傷殘賠償申請表 第一部份
APPLICATION FOR DISABILITY CLAIM PART I
(由受保人或索償人填寫 To be completed by Insured / Claimant)

公司名稱/團體保單投保公司名稱 Name of Employer / Group Policyholder		團體保單號碼 Group Policy Number	
		TPLHK	
受保人姓名 Name of Insured		年齡 Age	保額 Amount of Assurance HKD
聯絡電話號碼 Contact Number	電郵地址 E-mail	性別 Sex	香港身份証號碼 HKID Card No.
聯絡地址 Correspondence Address			

請在以下適當空格填上✓。 Please tick ✓ in the appropriate box below.

第 1 部份: 基本索償資料 **Section 1: Particulars of the Claim**				
1	這次是 This is a:	☐ 首次索償 New Claim	☐ 再次索償 Further Claim	☐ 重批 / 覆核 Review / Appeal
2	索償類別 Type of Claim	☐ 永久喪失工作能力賠償 Permanent Total Disability	☐ 意外斷肢賠償 Accident Dismemberment	

第 2 部份: 賠償性質及有關資料 **Section 2: Nature of Claim and related details**		
3	若因疾病導致，請詳述該疾病之詳情 If due to illness, please give details of the illness	首次出現病徵之日期 Date of first appearance of the symptoms _____ (日/月/年 DD/MM/YYYY) 詳述所患之病徵及異常 Describe the symptoms & abnormalities 主診醫生 / 醫院名稱 Name of the attending physician / hospital
4	若因意外導致，請詳述該意外之詳情 If due to accident, please give details of the accident	意外發生日期及時間 Date and time of accident _____ (日/月/年 DD/MM/YYYY) 意外發生地點 Accident Place 意外詳情、受傷部位及傷勢 Accident details, part of the body injured and nature of injury 有否報警? Was the case reported to police? ☐ 沒有 No ☐ 有 (請附警察報告 / 口供紙 / 酒精測試報告) Yes (Please attach police report / statement / Alcohol Test Report) 警署 Police Station: _____ 檔案編號 Reference No.: _____

香港銅鑼灣新寧道 8 號中國太平大廈 1 期 7 樓
7/F, China Taiping Tower Phase I, 8 Sunning Road, Causeway Bay, Hong Kong
電話 (Tel) : 800 961 589 (中國香港 China HK) / 95589 (中國內地 Mainland China) 網址 (Website): tplhk.cntaiping.com

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第 3 部份: 過往之診治及住院記錄
Section 3: Record of medical consultation / hospitalisation

5 請提供首次及曾診治此疾病或傷勢的醫院、醫生或專科醫生資料。
Please give details of any hospital(s), physician(s) or specialist(s) consulted firstly and following in connection with this illness or injury.

醫院 / 醫生 / 專科醫生名稱 Name of Hospital / Physician / Specialist	地址 Address	求診日期 (日/月/年) Date of Consultation (DD/MM/YYYY)

6 請提供與此疾病或傷勢有關之住院記錄。
Please give details of any hospitalization in connection with this illness or injury.

醫院名稱 Name of Hospital	入院日期 (日/月/年) Date of Admission (DD/MM/YYYY)	出院日期 (日/月/年) Date of Discharge (DD/MM/YYYY)

第 4 部份: 其他資料
Section 4: Other Information

7	閣下慣常求診之醫生 / 醫院名稱、地址及聯絡電話 The name, address and contact phone number of your usual physician / hospital	

8 直系親屬中有否曾患有相同或有關之疾病？如"有"， 請填寫下欄。
Have any of your blood relatives suffered from a similar or related illness? If "yes", please state.

親屬關係 Relationship of Relative	疾病類別 Nature of Illness	診斷日期 (日/月/年) Date of Diagnosis (DD/MM/YYYY)

9 閣下曾否患上類似 / 相關此疾病或其它病症因而作檢驗或治療？如"有"， 請提供詳細資料。
Have you previously suffered from, tested or received treatment for similar or related illness? If so, please give details.

