checkbox"/> 借记卡 Debit Card	<input type="checkbox"/> 信用卡 Credit Card	信用卡到期日: _____ 年 ____ 月 ____ 日 Credit Card Expiry Date (YYYY/MM/DD)
	账户所有人姓名: Account Holder's Name		开户行及支行: Account Opening Bank and Branch
	银行账号 Bank Account Number: _____		

银行自动转账授权声明: 1. 本人在此保证上述银行自动转账账户为本人合法独立所有。2. 本人授权银行按照保险合同约定期限、交费日期、交费方式、交费期间、保险费金额, 从本人上述银行自动转账账户向招商信诺人寿保险有限公司(以下简称“招商信诺”)指定账户直接扣划首期、续期保险费及办理相关业务应收的款项及因差错给付的款项(如有), 本人对银行上述扣款行为无异议。同时本人授权招商信诺将应付本人的相关款项转入此账户, 该款项一经转入此账户则视为本人已领取。3. 在任何情况下, 若因招商信诺给付金额或给付对象等有误而导致账户所有人并非基于法律规定或合同约定收到该误付款项, 则本人同意无条件的及时返还全部误付款项予招商信诺。4. 本人知晓授权账号变更将可能影响款项扣取或到账时效, 并确认进行该项操作。

Bank Direct Debit Authorization Statement: 1. I hereby confirm that the above bank account designated for direct debit is legally and exclusively owned by me. 2. I hereby authorize the bank to directly debit from the above bank account the first and renewal premiums, as well as any amounts payable in connection with related transactions and any payments made in error (if applicable), in accordance with the premium due dates, payment methods, payment periods, and premium amounts stipulated in the insurance contract, and to transfer such amounts to the designated account of Cigna & CMB Life Insurance Co., Ltd. ("Cigna & CMB"). I raise no objection to any such debits made by the bank. At the same time, I authorize Cigna & CMB to credit into this account any amounts payable to me. Once such amounts have been credited to this account, they shall be deemed to have been received by me. 3. Under all circumstances, if the account holder receives any payment in error due to incorrect payment amounts or incorrect payee information on the part of Cigna & CMB, and such payment is not based on legal provisions or contractual terms, I agree to unconditionally and promptly return the full amount of such erroneous payment to Cigna & CMB. 4. I understand that any change to the authorized bank account may affect the timeliness of premium deductions or payment receipts, and I confirm my consent to proceed with such changes.

<input type="checkbox"/> A8. 补发资料 (如果补发保险合同、发票或会员卡, 则原资料作废。) Reissuance of Documents (If the insurance contract, invoice, or membership card is reissued, the original document will be void.)	
<input type="checkbox"/> 保险合同 Insurance Contract	<input type="checkbox"/> 会员卡 Membership Card (被保险人姓名 Insured Person's Name: _____)
<input type="checkbox"/> 发票 Invoice	<input type="checkbox"/> 其它 Other: _____

B类-保障变更类 (如变更对象为多人, 请填写多份申请书。)

Category B - Coverage Change (If multiple individuals are subject to the change, please complete a separate application form for each person.)

<input type="checkbox"/> B1. 增加被保险人 (增加被保险人须同时在【B2. 变更社保状况及参加类型】勾选新增人员的社保状况, 并递交最新的健康告知书。) Addition of Insured Person (When adding an insured person, please also select the new person's social insurance status under [B2. Change of Social Insurance Status and Participation Type], and submit the latest health declaration.)			
原因 Reason: <input type="checkbox"/> 续保时加入 Add at Renewal <input type="checkbox"/> 出生 Newborn <input type="checkbox"/> 结婚 Marriage <input type="checkbox"/> 其他 Other: _____			
新被保险人姓名 New Insured Person's Name:		与投保人关系 Relationship to Policyholder:	
出生日期: _____年____月____日 Date of Birth (YYYY/MM/DD)	身高 Height: _____ CM	体重 Weight: _____ Kg	性别: <input type="checkbox"/> 男 <input type="checkbox"/> 女 Gender Male Female
证件号码: _____ ID Number	证件类型: <input type="checkbox"/> 身份证 <input type="checkbox"/> 其他 _____ ID Document Type Identity Card Other	国籍/地区: _____ Nationality / Region	
证件有效期: _____年____月____日至____年____月____日 / <input type="checkbox"/> 长期 ID Validity Period YYYY/MM/DD to YYYY/MM/DD / <input type="checkbox"/> Permanent	联系电话: _____ Contact Number		
联系地址: _____ (须详至门牌号) Contact Address (Must include detailed address down to the door/house number)			
行业: _____ Industry	职务: _____ Title	工作内容: _____ Job Duties	
工作单位/学校: _____ Employer/School	年收入: _____ 万元 Annual Income (in RMB 10,000)		
常住地: <input type="checkbox"/> 中国大陆 <input type="checkbox"/> 其他 _____ Place of Residence Chinese Mainland Other	免赔额: _____ (仅限特定产品且需符合投保规则) Deductible (Applicable only to specific products and subject to underwriting rules)		
其他 Other: _____			

