

中美联泰大都会人寿保险有限公司人身保险投保单

Sino-US United Metlife Insurance Company Limited Application Form

银行代理保险专用



在本投保书中，如中文表述与英文表述不一致，则以中文表述为准。

If the English version is not consistent with Chinese version, Chinese version

签署地Place of Signature: 天津市

投保单编号 Application No. :

211111124237

投保事项 DETAILS OF INSURANCE APPLIED FOR ( 币值单位Currency:人民币元RMB )

险种名称 Basic Plan/Rider Name	险种代码 Code	基本保险金额 ( 1000元的整 数倍 ) Basic Sum Assured	保险期限 Benefit Term	交费年期 Premium Term	年金/约定 领取年龄 Eligible Age	年金领取方式 ( 若未填, 则 默认为年领 ) Annuity Option
都汇康健重大疾病保险	DD11BA	500000	保障终身	缴费10年		

其他事项  
A. 保险费交付方式Premium Mode : ☒ 年交Annually ☐ 月交Monthly ☐ 一次性交付Single Premium  
B. 溢交保险费转下期保险费选择PDF Option : ☐ 同意Yes ☒ 不同意No ( 如未勾选, 则作不同意处理 )  
C. 保险费逾期未付选择APL Option : ☒ 自动垫交APL ☐ 中止Lapse  
( 若投保的险种无自动垫交功能或者未勾选, 则作中止处理 ) If there is no function of automatic premium loan in the insurance or the choices are not ticked, suspending will work  
D. 红利给付方式Dividend Option : ☐ 现金领取Drawing Cash ☐ 累积生息Accumulating with interest ☐ 增额红利 Reversionary Dividend  
( 如条款对红利领取有特别约定, 则以条款为准, 勾选无效。如条款未约定红利领取方式且投保单未勾选则作累积生息处理。 ) If the insurance term has a special stipulation on the dividend. Subject to the insurance term, the choice ticked off will be invalid. If the choices are not ticked, accumulating dividends will function; If there is not bonus paid in the insurance, the choice ticked off will be invalid.

1. 采用月交保险费方式的, 首次需交纳二个月保险费, 实际应交保险费以保险合同中的每期保险费为准。Used to pay premiums by monthly mode, Required to pay premiums for the first time two months, The actual premium will be printed on the policy contract.
2. 如您选择了自动垫交, 在超过宽限期仍未交费, 而您的保险合同当时的现金价值扣除您尚未清偿的保单贷款及其累计利息之后的余额, 足以垫交到期保险费时, 我们将自动贷款给您, 为您垫交该期保险费, 该利率同保单贷款利率。If you choose APL option and without getting your premium after overdue day, we ' ll advance a sum of money automatically for due premium, if your balanced cash value is enough after pay off your loan and interest, we ' ll charge you interest on loan while you repay premium.
3. 本合同效力中止后2年内, 您可以申请恢复合同效力。经我们与您协商并达成协议, 在您补交保险费后合同效力恢复。You could apply for policy reinstatement within 2 years after policy lapsed. If we approve your application, you should repay premium, then the policy will be reinstated successfully.

首次预估保险费交纳总额Initial Estimated Premium to be paid : 贰万肆仟柒佰陆拾元整  
( 实际应交保险费金额以保险合同中的每期保险费为准 ) The actual premium will be printed on the policy contract.

投保人资料填写 ( 如投保人与被保险人不是同一人, 则投保人必须为被保险人的配偶、父母或子女 )  
POLICYOWNER DETAILS ( If policy owner is not the insured, the policy owner must be the insured ' s spouse, parent child. )

姓名 Full Name : 测试九	与被保险人关系Relationship to Insured: <input checked="" type="checkbox"/> 本人Owner <input type="checkbox"/> 配偶Spouse 父子Father and son 父女Father and daughter 母子Mother and son 母女Mother and daughter 其他Other: _____	国籍 Nationality <input checked="" type="checkbox"/> 中国China <input type="checkbox"/> 美国U.S.A 其他 Other: _____
证件类型 ID Type : <input checked="" type="checkbox"/> 身份证 ID Card <input type="checkbox"/> 护照 Passport 其他Other : _____	出生日期 Date of Birth: 1997年 07月 05日 (YYYY/MM/DD)	性别 Gender: <input checked="" type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female
证件号码 3 1 0 1 0 4 1 9 9 7 0 7 0 5 6 0 7 0	证件有效期限Date of valid ID to 2026年 03月 31日 YYYY/MM/DD 终身 Whole Life 证件递交ID Submit 是 Yes 否No ( 保险公司填写 ) 职务及工作内容 Responsibility _____ 职员 _____ 职业代码: 外勤商旅餐饮 ( 保险公司填写 )	公司名称 company dasda 居住地址 Residential Address: 河北省秦皇岛市海港区dsads 邮政编码 Postal Code: 226633
家庭电话 Contact Tel.No. _____	手机 Mobile: 13525826300	邮箱地址 E-mail Address: dasdas@qq.com
年收入Annual Income(万 Ten thousand): 110 ( 单位为万元 )	保费预算Premium budget(元 Yuan): 1200000	投保人家庭年收入Policyholder ' s family income : 150 ( 单位为万元 ) ( unit : 10,000 )
投保人家庭年收入Policyholder ' s family income : 150 ( 单位为万元 ) ( unit : 10,000 )	投保人为: <input checked="" type="checkbox"/> 1. 城镇居民 Urban resident <input type="checkbox"/> 2. 农村居民suburban resident	
投保人联系地址 Policy Owner Mailing Address(若未勾选, 默认为居住地址): 其它地址Other Address :	<input checked="" type="checkbox"/> 同居住地址 The Same As Residence 邮政编码Postal Code : 226633	