醫院 / 醫生 / 專科醫生名稱 Name of Hospital / Physician / Specialist	疾病名稱 / 類別 Name / Nature of Illness	檢驗 / 診斷日期 Date of test / diagnosis	檢驗 / 診斷結果 Result of test / diagnosis

10 閣下有否在其它機構包括保險公司、政府及僱主享有類似的傷殘保障？如"有"，請提供詳細資料。
Are you insured for similar benefits with any other organizations including insurer, the government & employer? If "yes", please give details.

投保公司名稱 Name of Insurance Company	投保類別及保單號碼 Type of Benefit & Policy Number	投保金額 Amount of Benefit	索償結果(如有) Claim Result (if any)

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第5部份: 就業詳情 **Section 5: Employment Particulars**		
11	患病/受傷時之職業、職位及職責 (請列明所有包括兼職) Occupation, Position and Nature of occupational duties before sickness/injury (please state all includes part-time)	
12	公司或僱主名稱、地址及聯絡資料 Name, Address and Contact information of Business or Employer	
13	閣下會否被安排判傷或接受醫療評估？ Have you arranged Medical Assessment?	☐ 沒有 No ☐ 有, 請提供報告及驗傷日期 Yes, please provide Report and the date of exam. (DD日/MM月/YYYY年)
14	最後工作日期 Date of Absence from work	(DD日/MM月/YYYY年)
15	恢復工作日期 (倘未復工請回答16題) Date of Return to work (please answer question 16 if not yet returned to work)	(DD日/MM月/YYYY年)
16	預算復工日期 Expect Date of Return to work	(DD日/MM月/YYYY年)

第6部份: 賠款選項
Section 6: Settlement option

支票交付方式 Cheque Collection Method
☐ 親臨客戶服務中心領取
Pick up at the Customer Centre in person
☐ 由代理人轉遞 via Agent

支票幣值 Cheque Currency
☐ 港幣 HKD*
☐ 保單貨幣 Policy currency
* 按中國太平人壽保險(香港)有限公司每月之固定兌換率計算
at monthly fixed rate of China Taiping Life Insurance(Hong Kong)Company Limited

註 Remarks:
1. 請就每宗理賠申請選擇一種理賠支付方式。如未有註明或清晰指示，理賠之港元支票將交由代理人轉遞。
Please select only one of the settlement options for each claim submission. If unspecified or without clear instruction, claims cheque in HKD will be delivered via Agent.
2. 中國太平人壽(香港)有限公司對理賠支付方式擁有最終的決定權。
China Taiping Life Insurance (Hong Kong) Company Limited reserves the right for final decision of the claims settlement option.

第 7 部份: 索償文件參考表
Section 7: Claims document checklist

請於連同索償表格遞交文件格內加上" ✓ "號。如需要閣下或其他機構提供進一步資料作閣下之索償申請，本公司將會通知閣下或閣下之理財顧問。由於收集有關之資料時間有異，閣下之索償申請時間有可能因此而延長。Please tick " ✓ " against the documents you have submitted together with this claim form. We will notify you or your financial consultant if we need to obtain extra information from you or from other parties to assess your claim. As the time required for obtaining the information varies, the processing time of your claim will likely take longer time.

