「傷殘賠償申請表甲部」– 填寫指引

✓ 適用範圍 : 因**疾病或意外**而引致的付款人傷殘、完全及永久傷殘及豁免保費賠償。填表前，請先詳閱申請表內的「**索償文件清單**」。

✓ 請儘量回答**所有**問題，避免賠償因資料不足而延誤批核。

✓ 如此疾病或意外是首次索償，請選擇首次理賠。如此疾病或意外是延續索償而並非首次，請選擇持續理賠。

索償類別 Benefit(s) to Claim ☐付款人傷殘 Payor's Disability ☐完全及永久傷殘 Total and Permanent Disability ☐豁免保費 Waiver of Premium			理賠種類 Type of Claim ☐首次理賠 New Claim ☐持續理賠 Further Claim	
保單編號 Policy No. 2xxxxxxxx8	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
通訊地址 Mailing Address 與保單地址相同				

1. 就業詳情 Employment details	傷殘前的職位及職責 Occupation and exact nature of occupational duties before disability 經理，處理文職 僱主名稱及地址 Name and address of employer Xxxxxxx Company 有否向僱主遞交病假證明書? Did you file a sick leave certificate with your employer? ☐ 是 Yes 由 from 2015/02/02 (年/月/日) (YY/MM/DD) 至 to 2016/02/05 (年/月/日) (YY/M//DD) ☐ 否 No 最後工作日期 Date you last worked : 2016/02/05 (年/月/日) (YY/MM/DD) 預料復職日期 Expected to return to work: 2016/02/06 (年/月/日) (YY/MM/DD)
2. 若因意外導致傷殘，請詳述意外之詳情。 If the Disability due to Accident, please describe the accident in details.	日期 (年/月/日) Date (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. 若因疾病導致傷殘，請詳述疾病之詳情。 If the Disability due to Illness, please describe the illness in details.	病徵首次出現日期 Date symptoms first appeared 2015/01/01 (年/月/日) (YY/MM/DD) 病徵詳情 Symptoms details 大便出血，最後確診為大腸癌
4. 初診此傷殘的醫院/ 醫生資料 The hospital/physician first consulted for this Disability	初診日期 First Consultation Date (年/月/日) (YY/MM/DD) 醫院/ 醫生名稱及地址 Name and address of the hospital/physician
5. 其他曾應診此傷殘的醫院/ 醫生資料 Other hospitals/physicians consulted for this disability	求診日期(年/月/日) Consultation Date (YY/MM/DD) 2015/02/03 醫院/ 醫生名稱及地址 Name and address of the hospital/physician 瑪麗醫院
6. 就此傷殘有否申請其他保險索償? Apply any other insurance claim for this disability?	☐ 有 YES， 公司名稱 Name of Company 友邦保險 ☐ 否 NO 保單編號 Policy No. Bxxxxxxxxx

1. 有關初診此病的求診日期: 指首次就有關病徵而求診之日期。如未能提供確實的求診日期，亦應儘量提供有關的年份及月份，例如 2015年1月中。
2. 其他曾應診此病的求診日期: 如沒有就相關病症向其他醫院/醫生求診，請不要將問題漏空，應填上「沒有」。
3. 其他保險公司索償: 如未能提供確實的保險編號，亦應儘量提供保險公司的名稱。

7. 賠付方式 Claim Payment Options	賠償貨幣 Currency Option ☐ 港幣 HKD ☐ 保單貨幣 Policy Currency 賠償方法 Settlement Method ☐ 支票 Cheque ☐ 自動轉賬 Autopay (請遞交相關的戶口證明 Please submit proof of the bank account) 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.