<input type="checkbox"/> B2. 变更社保状况及参加类型 Change of Social Insurance Status and Participation Type 变更对象 Change Target: <input type="checkbox"/> 被保险人姓名 Insured Person's Name: _____	
<input type="checkbox"/> 无社保 No Social Security	
<input type="checkbox"/> 有社保 - 以社保身份参加本计划 With Social Insurance - Participating in this Plan under Social Insurance Status	
<input type="checkbox"/> 有社保 - 不以社保身份参加本计划 With Social Insurance - Not Participating in this Plan under Social Insurance Status	

<input type="checkbox"/> B3. 减少被保险人 Removal of Insured Person	
原因 Reason: <input type="checkbox"/> 续保时减人 Remove at Renewal <input type="checkbox"/> 身故 Deceased <input type="checkbox"/> 离异 Divorce <input type="checkbox"/> 其他 Other: _____	
被保险人姓名 Name of Insured Person:	证件号码 ID Number: _____

<input type="checkbox"/> B4. 变更计划或保障区域 (注意: 增加保障区域、升级计划须同时递交被保险人的最新健康告知书。) Change of Plan or Coverage Area (Note: Expanding the coverage area or upgrading the plan requires submission of the insured person's latest health declaration.)
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原计划 Original Plan:
变更后计划 Revised Plan:

<input type="checkbox"/> B5. 变更责任 (注意: 增加保障责任须同时递交被保险人的最新健康告知书。) Change of Coverage Benefits (Note: Adding coverage benefits requires submission of the insured person's latest health declaration.)

原计划 Original Plan:
变更后计划 Revised Plan:

<input type="checkbox"/> B6. 变更免赔额、自负比例、限额 (注意: 减少免赔额、降低自负比例、提升限额须同时递交被保险人的最新健康告知书。) Change of Deductible, Copay, or Limit (Note: Reducing the deductible, lowering the copay, or increasing the limit requires submission of the insured person's latest health declaration.)

原计划 Original Plan:
变更后计划 Revised Plan:

C类-其他服务 Category C - Other Services

<input type="checkbox"/> C1. 退保 (如您需变更账号支付, 请同步勾选并填写【A7. 变更银行账号】) Surrender (If you need to change the payment account, please also check and complete [A7. Change of Bank Account Information])	
退保原因: _____ Reason for Surrender	<input type="checkbox"/> 经济原因 Financial Reasons <input type="checkbox"/> 家人反对 Family Opposition <input type="checkbox"/> 对服务不满 Dissatisfaction with Service <input type="checkbox"/> 已有同类产品 Already Have Similar Product <input type="checkbox"/> 其它 Other: _____
<input type="checkbox"/> C2. 其他 Other: _____	

