

# 危疾賠償申請表 CRITICAL ILLNESS CLAIM FORM

第一部份 (由受保人或索償人填寫) PART I (To be completed by Insured / Claimant)						
保單號碼 Policy Number		保險中介人姓名 / 編號 保險中介人聯絡電話 Insurance Intermediary's Insurance Intermediary's Contact Number				
T P L H K	0 0 8					
申請人 / 持有人姓名		受保人姓名				
Name of Claimant/Owner		Name of Insured				
身份證 / 護照號碼		身份證 / 護照號碼				
ID Card / Passport No.		ID Card / Passport No.				
出生日期		出生日期				
Date of Birth		Date of Birth				
聯絡電話 / 電郵地址		聯絡電話/電郵地址				
Contact phone no./Email		Contact phone no./Email				
address		address				

auu	1622	address								
請在以	从下適當空格填上✔。 Please tick ✔ in t	e appropriate box below.								
第 1	1 部份: 基本索償資料 SECTION 1: PARTICULARS OF THE CLAIM									
1.	這次是 This is a: □ New Claim	f次索償   □ Further Claim 再次索償   □ Review / Appea	重批 / 覆核							
第 2	第 2 部份: 賠償性質及有關資料 SECTION 2: NATURE OF CLAIM AND RELATED DETAILS									
2	疾病 / 危疾名稱 Illness / Critical illness									
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MM / 月MM / <sup>£</sup>	₹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 MM / 月 MM / <sup>1</sup>	年 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, 請提供所需資料 Yes, please provide information								
		警署 Police Station:								
		檔案編號 Reference No.:								
		註: 請附上警察報告/交通意外報告/口供紙/酒精測試報告影印本 Remarks: Please attach a copy of the Police Report /Traffic Accident Repor Alcohol Test Report	t / Police Statement /							

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第 3	第 3 部份: 過往之診治及住院記錄 SECTION 3: RECORD OF MEDICAL CONSULTATION / HOSPITALIZATION										
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。										
				(s) or specialist(s) consulted <b>firstly</b> and following in connection with this illness or injury.							
	醫院/醫生/專科醫生名			地址							
	Name of Hospital / Physician / S	pecialist	Ad	ddress	Date of Con	sultation (DD/MM/YYYY)					
6	請提供與此疾病或傷勢有關之住院 Please give details of any hospitali		nnection with this illness o	r iniury.	<u> </u>						
	醫院名稱		入院日期	朝 (日/月/年)	出 出	完日期 (日/月/年)					
	Name of Hospital			ion (DD/MM/YYYY)		scharge (DD/MM/YYYY)					
	Traine of Floophar		Date of Marineo	ion (DD/WW/TTTT)	Bate of Bit	bendige (BB/WW/TTTT)					
第 4	部份: 其他資料	SECTION	N 4: OTHER INFORMA	TION	•						
7	閣下慣常求診之醫生 / 醫院名稱、 絡電話	地址及聯	醫生 / 醫院名稱 Name of the physicia	on / hoopital							
	The name, address and conta		Name of the physicia	an / nospital							
	number of your usual physician / h	ospital	₩9 /十 / ₩9 /7ウ 1.4.1.1.1.								
			醫生/醫院地址 Address of the physi	cian / hospital							
			, py								
			醫生 / 醫院聯絡電記 Contact phone numb								
			physician / hospital	Del Oi tile							
8	直係親屬中有否曾患有相同或有關	力佐侍り加"	<b>左</b> " 建填宽工棚			_					
0	Have any of your blood relatives s	之妖网?如 uffered from	a similar or related illness	? If "yes", please state.							
	親屬關係 Polationable of Polative		,	疾類別 Critical Illness		斷日期 (日/月/年)					
	Relationship of Relative		inature of	Critical liliness	Date of Diagnosis (DD/MM/YYYY)						
9	閣下曾否患上類似 / 相關此疾病或				1						
	Have you previously suffered from										
	疾病名稱 / 類別		☆驗 / 診斷日期 s of toot / diagnosis	醫院 / 醫生 / 專科醫		檢驗 / 診斷結果					
	Name / Nature of Illness	Date	e of test / diagnosis	Name of Hospital / Physicia	in / Specialist	Result of test / diagnosis					
10	閣下有否在其它機構包括保險公司。				amployer? If "yo	e" please give details					
	Are you insured for similar benefits 投保公司名稱		ther organizations including 保類別及保單號碼	g insurer, the government & e 投保金額	ampioyer: II ye	s, please give details. 索償結果﹝如有﹞					
	Name of Insurance Company		Benefit & Policy Number	Amount of Bene	fit	Claim Result (if any)					
		<u> </u>									

### 第5部份:聲明及授權 **SECTION 5: DECLARATION AND AUTHORIZATION**

## 個人資料收集及使用

個人資料收集及使用本人/我們在閱讀、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/我們本任何有關本人/我們亦不時提出之索賠、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學明所述的第三機構(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 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.