<u>賠付方式:</u>

客戶可選擇賠償貨幣為保單貨幣或港幣。

客戶可選擇以下方式收取賠償款項:

1. **自動轉賬**
   - ✓ 只限中國銀行 (香港) /南洋商業銀行 /集友銀行(所提供的銀行之戶口，將作其後各類保單給付金額之用，包括理賠款項。)
   - ✓ 客戶必須填寫戶口的賬戶名稱及賬戶號碼
   - ✓ 戶口持有人的姓名必須與保單權益人相同
   - X 不接納聯名戶口

   如理賠金額未能成功轉至指定之銀行戶口，或提供之戶口並不是中國銀行 (香港) /南洋商業銀行 /集友銀行賠款會以支票發出。
2. **支票**

   如無特別指示，支票將會郵寄予保單權益人

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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，均可將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，可就此賠償申請替本人/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讓人具有約束力；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 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。

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Guidance Notes of "Disability Claim Form Part I"

✓ Applicable to: Payor's Disability, Total and Permanent Disability and Waiver of Premium caused by illness and accident. Please read through the "**Claims Document Checklist**" before filling the form.

✓ 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.

索償類別 Benefit(s) to Claim
☐付款人傷殘 Payor's Disability ☐完全及永久傷殘 Total and Permanent Disability
☐豁免保費 Waiver of Premium

理賠種類 Type of Claim
☐首次理賠 New Claim ☐持續理賠 Further Claim

保單編號 Policy No.	受保人姓名 Name of Insured	身份證號碼 ID No.	年齡/性別 Age/Sex	聯絡電話 Contact Tel No.
2xxxxxxx8	Lee xxx xxx	Gxxxxxx(2)	38/M	98xx xxxx

通訊地址 Mailing Address
Same as policy record

1. 就業詳情 Employment details

傷殘前的職位及職責 Occupation and exact nature of occupational duties before disability
Manager

僱主名稱及地址 Name and address of employer
Xxxxxxx Company

有否向僱主遞交病假證明書?
Did you file a sick leave certificate with your employer?
☐ 是 Yes 由 from 2015/02/02 (年/月/日) (YY/MM/DD) 至 to 2016/02/05 (年/月/日) (YY/M/DD)
☐ 否 No

最後工作日期
Date you last worked : 2016/02/05 (年/月/日) (YY/MM/DD)

預料復職日期
Expected to return to work: 2016/02/06 (年/月/日) (YY/MM/DD)

2. 若因意外導致傷殘，請詳述意外之詳情。 If the Disability due to Accident, please describe the accident in details.

日期 (年/月/日) Date _____(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. 若因疾病導致傷殘，請詳述疾病之詳情。 If the Disability due to Illness, please describe the illness in details.

病徵首次出現日期
Date symptoms first appeared 2015/01/01 (年/月/日) (YY/MM/DD)

病徵詳情
Symptoms details Rectal bleeding

4. 初診此傷殘的醫院/ 醫生資料 The hospital/physician first consulted for this Disability

初診日期
First Consultation Date _____(年/月/日) (YY/MM/DD)

醫院/ 醫生名稱及地址
Name and address of the hospital/physician _____

5. 其他曾應診此傷殘的醫院/ 醫生資料 Other hospitals/physicians consulted for this disability

求診日期(年/月/日) Consultation Date (YY/MM/DD)	醫院/ 醫生名稱及地址 Name and address of the hospital/physician
2015/02/03	Queen Mary Hospital

6. 就此傷殘有否申請其他保險索償? Apply any other insurance claim for this disability?

☐ 有 YES， 公司名稱 Name of Company AIA ☐ 否 NO
保單編號 Policy No. Bxxxxxxxxx

1. For First consultation date for the illness, you should at least provide the month and year (e.g. around Jan 2015) that the first consultation was made if you could not remember the exact date.
2. 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.
3. For other insurance claims, you should at least provide the name of the insurance company if you could not remember the policy no.

7. 賠付方式 Claim Payment Options

賠償貨幣 Currency Option
☐ 港幣 HKD ☐ 保單貨幣 Policy Currency

賠償方法 Settlement Method
☐ 支票 Cheque
☐ 自動轉賬 Autopay (請遞交相關的戶口證明 Please submit proof of the bank account)

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.

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 with be issued and mailed to Policy Owner

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聲明及授權 DECLARATION & AUTHORIZATION

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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 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.