被保险人资料填写 INSURED DETAILS ( 若被保险人为投保人本人, 可免填本栏) ( Ifinsured is the policyowner,this item can be blank )

姓名  
Full Name:测试九

证件类型  
ID Type: √身份证 ID Card 护照 Passport 其他Other:

证件号码  

3

1

0

1

0

4

1

9

9

7

0

7

0

5

6

0

7

0

国籍  
Nationality √中国China 美国U.S.A 其他 Other:

出生日期  
Date of Birth: 1997 年 07 月 05 日(YYYY/MM/DD)

性别  
Gender: √男 Male 女 Female

证件有效期限Date of valid ID to 2026 年 03 月 31 日 YYYY/MM/DD 终身 Whole Life

证件递交ID Submit 是 Yes 否No ( 保险公司填写 )

职务及工作内容  
Responsibility 职员 职业代码 外勤商旅餐饮( 保险公司填写 )

公司名称  
companydasda

居住地址  
Residential Address:河北省秦皇岛市海港区dsads

家庭电话  
Contact Tel.No.

手机  
Mobile:13525826300

邮政编码  
Postal Code:226633

邮箱地址  
E-mail Address:dasdas@qq.com

年收入Annual Income(万 Ten thousand):110 ( 单位为万元 )

身故保险金受益人资料 DEATH BENEFICIARY DETAILS

身故受益人姓名 Full Name	性别 Gender	证件类型 ID Type	证件号码 ID No.	出生日期 Date of Birth	与被保险人关系 Relationship to Insured	保险金给付方式 Benefit Payment method	
						受益比例 ( % ) By Share	受益顺序 By Order

身故保险金受益人Death Beneficiary：如无特别指定，受益人为被保险人的法定继承人。If no beneficiary is designated, Death Benefit proceeds will be paid to insured ' s heir at law 按填写的受益顺序By Order ( 受益顺序从上至下，以上为先，后一顺序的受益人只有在前一顺序的受益人丧失受益权的情况下才具有受益权 ) (from top to bottom)

被保险人/投保人情况告知 Details of Insured/payor (如申请豁免保险费重大疾病保险，且投保保人非同一人，请投保人同时完成告知)

投保人  
policy owner

被保人  
Insured

1 您是否计划未来一年内前往国外定居或工作或自助旅游一个月以上? ( 不包含下列国家和地区：澳大利亚、加拿大、日本、新西兰、新加坡、文莱、马来西亚、韩国、法国、英国、德国、意大利、比利时、荷兰、爱尔兰、卢森堡、希腊、西班牙、葡萄牙、丹麦、泰国、马尔代夫、斯里兰卡、瑞典、芬兰、阿根廷、巴西、摩纳哥、阿联酋、毛里求斯、塞舌尔 )  
Are you planning to reside or work abroad or travel for more than 30days within one year? (except Australia; Canada; Japan; New Zealand; Singapore; Brunei; Malaysia; Korea; France; the United Kingdom; German; Italy; Belgium; Holland; Ireland; Luxembourg; Greece; Spain; Portuguesa; Denmark; Thailand; Maldives; Sri Lanka; Sweden; Finland; Argentina; Brazil; Monaco; UAE; Mauritius; Seychelles)

A01

是

否

是

√否

2 您是否正在或计划参加危险运动,如深度潜水(超过20米)、跳伞、攀岩、野外探险、打猎、赛车、赛马、冲浪等?  
Are the insured planning to take part in risky activity, such as diving to a depth of over 20 meters, parachuting,  
or rock climbing, exploration in field, hunting, motor-racing, horse racing, surfing

A02

是

否

是

√否

3 目前身体机能是否有失明、聋哑或言语、咀嚼、四肢机能障碍或缺损或畸形、智能障碍?  
At present, does the insured suffer for blindness, deaf-mute, dysfunction or impairment with dysphonia, dysmasesis,  
dyskinesia, or abnormality, intellectual impairment?

A04

是

否

是

√否

4 被保险人身高Insured Height:175 厘米 cm 投保人身高 payer Height:180 厘米 cm

A05

5 被保险人体重 Weight75 公斤 kg 投保人体重 Weight80 公斤 kg

A06

6 您是否有近亲属因疾病在60岁前身故? 若“是”，请列明具体人员和疾病：  
Do you have any family history relevant in those your immediate family members died under age 60? If tick “ Yes ”, please give the detail of the relationship and the cause of death.

A08

是

否

是

√否

7 过去两年内是否曾因健康检查有异常而被建议接受复查或其他检查或治疗或是否曾接到医生对您有关吸烟、饮酒的建议和告诫？  
In the past 2 years, have you been suggested having other check-up or treatment, or received suggestion and advices from the doctor about drinking and smoking, because of medical check-up anomaly?