- - 本均有同等效力。 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。 本人 / 我們聲明,本人 / 我們明白貴公司或會從保單的給付金額及/ 或貴公司為保單所收金額中,根據適用法定及/或規管要求扣除任何逾期金 額,包括保險業監管局收取的徵費。本人 / 我們明白及承認如保單持有人過期繳交保費徵費,公司須向保險業監管局提供保單持有人的資料。 / 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.
  - 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.
  - I/We represent that I am / We are the Policyowner / Assignee / Trustee / Beneficiary (as the case may be) under the policy(ies) as given on this form. I / We hereby give my / our irrevocable consent to the Company to deduct any outstanding amount applicable from the payout and/or sum received by the Company under the policy according to the applicable statutory and/or regulatory requirement(s), including levy collected by the Insurance Authority. I / We also understand and acknowledge that the Policyowner's' information is required to be provided to the Insurance Authority if the levy is overdue.
- 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。

Applicant

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.

索償人姓名 (以正楷書寫) 及簽署 身份證 / 護照號碼 與受保人關係 日 DD / 月 MM / 年 YYYY Name of the Claimant (in BLOCK ID card / Passport No. Relationship with the Insured letters) with Signature 理財顧問 / 公司代表 / 申請人姓名 理財顧問 / 公司代表 / 申請人簽署 申請人職位 (如適用) 日 DD / 月 MM / 年 YYYY Signature of Financial Consultant / Position of the Applicant (if Name of Financial Consultant / Company Representative / Applicant Company Representative / applicable)

保單號碼 Policy Number Н

第6	部份: 賠款選項	SECTION 6: SETTLEM	MENT OPTION				
	要交付方式 Cheque Collection Method 郵寄至保單持有人於本公司紀錄上的通訊均 By Mail to Policy owner's correspondence Company's record 由代理人轉遞 via Agent 親臨客戶服務中心領取 Pick up at the Customer Centre in person	址 [ address in the [	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				
第7	部份: 索償文件參考表	SECTION 7: CLAIMS	DOCUMENT CHECKLIST				
Pleas	•		and kindly tick " ✓ "against the documents submitted with this form.				
文件	類別 Document Type						
	危疾賠償申請表 第II部份 - 主診醫生報告 Application for Critical Illness Claim Part		Statement				
	收據正本或由其他保險公司簽發的收據核實副本之原件 (只適用於癌症特藥保)						
	Original receipt or Certified True Copy issued by other insurer (Only applicable to Cancer Drug Protector)						
	出院總結/列有診斷証明之病假証明書 Hospital Discharge Summary / Sick Leav	o Cortificato with Diagnosis					
	病理檢驗報告 Histopathological Report	e Certificate with Diagnosis					
	化驗、超聲波、X-光、電腦掃描及磁力共	振報告					
	Laboratory, Ultra sonogram, X-Ray and/c 醫生覆診卡副本	r MRI Report(s)					
	Patient Card Copy of Consulted Doctor(s	)					
	附加文件,如有:醫生轉介信/物理治療						
	Additional Documents, if any: Referral Le 自我證明表格 – 個人 (如適用) Self-Certification Form – Individual (if app		nerapy or Occupational Therapy Report(s)				
	事項 Important note:	·	2.才详有的尺臂的引起打体				

- 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.
- 索償申請須於被診斷患有嚴重疾病日期起計 180 天內連同所有證明文件一併呈交。 2.
  - Claims must be submitted along with all supporting documents within 180 days from diagnosis date of the critical illness.
- 為使能儘速辦理您的索償申請,請將此表格連同有關索償文件一併遞交。有關申請索償所需遞交之文件,請參閱此表格之"索償文件參考表"。 文件的核證副本可於我們的客戶服務中心或賠償部辦理。若我們有需要就審核閣下之賠償申請向您或其他人士索取額外資料,我們會通知閣下或 您的保險顧問。因索取有關資料需時,賠償申請的審核時間會較長。

In order to speed up your claim application, please attach the required claims documents together with this application form. You may check the required documents as stated in this application form "Claims Document Checklist". Documents can be certified at our Customer Service Centre or Claims Department. We will notify you or your broker if we need to obtain extra information from you or from outside parties to assess your claim. As the time required for obtaining the information is variable, the processing time of your claim will likely be longer.