

To be completed in English. The Chinese version of this form is for reference only. If there is any conflict between the meaning of the words of terms of the English version and the Chinese version of this form, the meaning of the English version shall prevail.

須以英文填寫。此表格之中文版本只供參考之用。若此表格英文版本與中文版本條款用語之涵義有任何抵觸，應以英文版本之涵義為準。

A separate Reinstatement Application must be completed for each Proposed Insured. Reinstatement is requested on the following Proposed Insured:
每名擬投保人必須填寫獨立之復效申請書。以下擬投保人要求復效：

Proposed Insured 擬投保人		Policy No. 保單號碼	
Mailing Address 郵遞地址			
Occupation/Industry/Duties 職業 / 行業 / 職務		HKID/SSN/Passport No. 香港身份證號碼 / 社會保障號碼 / 護照號碼	
Amount Paid With This Application US\$ 與此申請書同付之款項	Home Phone 住宅電話	Work Phone 辦公電話	

PLEASE MAKE ALL CHECKS PAYABLE TO TRANSAMERICA LIFE (BERMUDA) LTD. DO NOT NAME ANY OTHER PAYEE AND DO NOT LEAVE THE PAYEE SPACE BLANK.

所有支票抬頭請付全美人壽(百慕達)有限公司。切勿填寫其他受款人之名稱，亦切勿將受款人一欄漏空。

Transamerica Life (Bermuda) Ltd., "the Company", may require additional evidence of insurability. This is an Application for reinstatement of the above Policy in accordance with its provisions.
全美人壽(百慕達)有限公司(下稱「公司」)可能要求提供額外可受保證明文件。此為上述保單按其條文復效之申請書。

The Proposed Insured must answer each of the following questions:

擬投保人必須回答下列每條問題：

- Have you used nicotine at any time?
您是否曾經於任何時間使用尼古丁？

<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否	Cigarettes 香煙	Date last used 最後一次吸食日期	_____
<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否	Cigar/Pipe/Chewing Tobacco 雪茄/煙斗/咀嚼煙草	Date last used 最後一次吸食日期	_____
<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否	Other (e.g. patch, gum, etc.) 其他(例如：膠貼、香口膠，等)	Date last used 最後一次使用日期	_____
- Do you intend to fly other than as a passenger or have you flown other than as a passenger during the past two years?
您是否打算以非乘客身份飛行或您是否在過去兩年內曾以非乘客身份飛行？
If "Yes", indicate type of license
如「是」，請說明執照類別
no. of solo hours
單獨飛行小時
Advanced Ratings (IFR/ATC)
; 進階級執照(IFR/ATC)
hours flown past 24 months
; 過去 24 個月飛行小時

- Do you plan to travel outside the U.S., Canada, Western Europe, Hong Kong, Singapore, Taiwan, Japan, Australia or New Zealand, for business or leisure, within the next 24 months?
您是否計劃在未來 24 個月內到美國、加拿大、西歐、香港、星加坡、台灣、日本、澳洲或新西蘭境外公幹或旅遊？
If "Yes", give destinations, length of stay, number of trips per year and purpose of travel in Remarks.
如「是」，請在備註欄說明目的地、逗留時間、每年出行次數及行程性質。
- Within the past ten years, have you been convicted of or pleaded guilty to any driving violations, which includes driving under the influence of alcohol and/or other drugs or reckless driving?
您在過去十年內是否曾就任何違例駕駛被定罪或認罪，包括受酒精及 / 或其他藥物影響下駕駛或魯莽駕駛？
If "Yes", give dates and types.
如「是」，請說明日期及違例類別。
- Within the past two years, have you participated in aeronautics, powered racing of competitive vehicles, skin or scuba diving, mountain climbing, rodeo or competitive skiing? If "Yes", give details in Remarks.
您在過去兩年內是否曾參與航空、賽車或競賽交通工具、徒手或水肺潛水、攀山、騎術競技或競技滑雪？如「是」，請在備註欄說明詳情。
- Present height and weight: _____ ft. _____ in. _____ lbs.
現時身高及體重： _____ 呎 _____ 吋 _____ 磅



7. Name and address of your personal physician:

您的私人醫生之姓名及地址：

8. What medication (s) are you presently taking?

您目前正在服用甚麼藥物？

9. During the past five years, have you:

在過去五年內，您是否曾經：

Yes No
是 否

a.) Had any illness, injury or disease?
有任何疾病、損傷或病症？

Yes No
是 否

b.) Consulted or been examined by any physician?
接受任何醫生診症或檢驗？

Yes No
是 否

c.) Required any hospitalization(s)?
需要住院？

Yes No
是 否

d.) Been declined, rated, modified, postponed, refused renewal or refused reinstatement for any life insurance application?
於申請人壽保險時被拒絕、加費、修改、延期、拒絕續期或拒絕恢復生效？

