



中國人壽保險(海外)股份有限公司 香港分公司
China Life Insurance (Overseas) Co. Ltd. Hong Kong Branch

SPECIAL LADY INSURANCE CLAIM FORM
時代女性保障計劃賠償申請書

PART I 第一部份

In order to help us process your claim promptly, this form must be completed by Insured/Claimant directly.
為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。

Insured's Particulars 被保人資料

Policy No. 保單編號	Name of Insured 被保人姓名	Age/Sex 年歲/性別	ID. Number 身份證編號
Name of infant 初生嬰兒姓名	Date of Birth 出生日期	Sex 性別	Birth Cert. Number 出生證明書編號
Mailing Address 通訊地址	Contact Phone No 日間聯絡電話		

Nature of Claimed Benefit(s) (please tick the appropriate box) 索償保障類別(請在適當之方格內劃上 ✓ 號)

<input type="checkbox"/> Maternity Benefit 新生嬰兒獎賞	- <input type="checkbox"/> 1 st Born Baby 第一胎嬰兒	<input type="checkbox"/> 2 nd Born Baby 第二胎嬰兒				
<input type="checkbox"/> Pre-Cancerous Changes of Breast and Female Genital System 乳房及女性生殖系統內的前癌性病變	- <input type="checkbox"/> Breast 乳房	<input type="checkbox"/> Uterus 子宮	<input type="checkbox"/> Cervix Uteri 子宮頸	<input type="checkbox"/> Fallopian Tube 輸卵管	<input type="checkbox"/> Ovary 卵巢	<input type="checkbox"/> Vagina 陰道
<input type="checkbox"/> Systemic Lupus Erythematosus with Lupus Nephritis 有狼瘡性腎炎的系統性紅斑狼瘡						
<input type="checkbox"/> Complications of Pregnancy 妊娠期間的併發病	- <input type="checkbox"/> Ectopic Pregnancy 宮外孕	<input type="checkbox"/> Hydatidiform Mole 葡萄胎				
	- <input type="checkbox"/> Disseminated Intravascular Coagulation 血管內瀰漫性凝血	<input type="checkbox"/> Postpartum Psychosis 產後嚴重抑鬱				
<input type="checkbox"/> Fetus & Infant Protection 嬰胎保障						
<input type="checkbox"/> Congenital Anomalies 嬰兒先天性異常	- <input type="checkbox"/> Down's Syndrome 唐氏綜合症	<input type="checkbox"/> Spina Bifida 腦脊膜突出	<input type="checkbox"/> Tetralogy of Fallot 法洛氏四重症			
	- <input type="checkbox"/> Oesophageal Atresia & Oesophago Tracheal Fistula 食道閉鎖及食道氣管漏	<input type="checkbox"/> Hydrocephalus 腦積水				

Details of Medical Consultation 有關就診詳情

1. Date when symptoms first appeared (For Systemic Lupus Erythematosus with Lupus Nephritis & Pre-Cancerous Changes of Breast or Female Genital System) 初次出現病徵的日期(有關有狼瘡性腎炎的系統性紅斑狼瘡或乳房、女性生殖系統內的前癌性病變)	1.
2. Have you previously suffered from or been treated for the above condition? If so, please give details. 閣下是否曾患有上述病徵或情形? 請提供有關詳情。	2.
3. Details of medical consultation 就診詳情	<u>Name & Address 姓名及地址</u> <u>Diagnosis 診斷</u> <u>First Consultation Date 初次求診日期</u>
i) The Doctor first consulted for the above condition 病人就上述疾病 / 情況而首次求診的醫生	
ii) The Doctor last consulted for the above condition 病人就上述疾病 / 情況而最後求診的醫生	
iii) All other Doctor(s) consulted for the above condition 病人就上述疾病 / 情況而求診的其他醫生	
4. The Hospital / Clinic / Institution that has attended to the above condition 病人就上述疾病 / 情況而求診的醫院 / 醫生 / 診所 / 醫療機構	<u>Name & Address 姓名及地址</u> <u>Diagnosis 診斷</u> <u>Date of Admission 入院日期</u> <u>Date of Discharge 出院日期</u>
5. Details of your Family Doctor / Usual Doctor. 家庭醫生 / 經常就診的醫生有關資料	<u>Doctor Name (s) 醫生姓名</u> <u>Tel. No. & Address 電話及地址</u> <u>Date of last Consultation 最近期之就診日期</u> <u>Patient Card No. 病人覆診咭編號</u>

Other Details 其他資料

6. Have any of your immediate family members suffered from a similar or related illness? If yes, please state relationship to relative, name of illness and the date when the illness was first diagnosed.