A09

是

否

是

√否

8 过去三个月内是否曾因受伤或生病接受医生治疗、诊疗或用药？  
In the past 3 months, have you received diagnosis and treat or medicines because of illness or injury?

A10

是

否

是

√否

9 过去或现在是否患有下列“注一”之疾病，或曾因受伤或生病住院治疗或手术治疗七天以上？  
In the past or at present, did/do you suffer from the diseases listed below as “ Note 1 ” ? Or have you been in hospital for more than 7 days because of illness or injury?

A12

是

否

是

√否

10 过去两年内是否曾患有下列“注二”之疾病？  
In the past two year, did you suffer from the diseases listed below as “ Note 2 ” ?

A13

是

否

是

√否

11 被保险人投保年龄<=12周岁以下时，且您申请购买住院补贴健康保险，请补充告知：

被保人

第2页/共5页

If the insured is younger than age 12 and applies Hospital Income rider, please answer the following questions: 被保险人出生时是否难产或早产或有窒息史、抢救史或置于保温箱史？ Was the insured dystocia or premature delivery? Or did he (or she) have a history of asphyxia, emergency treatment or infant-incubation when he (or she) was born? 被保险人是否被告知患有先天性疾病、遗传性疾病、先天性畸形或缺陷或曾因此接受治疗？ Does the insured have congenital disease, genetic disease, congenital abnormalities or impairment? Or had he (or she) been treated due to the above diseases?			insured			
			A19			
			是	√否		
			A20			
12 已购买或正在申请投保其他保险公司的产品是否超过以下保额？寿险产品总保额300万、意外险产品总保额100万、重大疾病险产品总保额50万。 Does the accumulative total coverage amount, which you already have or are applying for other company ' s insurance, exceed 3 million life insurance、1 million accident insurance、or half million critical illness insurance?			是		√否	
			B01			
13 任何投保人为您投保的人寿保险、意外或健康保险是否曾被拒保、延迟承保、加费承保、部分保险责任限制或降低保额承保？ Have you ever had other insurance applications declined, postponed, accepted with extra premium or modified terms? 若“是”，请说明 If tick “Yes”，please complete 保险品种 Product Name: _____  投保日期：Application Date: _____  原因 Reason: _____			投保人 Policy owner		被保险人 insured	
			B02			
			是	否	是	√否
14 您的保费额度是否大于或等于投保人保费预算的150%？ Your premium amount is greater than or equal to 150% of policyholder ' s budget?			是		√否	
<p>（注一）：高血压病（收缩压≥140，舒张压≥90）、冠心病（包括心绞痛、心肌梗塞，冠状动脉手术或支架等）、心脏病变、心内膜炎、风湿性心脏病、先天性心脏病、主动脉搏血管瘤、心律失常、心脏瓣膜疾病（狭窄、闭锁不全、畸形）、短暂性脑缺血、脑中风、脑瘤、脑动脉血管瘤、癫痫、脑积水、脑炎、脑膜炎、老年痴呆（阿尔茨海默病）、惊厥，抽搐，肌肉萎缩、重症肌无力、多发性硬化症、运动神经元疾病（如进行性肌萎缩、肌萎缩性侧索硬化）、进行性球麻痹、震颤麻痹（帕金森氏）综合征、智能障碍、精神疾病、肺气肿、哮喘、支气管扩张症、尘肺、肺结核、肝炎（除甲型、戊型）、肝硬化、肝功能异常、肝脾肿大、溃疡性结肠炎、克隆病、肾炎、肾病综合征、肾功能异常、尿毒症、视网膜出血或剥离、视神经病变、癌症、血友病、白血病、再生障碍性贫血、紫癜、糖尿病、类风湿性关节炎、肢端肥大症、垂体机能亢进或减退、血糖升高，多囊肝，多囊肾，近3个月新发现的淋巴结肿大，甲状腺或甲状旁腺机能亢进或减退、硬皮病、红斑狼疮、混合结缔组织病、系统性硬化病、艾滋病或艾滋病毒携带者、颈部甲状腺，乳腺或者身体其他部位的肿块，结节，新生物，赘生物等或者体检、检查结果显示前述部位存在异常，未经证实为良性或恶性之肿瘤。 (Note 1): hypertension; coronary heart disease (include heart pain, myocardial infarction etc) ; myocardium pathological changes; endocarditis; rheumatic heart disease; congenital heart disease; aorta haemangioma; arrhythmia; heart valve disorders(stenosis, insufficiency, abnormality); transient cerebral ischemia; cerebral apoplexy; brain tumor; cerebral arterial haemangioma; epilepsy; hydrocephalus; encephalitis; meningitis; senile dementia (Alzheimer ' s disease); convulsion; twitch,muscular atrophy; multiple sclerosis motor neuron disease(for example, progressive muscular atrophy, amyotrophic lateral sclerosis); progressive bulbar paralysis; Parkinson ' s disease; intellectual impairment; mental disorder; emphysema; asthma; bronchiectasis; pneumoconiosis; pulmonary tuberculosis; hepatitis (except hepatitis A, hepatitis E); cirrhosis; hepatic dysfunction; hepatosplenomegaly; ulcerative colitis; Crohn ' s disease; nephritis; nephrotic syndrome; kidney dysfunction; uremia; retinal detachment; optic nerve disease; cancer; hernophilia; leukemia; aplastic anemia; purpura; diabetes mellitus; rheumatoid arthritis; acromegaly; hyperpituitarism or hypopituitarism; blood sugar elevated, polycystic liver; polycystic kidney, lymph enlargement in past 3 months, hyperparathyroidism or hypoparathyroidism; scirrhosarcar; lupus erythematosus; mixed connective tissue disease; systemic sclerosis; aids or aids virus carrier; Neck thyroid gland, breast, and other parts of the body ' s nodule, lump, neogrowth, neoplasm etc. and physical exam and other check items show the abnormal of above mentioned parts of the body, un-identified tumou.