

- ## 「危疾賠償申請表甲部」－填寫指引

聲明及授權 DECLARATION & AUTHORIZATION

聲明 DECLARATION

本人謹此代表本人/受保人及其他在此賠償申請表提及之人士(“相關人士”)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,均為事實之全部並確實無訛;(2)本人/我們已收妥、閱讀及完全明白載於本文件的個人資料收集聲明,及同意相關人士的任何個人資料可用作該聲明第7段所述之用途及貴公司可把該等個人資料提供給該聲明第8段所述各方作上述用途。本人聲明及同意已獲相關人士授權及同意本人作出上述聲明及同意。

I HEREBY DECLARE AND AGREE on behalf of myself/the insured and other persons referred to in this claim form (“Relevant Persons”) that (1) all 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; and (2) I/We have received, read and fully understood the Personal Information Collection Statement contained in this document, and agree that any personal data of the Relevant Persons may be used for the purposes set out in paragraph 7 of that Statement and the Company may provide the personal data to the parties set out in paragraph 8 of that Statement for the aforementioned purposes.

I declare and agree that I have the full authority from and consent of the Relevant Persons to make the above declarations and agreements.

授權 AUTHORIZATION

本人謹此代表本人/受保人授權(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,及/或曾診驗或可能將會診驗本人/受保人者,均可向該等資料提供給中銀集團人壽保險有限公司;(2)中銀集團人壽保險有限公司或任何其指定之醫生或化驗所,可就其賠償申請替本人/受保人進行所需之醫療評估及測試,作為審核本人/受保人之健康狀況。此授權對本人之繼承人及受遺人具有約束力;即使死亡或無行為能力時,此授權仍具效力。本授權書的影印本與正本均有同等效力。

本人謹此同意及授權貴公司,從原可支付給本人之保險金額中(如有),扣除未繳保費(如有)及貴公司代政府或監管機構(包括但不限於保險業監管局)按相關規定收取的相應徵費及/或費用(如有)。

本人聲明及同意已獲受保人授權及同意本人作出上述授權。

I HEREBY AUTHORIZE on behalf of myself/the insured (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 and who has attended or may hereafter attend myself/the insured to disclose such information to BOC Group Life Assurance Co. Ltd.; (2) BOC Group Life Assurance Co. Ltd. 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 my successors and assignees and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

I hereby agree and authorize the Company to deduct unpaid premium(if any) and corresponding levy and/ or charges (if any) to be collected by the Company on behalf of the government or the regulatory authority (including but not limited to the Insurance Authority) according to relevant requirements, from the policy proceeds payable to me (if any).

I declare and agree that I have the full authority from and consent of the insured to make the above authorizations.

權益人簽署 Signature of Policy Owner

姓名 Name in Block Letter

身份證號碼 ID No

簽署日期 Date

受保人簽署 Signature of Insured

姓名 Name in Block Letter

身份證號碼 ID No

簽署日期 Date

請參閱下頁的個人資料收集聲明

Please read the Personal Information Collection Statement on next page

- 此表格必須由權益人簽署
- 如受保人與保單權益人不同,而受保人於申請賠償時已年滿18歲,則表格的應由受保人及權益人簽署,而相應的姓名及身份證號碼亦應填上受保人及權益人的資料。

Guidance Notes for “Critical Illness Claim Form Part I”

- ✓ Please read through the “**Claims Document Checklist**” before filling the form.
- ✓ Please answer **all** questions to avoid unnecessary delay due to insufficient information.
- ✓ If the claiming symptom is first claim, please chose the NEW Claim. If the claiming symptom is recurrence, please chose the Further Claim.

