中国太平 CHINA TAIPING

中國太平人壽保險(香港)有限公司
CHINA TAIPING LIFE INSURANCE(HONG KONG)COMPANY LIMITED

醫療 / 意外理賠申請表
MEDICAL / ACCIDENT 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 Insurance Intermediary's Name / Code	保險中介人聯絡電話 Insurance Intermediary's Contact Number
T P L H K 0 0 8		

索償人持有人姓名 Name of Claimant/Owner		受保人姓名 Name of Insured	
身份證 / 護照號碼 ID Card / Passport No.		身份證 / 護照號碼 ID Card / Passport No.	
聯絡電話 / 電郵地址 Contact No. / Email address		聯絡電話 / 電郵地址 Contact No. / Email address	

重要事項 Important note:

1. 此申請表應由受保人或索償人填寫。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. 請回答此申請表上的所有問題，以供我們批核閣下的索償申請。To enable us to process your claim promptly, please answer all questions in this form as fully and accurate as you can.
3. 如之前未有遞交受保人及/或保單持有人的身份證明文件，請隨此申請表一併遞交。Please submit a copy of the identification document of the Insured and/or Policy owner, unless submitted before, together with this form.
4. 索償申請須於出院/治療後 90 天內連同所有證明文件一併呈交。Claims must be submitted along with all supporting documents within 90 days from date of discharge/treatment.
5. 請將已填妥的索償申請交予您的保險中介人或郵寄至以下地址: 香港銅鑼灣新寧道 8 號中國太平大廈 7 樓 1 期客戶服務中心 (運營服務部理賠)
   Please submit completed claim application to your insurance intermediary or send it to us at the following address: Customer Service Centre (Operation Department – Claims) 7/F China Taiping Tower Phase I, 8 Sunning Road, Causeway Bay, Hong Kong

第 1 部份：住院 / 門診治療原因
SECTION 1：Cause of Hospital Confinement / Outpatient Treatment

因意外受傷 Due to Accident

1. (a) 意外發生日期及時間 Date and time of accident

_____ / _____ / _____
日 DD 月 MM 年 YYYY

(b) 意外發生地點 Accident Place

(c) 意外詳情、受傷部位及傷勢 Accident details, part of the body injured and nature of injury

因疾病導致 Due to Illness

2. (a) 請詳細敍述疾病的病徵 Please describe the symptoms of illness in details

(b) 病徵首次求診日期
First Consultation Date

_____ / _____ / _____
日 DD 月 MM 年 YYYY

(c) 閣下在以上首次求診日期起，以上的病徵已存在多久？
How long have you been having these symptoms from the date of first consultation?

第 2 部份：就業詳情 (僅適用於意外理賠)
SECTION 2：Employment particulars (For Accident claim only)

1. 現職 (若有兼職請列明) 職位及職責
   Present occupation (if more than one, state all) and exact nature of occupational duties

2. 公司或僱主名稱及地址
   Name and address of business or employer

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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3. 有否向僱主遞交病假證明書?
Did you file a medical leave certificate to your employer?
☐ 有 Yes ☐ 沒有 No

4. 有否就此意外申請勞工賠償?
Did you submit a claim for workmen's compensation for this accident?
☐ 有 Yes ☐ 沒有 No

5. 有否就此意外報警? Did you report to the police for this accident?	☐ 沒有 No	☐ 有, 請提供所需資料 Yes, please provide information	警署地點 Police station	
			檔案編號 Case Number	

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 Report / Police Statement / Alcohol Test Report

第 3 部份：求診及治療詳情
SECTION 3：Consultation and Treatment Details

1. 首次就診的醫生資料
The doctor first consulted for this condition

日 DD / 月 MM / 年 YYYY

醫生 / 醫院名稱及地址 Name & Address of Doctor / Hospital

2. 建議入院的醫生資料 / 其他曾診治此病或過往同類病況的醫生資料
The doctor who referred the insured to hospital / other doctors seen for this or similar past condition

日 DD / 月 MM / 年 YYYY

醫生 / 醫院名稱及地址 Name & Address of Doctor / Hospital

3. (a) 請提供入院及出院日期。
Please give the date of admission and the date of discharge.

入院日期 Date of Admission	出院日期 Date of Discharge
日 DD / 月 MM / 年 YYYY	日 DD / 月 MM / 年 YYYY

(b) 請提供入住深切治療部日期，如適用:
Please give the admission period in Intensive Care Unit, if any:

由 From	至 To
日 DD / 月 MM / 年 YYYY	日 DD / 月 MM / 年 YYYY

(c) 否於住院期間請假外出？
Have you taken any home leave during the hospital confinement?
☐ 沒有 No ☐ 有 Yes

(d) 如有，請列明外出之日期及時間。
If Yes, please state the date and time of your home leave.