</p> <p>（注二）：酒精或药物滥用成癮、脊髓灰质炎、眩晕症、食道、胃、十二指肠溃疡或出血或穿孔、胰腺炎、肝炎病毒携带、脂肪肝、肝脓肿、肝血管瘤、肝内结石、疝、慢性阑尾炎、痔疮或肛周疾病、痛风、慢性支气管炎、肺脓肿、青光眼、白内障、心肌炎、脑膜炎、梅尼氏症、呼吸暂停综合症，中耳炎、鼻窦炎、鼻中隔弯曲、慢性扁桃体炎、肺炎、胸膜炎、气胸、胆结石、胆囊炎、息肉、便血、泌尿系统结石或炎症、蛋白尿（泡沫尿）、血尿、肾囊肿、盆腔炎、前列腺肥大、前列腺炎、性病、关节炎、椎间盘突出、坐骨神经痛、蚕豆病、贫血、静脉曲张、良性肿瘤（以下请女性被保险人回答）乳房疾病、子宫内膜异位症、阴道异常出血、子宫肌瘤、宫颈疾病，妊娠并发症、习惯性流产或其他生殖系统疾病或妇科检查异常、怀孕，若怀孕，_____周。 (Note 2): alcohol or drug abuse; poliomyelitis; vertigo; esophageal, gastric or duodenal ulcer, bleeding or perforation; pancreatitis; hepatic virus carrier; fatty liver; liver abscess; hepatic haemangioma; intrahepatic stone; hernia; chronic appendicitis; hemorrhoid or anal diseases; gout; chronic bronchitis; lung abscess; glaucoma; cataract; myocarditis; meningitis; meniere ' s syndrome; sleep apnea; otitis media; nasosinusitis; deviation of nasal septum; chronic tonsillitis; pneumonia; pleurisy; pneumothorax; gallstones; cholecystitis; polyp; haematochezia; urological system ' s lithiasis or urinary system inflammation; proteinuria (bubble-urine); haematuria; renal cyst; pelvic inflammatory disease; prostatic hypertrophy; prostatitis; STDS; arthritis; intervertebral disc herniation; sciatica; avism; anemia; varicose veins; benign tumor; (if the insurant is a female, please answer the following questions) breast diseases; endometriosis; vaginal bleeding; hystermomyoma; cervical disease; pregnancy complications; habitual abortion, or other reproductive system disease, or gynecologic exam anomaly; pregnant; if pregnant,_____week.</p>						
上述告知栏中若有回答为“是”者，请在本栏具体说明：If the answer is “Yes” for the above questions in part IV, please give the details as follows:						
疾病名称 Disease：医院名称 Name of the Hospital：患病时间 Date of attack and diagnosis：目前情况 Present Condition：						
FATCA 告知事项 FATCA Details (请投保人告知您本人是否存在以下美国身份表征,如您本人符合以下任何一种情况,则勾选“是”，如申请年金保险,请被保险人同时完成本项告知)			投保人		被保险人	
1) 本人持有美国护照或美国绿卡; I hold a US green card or US passport. 2) 本人是美国纳税人; I am a US tax payer. 3) 本人的出生地是美国; My place of birth is the United States. 4) 本人在美国有常住地址、联系地址、联系电话。 I have residential address, mailing address and telephone numbers in the United States.			是	否	是	√否
投保人及被保险人声明与授权						
1. 本人通过本投保单及其他任何问卷及文件对贵公司的各项声明与陈述均完整、正确,并由本人亲笔签署。本人知晓所有保险责任均以保险合同(包括由贵公司经正式程序修改或批准的内容)所载为准。若本人未履行如实告知义务,贵公司有权按照《保险法》相关规定不予承担保险责任。 I declare that to the best of my knowledge and belief all the deciaration and statement made in this policy or any other questionnaire or document is true and complete with my signature. I acknowledge that the insurance liabilities (including amendment or note made by the Company with formal procedure) stated in the insurance contract shall override all other insurance liabilities. If I default to provide true information, the Copany will not undertake any liability by law.						
2. 在本人确定投保之前,贵公司已向本人出示并提供了保险合同条款,并且贵公司已向本人明确说明了保险合同内容,本人已认真阅读、理解并接受了产品说明书及保险条款 (特别是保险责任、免除保险责任的条款,等待期、犹豫期、续保、解除合同规定及其相关金额)的内容。本人确认所投保的产品及选择的保险金额和保险期间适合本人。 On the explicit explanation by the Company, I ' ve read, understood and accepted the instructions and the insurance terms (especially insurance liabilities, waiting period, cooling-off period, liability exemption, withdraw regulations and amount). I acknowledge that the insurance product and the sum insured and period of insurance I choose is suitable for me.						
3. 本人确认:如本人选择分期按时交纳保费的,则本人已根据自身财务状况,选择了合适本人的交费期限和交费金额;本人已知晓:无法持续交纳保费可能导致合同效力中止或保险合同解除。 I acknowledge that if I joined the installment plan, I have, based on my financial status, choose the appropriate payment term and amount; and I understand that any default on payment of premium may invalidate or terminate the insurance contract.						
4. 本人已知晓,本人向贵公司交付全部或部分保险费的行为并不必然导致保险合同生效,贵公司将在收到本人交付首期保险费并通过核保出具正式保险合同才生效。贵公司以保险单上注明的保险单生效日的24时开始承担保险责任;首期保险费以支票或自动转账途径交付的,若支票无法承兑或授权账户未能使贵公司在投保日期起,经银行2次扣款收到全额首期保险费,本合同保险责任自始不开始,本合同生效日的24时起发生的保险事故,贵公司不承担保险责任。本人亦知晓:贵公司在核保时会根据实际情况要求被保险						