文件類別 Document Type

☐ 傷殘賠償申請表 第二部份 – 主診醫生報告 Application for Disability Claim Part II – Attending Physician's Statement

☐ 出院總結/列有診斷証明之病假証明書 Hospital Discharge Summary / Sick Leave Certificate with Diagnosis

☐ 病理檢驗報告 Histopathological Report

☐ 化驗 / X光/ 電腦掃描 / 磁力共振 / 相關病理檢驗報告副本 Laboratory, Ultrasonogram, X-Ray and/or MRI Report(s)

☐ 醫生覆診卡副本 Patient Card Copy of Consulted Doctor(s)

☐ 附加文件，如有：醫生轉介信 / 物理治療報告 / 職業治療報告。Additional Documents, if any: Referral Letter by Physician / Physiotherapy or Occupational Therapy Report(s)

☐ 附加文件，如有：僱主信 / 勞工賠償評估証明書 / 警察報告、交通意外紀錄或口供紙 Additional Documents, if any: Employer Letter / Labour Department Assessment Certificate / Police Report, Traffic Accident record or Police Statement

重要事項 Important note:
1. 此申請表應由受保人或申請人填寫。請勿在空白申請表上簽署，而簽名式樣須與保單的記錄相符。This form is to be filled by the Insured/Claimant. Please do not sign on blank form and use the same signature as policy record.
2. 當受保人被確診完全殘廢/喪失功能，索償申請須於最後工作日起 / 意外發生當日起計一百八十(180)天內連同所有證明文件一併呈交。Claims must be submitted along with all supporting documents within 180 days from the date of last working or accident with proven of Total Disability or Dismemberment/Loss of function.

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第 8 部份: 聲明及授權
Section 8: Declaration and Authorization

個人資料收集及使用

本人 / 我們確認本人 / 我們已閱讀、完全明白中國太平人壽保險（香港）有限公司(以下稱"貴公司")的個人資料收集聲明（個人資料收集聲明）。本人 / 我們同意貴公司可使用、保留、處理、儲存、轉交、透露及 / 或共用在此申請表所載或貴公司不時從其他途徑所搜集、索取、整理或持有之任何有關本人 / 我們的個人資料或其他有關本人 / 我們、本人 / 我們的保單或投資資料，用作處理、管理、落實及實行在此申請表所載或本人 / 我們在任何其他申請表所不時提出之索賠、申請或要求，及介紹或提供其稍後或其他的服務或產品予本人 / 我們、作出直接促銷、資料核對及 / 或聯絡本人 / 我們之用途。本人 / 我們並同意貴公司可向與貴公司有關的本港或海外的人士、團體及 / 或機構及 / 或任何個人資料收集聲明所述的第三機構（包括並不限於再保險公司、私人調查方、索賠調查公司、及有關的政府或監管機關、基金管理公司、金融機構或提供貴公司業務運作有關服務之公司）轉交、透露、授權取得或共用本人 / 我們之個人或其他資料，用作以上列明個人資料收集聲明所述之用途。本人/我們明白到本人/我們有權向貴公司查閱及申請更改貴公司持有或管理與本人/我們有關的個人資料。有關的申請可於貴公司任何一間客戶服務中心辦理。若本人/我們不想收到貴公司發送的銷售資料或刊物，本人/我們會發出信函通知貴公司，而此後本人/我們的個人或其他資料將會存於貴公司為選擇不收取上述銷售資料或刊物的客戶而設的中央資料檔，並會供貴公司及有關之機構/人士作參考。

