

保險中介人姓名 Name of Insurance Intermediary	保險中介人號碼 Insurance Intermediary Code	聯絡電話 Contact Tel. No.
索償保障類別 Coverage Claiming For	<input type="checkbox"/> 人壽保險 Life Assurance <input type="checkbox"/> 有『身』心醫療保障計劃 SMP <input type="checkbox"/> 付款人豁免保費保障 PB <input type="checkbox"/> 綜合意外保障 AI <input type="checkbox"/> 意外死傷保障 ADD <input type="checkbox"/> 其他 Other	
附上文件 Documents attached	<input type="checkbox"/> 保單正本 Original Policy <input type="checkbox"/> 政府簽發之死亡證書 Official Death Certificate <input type="checkbox"/> 火葬紙 Cremation Certificate <input type="checkbox"/> 身份證 (死者 / 索償人) ID card (deceased / claimant) <input type="checkbox"/> 出世證書 Birth Certificate <input type="checkbox"/> 結婚證書 Marriage Certificate <input type="checkbox"/> 警署報告 Police Report <input type="checkbox"/> 死因法庭報告 Coroner's Report <input type="checkbox"/> 新聞剪報 Newspaper Clippings <input type="checkbox"/> 其他 Others	
填表須知 Instructions	<p>1. 如索償人超過一位，索償人可在同一申請書上填寫有關資料及簽署，亦可各自填寫一份申請書。 If there is more than one claimant, all may complete and sign on the same claim form or each claimant may complete a separate claim form.</p> <p>2. 發出此申請書並不表示本公司已接納是次索償申請。在此索償過程中，索償人無需支付任何性質之手續費予本公司之僱員或保險中介人。 The issue of this form is in no way an admission of liability. No fee, commission or charge of whatever nature is required to pay to the employees or insurance intermediaries of the company with respect to this claim.</p> <p>3. 請回答申請書第一部份所有問題。如有需要，申請書第二部份必須由主診醫生填寫並由索償人支付有關費用。 Please answer ALL the questions in Part I of this claim form. If required, Part II of this claim form MUST be completed and signed by the attending physician. The completion of this part is at claimant's own expenses.</p> <p>4. 請附上死亡證明文件，死者和索償人身份證明及死者和索償人關係證明文件，例如政府簽發之死亡證書、火葬紙、身份證、出世紙、結婚證書等以方便審核。 Please attach relevant documents to prove the death of the deceased, the identity card of the deceased and the claimant, the relationship between the deceased and the claimant such as official death certificate, cremation certificate, ID card, birth certificate, marriage certificate, etc. to enable us to assess your claim.</p> <p>5. 如因意外引致死亡，請提供有關是次意外及死因的證明文件，例如警署報告、死因法庭報告、新聞剪報等。 If the deceased died of accident, reports relating to the circumstances and the actual cause of death such as police report, coroner's report, newspaper clippings, if any, etc. are also required.</p> <p>6. 倘保險金納入死者之遺產，此申請書須由死者之遺產承辦人填寫及簽署，同時須遞交遺產承辦書。 Where "own estate" is stated as beneficiary, the Executor or Administrator must complete and sign this form, and Letter of Administration is required.</p> <p>7. 倘受益人為未成年或智障人士，此申請書須由其監護人填寫及簽署，同時須遞交法庭委任書。 If the beneficiary is a minor or incompetent, the guardian must complete and sign this form, and Guardianship Paper is required.</p>	

第一部份 - 索償人聲明(由索償人填寫)
PART I - CLAIMANT'S STATEMENT (to be completed by Claimant)

死者資料 Deceased's Details

1. 保單號碼 Policy No.	死者姓名 Name of Deceased	英文 in English	中文 in Chinese			
身份證號碼 ID Card No.	出生日期 Date of Birth	年 YY / 月 MM / 日 DD	年齡 Age	性別 Sex	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	
身故時之住址 Residential address at time of death						聯絡電話 Contact Tel. No.
身故時之僱主名稱及地址 Name and Address of last employer						聯絡電話 Contact Tel. No.
身故時之職業及職務 Occupation & job duties at time of death				最後工作日期 Last date of working	年 YY / 月 MM / 日 DD	
身故日期、時間和地點 Date, Time and Place of death	日期 Date	年 YY / 月 MM / 日 DD	時間 Time	<input type="checkbox"/> 上午 a.m. <input type="checkbox"/> 下午 p.m.	地點 Place	
身故原因 Cause of death						