理賠種類 Type of Claim <input type="checkbox"/> 首次理賠 New Claim <input type="checkbox"/> 持續理賠 Further Claim				
保單編號 Policy No. 2xxxxxxx8	受保人姓名 Name of Insured 李xx	身份證號碼 ID No. Gxxxxxx(2)	年齡/性別 Age/Sex 38/M	聯絡電話 Contact Tel No. 98xx xxxx
職業 Occupation Manager		僱主(公司)名稱及地址 Name and Address of Employer Room xx, xxxxx house, xxxxx street, xxxxx Company		
通訊地址 Mailing Address Same as policy record				
1. 申請賠償的危疾名稱 Name of the Critical Illness		Colon Carcinoma		
2. 若因意外導致，請詳述意外之詳情。 If due to Accident, please describe the accident in details.		日期 Date _____ (年/月/日/YY/MM/DD) 地點 Place _____ 意外詳情、受傷部位及傷勢 Accident details, part of the body injured and nature of injury		
3. 若因疾病導致，請詳述疾病之詳情。 If due to Illness, please describe the illness in details.		病徵首次出現日期 Date symptoms first appeared <u>2019/04/01</u> (年/月/日/YY/MM/DD) 病徵詳情 Symptoms details <u>Rectal Bleeding</u>		
4. 初診此疾病的醫院/醫生資料 The hospital/physician first consulted for this illness		初診日期 First Consultation Date <u>2019/04/10</u> (年/月/日/YY/MM/DD) 醫院/醫生名稱及地址 Name and address of the hospital/physician <u>Queen Mary Hospital</u>		
5. 其他曾應診此疾病的醫院/醫生資料 Other hospitals/physicians consulted for this illness		求診日期 Consultation Date <u>Nil</u> (年/月/日/YY/MM/DD) 醫院/醫生名稱及地址 Name and address of the hospital/physician <u>Nil</u>		
6. 過往五年內因其他病症曾就診之醫院/醫生資料 Hospitals/physicians consulted for other disorders in the past 5 years		醫院/醫生姓名及地址 Name of Doctor & Address <u>Dr. Chan Tai Man</u>	診治日期 (年/月/日) Consultation Date (YY/MM/DD) <u>2014/04/10</u>	病因 Illness/ Diagnosis <u>Rectal Bleeding</u>
7. 就此危疾有否申請其他保險索償? Apply any other insurance claim for this critical illness?		<input type="checkbox"/> 有 YES, 公司名稱 Name of Company <u>AIA</u> <input type="checkbox"/> 否 NO 保單編號 Policy No. <u>Bxxxxxxx</u>		

1. For Symptoms date, you should at least provide the month and year for which the symptoms first presented if you could not remember the exact onset date. (e.g. around April 2019)
2. For First consultation date for the illness, You should at least provide the month and year (e.g. around April 2019) that the first consultation was made if you could not remember the exact date.
3. For Other hospitals / physicians consulted, if you did not consult any other hospitals / physicians for the claimed illness, please put down “nil” but do not leave it blank.
4. For other insurance claims, you should at least provide the name of the insurance company if you could not remember the policy no.

8. 賠付方式 Claim Payment Options	賠償貨幣 Currency Option <input type="checkbox"/> 港幣 HKD <input type="checkbox"/> 保單貨幣 Policy Currency 賠償方法 Settlement Method <input type="checkbox"/> 支票 Cheque <input type="checkbox"/> 自動轉賬 Autopay (請遞交相關的戶口證明 Please submit proof of the bank account) <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> 戶口必須為保單權益人單獨持有之中國銀行(香港)/ 南洋商業銀行/ 集友銀行戶口。 The account must be a BOCHK/ NCB/ CYB account solely owned by the Policy Owner.
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Claims Payment Options

You can choose the claim payment either Policy Currency or HKD

You can receive the claim payment through:

1. Autopay

- ✓ Limited for BOCHK/ NCB/ CYB only (The account provided will be used for all kinds of policy proceeds thereafter, including claim payment.)
- ✓ The Account Number and the Name of the Account Holder must be stated clearly on the form
- ✓ Account Holder must be the Policy Owner of the claimed policy.
- X Joint Account is not accepted.
- The payment will be made by cheque if incomplete bank account information or autopay is unsuccessful or the provided Account no. is not BOCHK/NCB/CYB.

2. Cheque

If no instruction of payment options, claim payment cheque will be issued and mailed to Policy Owner.

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權益人簽署 Signature of Policy Owner

姓名 Name in Block Letter

身份證號碼 ID No

簽署日期 Date

受保人簽署 Signature of Insured

姓名 Name in Block Letter

身份證號碼 ID No

簽署日期 Date

請參閱下頁的個人資料收集聲明

Please read the Personal Information Collection Statement on next page

- The form must be signed by Policy Owner
- In case the Owner and the Insured are different person, the authorization should be **signed and completed by the Policy Owner and Insured** if the Insured already reached age **18** or above at the time of claims application.