香港人壽保險有限公司
Hong Kong Life Insurance Limited
香港皇后大道中 183 號中遠大廈 15 樓
15/F Cosco Tower, 183 Queen's Road Central, Hong Kong
電話 tel : 2290 2888　傳真 fax : 2530 5682　網址 website : www.hklife.com.hk

傷殘保障索償申請書
Disability Benefit Claim Form

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	☐ 豁免保費保障 WP	☐ 付款人豁免保費保障 PB	☐ 其他 Others

附上文件 Documents attached	☐ 出院報告 Discharge Summary	☐ 醫療報告 Medical Report	☐ 病假證明書 Sick Leave Certificate	☐ 其他 Others

填表須知 Instructions	1. 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. 2. 請回答申請書第一部份所有問題。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. 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. 3. 請附上有關報告或文件，例如醫院發出的出院報告並列明病症、病假紙、醫療報告等以方便審核。 Please attach other reports or relevant documents, such as discharge summary issued by hospital containing the exact diagnosis, sick leave certificate, medical report, etc. to enable us to assess your claim. 4. 請確保索償人在此申請書的簽署必須和投保書簽署一致。 Please make sure the signature of claimant on this claim form is in consistent with the one appearing on the policy application form.

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

☐ New Claim 首次索償　☐ Further Claim 再度索償　☐ Review/Appeal 重批/覆核

保單號碼 Policy No.		受保人姓名 Name of Life Insured	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	☐ 男 Male	☐ 女 Female
聯絡地址 Mailing address							聯絡電話 Contact Tel. No.			

就業詳情 Employment Details

1. 僱主名稱及地址 Name and Address of employer		聯絡電話 Contact Tel. No.	
如僱主與投保時不同，請說明何時轉工 If the employer is different from the one stated in the application, please state when it was changed	年 YY /	月 MM /	日 DD
傷殘前職業及職務(倘有兼職請列明) Occupation & job duties before disability (if more than one, state all)			

如傷殘因意外引致，請填報第 2 項 Complete item 2 if Disability 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 ☐ 上午 a.m. ☐ 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?	☐ 是， Yes, 報案警署名稱 Police station		檔案編號(請附上副本，如有) Police reference number (submit photocopy if any)		☐ 否 No

如傷殘因疾病引致，請填報第 3 項 Complete item 3 if Disability was due to Illness

3. a. 請敘述所患疾病及其病徵 Describe the nature of illness and the symptoms	
b. 何時首次因相關疾病向醫生求診? When did you first consult doctor for the related illness?	年 YY / 月 MM / 日 DD
c. 在首次求診前，病徵何時開始出現? Since when did you have these symptoms before the first consultation?	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	醫生姓名及地址(請附上病歷咭，如有) Name and Address of doctor (please attach patient card copy if available)
a. 首次求診的醫生 Doctor first consulted			
b. 建議入院的醫生 Doctor referred to hospital			
c. 過往就同類或有關類似病症曾求診的醫生 Doctors consulted in the past for same or similar or related condition			

住院詳情　Hospitalization Details

5. 就此傷病入住的醫院資料 Details of hospital confinement for the illness or injury	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)

傷殘情況　Extent of Disability

6. a. 請詳述現時傷病情況
Please describe the current condition of the illness or injury

b. 閣下何時開始完全不能工作？
When did you become completely unable to attend to any business or occupation?　年 YY / 月 MM / 日 DD

c. 請詳述由患有該傷病至今，不能工作之時期
Please state period of absence from work since your suffering from the illness or injury

傷病日期(年/月/日) Onset Date (YY/MM/DD)	原因/病因 Reason/Diagnosis	不能工作之時期 Period absent from work

d. 閣下是否已恢復工作或預料恢復工作?
Did you return or expect to return to work?　☐ 是 Yes　年 YY / 月 MM / 日 DD　☐ 否 No　原因 Reason

e. 有否向僱主遞交病假證明書?
Did you file a sick leave certificate with employer?　☐ 是 Yes　從 From　年 YY / 月 MM / 日 DD　至 to　年 YY / 月 MM / 日 DD　☐ 否 No

f. 傷殘前 12 個月內每月平均收入(包括津貼及花紅等)
Average monthly gross earning in past 12 months before disability (including allowance & bonus, etc.)　港幣 HK$

其他資料　Other Information

7. 閣下曾否因同一事故申索/接受其他機構包括保險公司、政府及僱主之傷殘保障賠償?(如是者，請提供以下資料)
Are you claiming/receiving similar benefit for the same event with any other organizations including insurance company, the government, and employer compensation? (If yes, please provide the following information)　☐ 是 Yes　☐ 否 No

保險公司/機構 Insurance Company/Organization	保障類別/保單號碼/團體保險編號 Benefit Type / Policy No. / Group Member No.	申索/接受之傷殘保障賠償 Benefits Amount Claimed/Received	結果/狀況 Result/Status

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、直接銷售保險產品及資料核對、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。

本人/我們明白如欲拒絕接收香港人壽推廣資料，可任何時候以書面形式向香港人壽資料保護主任提出有關申請。

☐ 若不同意根據「個人資料收集聲明」，提供、使用及/或轉移個人資料用作直銷推廣用途，請在左方空格上填上"✓"號。

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, direct marketing for insurance products and 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

I/We hereby understand that if I/we do not want to receive any promotional information from Hong Kong Life, I/we can make such request in writing to the Data Protection Officer of Hong Kong Life at any time.