个人信息授权 Authorization for Use of Personal Information

- 本人已知晓并授权招商信诺人寿保险有限公司（以下简称“招商信诺”）为订立、履行保险合同，提供产品和服务，以及为履行法定义务，将处理投保人、被保险人及受益人的个人信息（以下统称“个人信息”）。就本人所提供的其他主体个人信息，本人确认已取得相关主体的授权。
I hereby acknowledge and authorize Cigna & CMB Life Insurance Co., Ltd. (hereinafter referred to as "Cigna & CMB") to process the personal information of the policyholder, the insured person, and the beneficiary (collectively referred to as "Personal Information") for the purposes of concluding and performing the insurance contract, providing products and services, and fulfilling legal obligations. I confirm that I have obtained the necessary authorization from the relevant data subjects regarding any personal information of other individuals that I have provided.
 - 本人同意并授权，为订立和履行保险合同，提供核保、保全、理赔、客户服务等目的，招商信诺可向征信机构、医疗机构、以及其他单位、组织等第三方合作机构查询、收集本人的个人信息。
I hereby consent and authorize Cigna & CMB, for the purposes of concluding and performing the insurance contract, including but not limited to underwriting, policy administration, claims settlement, and customer service, to inquire and collect my personal information from credit reporting agencies, medical institutions, and other third-party cooperative entities or organizations.
 - 本人同意并授权，招商信诺可将本人提供的以及根据上述约定查询、收集的个人信息提供给关联公司，以及其他为提供服务所必须的第三方合作机构（如健康管理公司、医疗机构、再保险公司、理赔垫付服务机构等）。
I hereby consent and authorize Cigna & CMB to provide my personal information, including both the information I have provided and the information obtained through inquiries and collection as described above, to its affiliated companies and to other necessary third-party service providers (such as health management companies, medical institutions, reinsurers, claims advance payment service providers, etc.) for the purpose of service provision.
 - 本人同意并授权，为履行法定义务，招商信诺可将个人信息提供给司法机关、中国人民银行、国家金融监督管理总局及其派出机构等监管机构或其指定的第三方、保险行业协会、同业公会等相关机构组织。
I hereby consent and authorize Cigna & CMB to provide my personal information to judicial authorities, regulatory bodies such as the People's Bank of China and the National Financial Regulatory Administration and their local offices or designated third parties, as well as relevant industry associations including insurance associations, for the purpose of fulfilling legal obligations.
 - 本人同意并授权，在保险合同期间、或订立前、终止后，招商信诺、招商信诺关联公司及因服务必须委托的合作伙伴可向本人提供、推荐保险产品、理赔服务、及其他客户服务，如市场调查与信息数据分析等。
I hereby consent and authorize Cigna & CMB, its affiliated companies, and its necessary service partners to provide and recommend insurance products, claims services, and other customer services (such as market research and information data analysis) to me during the term of the insurance contract, prior to its conclusion, or after its termination.
 - 为向本人提供高端医疗保险境外理赔服务、境外就医直付服务，招商信诺需要根据实际情况将必要的个人信息提供给下列境外接收方：
To provide overseas claims services and direct billing services for overseas medical treatment under the high-end medical insurance, Cigna & CMB needs to provide the necessary personal information to the following overseas recipients, depending on the actual circumstances:
(1) 向信诺欧洲服务（英国）有限公司（Cigna European Services (UK) Limited；联系方式：european-compliance@cigna.com）提供必要的个人基本信息、个人身份信息、理赔申请相关信息及其他必要保单相关信息（包括但不限于姓名、性别、出生日期、家庭关系、保单信息、理赔金额），用于后续向本人提供具体的境外理赔服务；
Cigna European Services (UK) Limited (contact info: european-compliance@cigna.com): Necessary basic personal information, personal identification information, claim-related information, and other necessary policy-related information (including but not limited to name, gender, date of birth, family relationship, policy information, claim amount, etc.) for the purpose of enabling it to provide specific overseas claims services to me;
(2) 向信诺环球保险有限公司（Cigna Worldwide General Insurance Company Limited；联系方式：fiona.hung@cignahealthcare.com）提供必要的个人基本信息、个人身份信息、个人健康生理信息及个人财产信息等（包括但不限于姓名、性别、出生日期、保单号码、个人健康及医疗相关信息等），用于为本人提供境外就医直付服务及相关医疗支持。
Cigna Worldwide General Insurance Company Limited (contact info: fiona.hung@cignahealthcare.com): Necessary basic personal information, personal identification information, personal health and physiological information, and personal property information (including but not limited to name, gender, date of birth, policy number, personal health and medical-related information, etc.) for the purpose of enabling it to provide direct billing services for overseas medical treatment and related medical support to me.
- 上述境外接收方仅在此范围内对本人的个人信息进行处理。本人已知晓，若本人希望向上述境外接收方行使个人信息相关权利，可通过上述联系方式与其联系，也可通过招商信诺联系，要求其协助处理。
The above overseas recipients shall process my personal information only within the scope specified herein. I understand that if I wish to exercise my personal information rights with respect to the above overseas recipients, I may contact them using the contact information provided above, or contact Cigna & CMB to request assistance.
- 本人知晓并同意，个人信息包括姓名、性别、国籍、职业、联系地址、联系方式、身份证件信息、以及生物识别、医疗健康、金融账户等敏感个人信息，该等信息是招商信诺为订立、履行合同及提供服务所必需；同意招商信诺对个人信息的处理方式包括收集、存储、使用、加工、传输、提供、删除等；同意适用招商信诺隐私政策。
I acknowledge and agree that the personal information, which includes but is not limited to name, gender, nationality, occupation, contact address, contact details, identification document information, as well as sensitive personal information such as biometric data, medical health information, and financial account details, is necessary for Cigna & CMB to conclude and perform the contract and to provide services. I consent to Cigna & CMB processing such personal information through means including collection, storage, use, processing, transmission, provision, and deletion. I also agree to be bound by the Cigna & CMB Privacy Policy.
 - 本人同意并授权招商信诺向合作的代理公司或者经纪公司传输姓名、性别、出生日期、身份证件信息、国籍、通讯地址、联系电话、邮箱、保单信息（不含生物识别、医疗健康、金融账户等敏感个人信息）等个人信息，用于代理公司在为其客户提供相应服务期间建立业务档案目的。
I hereby consent and authorize Cigna & CMB to transmit personal information, including but not limited to name, gender, date of birth, identification document information, nationality, mailing address, telephone number, email address, and policy information (excluding sensitive personal information such as biometric data, medical health information, and financial account details), to its cooperating agency companies or brokerage company for the purpose of establishing business records during the period in which such agencies provide corresponding services to their clients.
 - 本人知晓，在符合法律规定的情形下，本人对个人信息拥有合法的查阅、更正、删除、撤回同意权。本人行使上述权利不会与为订立、履行保险合同及获得客户服务相违背，也不会与招商信诺履行法定义务相冲突。
I acknowledge that, to the extent permitted by applicable law, I possess the lawful rights to access, correct, delete, and withdraw consent regarding my personal information. I understand that the exercise of the aforementioned rights shall not conflict with the conclusion or performance of the insurance contract, the receipt of customer services, or Cigna & CMB's fulfillment of its legal obligations.

