中國人壽保險(海外)股份有限公司
China Life Insurance (Overseas) Company Limited
(於中華人民共和國註冊成立之股份有限公司)
(incorporated in the People's Republic of China with limited liability)

中國人壽 CHINA LIFE | 海外

長期病假賠償申請表
Long Term Sick Leave Claim Form

CS-CLA12

第一部份 PART I

爲使有關賠償申請能盡速辦理，此申請表必須由受保人/保單持有人填寫及簽署。
In order to process your claim promptly, this form must be completed and signed by Insured/Policyholder.

甲) 受保人資料 A) Particulars of Insured

保單號碼 Policy No.	受保人姓名 Name of Insured	年齡 及性別 Age and Sex	身份證/ 護照號碼 I.D. Card / Passport No.

聯絡電話 Contact phone no:

☐ 首次索償 New Claim ☐ 再度索償 Further Claim

通訊地址 Mailing Address

乙) 病症性質及有關資料 B) Nature of illness and related information

1. 病症名稱 Name of illness	
2. 請描述症狀 Please describe symptoms	
3. 症狀何時開始出現? When did these symptoms first appear?	_____ 年/月/ 日 YY/MM/DD
4. 初診醫生/醫院的資料: The physician/hospital first consulted for this injury or illness.	求診日期 Date of consultation: _____ 年/月/ 日 YY/MM/DD 醫生/醫院名稱及地址 Name & Address of Physician/Hospital
5. 其他曾診治此症或過往類似病況的醫生/醫院資料: Other physicians/hospital consulted for this or similar conditions:	求診日期 Date of consultation: _____ 年/月/ 日 YY/MM/DD 醫生/醫院名稱及地址 Name & Address of Physician/Hospital

6. 閣下是否在其他保險公司投保類似的保障? 若有，請提供詳細資料。 □ 是 Yes □ 否 No
Are you insured with other insurance company for similar benefits? If yes, please give details.
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

丙) 必須提供的索償文件 C) Claims documents to be submitted

1. 由主診醫生填寫之賠償申請表第二部份 應診醫生報告書
   Claim Form Part II Attending Physician's Statement to be completed by the attending physician
2. 化驗/ X光 / 電腦掃描/ 磁力共震/ 相關病理檢驗報告(如適用者)
   Laboratory/ X'ray / CT Scan/ MRI/ Pathological Reports (if applicable)
3. 由主診西醫發出的病假證明書
   Sick Leave Certificate issued by your attending physician.
4. 僱主發出之病假證明信(如適用)
   Employer confirmation letter for sick leave period, if any.

丁) 領款方式 D) Cheque Collection Method

☐郵寄 By Mail ☐親自提取 In person ☐經銀行營業員轉送(請指定銀行分行及經辦人員) Bank(Please state the branch and bank officer)
☐經代理人轉送 Agent ☐其他(請說明) Others (please specify)

聲明及授權 Declaration and Authorization

授　權

本人謹此授權 (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/受保人之紀錄者，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(以下簡稱「貴公司」)； (2) 貴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/受保人進行所需之醫療評估及測試，作爲審核本人/受保人之健康狀況。此授權對本人/受保人之繼承人及授讓人具有約束力；即使本人/受保人死亡或無行爲能力時，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。

AUTHORIZATION

I HEREBY AUTHORIZE (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 to disclose, release and transfer such information to China Life Insurance (Overseas) Company Limited (hereinafter called "the Company"); (2) the Company 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 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 photocopy of this authorization shall be as valid as the original.

聲　明

本人謹此聲明及同意(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，均爲事實之全部並確實無訛；本人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。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。

DECLARATION

I HEREBY DECLARE and AGREE 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 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 may have made to any person if not written or printed here. If any 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.

受保人/保單持有人簽署 Signature of Insured/Policyholder	受保人/保單持有人姓名 Name of Insured/Policyholder	身份證/護照號碼 I.D. Card / Passport No.	日期(年/月/日) Date (YY/MM/DD)

備　註: 此聲明及授權書必須由受保人簽署，若受保人爲小童，則可由其家長/合法監護人簽署。
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.

如受保人因傷殘不能書寫，其家屬或代理人可代爲填寫此申請書及簽字。.
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.

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

受保人姓名 (正楷書寫) _____ 與受保人/保單持有人關係_____
Name of insured (in block letter) Relationship with Insured/ Policyholder

收集個人資料聲明 Personal Information Collection Statement

本人確認已閱讀及明白中國人壽（海外）股份有限公司的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於www.chinalife.com.hk下載或向中國人壽（海外）股份有限公司索取。
I confirm that I have read and understood the personal information collection statement of China Life Insurance (Overseas) Company Limited. For the latest version of the personal information collection statement, it can be downloaded from www.chinalife.com.hk or is made available upon request.