4. 過往曾因同一原因入院治療的詳情 Details of past hospital confinement related to same condition

住院時間 / Confinement Period	醫生 / 醫院名稱 Name of Doctor / Hospital	地址 Address

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第 4 部份: 其他保障資料
SECTION 4: Other Insurance Coverage

有關是次治療，閣下有否向其他保險公司/機構申請賠償? Are you making any other insurance or compensation claim as a result of this treatment?
如有，請提供下列資料。 If yes, please provide the below information.

☐ 有 Yes ☐ 沒有 No

☐ 退回收據的核實副本 Require Certified True Copy of the Receipt(s) ☐ 退回醫療報告正本 Require Original of Medical Report(s)

保險公司名稱 Name of Insurance Company	保單编號 Policy Number	賠償結果 Claim Status

第 5 部份: 賠款選項
SECTION 5: SETTLEMENT OPTION

☐ 電子入帳服務 E-Bankin service
(只限已成功登記電子入帳服務之保單 Only applicable to successfully registered E-bankin service policy)

☐ 快速支付系統 (「轉數快」) Faster Payment System ("FPS")
(只適用於保單持有人之香港銀行戶口。如首次使用需附上銀行戶口證明副本, 例如: 銀行月結單或銀行卡 Only applicable to Policyowner's bank account in Hong Kong. For first time user, please provide a copy of bank account proof, e.g. bank statement or bank card.)

☐ 支票 By Cheque

支票交付方式 Cheque Collection Method
- ☐ 郵寄至保單持有人於本公司紀錄上的通訊地址 By Mail to Policyowner's correspondence address in the Company's record
- ☐ 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. 所有理賠方法以港元支付，而其港元等值將會以本公司內部釐定之匯率折算。
   All settlements will be made in HKD and the HKD equivalent is based on the currency exchange rate determined by China Taiping Life Insurance (Hong Kong) on the basis of the Company's internal exchange rate.
3. 如理賠金額未能成功轉至指定之銀行戶口或轉數快戶口，相關的理賠金額以支票形式支付及交由代理人轉遞。
   Claims payout will be made by cheque and delivered via Agent in case of failure to direct debit to designated bank account or FPS payment unsuccessful.
4. 經轉數快之付款，每份保單每日最高存款交易不能超逾港元 100,000 (或等值)。如交易超逾港元 100,000 (或等值) 或以上，或無法執行有關付款指示，總額將以支票形式支付，並由代理人轉遞。
   For payout through FPS, only applicable to payment with maximum daily transaction limit not exceeding HKD100,000 (or equivalent) per policy. If payment is exceeding HKD100,000 (or equivalent) or above, or the instruction cannot be executed, it will be issued by cheque and delivered by Agent.
5. 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.

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第 6 部份: 聲明及授權
SECTION 6: 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.

本人謹此聲明本人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。

I hereby declare that I understand that the Company may 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.

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.

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

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第 7 部份：索償文件參考表
SECTION 7：Claims Document Checklist

請將此表格連同以下文件遞交，並於提交的文件欄內畫上“ ✓ ”號。
Please attach the following documents together with this application form and kindly tick “ ✓ “against the documents submitted with this form.

文件類別 Document Type

☐ 醫療/意外理賠申请表第一部份正本 (由受保人/保單持有人填寫) Original medical claims form part I (To be completed by the Insured / Policy owner)

☐ 醫療/意外理賠申请表第二部份正本 (由主診醫生填寫) Original medical claims form part II (To be completed by Attending Physician)

☐ 接受治療的發票及付款收據正本 Original medical / hospital receipts and statement of charges

☐ 出院總結 Hospital discharge summary

☐ 化驗 / X光/ 電腦掃描 / 磁力共振 / 相關病理檢驗報告副本 Laboratory / X-ray / CT scan / MRI / Pathological Report(s)

☐ 其他保險公司或機構之賠償細算表 (如有) Compensation Breakdown from other Insurer / Party (if any)

☐ 如在之前未有遞交身份証明文件，請隨此申請表一併遞交保單持有人及受保人的身份証明文件副本。根據保險業監理處發出的「防止洗黑錢及恐怖份子籌資活動指引」，保險公司必須在不遲於付款時收集客戶的身份證明文件副本以作核實用途。Please submit copies of the identification document of the Policy owner and the Insured, unless submitted before, together with this form. This is in accordance with the Guidance Note on Prevention of Money Laundering and terrorist Financing issued by the Office of the Commissioner of Insurance which requires that copies of the identification document of customers should be collected no later than the time of payout for identification and verification.