特别提示 Special notes:

- 招商信诺非常重视个人信息保护，并尽最大努力合理保护个人信息，包括采取权限管理、加密管理、限制访问、与相关机构或人员签署保密协议等方式。如您不同意本授权条款或其中部分条款，可致电招商信诺客服热线95362/400-820-7553修改授权。请您妥善保管您的账户、密码及其他个人信息。您账户下的操作行为将视为您本人的操作行为。一旦您泄露该信息，如可能会对您有不利影响，您可立即与我们联系。
Cigna & CMB places great importance on the protection of personal information and makes every reasonable effort to safeguard such information through measures including but not limited to access control, encryption, restricted access, and the execution of confidentiality agreements with relevant institutions and personnel. If you do not agree to this authorization or any part thereof, you may contact Cigna & CMB's customer service hotline at 95362 or 400-820-7553 to modify your authorization. Please properly safeguard your account, password, and other personal information. Operations conducted under your account will be deemed as actions taken by you personally. If such information is compromised, potentially causing adverse effects for you, please contact us immediately.
- 招商信诺重视未成年人的信息保护。如被保险人不满14周岁的未成年人，请监护人仔细阅读本授权书条款，并予以授权。
Cigna & CMB values the protection of minors' information. If the insured person is a minor under the age of 14, the guardian is requested to read the terms of this authorization carefully and provide consent on their behalf.
- 您的生物识别、医疗健康、金融账户等信息属于敏感个人信息，提请您特别同意。
Your sensitive personal information, such as biometric data, medical health information, and financial account details, requires your specific and explicit consent.
- 如本保险计划涉及境外医疗服务、紧急救援服务等情形的，招商信诺将为履行上述服务向境外实体提供您必要的个人信息，提请您特别同意。
If this insurance plan involves services such as overseas medical treatment or emergency rescue, Cigna & CMB will need to provide your necessary personal information to overseas entities to fulfill these services. Your specific and explicit consent is required for this.
- 招商信诺可能适时修订隐私政策，并于官网（www.cignacmb.com）、APP公布更新，请您及时查阅。
Cigna & CMB may update its privacy policy from time to time. The updated version will be published on its official website (www.cignacmb.com) and APP. Please review it periodically for the latest information.

