

Request for Change in Policy Form

Please tick <input checked="" type="checkbox"/> appropriate box(es) for request			Insurer				
Policy No.:		Insured:		Policyowner:			
1. <input type="checkbox"/> Change of Personal Information (Please give documentary proof e.g. deed poll, ID card copy)		<input type="checkbox"/> Insured	<input type="checkbox"/> Policyowner				
		Name _____	Sex _____				
		ID/ Birth Cert/ Passport No. _____					
		Occupation & Job Duties _____					
		Date of Birth _____ / _____ / _____		Occupational Class change to _____			
		dd mm yyyy					
2. <input type="checkbox"/> Change of Correspondence Address (The address will be updated for all Policies unless specified). <input type="checkbox"/> Change of Insured Location		<input type="checkbox"/> All Policy	<input type="checkbox"/> Other Policy No. _____				
		Address _____					
		E-Mail _____					
		Home Tel No. _____	Office Tel No. _____	Mobile/Pager _____			
3. <input type="checkbox"/> Change of Occupation Position _____ Job Nature _____		4. <input type="checkbox"/> Change of Employer					
		Name: _____ Correspondence Address: _____ _____ Tel No. _____					
5. <input type="checkbox"/> Change of Beneficiary		Name	Relationship to the Insured	ID/ Birth Cert	Share (%)		
		_____	_____	_____	_____		
		_____	_____	_____	_____		
6. <input type="checkbox"/> Change of Benefits Covered (Attached Enrollment Form if necessary.) Effective Month _____ / _____ / _____ dd mm yyyy		Benefits Covered	Addition	Deletion	Increase	Reduce	New Sum Insured/ Class
		_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
		_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
		_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. <input type="checkbox"/> Others (Please state in details)							
Signature must be consistent with that in your policy application form.							
_____				_____			
Signature of Insured				Signature of Policyowner (if other than Insured)			
_____				_____			
Date				Date			
Payment Submitted: HK\$/ US\$ _____		Cheque No. _____					
Letter/ Endorsement will be delivered to Policyowner: <input type="checkbox"/> by Agent		<input type="checkbox"/> by Mail					
Attachment <input type="checkbox"/> Health Declaration Form		<input type="checkbox"/> ID Card/ Birth Cert/ Deed Poll Copy		<input type="checkbox"/> Others _____			
FOR OFFICE USE ONLY							
AGENT ONLY				GENERAL ADMIN. USE ONLY			
Attachment		Agent Code		In Date		Account	
		Request	<input type="checkbox"/> Invoice	<input type="checkbox"/> Receipt	Fax to Insurer		Accruals
I.D. Card		<input type="checkbox"/> Other		Confirm Receipt		Invoicing	
Others				Date		Remarks	
				Person			