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理賠部辦理。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 agent 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.

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第二部份 (索償人自費由主診醫生填寫) **PART II (To be completed by the Attending Physician at the Claimant's own expenses)**			
病人姓名 Name of Patient			
出生日期 Date of Birth		**年齡 Age**	
身份證 / 護照號碼 **ID Card / Passport No.**		**性別 Gender**	

1. 住院資料 Hospitalization information

醫院名稱 Name of Hospital: _____

入院日期(日/月/年)
Admission Date (DD/MM/YY) _____

出院日期(日/月/年)
Discharge Date (DD/MM/YY) _____

是次住院或手術的原因 Chief complaints of the patient relating to this hospitalization / surgery

病症結果 Final Diagnosis: _____ 國際疾病分類代碼 ICD-10 code: _____

若住院/手術與意外有關，請提供詳情 If the Hospitalization/Surgery is related to an accident, please give details below.

事故日期及時間
Date & Time of Incident _____ (日 DD /月 MM /年 YY) 事故地點 Place of Incident _____
事故發生的經過及詳情
Details of Incident

手術名稱
Surgical procedure _____

醫療服務術語代碼
CPT code _____ 手術日期 (日/月/年)
Operation date (DD/MM/YY) _____

出院撮要 (包括治療、診查程序、治療結果、跟進計畫)
Brief discharge summary (including investigation procedures, treatment, result and follow up plans)

該手術及檢查是否可以在日間手術中心或門診進行？
Can the procedure and the medical test(s) be done at day case / outpatient basis?
☐ 是 Yes ☐ 否 No

如否，請說明住院的原因 If no, please explain the reason for hospital confinement

於住院期間，病人有否外出? Has the patient taken any home leave during this hospitalization?
☐ 有 Yes ☐ 無 No

如有，請注明離院的原因 If yes, please specify the reason for home leave 離院時段(日/月/年) Period of home leave (DD/MM/YY)

保單號碼 Policy Number

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2. 醫療詳情 Medical condition

病徵出現/意外日期 Accident date / Symptom onset date (日 DD/月 MM/年 YY): _____

首次求診日期 Date of the first consultation for this condition (日 DD/月 MM/年 YY): _____

首次求診的病徵 Symptoms presented during the first consultation : _____

是次病況是否為復發性病症或慢性病症? Was the hospitalized illness a recurrent episode or a chronic disease?

☐ 是 Yes ☐ 否 No

如是，請提供首次病發日期

If yes, please provide the symptom onset date of the first episode (日 DD/月 MM/年 YY) _____

病人過去曾否患有同類病況? 如有，請詳細說明。

Has the patient ever had the same or similar conditions or symptom before? If yes, please give a brief summary

日期 Date (DD/MM/YY)	主訴 / 疾病 Complaint / Disease	治療 / 住院詳情 Details of treatment / hospitalization	醫生姓名 / 醫院名稱 Name of doctor / hospital

疾病/受傷是否因以下問題引起 Was the illness/injury due to or associated with the following condition		
先天性疾病	Congenital condition	☐ 是 Yes ☐ 否 No
精神病	Psychiatric condition	☐ 是 Yes ☐ 否 No
酒精藥物或麻醉影響	Influence of alcohol, drug or intoxicant	☐ 是 Yes ☐ 否 No
肥胖,體重控制	Obesity, weight control	☐ 是 Yes ☐ 否 No
懷孕,分娩,流產	Pregnancy, childbirth, abortion	☐ 是 Yes ☐ 否 No

病人是否經其他醫生轉介? Was the patient referred by another doctor?

☐ 是 Yes ☐ 否 No

如是，請提供轉介醫生姓名及地址

If yes, please provide the name and address of the referral doctor

3. 主診醫生聲明書 Declaration of Attending Physician

主診醫生姓名 Name of Attending Physician		電話 Telephone No.	
專業資格 Field of Specialization and Qualification		電郵 Email Address	

本人謹此聲明本人曾親自為病人的病情和疾病進行了檢查、建議和治療，以上陳述是按本人專業所知所信真實及完整的填報。我在此聲明並同意將上述陳述作為索賠表的一部分。

I hereby declare that I have personally examined, advised and treated the Patient in connection to the conditions and illnesses herein and that the foregoing statements are true and complete to the best of my professional knowledge and belief. I hereby declare and agree to make my statements above as part of the claim form.

_____

主診醫生簽署和蓋章

Signature and Official Chop of Attending Physician

_____ _____

簽署日期 Date of Signing
(日 DD/月 MM/年 YYYY)

簽署地 Place of Signing