免繳/供款者免繳保費賠償申請表
Waiver of Premium / Payor Benefit Claim Form

CSM-CLA13

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/供款者資料 A) Particulars of Insured/Payor

保單號碼 Policy No.	受保人/ 供款者姓名 Name of Insured / Payor	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

僱主名稱、聯絡電話及地址 Name, phone no. and address of Employer

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

1.身故原因、日期及地點 (如適用者) Cause, date and place of death (If applicable)

2. 病症名稱 Name of illness

3. 受保人/供款者於何時開始就此病/意外向醫生求診
When did the Insured/Payor first consult a physician for this illness/ injury? _____/_____/_____(年 YYYY / 月MM / 日DD)

4. 如因意外引致身故/傷病，請詳述意外發生經過 If death/injury/illness/disease is due to accident, please give details.

5. a)曾否向僱主遞交病假證明書 Has sick leave certificate submitted to employer?是Yes □ 否No □

b)最後工作日期 Last date of work：_____

c)是否已恢復工作 Is work resumed?：是Yes □ 否No □

d) 如是，請提供恢復工作日期 If yes, please provide date of resumed work? 日期 Date: _____/_____/_____(年 YYYY / 月MM / 日DD)

e) 如否，預計何時可恢復工作 If no, please provide expected date to resume work?日期 Date: _____/_____/_____(年 YYYY / 月MM /日DD)

f) 是否已向勞工處申報 Was the case reported to Labour Department ? 是Yes □ 否No □
如是，請提供檔案編號 If yes, please provide case no. 檔案編號 Case No. _____

6. 請列出受保人/供款者於五年內求診之醫院及醫生姓名和地址
Name and address of all physicians/hospital treated during the five years.

醫生姓名 / 醫院名稱 Physician / Hospital	地址 Address	診治日期 Date of attendance	病因 Disease or condition

7.受保人/供款者是否在其他公司投保？如"是"，請填寫下欄
Is the Insured/Payor insured for similar benefits with any other Company? If "yes", please state.

公司名稱 Companies	保單號碼 Policy Number	保額 Amount of Benefit

丙) 申請人資料(如非受保人/供款者) C) Information of Applicant (Other than Insured/Payor)

申請人姓名 Name of Applicant	年齡 / 性別 Age / Sex	身份證號碼 I.D. Card No.	與受保人/供款者關係 Relationship with Insured / Payor
通訊地址 Mailing Address		聯絡電話 Contact phone no:	

丁) 必須提供的索償文件 D) Claims documents to be submitted

爲使能儘速辦理閣下的賠償申請，請將此表格連同以下文件一起遞交。

In order to speed up your application, please attach the following documents together with this claim form : --

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 / 心電圖/ 相關病理檢驗報告(如適用者)
   Laboratory/ X'ray / CT Scan / MRI/ E.C.G. / other 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.
5. 供款者之死亡證正本或已核實之副本(只適用於供款者免繳)
   Original Death Certificate or certified true copy for the Payor. (for Payor Benefit only)

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/供款者/申請人簽署 Signature of Insured/Payor/Applicant	受保人/供款者/申請人姓名(正楷填寫) Name of Insured/Payor/Applicant(in block letter)	身份證/ 護照號碼 I.D. Card / Passport No.	日期(年/月/日) Date (YYYY/MM/DD)

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 Signature of Insured/Policyholder	日期 (年/月/日) Date (YYYY/MM/DD)

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 (YYYY/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 YYYY/MM/DD)

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

3. 病人首次就有關病症/此意外之求診日期 Date of first consultation for this illness or injury _____
(年/月/日 YYYY/MM/DD)

4. 請詳細說明首次會診時之徵狀 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 YYYY/MM/DD)

(a) 請提供病人首次未能工作日期
Please give the date the patient first absent from work _____/_____/_____(年/月/日 YYYY/ MM / DD)

(b) 如已恢復工作能力，請提供病人可恢復工作的日期
Please give the expected date the patient to resume work _____/_____/_____(年/月/日 YYYY/ MM / DD)

8. 請詳述病人如何因是次診斷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 diagnosis prevents the patient from resuming work

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

10. 若病人目前仍喪失工作能力，您認爲該情況將會持續多久?
If the patient is still totally disabled, how long will such disability be expected to continue？

C. 治療詳情 TREATMENT DETAILS

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.

D. 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 YYYY/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
Signature & Stamp of Attending Physician/ Hospital　　日期 (年/月/日)
Date (YYYY/MM/DD)