

Direct Debit Authorization Form



16/F, 348 Kwun Tong Road,
Kwun Tong, Kowloon, Hong Kong

Tel: 2560 1990 Fax: 2886 3722
www.cigna.com.hk

Private & Confidential

Policy Number Person Insured Policyholder

Please submit copy of the Policyholder's valid identity document (unless submitted before).

Policyholder signature is required and ensure the consistency of your signature with our record for verification if change of Premium Payment Frequency. This form is only for subsequent premium payment only. Please complete in Block Letters and tick where applicable.

A. Direct Debit via Savings/Current Account (Applicable to subsequent premium payment only)

Name to be credited

Cigna Worldwide General Insurance Company Limited (The Beneficiary)

I/We hereby authorize my/our below named Bank to effect transfers from my/our account to the account of the above named beneficiary (hereinafter referred to as the "Beneficiary") in accordance with such instructions as my/our Bank may receive from the Beneficiary from time to time, including the settlement of policy premium, levy, or other relevant charges under the relevant policy(ies). This authorization shall remain valid until further notice.

I/We further agree and confirm:

1. my/our Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me/us.
2. my/our signature(s) on this authorization form is/are the same as that/those for the operation of my/our Savings/Current Account to be debited for the transfer.
3. to notify the Beneficiary of any change of bank account or cancellation of payment method.
4. to jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our account which may arise as a result of any such transfer(s). I/We agree that should there be insufficient funds in my/our Bank account to meet any transfer hereby authorized, the Bank shall be entitled, at its discretion, not to effect such transfer in which event the Bank may make the usual service charge to be paid by me/us.
5. that any notice of cancellation or variation of this authorization which I/we may give to my/our Bank shall be given at least fifteen (15) working days prior to the date on which such cancellation/ variation is to take effect.

BANK NAME:

BANK ACCOUNT:

| | | |
|--|--|--|
| | | |
|--|--|--|

| | | |
|--|--|--|
| | | |
|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| | | | | | | | |
|--|--|--|--|--|--|--|--|

Bank Code. Branch Code. Account No.

Please note:

- It takes 6-8 weeks to process this authorization, as such two (2) months' and all outstanding premium, levy, and other relevant charges under the relevant policy(ies) are requested to be sent along with this Authorization Form.
- At least fifteen (15) working days' written notice in advance is required for termination of this payment instruction.
- This facility is applicable to the Policyholder or Person Insured/Proposed Person Insured only.

B. Direct Debit via Credit Card

NAME OF CARD ISSUING BANK: COUNTRY OF CARD ISSUING BANK:

VISA/MASTERCARD CREDIT CARD ACCOUNT: | | | | | | | | | | | | | | | | | | | | | |

CARD EXPIRY DATE (MONTH/YEAR): /

Please note:

1. The Issuer of the credit card identified above is authorized to pay the amount as requested by the Beneficiary upon proper presentation. The Cardholder promises to pay such total (including policy premium and levy under the relevant policy(ies), together with any other charges due thereon) subject to and in accordance with the agreement governing the use of such credit card.
2. All outstanding premium, levy, and other relevant charges under the relevant policy(ies) are requested to be sent along with this Authorization Form.
3. This facility is applicable to the Policyholder or Person Insured/Proposed Person Insured only.
4. This payment method is for regular premium and selected products only.
5. Annually premium will be debited on the same month of the premium due date. In case of unsuccessful transaction, premium will be debited again (if applicable).
6. At least fifteen (15) working days' written notice in advance is required for termination of this payment instruction.
7. Prior approval is required for non-Hong Kong issued credit card.

C. General Information

| | | |
|--|--|--------------|
| I.D. NUMBER OF ACCOUNT HOLDER(S): | I.D. TYPE: <input type="checkbox"/> HKID <input type="checkbox"/> PASSPORT <input type="checkbox"/> BUSINESS REGISTRATION <input type="checkbox"/> CERTIFICATE OF INCORPORATION <input type="checkbox"/> OTHERS _____ | |
| NAME OF ACCOUNT HOLDER(S) IN ENGLISH: (AS RECORDED IN STATEMENT/PASSBOOK/CREDIT CARD) | SIGNATURE OF ACCOUNT HOLDER(S): SIGNATURE MUST BE CONSISTENT WITH YOUR BANK'S RECORD | Date (Y/M/D) |

D. Change of Premium Payment Frequency

☐ Annually ☐ Monthly

SIGN DATE:

Please ensure that your signature is consistent with that in your policy record.