如屬意外身故，請填報第 2 項

Complete item 2 if Death was due to Accident

2. a. 意外發生日期、時間和地點 Date, Time and Place of accident	日期 Date	年 YY / 月 MM / 日 DD	時間 Time	<input type="checkbox"/> 上午 a.m. <input type="checkbox"/> 下午 p.m.	地點 Place
b. 意外發生經過? How did the accident happen? (請附上新聞剪報，如有) (attach newspaper clippings, if any)					
c. 受傷部位? Which part(s) of body injured?					
d. 受傷程度? What is the extent of the injury?					
e. 是否有報警? Had reported to police?	<input type="checkbox"/> 是， 報案警署名稱 Yes, Police station	檔案編號(請附上副本，如有) Police reference number (submit photocopy if any)			<input type="checkbox"/> 否 No

3. a. 請敘述導致死者身故之疾病及病徵 Describe the nature and the symptoms of the deceased's last illness			
b. 死者何時首次因相關疾病向醫生求診? When did the deceased first consult physician for the related illness?	年 YY /	月 MM /	日 DD
c. 死者何時開始顯示患有導致其身故之病徵? When did the deceased first complain of or give indications of his/her last illness?	年 YY /	月 MM /	日 DD

診治詳情 Consultation Details

4. 就此傷病求診之醫生資料 Details of consultation for the illness or injury	求診日期(年/月/日) Consultation Date (YY/MM/DD)	原因/病因 Reason/Diagnosis	醫生或醫院名稱及地址(請附上病歷咭，如有) Name and Address of doctor/hospital (please attach patient card copy if available)
a. 就此傷病首次求診的醫生 Doctor first consulted for related illness or injury			
b. 建議入院的醫生 Doctor referred to hospital			
b. 在過去五年內就同類或有關類似病症或其他疾病曾求診的醫生 Doctors consulted for same or similar conditions or other illness in the past 5 years			

住院詳情 Hospitalization Details

5. 就同類或有關類似病症或其他疾病曾入住的醫院資料 Details of hospital confinement in the past for same or similar conditions or other illness	入院日期(年/月/日) Date of Admission (YY/MM/DD)	出院日期(年/月/日) Date of Discharge (YY/MM/DD)	原因/病因 Reason/Diagnosis	醫院名稱及地址(請附上病歷咭，如有) Name and Address of hospital (please attach patient card copy if available)
---	---	---	---------------------------	---

其他資料 Other Information

6. a. 是否已經或將會舉行死因研訊? Has there been or will there be a death inquest?	<input type="checkbox"/> 是，日期 Yes, Date	年 / YY	月 / MM	日 DD	地點 Place	<input type="checkbox"/> 否 No
b. 是否已經或將會進行屍體解剖? Has there been or will there be a post-mortem?	<input type="checkbox"/> 是，日期 Yes, Date	年 / YY	月 / MM	日 DD	地點 Place	<input type="checkbox"/> 否 No
7. 死者在其他保險公司之人壽或意外保險資料 Other life or accident insurance carried by the deceased with other insurance companies?	保險公司 Insurance Company	保單號碼/團體保險編號 Policy No. / Group Member No.	保額 Amount of Coverage	生效日期(年/月/日) Effective Date (YY/MM/DD)		

