香港人壽 hong kong life

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

業務代表姓名 Name of Technical Representative		業務代表號碼 Technical Representative 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業務代表。
   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 technical representatives 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

本人謹此明白及同意：

(1) 所有在本申請書的一切陳述及答案，不論是否本人親手所寫，就本人所知所信，均為事實無訛；(2) 香港人壽保險有限公司(以下簡稱「貴公司」) 所收集或持有本人或其他在本申請書提及之人仕的個人資料，可儲存、使用、透露、發放及轉交予 (不論在本港或海外) 任何與貴公司有關之人仕/機構或任何貴公司認為有需要之人等，以用作處理本申請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、統計或精算研究用途、直接銷售及資料核對、與本人或貴公司認為有關之機構/人仕溝通；(4) 本人有權查閱及要求更正貴公司持有任何由本人提供有關於本人或其他在本投保書提及人仕之個人資料。有關的要求可以書面向貴公司資料保護主任提出。

本人謹此授權：

(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之個人資料 (不論是醫療或其他資料)，均可向貴公司或其代表透露、發放或轉交該等資料，以作為處理本申請；(2) 貴公司或任何其指定之醫護人員或化驗所，可就本申請，替本人進行所需之醫療評估及測試以審核本人之健康狀況。即使本人死亡或喪失能力，此授權書仍具效力，而本人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。

I hereby understand and agree that:

(1) All statements and answers in this application whether or not written by my own hand are complete and true to the best of my knowledge and belief; (2) Any personal information relating to me or other persons named herein collected or held by HONG KONG LIFE INSURANCE LIMITED ("the Company") may be stored, used, disclosed, released and transferred (whether within or outside Hong Kong) by the Company to any individuals/organizations associated with the Company or any selected party as the Company may consider necessary for the purpose of processing this application or any other application for insurance or financial related product/service and providing all on-going services related to such application, claim processing or any analysis of it, statistical or actuarial research, direct marketing and data matching, and communication with me or any relevant organization/person as the Company may consider necessary; (4) I have the right to obtain access to and to request correction of any personal information provided by me and held by the Company concerning me or other persons named herein. Such request can be made in writing and addressed to the Data Protection Officer of the Company.

I 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 (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to this application; (2) the Company 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 in relation to this application. This authorization shall bind the successors and assignees of me 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)	業務代表/見證人身份證號碼 ID Card No. of Technical Representative/Witness	業務代表/見證人姓名 Name of Technical Representative/Witness	業務代表/見證人簽署 Signature of Technical Representative/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 Duties | 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.