閣下的直系親屬中曾否患有相同或類似的疾病？如有，請列出與該親屬的關係，並需列明有關該疾病的名稱及首次被診斷患有該疾病的確診日期。

No 否 Yes 有 Please Specify 請註明

7. Do you smoke cigarettes? If yes, state quantity, type and duration of smoking.

閣下是否有吸煙之習慣？如有，請列明數量、類別及持續吸煙已多久

No 否 Yes 有 Type 類別

Duration of smoking 持續吸煙已多久 _____ Daily Quantity 每天數量 _____

8. Are you insured for similar benefits with any other Insurance Company? If yes, state the name of the Insurance Company, the amount of benefit insured, policy no. and whether you have submitted a claim in connection with this illness.

閣下有否在其他保險公司作類似的投保？如有，請列出該保險公司的名稱、投保金額、保單號碼及有否向該保險公司遞交與此次疾病有關的索償申請。

No 否 Yes 有 Name of Insurance Company 保險公司名稱 _____

The amount of benefit insured 投保金額 _____ Policy No. 保單號碼 _____

Declaration and Authorization 聲明及授權

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.

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（不論是可否對相關人士採取不利行動）核對貴公司請表或持有之任何相關人士的個人資料（不論是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，進行保險或再保險業務之公司，中間人，賠償調查員，其他提供有關保險業務服務者，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，或任何貴公司認為有需要之有關人等（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之賠償申請。

本人/吾等聲明及同意已獲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22/F）。本人/吾等同時明白貴公司可就有關要求酌量收費。

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.

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/或曾診驗或可能將本人/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）股份有限公司或其指定之醫生或化驗所，可就此賠償申請管本人/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。

Dated at _____ on _____
簽署於 _____ 在 _____
地方 年/月/日
Signature of Agent/Witness _____ Signature of Insured _____ Signature of Owner/Claimant (if other than insured) _____
營業員/見證人簽署 被保人簽署 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。

Name of insured (in block letter) 被保人正楷姓名	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

Suggested Checklist 建議參考事項

- ※ Please write down the correct insured name & policy number. 請填上正確被保人姓名及保單編號；
- ※ Please complete all the questions in Part I. 此表格上所有問題都必須作答；
- ※ Please ensure Part II to be completed by a registered doctor. 請確保填寫表格第二部份之醫生是註冊西醫；
- ※ Please make sure the signature of the insured / owner is consistent with that in policy application. 請確保以上之簽名與保單申請書之簽名一致；
- ※ For Claims of Maternity or Congenital Anomaly Benefits, proof of relationship (e.g. Birth Certificate), is needed.
如閣下是次為申請新生嬰兒獎賞或嬰兒先天性異常之有關償者，祈請同時帶附上索償表格及關係證明，例如出生證明書，一併遞交申請；
- ※ Please complete relevant Claim Forms for claims related to Death Claim, Waiver of Premium, Dread Diseases and all other supplements.
如閣下是次為申請其他有關之索償類別者，如身故壽險、豁免保費、重疾保障及其他，祈請閣下必須填寫個別有關之索償表格交予本保險公司；
- ※ References such as the Patient's Card, diagnostic or laboratory reports should be submitted. 閣下應提供有關之病歷咭、各項化驗檢查及診斷結果報告等參考資料予本保險公司；
- ※ China Life Insurance(Overseas) Co. Ltd. (HK Branch) reserves the right to request the Insured or the Insured's child to be examined by a medical practitioner of our choice.
中國人壽保險(海外)股份有限公司香港分公司保留要求被保人及其嬰兒需前往由本保險公司指定之醫生接受檢驗的權利。

For Agent's / Witness's Use only 營業員/見證人專用

I believe that the answers given above are true to the best of my knowledge. 我認為上述之答案全屬正確無訛

Documents attached with this claim form 與申請表一起呈遞之文件

1. Please specify 請註明： _____

Signature of Agent/Witness 營業員/見證人簽署	Name of Agent/Witness (in block letter) 營業員/見證人姓名 (正楷書寫)	Agent Code & Region (if any) 營業員編號及區域(如適用者)	Date (YY/MM/DD) 日期 (年/月/日)
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ATTENDING PHYSICIAN'S STATEMENT

PART II

To be completed by the attending physician at the claimant's own expenses.