索償人資料 Claimant's Details

	(1)	(2)	(3)
索償人姓名 Name of Claimant	<input type="text"/> 英文 in English <input type="text"/> 中文 in Chinese	<input type="text"/>	<input type="text"/>
與死者關係 Relationship to the deceased	<input type="text"/>	<input type="text"/>	<input type="text"/>
身份證號碼 ID Card No.	<input type="text"/>	<input type="text"/>	<input type="text"/>
出生日期(年/月/日) Date of Birth (YY/MM/DD)	/ /	/ /	/ /
性別 Sex	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female
聯絡地址及電話 Corresponding Address & Tel. No.	<input type="text"/>	<input type="text"/>	<input type="text"/>
以何名義申請索償 Capacity for submitting the claim	<input type="checkbox"/> 受益人 Beneficiary <input type="checkbox"/> 保單權益人 Policyowner <input type="checkbox"/> 受讓人 Assignee <input type="checkbox"/> 信託人 Trustee <input type="checkbox"/> 監護人/父母 Legal Guardian/Parent <input type="checkbox"/> 其他 Others	<input type="checkbox"/> 受益人 Beneficiary <input type="checkbox"/> 保單權益人 Policyowner <input type="checkbox"/> 受讓人 Assignee <input type="checkbox"/> 信託人 Trustee <input type="checkbox"/> 監護人/父母 Legal Guardian/Parent <input type="checkbox"/> 其他 Others	<input type="checkbox"/> 受益人 Beneficiary <input type="checkbox"/> 保單權益人 Policyowner <input type="checkbox"/> 受讓人 Assignee <input type="checkbox"/> 信託人 Trustee <input type="checkbox"/> 監護人/父母 Legal Guardian/Parent <input type="checkbox"/> 其他 Others
是否委任合法之 代表或律師 Have you appointed a legal representative/solicitor?	<input type="checkbox"/> 是, 請在下面詳述 Yes, please provide details below <input type="checkbox"/> 否 No 姓名 Name 地址 Address Telephone 電話	<input type="checkbox"/> 是, 請在下面詳述 Yes, please provide details below <input type="checkbox"/> 否 No 姓名 Name 地址 Address Telephone 電話	<input type="checkbox"/> 是, 請在下面詳述 Yes, please provide details below <input type="checkbox"/> 否 No 姓名 Name 地址 Address Telephone 電話

個人資料收集聲明

本人/我們清楚明白及完全同意以下各項：(1) 香港人壽保險有限公司（下稱「香港人壽」）收集所需的個人資料是為處理投保或其他保險或財務產品/服務之申請，及提供所有關於該等申請之繼後服務，處理理賠或其有關分析、處理權益轉讓協議、統計或精算研究用途、訴訟、通訊、內部/外界審計、提供客戶服務（包括但不限於處理查詢及投訴）及有關活動、資料核對、與任何因香港人壽提供的產品及/或服務之機構/人士溝通及為遵從適用於香港人壽之任何本地或海外法律、由任何法定、監管、政府、稅務、執法或其他機構，或由金融服務提供者之行業的團體或組織所發出或提供之任何指引或指導、任何合約承諾或其他承諾及/或適用稅務法律的義務。香港人壽或會就上述目的將該等資料儲存、使用、透露、發放及/或轉交予（不論在本港或海外）任何從事與保險或再保險業務有關之公司、中介人、第三方管理人、第三方服務供應商（包括但不限於保險公司、銀行、律師、會計師，以及其他提供行政、電訊、電腦、付款、印刷、贖回或其他服務以令香港人壽的業務可以運作的第三方服務供應商）、理賠調查員、醫療賬單審查公司、有關提供保險業務服務之公司、專業顧問、研究人員、政府機關、任何保險業組織或聯會、信貸資料服務機構、收賬代理、伙伴金融機構、符合法例或法庭頒令的資料披露規定之單位、或根據監管或其他有關機構所發出的指引而作出披露之單位；(2) 提供個人資料予香港人壽純屬自願性質，但若未能按要求提供所需的個人資料，可能會導致香港人壽無法處理保險申請或提供或繼續提供保險產品及服務及/或其他相關產品及/或服務予本人/我們；(3) 本人/我們有權知悉香港人壽是否持有本人的資料及有權查閱該等資料，若認為有關本人/我們的資料不準確，有權要求香港人壽給予改正。任何關於查閱或改正資料申請，或欲查悉香港人壽對於個人資料的政策與實務做法或所持有的資料類別，可以致電 2290 2882 或書面形式致函香港皇后大道中 183 號中遠大廈 15 樓，向香港人壽資料保護主任提出。香港人壽有權就處理任何查詢資料的要求收取合理費用。