人进行体检,或要求补充其他材料;根据核保的有关情况,贵公司可能会要求增加保险费,或是拒绝承保。 I acknowledge that the insurance policy may not necessarily take effect upon full or part payment of premium to the Company and will only take effect provided the initial installment premium has been received and a policy is issued by the Company. The Company will not undertake any liability until 24:00 of the effective date given on the insurance policy; for the initial installment premium paid by check or Auto-Pay, if the check is unacceptable or the Company fails to debit the authorization account for the initial installment premium for twice as of the date of insured, the insurance liabilities of this policy shall not take effect and the Company will not undertake any liability for any insured accident as of 24:00 of the effective date. I also acknowledge that the Company, during data verification, may require the insured person to have a physical examination or provide other data; the Company, based on data verification, may increase the premium or reject the insurance application.

5. 本人同意,贵公司可向内、外科医生、医院、诊所、其他保险公司或其他任何组织或个人查阅有关本人的资料或索取有关证明文件;且贵公司可向再保险公司或本人申请投保的其他保险公司提供本人相关资料。 I agree that the Company may obtain access to any/or to verify any of my personal data from any physician, surgeon, hospital, clinic, insurance company or any other organization or person; and the Company is authorized to provide my personal data to reinsurance company or other insurance company I apply for insurance.
6. 本人同意,为未成年人投保人身保险应符合《保险法》的相关规定,累计给付的死亡保险金额总和不得超过中国保险监督管理委员会规定的限额,如果本人未履行如实告知义务,出现未成年人身保险的累计死亡保险金额超过中国保险监督管理委员会规定限额的情况,超过部分贵公司不承担给付保险金的责任。 I agree to obey CIRC ' s regulation rule of the maximum death benefit for juvenile. If there is any non-disclosure and the rule is broken, the insurance company need not to pay the benefit exceeding the maximum limit.
7. 本人已知晓理赔程序以及理赔文件要求。 I have been informed claim procedures and requirements of claim documents.
8. 个人信息使用授权:本人(即投保人及,如适用,被保险人)在此授权贵公司,贵公司继承人、受让人、中国境内外关联方以及贵公司授权的第三方服务者(以下统称:贵公司及相关方)在适用法律、法规允许或要求的范围内,在中国境内外,从各种渠道收集与本保险申请和与可能订立及履行相关保险合同有关的任何本人的个人信息,并已知晓并同意贵公司及相关方将在下列情况下收集、使用、存储、披露、传送或以其他方式处理任何本人的个人信息:(1)审核本申请书,签订或履行可能订立的相关保险合同,并/或提供相关售后服务时;(2)遵守适用的法律法规或贵公司的合规制度或计划时;(3)拟向本人提供其他金融产品和/或服务时;(4)进行直接行销、或数据处理等。同时本人在此确认已经获得本人所指定的受益人和其他相关人员的同意,为上述目的向贵公司及相关方提供和授权使用他们的个人信息资料。 I (referring to the Policy Holder and, where applicable, the Insured) hereby authorize the Company, its successors, assignees, affiliated companies inside or outside of China, as well as the third-party service providers authorized by the Company (collectively, " the Company and Related Parties " ), to the extent permitted by the applicable laws and regulations, to collect by any means, inside or outside China, any of my personal data in relation to this appplication and to the execution and implementation of any relevant insurance contracts, and hereby acknowledge and agree that my personal data will be collected, used, stored, disclosed, transferred or processed by any other means by the Company and Related Parties, for the purposes of: (1) processing this application, entering into or performing any relevant insurance contracts, and / or providing subsequent services; (2) implementing the applicable laws, regulations or the Company ' s compliance policies or plans; (3) providing other financial products and/or services; (4) direct marketing and data processing, etc. I further confirmed that I have duly obtained the consent from the beneficiaries designated and from other related persons to provide to the Company, and authorize the Company and Related parties to use their personal data for the purpose mentioned above.
9. 本人已知悉并同意,保险合同下的满期保险金(如有)属于保险责任的一种,到期时,需要按照保险合同的约定申请领取;如到期未申领,大都会人寿将仅按保险合同载明的金额无息支付满期保险金(如有)。 I have known and agreed that the maturity amount of policy (if any) is one kind of policy benefits, please apply for it, after policy maturity. If you don ' t claim for maturity amount immediately, Metlife will only pay interest-free maturity amount according clause (if any).

