香港人壽 hong kong life

危疾保障索償申請書
Dread Disease 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	☐ 危疾保障 DD	☐ 其他 Others

附上文件 Documents attached	☐ 病理報告 Pathological Report	☐ 出院報告 Discharge Summary	☐ 病假證明書 Sick Leave Certificate	☐ 醫療報告 Medical Report	☐ 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(對應申索危疾種類的醫生診斷報告)必須由主診醫生填寫並由索償人支付有關費用。其他有關報告或文件如病理報告、化驗報告等必須一併呈上。
   Please answer ALL the questions in Part I of this claim form. Part II of this claim form (Attending Physician Statement corresponding to the dread disease claiming for) MUST be completed and signed by the attending physician. The completion of this part is at claimant's own expenses. Any other reports or documents such as pathological and laboratory reports or evidences, etc. must be submitted.
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 that 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)

申請索償之危疾名稱 Name of Dread Disease claiming for	

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
患有危疾前職業及職務(倘有兼職請列明) Occupation & job duties before dread disease (if more than one, state all)			

如危疾因意外引致，請填報第 2 項 Complete item 2 if Dread Disease 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

如危疾因疾病引致，請填報第 3 項 Complete item 3 if Dread Disease 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

住院詳情 Hospitalization Details

4. 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)

診治詳情 Consultation Details

5. 閣下慣常求診之醫生 Details of your regular doctor	姓名 Name		自從 Since	年 YY / 月 MM / 日 DD

6. 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			

有關傷病資料 Related Illness Information

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

b. 閣下以往曾否患有類似或相關之疾病或就此作檢驗或治療? 如是者，請於下面詳述。 Have you previously suffered from, tested or received treatment for similar or related illness? If yes, please give details below. ☐ 是 Yes ☐ 否 No

閣下的直系親屬中曾否患有類似或相關之疾病或就此作檢驗或治療? 如是者，請於下面詳述。 Have any of your blood relatives suffered from, tested or received treatment for similar or related illness? If yes, please give details below. ☐ 是 Yes ☐ 否 No

親屬關係 Relationship of Relative	診斷日期(年/月/日) Date of Diagnosis (YY/MM/DD)	疾病名稱 Illness	診治醫生或醫院名稱及地址(請附上病歷咭，如有) Name and Address of doctor/hospital treated for (please attach patient card copy if available)
索償人 Claimant			

其他資料 Other Information

8. 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