Personal Information Collection Statement

I/We hereby declare, understand and agree that: (1) Hong Kong Life Insurance Limited (hereinafter referred to as "Hong Kong Life") only collects necessary personal information for the purpose of processing your application or any other applications for insurance or financial related products/ services and providing all on-going services relating to such applications, claim processing or any analysis of it, assignment processing, statistical or actuarial research, litigation, communication, internal/ external audit, providing customer services (including but not limited to, processing enquiries and complaints) and related activities, data matching, communication with any relevant organization/ person in respect of any services and/or products provided by Hong Kong Life and comply with any local or foreign law, any guidelines or guidance, contractual or other commitment and applicable tax laws given or issued by any local or foreign legal, regulatory, governmental, tax, law enforcement or other authorities, or industry bodies or associations of financial services providers that apply to Hong Kong Life. Any personal information collected or held by Hong Kong Life is to enable it to carry on insurance business and may be stored, used, disclosed, released and/ or transferred (whether within or outside Hong Kong) by Hong Kong Life to any other companies carrying on insurance or reinsurance related businesses or any intermediaries, third party administrators, third party service providers (including but not limited to insurers, bankers, lawyers, accountants, and other third party service providers who provide administrative, telecommunications, computer, payment, printing, redemption or other services to Hong Kong Life), claims investigators, medical bill review companies, other service providers providing services relevant to insurance business, professional advisors, researchers, government authorities, any associations or federation of insurance companies, credit reference agencies, debt collection agencies, partnering financial institutions, any organizations which meet disclosure requirements imposed by law or court orders or pursuant to guidelines issued by regulators or other relevant authorities for any of the above purposes; (2) the provision of such personal data is voluntary, but failure to do so may result in Hong Kong Life being unable to process the insurance applications or to provide or continue to provide the insurance products and services and/or the related products and/or services to me/ us; (3) I/We have the right to check whether Hong Kong Life holds data about me/us and the right to access to such data and require Hong Kong Life to correct any data relating to me/us which are inaccurate. Such request can be made in writing and addressed to the Data Protection Officer of Hong Kong Life at 15/F, Cosco Tower, 183 Queen's Road Central, Hong Kong or by calling Hong Kong Life at 2290 2882. Hong Kong Life has the right to charge a reasonable fee for the processing of any data access request.

聲明及授權

本人/我們謹此明白及同意所有在本申請書的一切陳述及答案，不論是否本人/我們親手所寫，就本人/我們所知所信，均為事實無訛。

本人/我們謹此授權(1) 任何僱主、醫生、醫院、診所、保險公司、政府部門、其他機構或人仕，凡曾已或將會知悉或持有本人/我們或其他在本申請書提及之人仕之個人資料（不論是醫療或其他資料），均可向香港人壽或其代表透露、發放或轉交該等資料，以作為處理本申請；(2) 即使本人/我們死亡或喪失能力，此授權書仍具效力，而本人/我們之繼承人及承讓人亦會受此授權書約束。本授權書之影印本與正本均有同等效力。

Declaration and Authorization

I/We hereby understand and agree that all statements and answers in this application whether or not written by my/our own hand are complete and true to the best of my/our knowledge and belief.

I/We further hereby authorize (1) any employer, doctor, hospital, clinic, insurance company, government office or any organization or person who has or may hereafter have any record, knowledge or information of me/us or other persons named herein (whether medical or otherwise) to disclose, release or transfer to Hong Kong Life or its representative such record, knowledge or information pertinent to this application; (2) This authorization shall bind the successors and assignees of me/us and remain valid notwithstanding death or incapacity. A photocopy of this authorization shall be valid as the original.

日期 (年/月/日) Date (YY/MM/DD)	/ /	/ /	/ /	/ /
索償人簽署 Signature of Claimant				
索償人姓名 Name of Claimant				

/ /	日期 (年/月/日) Date (YY/MM/DD)	保險中介人/見證人身份證號碼 ID Card No. of Insurance Intermediary/Witness	保險中介人/見證人姓名 Name of Insurance Intermediary/Witness	保險中介人/見證人簽署 Signature of Insurance Intermediary/Witness
-----	-------------------------------	--	---	--

公司專用 FOR OFFICE USE ONLY	Claim No.	Date Received	Captured By	Signature Verified by	Checked By	Approved By	Remarks