FATCA 合规声明及同意  
Clarification re FATCA Compliance

作为美国2010年《外国账户税务遵守法案》(Foreign Account Tax Compliance Act of 2010,下称“ FATCA ”)中所定义的外国金融机构,中美联泰大都会人寿保险有限公司及其在中国的分支机构(下称“ 公司 ”)有义务征得您对下列内容的同意:

A、 本人不可撤销地同意,在不被中国法律法规或监管机构所禁止的范围内,公司可以为遵守任何目前或将来存在的法律法规、监管要求、合同约定或基于FATCA的目的,在中国境内外收集、使用、保存、披露、传输和以其他方式处理本人的个人资料,包括公司向任何政府或税务机关(不论是在中国境内大陆还是境外)披露本人的个人资料;

B、 本人不可撤销地同意填写和签署公司为确保其遵守FATCA而合理要求的文件,采取公司为确保其遵守FATCA而合理要求的行动,并且,在本人的任何个人资料出现变更或增补时,将本人个人资料的任何变更或增补(包括但不限于本人取得任何新的国籍或居留资格)告知公司,并在公司要求的时间内,填写和签署公司为确保其遵守FATCA而合理要求的文件,采取公司为确保其遵守FATCA而合理要求的行动;

C、 本人确认公司有权:(i)要求任何其他相关主体提供公司合理要求的个人资料,及/或填写和签署相关文件;以及(ii)将以上(i)项所指的任何及所有资料披露给任何政府或税务机关(不论是在中国大陆境内还是境外)。

\* “ 相关主体 ” 指“ 本保单 ” 的拥有人或保单持有人,以及有权获得“ 本保单 ” 的价值(例如通过借款、领取、退保、按保单索赔、获得保险给付或以其他方式)、有权更改“ 本保单 ” 的受益人或者有权要求或获得“ 本保单 ” 项下的给付的每一人士,或者有权获得“ 本保单 ” 项下的任何未来给付的任何人士。在“ 本保单 ” 项下给付款项的义务一旦产生或得以确立,则有权获得给付的每一人士(例如保单索赔人、受益人或受让人)将于该等义务产生或得以确立之时成为一名相关主体。

\* “ 个人资料 ” 包括但不限于本人及相关主体的姓名、身份证(护照)号码、(住所)地址(或永久住址)、纳税识别号、社会安全号码(美国)、出生日期、出生地点、国籍、邮件地址、居留地、税务居留地以及“ 本保单 ” 方面的或者与之有关的任何资料,包括但不限于适用的保单号码、保单现金价值、付入“ 本保单 ” 的款项、从“ 本保单 ” 中提取的款项、从“ 本保单 ” 中支付的款项以及公司不时就“ 本保单 ” 收集的其他资料。

本人特此确认:上述声明及同意的内容亦将构成公司与本人所签保险合同的组成部分,并对双方具有约束力。

As a foreign financial institution ( “ FFI ” ) defined under the U.S. Foreign Account Tax Compliance Act of 2010 ( “ FATCA ” ), Sino-US United MetLife Insurance Company Ltd. And its branches in China (hereinafter “ the Company ” ) are obliged to seek your agreement as to the following:

- A. I irrevocably agree that the Company, to the extent not prohibited by Chinese laws, regulations or regulatory authorities, may for the purpose of complying with any present or future regulatory or contractual requirement and that of the FATCA to collect, use, store, disclose, transmit, and otherwise process my personal information in or outside of China; including disclosure by the Company of my personal information to any government or tax authority (whether within or outside the Mainland China);
- B. I irrevocably agree to complete and sign such documents and do such things as the Company may reasonably require for the purposes of ensuring the Company ' s compliance with the FATCA and, in the event of a change or addition to any of my personal information, to update the Company of any changes or additions to any of my personal information, including but not limited to any new citizenships or residency that I may acquire, complete and sign, within such time as the Company may reasonably require from time to time, such documents and do such things as the Company may reasonably require for the purposes of ensuring the Company ' s compliance with the FATCA;
- C. I acknowledge the Company shall have the right to: (i) request any other Consenting Person to provide the personal information, and/or complete and sign the relevant documents which the Company may reasonably require; and (ii) disclose any and all information under (i) to any government or tax authority (whether within or outside of the Mainland China).

\* “ Consenting Person ” means an owner or policyholder of [this policy] and each person who is entitled to access [this policy ' s] value (for example, through a loan, withdrawal, surrender, policy claim, benefit payment or otherwise), change a beneficiary, or claim or receive a benefit payment or any person who is entitled to a future benefit payment under [this policy]. When an obligation to pay an amount under [this policy] arises or becomes fixed,each person entitled to receive a payment (such as a policy claimant, beneficiary or assignee) will become a Consenting

Person at the time such an obligation arises or becomes fixed.