退保金额说明 Explanation of Surrender Value

- 犹豫期内退保: 如果您在犹豫期内要求解除本合同, 我们将向您无息退还本合同项下已支付的全部保险费。
Surrender during the cooling-off period: If you request to terminate this contract during the cooling-off period, we will refund the total premium paid under this contract to you without interest.
- 犹豫期后退保: 如果您在犹豫期后要求解除本合同, 我们将向您退还本合同项下在终止之日的现金价值, 具体以保险条款约定为准。(现金价值: 通常体现为解除合同时根据精算原理计算的由本公司退还的那部分金额)。
Surrender after the cooling-off period: If you request to terminate this contract after the cooling-off period, we will refund the cash value of this contract as of the date of termination. The specific amount shall be determined in accordance with the provisions of the insurance policy terms. (Cash value: Generally reflected as the amount of the portion refunded by the company and calculated in accordance with the actuarial principle upon surrender.)
- 未还款项的处理: 如本保单项下有未还的款项, 退费款项需先用于偿还本保单的未还款项。
Treatment of outstanding amounts: If there are any outstanding amounts under this policy, the surrender proceeds shall first be used to repay such outstanding amounts.

声明与授权 Declaration and Authorization

- 本人经仔细阅读后确认本申请各项填写内容均属实, 与之有关的资料均完整, 确实无误, 并由本人亲自提供。
I hereby confirm, after careful review, that all information provided in this application is true, accurate, and complete. All related materials are complete and correct, and have been provided by me personally.
- 本人已知晓本申请书必须由本人亲笔签名确认, 同时知晓所申请的变更事项须经贵公司同意批准后生效, 其生效日以招商信诺批注等文件或通知所载或所告知的生效日为准。
I acknowledge that this application form must be confirmed by my own handwritten signature. I am also aware that the requested changes are subject to the company's approval and will only become effective upon such approval. The effective date shall be the date specified in the endorsement document, notice, or communication issued by Cigna & CMB.
- 本人知晓, 若保障计划升级或新增, 升级或新增部分的等待期(如有)将重新计算。具体案例包括但不限于: 保障区域由全球除美国变更为全球, 在美国进行的医疗或者生育的等待期需重新计算; 去除或减少核心计划的免赔额, 去除或减少部分的等待期需重新计算。
I understand that if the coverage plan is upgraded or expanded, any applicable waiting period for the upgraded or newly added portions will be recalculated. Specific examples include, but are not limited to: changing the coverage area from Worldwide excluding US to Worldwide, in which case the waiting period for medical or maternity services received in the USA will be recalculated; or removing or reducing the core plan deductible, in which case the waiting period for the removed or reduced portion will be recalculated.
- 本保险合同并无任何转让、抵押、质押的事实; 本人未有涉及与本保险合同有关的诉讼或仲裁事项。
There are no existing assignments, mortgages, or pledges of this insurance contract. I am not involved in any litigation or arbitration proceedings related to this insurance contract.
- 若本人申请解除保险合同, 本人已知悉并同意招商信诺自收到完整的解除合同通知书之日起保险合同终止(解除合同通知书指本次申请所需要的全部资料, 包括申请书、身份证件资料、申请核实过程资料等)。在保险合同解除后, 招商信诺所负之保险责任同时终止, 投保人、被保险人、受益人不再享有相应的保障和利益, 且保险合同效力不可恢复; 本人知晓应退还保险合同原件、保险费发票和会员卡, 如未退还, 则招商信诺可视同已遗失或已损毁。
If I apply to terminate this insurance contract, I acknowledge and agree that the contract will terminate on the date Cigna & CMB receives the complete notice of contract termination. (The notice of contract termination refers to all documents required for this application, including the application form, identification documents, and materials from the verification process). After the termination of the insurance contract, all insurance liabilities of Cigna & CMB shall cease simultaneously. The policyholder, the insured person, and the beneficiary will no longer be entitled to the corresponding coverage and benefits, and the validity of the insurance contract cannot be reinstated. I understand that I should return the original insurance contract, premium invoices, and membership cards. If these items are not returned, Cigna & CMB may treat them as lost or destroyed.
- 新投保人声明: 招商信诺已对投保险种的各项保险条款内容履行了说明义务, 并对保险责任、责任免除条款、免赔率、免赔额、比例赔付、退保条款、犹豫期条款等履行了提示和说明/明确说明义务, 上述内容本人均已完全理解, 并同意遵守。
Declaration by the new policyholder: Cigna & CMB has fulfilled its obligation to explain the terms and conditions of the insurance product applied for, and has duly provided notice and a clear explanation regarding the insurance coverage, exclusions, deductible rates, deductible amounts, copay, surrender provisions, and cooling-off period clauses, among others. I hereby confirm that I have fully understood all the aforementioned contents and agree to be bound by them.