直接付款授權書



16/F, 348 Kwun Tong Road,
Kwun Tong, Kowloon, Hong Kong
Tel: 2560 1990 Fax: 2886 3722
www.cigna.com.hk

私人密件

| | | | | | |
|------|-------------|-----|-------------|-------|-------------|
| 保單編號 | <div></div> | 受保人 | <div></div> | 保單持有人 | <div></div> |
|------|-------------|-----|-------------|-------|-------------|

請遞交保單持有人的身分證明文件之認證複本* (如已遞交則除外)。
如更改保費支付形式, 保單持有人簽名必須確保簽名樣式與保單紀錄一致以作核實。此表格只適用於首期保費後之每期保費。請用正楷填寫, 並在適合的地方打勾。

甲. 經儲蓄/來往賬戶直接付款 (只適用於首期保費後之每期保費)

收款之一方

Cigna Worldwide General Insurance Company Limited (受益人)

本人/吾等現授權本人/吾等之下述銀行, 根據上述受益人(以下簡稱“受益人”)不時給予本人/吾等銀行之指示, 自本人/吾等之賬戶內轉賬予受益人之賬戶, 以繳付保費、徵費或其他相關保單費用。
本授權書將繼續生效直至另行通知。
本人/吾等同意及確認:

- 本人/吾等之銀行毋須證實該等轉賬通知是否已交予本人/吾等。
- 本人/吾等證明本人/吾等在此授權書上之簽名式樣與本人/吾等之儲蓄/來往賬戶簽名式樣一致。
- 如更改銀行賬戶或取消此付款方式時, 將通知受益人。
- 如因該等轉賬而令本人/吾等之賬戶出現透支(或令現時之透支增加), 本人/吾等願共同及個別承擔全部責任。本人/吾等並同意如本人/吾等之賬戶並無足夠款項支付該等轉賬時, 本人/吾等之銀行有權不予轉賬, 且銀行可收取慣常之服務費用。
- 本人/吾等取消或更改本授權書之任何通知, 須於取消/更改生效日最少十五個工作天之前交予本人/吾等之銀行。

銀行名稱:

銀行賬戶:

銀行編號 分行編號 賬戶編號

請注意:

- 由於銀行處理此授權書需時約6至8個星期, 故此請連同兩個月保費及所有所欠之保費、徵費及其他相關保單費用一併交回。
- 如需取消此繳費指示, 請於最少15個工作天前以書面提出。
- 此項目只適用於保單持有人或受保人。

乙. 經信用卡直接付款

發卡銀行名稱: 發卡銀行國家:

VISA/萬事達卡信用卡賬戶號碼:

信用卡有效日期 (月/年): /

請注意:

- 本人授權發出上述信用卡之機構, 在收到有關指示時, 即支付受益人所要求之金額。本人承諾根據所持信用卡之合約繳付全部款項(包括相關保險的保費、徵費, 及其他相關保單有關費用)。
- 請將此授權書連同所欠之保費、徵費及其他相關保單費用一併交回。
- 此申請只適用於保單持有人或受保人/準受保人。
- 此付款方式只適用於定期繳付之保費及指定之保險計劃。
- 非每月供款之保費將於保費到期日之同一月份過數, 如未能成功過數, 保費將會再扣除(如適用)。
- 如需取消此付款指示, 請於最少15個工作天前以書面提出。
- 如信用卡非由香港銀行發行, 必須預先獲本公司審批。

丙. 一般資料

| | | |
|-----------------------------------|---|-----------|
| 賬戶持有人身份證明文件號碼: | 身份證明文件類別: <input type="checkbox"/> 香港身份證 <input type="checkbox"/> 護照 <input type="checkbox"/> 商業登記証 <input type="checkbox"/> 公司註冊證明書 <input type="checkbox"/> 其他 <div></div> | |
| 賬戶持有人英文姓名: (在月結單/存摺/信用卡所記錄之名稱) | 賬戶持有人簽名: 簽名式樣必須與銀行檔案相同 | 日期(年/月/日) |

丁. 更改保費支付形式

☐ 每年 ☐ 每月

保單持有人: 簽名日期:

閣下簽名之模式, 應與保單紀錄之簽名一致, 以作核對。