\* " Personal information " includes, but is not limited to, my name, my (domicile) address, (or permanent residential address(es)), taxpayer identification number(s), social security number, date of birth, place of birth, citizenship(s), mailing address, residency, tax residency as well as any information in respect of, or relating to, [this policy].including but not limited to the applicable policy numbers, the policy balances or values, and payments made into, withdrawals from, and payments from [this policy], and such other information collected from time to time by the Company in respect of [this policy]. Hereby I confirm, the above declaration and consent, would constitute part of the insurance agreement between the Company and myself and would be binding on both parties accordingly.

个人税收居民身份声明

投保人声明：√ 1.仅为中国税收居民                      2.仅为非居民                      3.既是中国税收居民又是其他国家（地区）税收居民

如在以上选项中勾选第2项或者第3项，请填写下列信息：

姓（英文或拼音）：\_\_\_\_\_ 名（英文或拼音）：\_\_\_\_\_

现居地址（中文）：\_\_\_\_\_ 同投保人居住地址  
（英文或拼音）：\_\_\_\_\_（国家）\_\_\_\_\_（省）\_\_\_\_\_（市）\_\_\_\_\_

出生地（中文）：\_\_\_\_\_ 同投保人居住地址  
（中文）：\_\_\_\_\_（国家）\_\_\_\_\_（省）\_\_\_\_\_（市）\_\_\_\_\_（境外地址可不填此项）  
（英文或拼音）：\_\_\_\_\_（国家）\_\_\_\_\_（省）\_\_\_\_\_（市）\_\_\_\_\_

税收居民国（地区）	纳税人识别号

如不能提供居民国（地区）纳税人识别号，请选择原因：

居民国（地区）不发放纳税人识别号

账户持有人未能取得纳税人识别号，如选此项，请解释具体原因：\_\_\_\_\_

税收居民身份释义：

1. 本表所称中国税收居民是指在中国境内有住所，或者无住所而在境内居住满一年的个人。在中国境内有住所是指因户籍、家庭、经济利益关系而在中国境内习惯性居住。在

境内居住满一年，是指在一个纳税年度中在中国境内居住365日。临时离境的，不扣减日数。临时离境，是指在一个纳税年度中一次不超过30日或者多次累积不超过90日的离境。

2. 本表所称非居民是指中国税收居民以外的个人。其他国家（地区）税收居民身份认定规则及纳税人识别号相关信息请参见国家税务总局网站

<http://www.chinatax.gov>.

3. 军人、武装警察无需填写此声明文件。

我已知晓并同意，在任何时候当我在除中国以外的其他国家有纳税申报要求时，大都会人寿可以将我的保单信息提供给相关的中国税务机关，中国税务机关可以提供给相关海外政府机关。

本人确认上述信息的真实、准确和完整，且当这些信息发生变更时，将在30日内通知贵机构，否则本人承担由此造成的不利后果。

签名栏 SIGNATURE FIELD (务必确保投保人及被保险人签名由其本人所为must be signed by policy owner and Insured)

\*本人谨此声明已认真阅读并理解本投保单相关告知与声明中的所有内容并同意遵守

如果您选购的产品为新型保险产品（投资连结保险、万能保险、分红保险以及中国保险监督管理委员会认定的其他产品），请投保人亲笔抄录以下文字：

"本人已阅读保险条款、产品说明书和投保提示书，了解本产品的特点和保单利益的不确定性，并自愿承担保单利益不确定的风险。"

I hereby confirm that I have read the policy terms, Products specifications and the application tips, I understand the product features and the uncertainty policy benefits, and voluntarily take uncertain risk of policy benefits.


投保人签名

投保日期

Signature of Policy owner：\_\_\_\_\_ Application Date：\_\_\_\_\_年\_\_\_\_\_月\_\_\_\_\_日(YYYY/MM/DD)

被保险人签名（法定监护人签名）

Signature of Insured(Legal Guardian Signature)：\_\_\_\_\_ 受理人员确认栏（保险公司填写）：\_\_\_\_\_

保险合同领取方式Policy Receive Method：\_\_\_\_\_ 电子保单（电子保单将发送至您在“投保人信息填写”栏提供的“邮箱地址”）e-policy（The e-policy will be sent to the E-mail address provided in the POLICY OWNER DETAILS）  
√ 快递递送至投保人联系地址By Post

特别提醒：请您务必真实、清晰、完整地填写投保单中有关投保人、被保险人、指定受益人相关个人信息。该客户信息将被用于本公司为您公允地计算保费、核保、及时送达保单、客户回访以及提供其他各类客户服务。若您未真实、清晰、完整地填写投保单中的客户信息，将会影响本公司向您提供服务的质量，甚至影响您的保险合同效力。人身保险公司承诺未经客户同意，不会将客户信息用于人身保险公司和第三方机构的销售活动。如果您的联系电话和联系地址等客户信息发生变更，应及时办理更正手续。

Note: Please be sure to fill policyholder 's, insured 's or beneficiaries ' information in application forms as true, clear, complete. The customer information will be used for the company in the fair for you to calculate premium, underwriting, timely policy delivery, call service, and provide other kinds of customer service. If your information in the application forms is not true, unclear, incomplete, it will be affected the service quality provided to you, and even affect your policy effectiveness, we promise seriously we 're not allowed to use your personal information for sales of life insurance company or third part institution without your approval. If your phone number and contact address customer information is changed, please inform us to update information in time.