(原)投保人签名: _____
(Original) Policyholder Signature

被保险人(监护人)签名: _____
Insured Person (or Guardian) Signature

(新)投保人签名: _____
(New) Policyholder Signature

签署日期: _____年(YYYY)____月(MM)____日(DD)
Date of Signature

被保险人监护人手机号码(监护人代办时需填写): _____
Mobile Number of the Insured Person's Guardian (Required when a guardian is acting on behalf of the insured person)

温馨提示:
Notice:

- 招商信诺从未销售过非保险金融产品, 更未委托或者授权任何人士销售非保险金融产品, 敬请知悉。
Cigna & CMB has never sold non-insurance financial products, nor has it ever authorized or appointed any individual to sell such products. Please be informed accordingly.
- 保险从业人员不得违规销售非保险金融产品, 如遇推荐、宣传非保险金融产品, 并唆使您办理保单退保或贷款等, 请提高警惕, 避免卷入非法集资陷阱, 按照我国法律规定, 参与非法集资, 风险损失自担。
Insurance sales personnel are prohibited from marketing non-insurance financial products in violation of regulations. Should you encounter anyone recommending or promoting non-insurance financial products and advising you to surrender your policy or take out a loan, please remain vigilant to avoid involvement in illegal fundraising schemes. Please be advised that according to Chinese law, participants in illegal fundraising activities bear their own risks and losses.
- 为维护您的合法权益, 请勿在空白申请书上签名, 请确保您已完整提交本次申请所需要的全部资料, 招商信诺将以收到前述完整资料之日作为您的实际申请日期。
To safeguard your legitimate rights and interests, please do not sign any blank application forms. Please ensure you have submitted all documents required for this application. The date on which Cigna & CMB receives the aforementioned complete set of documents will be regarded as the actual application date.

以下为收件/初审人员填写 For Completion by Receiving / Preliminary Review Staff

受理渠道: 银行柜面 公司柜面 上门亲办 其他
Application Channel Bank Counter Company Counter Home Visit Other: _____

本次随附资料: 身份证件复印件 银行卡复印件 个人税收居民身份声明 其他
Documents Attached Copy of ID Document Copy of Bank Card Individual Tax Residency Self-Certification Form Other: _____

亲见客户声明: 本人已亲见申请资格人及签名人员, 并已核对身份证明原件, 人证相符, 确认身份, 复印件与原件一致。
Declaration of In-Person Verification: I have personally met the applicant and the signatory, verified their original identification documents, confirmed their identities as matching the documents, and verified that the copies are consistent with the originals.

银行网点名称及代码: _____ 银行办理/见证人员签名及代码: _____ 日期: _____年____月____日
Bank Branch Name & Code Signature & Code of Bank Handling/Witnessing Officer Date(YYYY/MM/DD)

招商信诺服务人员签名及手机号码: _____ 日期Date: _____年(YYYY)____月(MM)____日(DD)
Signature & Mobile Number of Cigna & CMB Service Personnel

分公司初审人员签名及手机号码: _____ 日期Date: _____年(YYYY)____月(MM)____日(DD)
Signature & Mobile Number of Branch Preliminary Review Officer