☐ Please check the box on the left if you do not agree with the provision to provide, use and/or transfer your personal data for direct marketing purposes in accordance with the Personal Information Collection Statement.

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) 香港人壽或任何其指定之醫護人員或化驗所，可就本申請，替本人/我們進行所需之醫療評估及測試以審核本人/我們之健康狀況。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 (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) Hong Kong Life or any of its appointed medical/paramedical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of me/us in relation to this application. 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/受保人身份證號碼 ID Card No. of Claimant/Life Insured	索償人/受保人姓名 Name of Claimant/Life Insured	索償人/受保人簽署 Signature of Claimant/Life Insured
/ /			
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

第二部份 - 醫生診斷報告(索償人自費由主診醫生/手術醫生填寫)

PART II - ATTENDING PHYSICIAN'S STATEMENT (to be completed by attending physician/surgeon at claimant's expense)

1. Name of Patient		Age / Sex		ID Card No.	

2. a. Date of first consultation for the patient's illness or injury: ____ / ____ / ____ (YYYY / MM / DD)

Date when symptoms first appeared or accident happened: ____ / ____ / ____ (YYYY / MM / DD)

b. Chief complaints and symptoms of the patient relating to the illness/injury

c. If the disability was due to accident, was there evidence of an external and visible bruise or wound at first visit? ☐ Yes ☐ No
Please describe which part of the body injured and the cause, character and extent of the injury.

d. According to the patient, has he/she been having same or similar conditions or symptoms before? If yes, please give details. ☐ Yes ☐ No

Date of occurrence (YY/MM/DD)	Exact Nature/Cause of Attack	Test/Treatment received	Duration of Disability	Physician Attended

e. In your opinion, has the patient ever had same or similar conditions or symptoms before? If yes, please give details. ☐ Yes ☐ No

f. Diagnosis

Underlying cause of diagnosis

Date of diagnosis: ____ / ____ / ____ (YYYY / MM / DD)

g. Has the patient received any surgical procedure, medical treatment, laboratory tests such as cytological, X-ray, pathological or serological studies, etc.? ☐ Yes ☐ No
Has the patient received any special treatment such as physiotherapy, occupational therapy or chemotherapy, etc.? ☐ Yes ☐ No
If yes, please give details and provide us with a set of the results if available.

Date Performed (YY/MM/DD)	Details of Procedure/Treatment/Test (type, frequency, result/readings)	Physician Attended / Hospital Confined

h. Are you the patient's usual physician? ☐ Yes ☐ No
Please list down the date and details of each visit of the patient to your clinic/ hospital in the order of dates.

Consultation Date (YY/MM/DD)	Complaints	Diagnosis	Treatment/Physiotherapy (Length of Course)

i. Was the patient referred to you by other physician? If yes, please give details. ☐ Yes ☐ No
Did the patient consult any other physicians or admit in hospital for same or similar conditions or for any serious disorders? ☐ Yes ☐ No
If yes, please give details.

Consultation Date/ Period of Confinement (YY/MM/DD)	Diagnosis/Treatment	Name and Address of other physicians/hospitals

3. a. What is the current condition and prognosis of the patient?

b. Current state of mobility

☐ Ambulatory ☐ Home confined ☐ Hospital confined ☐ Bed confined

Please give details (the causes, areas of involvement, and whether permanent in nature)

c. With the current health condition of the patient, please rate the class of the patient's physical impairment as follows:

☐ Class 1 No limitation of functional capacity; capable of heavy work without restrictions
☐ Class 2 Capable of medium manual activity
☐ Class 3 Slightly limitation of functional capacity; capable of light manual work
☐ Class 4 Moderate limitation of functional capacity; capable of clerical or administrative work
☐ Class 5 Serious limitation of functional capacity; incapable of minimal activity

Please give details:

4. a.

Patient's Occupation and Job		Date first become unable to engage in employment or business	/ / YYYY MM DD

b. According to the occupation of the patient, please indicate the effect on the disability:

☐ Inability to perform one or more duty of his/her OWN job
for ☐ less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-24 months ☐ > 24 months

☐ Inability to perform each and every duty of his/her OWN job
for ☐ less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-24 months ☐ > 24 months ☐ Permanently

☐ Inability to engage in ANY work, occupation or business for which he is reasonably suited by education, training or experience
for ☐ less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-24 months ☐ > 24 months ☐ Permanently

Please give reasons:

c. What are the limitations to the patient's occupational activities?

d. If the patient cannot resume his/her past occupation, could he/she engage in any other occupation? ☐ Yes ☐ No
If yes, what type of job would you suggest him/her to do and from when he/she can perform?

e. Is there any planned treatment or rehabilitation plan to the patient? If yes, please give details with dates. ☐ Yes ☐ No

5. Was the illness or injury caused by or in any way associated with any of the following? Please tick where appropriate and give details.

☐ Past injury or illness
☐ Pre-existing physical or mental defects
☐ Self-inflicted injury
☐ Alcohol or drugs
☐ HIV/AIDS related illness
☐ Degenerative changes
☐ Congenital deformities or anomalies
☐ Childbirth, pregnancy, miscarriage, abortion or prenatal care

Details:

6. Any further information you consider relevant to this claim

I hereby certify that I have personally examined and treated the patient for the above illness or injury and that the information as stated above is true and complete to the best of my knowledge and belief.

Name & Qualification of Attending Physician

Signature and Chop of Attending Physician

/ /
Date (YY/MM/DD)

Address

Telephone No.