销售人员姓名 Sales Name\_\_\_\_\_ ybt

销售人员代码 Sales Code\_\_\_\_\_ ybt

代理网点名称 Bank Branch Name\_\_\_\_\_ 天津支行

代理网点代码 Bank Branch Code\_\_\_\_\_ 205

## 自动转账授权书

(银行专用)

投保单号 211111124237

保单号码

致：中美联泰大都会人寿保险有限公司本人授权中美联泰大都会人寿保险有限公司及下列银行按下述授权内容进行保险费的划扣及相关权益的给付：  
首、续期保险费  
本次申请涉及的保险金或其他权益、费用  
授权账户所有人必须为投保人

每期转账金额：	24760	元	交费年期：	缴费10年	交付方式：	<input type="checkbox"/> 月缴	<input type="checkbox"/> 年缴	<input type="checkbox"/> 一次性缴付												
授权账户信息																				
首期交费方式	<input type="checkbox"/> 自动转账 <input type="checkbox"/> 柜台交费		续期交费方式	<input type="checkbox"/> 自动转账 <input type="checkbox"/> 其他（收费）（此选项只针对一年期主险）																
户名	测试九		开户银行	汇丰银行(中国)有限公司																
账户类型	个人结算账户																			
授权账号	C	N	H	S	B	C	6	2	4	0	2	1	8	2	0	0	5	0		

授权人声明：

1. 账户所有人同意以此授权资料作为投保人交纳各期保险费之用，并同意按银行的各项规定和保险公司的流程执行。
2. 账户所有人同意，账户所有人如对同一保险合同有多次自动转账授权，以中美联泰大都会人寿保险有限公司收到并同意之最后一次有效授权为准，且以前提供之转账授权书自动作废，并不予退还授权书。
3. 账户所有人如果再同一授权账户内同时授权两张或两张以上与中美联泰大都会人寿保险有限公司签订的保险合同的保险费自动转账，则
4. 账户所有人所提供的授权账户，必须是其本人的个人结算账户（如：借记卡、个人活期结算存折）。账户所有人同意于每期保险费转账成功后，需在授权账户中保留至少人民币一元，否则可能导致扣款失败并影响该保险合同的效力。
5. 账户所有人确认已知晓上述转账授权可能影响授权账户投资资金情况，导致一定的损失。账户所有人确认由此产生的损失，贵公司不承担相关责任。
6. 如续期交费方式未勾选，并已填写帐号，则默认为通过转账方式自动续保。
7. 如您购买的保险产品中含有一年期附加险视同您接受续保条款，如需中止则在保单周年日之前提出保全变更申请。

授权人（投保人本人）签名：\_\_\_\_\_

日期：\_\_\_\_\_年\_\_\_\_\_月\_\_\_\_\_日

HO-NB-300-1011

第  
一  
联  
公  
司

# 自动转账授权书

(银行专用)

投保单号 211111124237 保单号码

致：中美联泰大都会人寿保险有限公司本人授权中美联泰大都会人寿保险有限公司及下列银行按下述授权内容进行保险费的划扣及相关权益的给付：  
首、续期保险费  
本次申请涉及的保险金或其他权益、费用  
授权账户所有人必须为投保人

每期转账金额：	24760	元	交费年期：	缴费10年	交付方式：	<input type="checkbox"/> 月缴	<input type="checkbox"/> 年缴	<input type="checkbox"/> 一次性缴付												
授权账户信息																				
首期交费方式	<input type="checkbox"/> 自动转账 <input type="checkbox"/> 柜台交费		续期交费方式	<input type="checkbox"/> 自动转账 <input type="checkbox"/> 其他（收费）（此选项只针对一年期主险）																
户名	测试九		开户银行	汇丰银行(中国)有限公司																
账户类型	个人结算账户																			
授权账号	C	N	H	S	B	C	6	2	4	0	2	1	8	2	0	0	5	0		

授权人声明：

1. 账户所有人同意以此授权资料作为投保人交纳各期保险费之用，并同意按银行的各项规定和保险公司的流程执行。
2. 账户所有人同意，账户所有人如对同一保险合同有多次自动转账授权，以中美联泰大都会人寿保险有限公司收到并同意之最后一次有效授权为准，且以前提供之转账授权书自动作废，并不予退还授权书。
3. 账户所有人如果再同一授权账户内同时授权两张或两张以上与中美联泰大都会人寿保险有限公司签订的保险合同的保险费自动转账，则
4. 账户所有人所提供的授权账户，必须是其本人的个人结算账户（如：借记卡、个人活期结算存折）。账户所有人同意于每期保险费转账成功后，需在授权账户中保留至少人民币一元，否则可能导致扣款失败并影响该保险合同的效力。
5. 账户所有人确认已知晓上述转账授权可能影响授权账户投资资金情况，导致一定的损失。账户所有人确认由此产生的损失，贵公司不承担相关责任。
6. 如续期交费方式未勾选，并已填写帐号，则默认为通过转账方式自动续保。
7. 如您购买的保险产品中含有一年期附加险视同您接受续保条款，如需中止则在保单周年日之前提出保全变更申请。

授权人（投保人本人）签名：

日期： 年 月 日

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