Yes No
是 否

e.) Filed for, received or been refused disability benefits?
申請、領取或被拒付殘疾賠償？

For "Yes" answers, in Remarks include all dates, diagnoses, durations of any illness and provide names and addresses of all attending physicians and hospitals. 如回答「是」，請在備註欄填上所有日期、診斷、患病歷時多久，並且提供所有主治醫生的姓名和地址以及所有主治醫院的名稱和地址。

Remarks 備註

The Policy Owner must answer the following question:

保單擁有人必須回答以下問題：

Is the Policy Owner a U.S. Person for Tax Purposes? Yes 是 No 否

保單擁有人是否就稅務而言的美國人士？

If "Yes", please provide the following information:

如「是」，請提供以下資料：

Name: _____

姓名：

U.S. Taxpayer Identification Number: _____

美國納稅人身份識別號碼：

I represent that the statements and answers given in this Application are complete and true to the best of my knowledge and belief and may be relied on by the Company as the basis for reinstatement of the Policy. I understand that the Company may require additional evidence of insurability. I understand that the Company may, subject to the reinstatement provisions of the Policy, deposit any payment or cash any check without prejudice to its rights to decline to reinstate the Policy. I understand that if the Company declines to reinstate the Policy, any payment paid with this Application will be refunded.

本人聲明，本申請書所填寫之各項陳述及答案，盡本人所知及所信均屬完整和真確，貴公司可信賴作為保單復效依據。本人明白，貴公司可能要求提供額外可受保證明文件。本人明白貴公司可能在符合保單的復效條款下繳存任何款項或兌現任何支票而不會損害其拒絕保單復效的權利。本人明白，若貴公司拒絕保單復效，與此申請書同付之任何款項將予退回。

Signed at _____ on _____
簽署地點 City, Country 城市，國家 日期 Date (mm/dd/yyyy) 日期 (月 / 日 / 年)

Signature of Proposed Insured
(or parent or guardian if Proposed Insured is a minor)
擬投保人 (如擬投保人乃未成年人士，則父母或監護人)
之簽署

Signature of Proposed Owner (if other than Proposed Insured)
擬擁有人 (如非擬投保人) 之簽署

PLEASE COMPLETE AUTHORIZATION

請填寫授權書

AUTHORIZATION TO OBTAIN INFORMATION
獲取資料授權書
TRANSAMERICA LIFE (BERMUDA) LTD. (“the Company”)
全美人壽(百慕達)有限公司 (「公司」)

I, the Proposed Insured, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, consumer reporting agency, or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me and any non-medical information of me to give the Company or its legal representative, any and all such information.

本人 (擬投保人) 謹此授權可備有關於檢驗、診斷、治療及預斷本人之任何身體或精神狀況及 / 或本人之治療資料以及本人之非醫療性資料之任何醫護人員、醫生、醫院、診所、其他醫療或與醫療有關之機構、承保或再保公司、消費者報告代理或僱主，將任何及所有該等資料給予貴公司或其法定代表。

I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, or other persons or organizations performing business or legal services in connection with my Application, claim or as may be otherwise lawfully required or as I may authorize.

本人明白，透過使用此授權書所獲得之資料將由貴公司用以釐定是否有資格獲得保險及是否有資格獲得現有保單下之賠償。公司不會將所取得之任何資料向任何人士或機構發佈，惟向再保公司，或執行與本人之申請書、索償有關之商業或法律服務之其他人士或機構，或在其他依法需要之情況下在本人授權之情況下發佈有關資料則屬例外。

I know that I may request to receive a copy of this Authorization.

本人知道，本人可要求取得一份此授權書之副本。

I agree that a photocopy of this Authorization shall be as valid as the original.

本人同意，此授權書之影印本應與正本同樣有效。

I agree this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether living or deceased.

本人同意，此授權書應自下文所列日期起計兩年半內有效，無論本人之情況為何及是否在世。

Note: If information is to be released by a person or facility located in the U.S., the Authorization for Release and Disclosure of Health Related Information form must be completed and attached.

注意：如資料須由位於美國之人士或機構發佈，則必須填寫及附上發佈及披露健康相關資料授權書。

I understand that if an investigative consumer report is ordered in connection with this Application, I may elect to be interviewed in connection with the preparation of the report and, upon request, I will be provided with a copy of the report.

本人明白，若須就此申請書安排一份消費者調查報告，本人可以選擇就編製有關報告而被接見。在提出要求後，本人將會獲得一份報告副本。

Yes No I elect to be interviewed if an investigative consumer report is prepared.
是 否 如需編製消費者調查報告，本人選擇被接見。

Signed at _____ on _____
簽署地點 City, Country 城市，國家 日期 Date (mm/dd/yyyy) 日期 (月 / 日 / 年)

Signature of Proposed Insured
(or parent or guardian if Proposed Insured is a minor)
擬投保人 (如擬投保人乃未成年人士，則家長或監護人)
之簽署

Signature of Proposed Owner (if other than Proposed Insured)
擬擁有人 (如非擬投保人) 之簽署