受保人/保單持有人簽署　　日期(年/月/日)

保險中介人專用 For Insurance Intermediary use only

本人認爲上述之答案全屬正確無訛。
I believe that the answers given above are true and to the best of my knowledge.

保險中介人簽署 Signature of Insurance Intermediary	保險中介人姓名 (正楷填寫) Name of Insurance Intermediary (in block letter)	保險中介人代碼(如適用者) Insurance Intermediary Code (if any)	日期 (年/月/日) Date (YY/MM/DD)

應診醫生報告書 ATTENDING PHYSICIAN STATEMENT

第二部份 PART II

由主診醫生填寫，所有費用由索償人自行承擔

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

病人姓名 Name of Patient	年齡及性別 Age and Sex	身份證/ 護照號碼 I.D.Card / Passport No.

A. 臨床資料 CLINICAL DETAILS

1 病人之醫療記錄可追溯至 We can trace the medical record of patient back to _____
(年/月/日 YY/MM/DD)

2 首次出現病徵日期發生日期 Date of the symptoms first appeared _____
(年/月/日 YY/MM/DD)

3 病人首次有關此病症之求診日期 Date of first consultation for this condition or related illness _____
(年/月/日 YY/MM/DD)

4 請詳細說明首次會診時之徵狀和病症 Please describe the symptoms and complaints at first consultation.

_____

5 病人是否由其他醫生轉介？如是，請提供該醫生之姓名及地址。
Is the patient referred by other physician? If yes, please give the name and address of the referring doctor.

_____

6 診斷 Diagnosis _____

7 何時確診 When was the diagnosis made _____
(年/月/日 YY/MM/DD)

8. 請述完全喪失工作能力原因
Please state the cause of total disability

9. 請詳述病人如何因是次疾病影響而導致完全不能回復本來之工作崗位Please state in details on how the disability prevents the patient from resuming work

10. 所有關於是項診斷之治療、檢查及其結果、有否任何併發症及出院後之覆診或跟進計劃
Any treatments, investigation procedures, results, and/or any complications and follow up plan regarding the subject diagnosis.

B. 閣下之專業意見 PROFESSIONAL COMMENT

1. 是次診斷是否復發個案，或與過往其他病況有關？如是，請提供有關診治日期及治療詳情。
Is the diagnosis a recurrent episode or related to any previous conditions? If so, please provide details of the diagnosis and treatments.

☐ 是Yes ☐ 否No

診治日期 Date of diagnosis/treatments (年/月/日 YY/MM/DD)

詳情(包括診斷/治療/檢查及結果) Details(including diagnosis/ treatments/ investigations and results)

2. 病人之家族史有否增加病人患上此症的風險? Is there any patient's family history which would increase the risk of this illness?

3. 病情預測The prognosis of the condition.

4. 是否與人體免疫缺損病毒有關 Is it HIV related?

C. 其他醫療病史 OTHER MEDICAL HISTORY

1. 請圈出病人過往有否以下病症/習慣。Does the patient have any medical history or habit as indicated below? Please circle the appropriate.

哮喘 Asthma /心臟病 Cardiac problem /糖尿病 Diabetes Mellitus / 乙型肝炎 Hepatitis B / 高血壓 Hypertension /

曾接受手術 Previous operation /濫藥 Drug abuse /飲酒習慣 Drinking /吸煙習慣 Smoking /

其他疾病，請說明 Other disease, please specify _____/ 以上皆沒有 None

2. 該病人曾否因患上述疾病或其他嚴重疾病接受醫生或醫院治療 ? 如是者，請述詳情。Had the patient previously been treated or hospitalized for the above disease or other major disease? If so, please give details.

日期 Dates	疾病 Disease	治療/住院詳情 Details or treatment/hospitalization	醫生姓名/醫院名稱 Name of Physician/Hospital

3. 請提供飲酒/吸煙習慣詳情 Please provide details of Drinking & Smoking habit.

習慣始自 Drinking/ Smoking start date since _____ (年/月/日 YY/MM/DD)

每日用量 Daily consumption _____ (支/包/樽/罐 piece/ pack/ bottle/ can)

_____ _____

主診醫生姓名 Name of Attending physician 資歷 Qualification

_____ _____

地址 Address 聯絡電話 Contact Phone No.

_____ _____

主診醫生簽署/ 醫院蓋章 日期 (年/月/日)

Signature & Stamp of Attending Physician/ Hospital Date (YY/MM/DD)