貴公司的個人資料收集聲明最新版本可於以下網址查閱：tplhk.cntaiping.com。

PERSONAL DATA COLLECTION AND USE

I / We CONFIRM that I / we have read and fully understood the Personal Information Collection Statement ("PICS") of China Taiping Life Insurance (Hong Kong) Company Limited ("the Company"). I / We AGREE that any personal data and other information relating to me / us or my / our policy(ies) or investments contained in this application or collected, obtained, compiled or held by the Company by any means from time to time may be used, maintained, processed, stored, transferred, disclosed and / or shared by the Company for the purposes of processing, administering, implementing and effecting the claims, applications or requests made in this application or any other applications by me / us from time to time, introducing or promoting or providing subsequent or other services or products to me / us, direct marketing, data matching and / or communicating with me / us. I / We further AGREE that the Company may transfer, disclose, grant authority for access of or share such personal data and other information to or with individuals, entities and / or organizations associated with the Company and / or to or with any third parties set out in the PICS (including, without limitation, reinsurance companies, private investigators, claims investigation companies, relevant governmental or regulatory authority, fund management companies, financial institutions, or companies providing services to the Company in connection with its business operation, in each case whether within or outside of Hong Kong, for any of the aforesaid purposes or purposes as set out in the PICS. I/We understand that I/we have the right to obtain access to and to request correction of my/our personal data held or controlled by the Company. Such request can be made to any of the Company's Customer Service Centres. If I/we do not wish to receive marketing information or materials from the Company, I/we will send an opt-out notice to the Company, in which case my/our personal data and other information will be stored thereafter in a centralized system for customers who have chosen not to receive the said marketing information or materials and will be accessible by the Company and its associated organizations/ persons for reference.

The updated version of PICS is available from its website: tplhk.cntaiping.com.

本人 / 我們現聲明以上每一項答案均為真確和完全。

1. 本人 / 我們不可撤銷地授權及代表受保人授權：
   a. 任何知悉或擁有本人 / 我們 / 受保人之工作、病假紀錄、意外或損失（任何類別）之詳情、健康狀況、病歷或任何治療或諮詢紀錄，或會為或將為本人 / 我們 / 被保人診治之機構、組織或人士在貴公司作出要求時向貴公司披露有關資料或文件。在法律上可行的情況下，即使本人 / 我們 / 被保人死亡或喪失行為能力，此授權仍具法律效力，而本人 / 我們 / 被保人之繼承人及轉讓人亦會受此授權書約束。此授權書之正本與副本均有同等效力。
   b. 貴公司或任何貴公司指定或認可之驗身醫生或化驗所，替本人 / 我們 / 被保人進行所需之醫療評估及測試，並對本人 / 我們 / 被保人之健康狀況進行審核及評估，用作處理本申請及其後與之有關的賠償事宜。此等化驗會包括，但並不限於，膽固醇及有關之血脂肪、糖尿病、腎或肝功能失常、愛滋病或感染人體免疫力缺乏病毒、免疫系統失常或體內藥物、毒品、尼古丁及其代產品之含量等化驗。
2. 本人 / 我們聲明本人 / 我們已獲相關人士授權及同意本人 / 我們作出上述授權。

I / We DECLARE that the answers given above are true and complete.

1. I / We hereby irrevocably AUTHORIZE and AUTHORIZE ON BEHALF OF THE INSURED:
   a. any organization, institution, or individual that has any knowledge or record of my / our / the Insured's employment, sick leave records, accident or loss details (of any sorts), health condition, medical history or treatment taken or consultation sought, that when requested by an authorized representative of the company may disclose any relevant information or document to the Company. This authorization shall bind my / our / the Insured's successors and assigns and remain valid notwithstanding my / our / the Insured's death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.
   b. the Company or any of its designated or approved medical examiners or laboratories to perform the necessary medical assessment and tests to assess and evaluate my / our / the Insured's health status for the purpose of handling this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.
2. I / We hereby declare that I / we have the full authority from and consent of the Insured to make the above authorizations.

此聲明及授權書必須由受保人簽署。若受保人為小童或精神上無行為能力的，則可由其家長 / 合法監護人簽署。

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

索償人簽署 Signature of the Claimant	身份證 / 護照號碼 ID card / Passport No.	於 On	日 DD / 月 MM / 年 YYYY
索償人姓名 (以正楷書寫) Name of the Claimant (in BLOCK letters)	與受保人關係 (若簽署者非受保人) Relationship with the Insured (If the form is not signed by the Insured)		受保人姓名及身份證/護照號碼 Insured Name & ID card/ Passport No.
理財顧問/見証人姓名 Name of Financial Consultant/witness	理財顧問/見証人簽署 Signature of Financial Consultant/witness	於 On	日 DD / 月 MM / 年 YYYY