



危疾索賠申請書
Dread Disease Claim Application Form

第一部份 PART I

爲使此賠償能盡速辦理，此申請表必須由被保人/申請人直接填寫。
In order to help us process your claim promptly, this form must be completed by Insured/Claimant directly.

甲) 被保人資料 A) Information of the Life Assured			
保單編號 Policy No.	被保人姓名 Name of Insured	年歲/性別 Age/Sex	身份證編號 I. D. Number
索償保障類別(請劃上 √ 號) Claimed Benefit(s) (please tick) <input type="checkbox"/> 附加危疾保險I <input type="checkbox"/> 附加危疾保險II <input type="checkbox"/> 附加危疾保險II		賠償個案類別 Case Type <input type="checkbox"/> 首次索償 New Claim <input type="checkbox"/> 再度索償 Further Claim	
通訊地址 Mailing Address		日間聯絡電話 Contact Phone No.	
現時職業 Present Occupation		僱主電話號碼 Employer's Tel. No.	
現時僱主名稱及地址 Name & address of present employer			
乙) 如危疾因病而導致，請提供下列資料 B) If Dread Disease was due to Illness			
申請危疾賠償項目的名稱 Name of dread disease you are claiming for			
請描述症狀 Please describe symptoms and abnormalities.			
症狀何時開始出現? When did these symptoms first appear?			
丙) 如危疾因意外導致，請提供下列資料 C) If Dread Disease was due to Accident, please specify			
申請危疾賠償項目的名稱 Name of dread disease you are claiming for			
意外發生日期，時間和地點 Date, Time & Location of Accident			
事發原因及經過和結果(如有新聞剪報，請附上)。 Why, where & how did it happen? (attach newspaper clippings if available)			
受傷部位及傷勢 Injured area and severity			
有沒有報警? Reported to police?		<input type="checkbox"/> 有 Yes <input type="checkbox"/> 沒有 No 警署 Police Station: 檔案編號 Reference No.:	
丁) 醫療資料 D) Medical Information			
曾就此疾病或有關病患/傷勢首次就診的醫生。 Who was first consulted for this or related illness/injury? 醫生/醫院 Physician/Hospital 地址及電話 Address & Tel. No. 日期 Date (請附上覆診卡) (Please attach patient card)			
就此疾病或有關病患/傷勢向其他醫生求診的資料。 Other physician(s) who have been consulted in connection with this or related illness/injury 醫生/醫院 Physician/Hospital 地址及電話 Address & Tel. No. 日期 Date (請附上覆診卡) (Please attach patient card)			

閣下慣常求診的醫生。 Who is your usual physician?

醫生/醫院 Physician/Hospital

地址及電話 Address & Tel. No.

日期 Date

(請附上覆診卡)

(Please attach patient card)

就此疾病或有關病患/傷勢所住的醫院。 Any hospitalization(s) required in connection with this or related illness/injury?

醫院名稱 Name of Hospital

入院日期 Admission Date

出院日期 Discharge Date

閣下在這次疾病或有關病患/傷勢之前，是否有其他病患/傷勢？

Are there any illness/complaint/injury treated for or suffered by you prior to this dread disease you are claiming for? 是 Yes 否 No

診斷日期 Date of diagnosis

疾病名稱 Illness

主診醫生/醫院名稱 Name & address of Physician/Hospital

閣下是否在其他公司投保類似的危疾保障？若是，請提供詳細資料。

Are you insured for similar benefits with other insurance company? If so, please give details. 是 Yes 否 No

保險公司 Name of Insurance Company

保單號碼 Policy No.

保障類別及保障金額 Type & Amount of benefit

戊) 賠償方法 E) Settlement Choice

給付支票方式 Cheque Delivery Method

經營業員轉送 By agent

郵寄 By Mail

親自提取 To be collected by claimant

其他(請說明) Others (please specify)

聲 明

本人/吾等謹此代表本人/被保人、所有受保人及其他在此賠償申請表提及之人士(“相關人士”) 聲明及同意 (1)上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所信，均為事實之全部並確實無訛；本人/吾等明白倘有任何未知是否屬於重要事項的資料均須透露；(2)本人/吾等對任何人所作出之任何聲明，如沒有在此申請書上填寫或印出，貴公司不須受其約束；(3)貴公司可以在任何情況下(不論是否打算對相關人士採取不利行動)核對貴公司所收集或持有之任何相關人士的個人資料(不論是否此賠償申請表所載或其他途徑所取得)及/或可以持有、使用、儲存、透露、發放及轉移(不論在本港或海外)任何貴公司所收集或持有之任何相關人士的個人資料(不論是否此賠償申請表所載或其他途徑所取得)給貴公司認為有需要之人士，不受限制地包括貴公司之任何關聯公司，經營保險或再保險業務之公司，中間人，賠償調查員，其他提供有關保險服務者，專業顧問，各團體，政府機關，保險業協會(現有或將來成立)，與貴公司有聯繫之個人或團體，或任何貴公司確認為有需要之有關人士(不論本地或外地)作以下用途：(i)有關保險或財務之產品或服務，或該等產品或服務之增加、更改、轉變、取消、更新或復效；(ii)任何保障範圍，賠償申請，或有關分析；(iii)審核及處理賠償申請書及/或審核及評估任何其他保單及/或投保申請；(iv)提供所有關於此賠償申請及/或審核及評估任何其他保單或投保申請之服務及推廣、改善及進一步推廣關於貴公司及其關聯公司所提供之服務；(v)直接銷售、資料核對；(vi)用於與相關人士作任何其他目的之溝通及/或遵守任何適用之司法區域之法律。