Full name of Patient	Age/Sex	I. D. Number
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A. GENERAL CONSULTATION HISTORY

1. Date on which the patient first consulted your clinic / institution for any illness.
_____ (YY/MM/DD)
2. The date of this patient first consulted your clinic / institution for signs and symptoms related to the condition declared in Part I ~ **Nature of Claimed Benefit(s)**.
_____ (YY/MM/DD)
3. The Doctor / Hospital from whom / where this patient was referred to your Clinic / Institution.
Name & Address _____ Referral Reason _____
4. Are you aware of other doctors whom this patient has consulted in connection with this condition ?

B. CLINICAL HISTORY OF CONDITION UNDER PRESENT CLAIM

5. Presenting Signs & Symptoms _____ Date Patient First Noticed Symptoms _____ Underlying Causes _____
6. Exact Diagnosis & Date _____ Basis of the Diagnosis _____ Date Patient was informed of Diagnosis _____
7. Patient's Condition During Last Consultation

<u>Condition</u>	<u>Date</u>	<u>Treatment</u>	<u>Prognosis</u>
_____	_____	_____	_____

C. INFORMATION(S) OF THE ABOVE CONDITION

8. If the diagnosis was Systemic Lupus Erythematosus with Lupus Nephritis :

i) Please confirm which of the following clinical manifestations is exhibited by the patient :

	Yes	No		Yes	No		Yes	No
Marlar rash	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Lymphopenia	<input type="checkbox"/>	<input type="checkbox"/>
Discoïd rash	<input type="checkbox"/>	<input type="checkbox"/>	Serositis	<input type="checkbox"/>	<input type="checkbox"/>	Haemolytic Anaemia	<input type="checkbox"/>	<input type="checkbox"/>
Photosensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Renal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia	<input type="checkbox"/>	<input type="checkbox"/>
Oral Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Leukopenia	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Others (Please specify)	_____							

ii) Results & Dates of the following laboratory tests (Please provide copies of test results) :

Anti-Nuclear Antibodies	LE Cells	Anti-Sm	Anti-DNA	Creatinine Clearance Rate Past Record	Latest Record
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iii) Results of other Investigations (e.g. Biopsy, Renal Function Tests, etc.)

9. If the diagnosis was Pre-Cancerous changes :

i) of the Breast(s),

Dates & Results of the biopsy (Please provide copies of histopathology reports):

When did the patient previously undergo investigations or receive treatment for any abnormality of the breasts ? From whom & where ?

ii) of Cervix Uteri,

Dates & Results of the latest & all previous Pap Smear Tests (Please provide copies of cytology reports):

Dates & Results of the Cone Biopsy or Colposcopy with Cervical Biopsy (Please provide copies of histopathology reports):

When did the patient previously receive treatment for Carcinoma-in-situ of the Cervix or for an abnormal smear ? From whom & where ?

10. If the diagnosis was one of the following :

i) Down's Syndrome,

Please give details of the clinical manifestations:

Please give the Names, the Dates and Results of all Diagnostic Tests or Investigation conducted:

Please comment on the patient's physical and mental development:

ii) Spina Bifida,

Please give details of all investigation conducted in the making of the diagnosis (Including dates & results):

Were there clinical manifestations of meningomyelocele or meningocele ?

Please give details of resultant neurological deficits:

iii) Tetralogy of Fallot,

What were the dates and findings of echocardiograms ?

Please give details of all investigations conducted in the making of the diagnosis (Including dates & results):

11. If the diagnosis was related to complications of pregnancy :

i) Disseminated Intravascular Coagulation,

What were the precipitating factors ?

What was the gestational stage when the condition first appeared ?

Was the condition a result of an abortion or its complications ?

How did the condition manifest ? What treatment was given ?

ii) Ectopic Pregnancy / Hydatidiform Mole / Postpartum Psychosis,

What were the precipitating factors ?

Date of Diagnosis and Details of all investigations conducted.

Please give details of the subsequent management and treatment of the patient:

Has the patient a previous history of ectopic pregnancy/ Hydatidiform Mole / Postpartum Psychosis? When?

D. PLEASE provide any additional information which you feel will help the assessment of this claim :

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his / her condition. I declare and agree to make the declarations on Part II of this claim form.

Name of Attending physician / Specialist (with qualification)
主診 / 專科醫生的姓名 (資歷)

Address
地址

Telephone
電話

Signature of Attending physician / Specialist
主診 / 專科醫生簽名

Date
日期