若相關人士不能提供任何此賠償申請表所需的資料，貴公司可能因此不能審核及處理此賠償申請。

本人/吾等聲明及同意已獲得相關人士授權及同意本人/吾等作出上述聲明及協議。

所有相關人士有權依據個人資料(私隱)條例要求查閱及更正任何貴公司持有關於相關人士之個人資料，他們可以以書面向中國人壽保險(海外)股份有限公司(香港分公司)理賠部之主管提出要求(地址:香港灣仔軒尼詩道313號中國人壽保險大廈22F)。本人/吾等同時明白貴公司可就有關要求酌量收費。

DECLARATION

I/WE HEREBY DECLARE AND AGREE on behalf of myself/the Insured and all Covered Person(s) and other Persons referred to in this claim form ("Relevant Persons") that (1) all the foregoing statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true. I/we also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. (2) the Company is not bound by any statement which I/we may have made to any person if not written or printed here. (3) any personal data of the Relevant Persons collected or held by the Company (whether contained herein or otherwise obtained), may be used in connection with matching for whatever purpose (whether or not with a view to taking any adverse action against the Relevant Persons) with such other personal data and/or may be held, used, stored, disclosed, released and transferred (whether within or outside Hong Kong) to such persons as the Company may consider necessary including without limitation any of its affiliated companies, or any other company carrying on insurance or reinsurance related business or any intermediary or claims investigator or other service provider providing services relevant to insurance business or professional advisor or any association or government authority or federation of insurance companies that exists or is formed from time to time or any individual/organization associated with the Company or any selected party as the Company may consider necessary whether local or overseas for the purpose of (i) any insurance or financial related product or service or any addition, alteration, variation, cancellation, renewal or reinstatement of them (ii) any scope of insurance coverage, claim processing and analysis of it (iii) process and deal with this claim and/or underwrite and evaluate any other existing policies and/or application for insurance (iv) provide all services related to this claim and underwrite and evaluate any other existing policies and/or application for insurance and promote, improve and further promotion of services by the Company and its affiliated companies (v) direct marketing and data matching (vi) communicate with the Relevant Persons for any other purpose and/or comply with the laws of any applicable jurisdiction.

If the Relevant Persons fail to provide any information requested in this claim form, it may result in the Company's inability to process and deal with this claim.

I/WE declare and agree that I/we have the full authority from and consent of the Relevant Persons to make the above declarations and agreements.

The Relevant Persons have the right under the Personal Data (Privacy) Ordinance to request access to and correct any of the personal data held by the Company concerning the Relevant Persons. Any request may be made in writing and addressed to the head of the Claims Department of China Life Insurance (Overseas) Co. Ltd. (Hong Kong Branch) at 22/F., China Life Insurance Building, No.313 Hennessy Road, Wan Chai, Hong Kong. I/we further understand that a reasonable fee may be charged for such request.

授 權

本人/吾等謹此代表本人/被保人及所有受保人授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、或其他機構、組織或人士、凡知道或持有任何有關本人/被保人或任何一位受保人之紀錄者，及/或會診驗或可能將會診驗本人/被保人及任何一位受保人者，均可將該等資料提供、發放及轉交給中國人壽保險(海外)股份有限公司；(2) 中國人壽保險(海外)股份有限公司或任何其指定之醫生或化驗所，可就此賠償申請替本人/被保人及任何受保人進行所需之醫療評估及測試，作為審核本人/被保人及任何受保人之健康狀況。此授權對本人/被保人之繼承人及授權人具有約束力；即使本人/被保人死亡或無行為能力時，此授權書仍具效力。此授權書的影印本與正本均有同等效力。

本人/吾等聲明及同意已獲被保人及所有受保人授權及同意本人/吾等作出上述授權。

AUTHORIZATION

I/WE HEREBY AUTHORIZE on behalf of myself/the Insured and all Covered Person(s) (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of me/the Insured or any of the Covered Person(s) and who has attended or may hereafter attend myself/the Insured and any of the Covered Person(s) to disclose, release and transfer such information to China Life Insurance (Overseas) Co. Ltd.; (2) China Life Insurance (Overseas) Co. Ltd. or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/the Insured or any Covered Person(s) in relation to this claim. This authorization shall bind the successors and assignees of me/the Insured and remains valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original.

I/WE declare and agree that I/we have the full authority from and consent of the Insured and all Covered Persons to make the above authorizations.

Dated at

_____ on _____

簽署於
地方

在 Y Y / M M / D D
年 / 月 / 日

Signature of Agent/Witness
營業員/見證人簽署

Signature of Insured
被保人簽署

Signature of Owner/Claimant (if other than insured)
保單權益人/申請人簽署 (如非被保人)

Remarks: This declaration and authorization must be signed by the Insured. If the Insured is a minor, the Insured's parent/legal guardian can sign on his/her behalf.

備 註: 此聲明及授權書必須由被保人簽署，若被保人為小童，則可由其家長/合法監護人簽署。

In the event of the Insured is physically incapacitated and prevent from signing, PART I may be signed by a close relative or other representative authorized by the Insured.

如受保人因傷殘不能書寫，其家屬或代理人可代為填寫此申請書及簽字。

Please complete if the signature is not given by the Insured. 若簽署者非被保人，請填寫此欄

Name (in block letter) _____
姓名 (正楷書寫)

Relationship with Insured : _____
與被保人關係