

Group Disability / Dismemberment Claim Form

團體傷殘 / 斷肢賠償申請書



Part A – To be completed by employee 甲部 – 由僱員填寫

Name of Employer (Policy Owner) 僱主名稱 (保單持有人)		Policy No. 保單號碼	
Name of Insured Employee 受保人姓名	Certificate No. 保險證號碼	Amount of Claim 保額	Currency 貨幣

1. (a) Present occupation and exact duties 現時職業及確實職務 _____
 (b) Date of employment 受僱日期 _____
 (c) Date last at active full-time work 最後全職工作日期 _____

2. Please complete either 2.1 (for accident) or 2.2 (for sickness) 請填妥 2.1 (如意外) 或 2.2 (如疾病)

2.1 Details of accident 意外資料

(a) When and where? 何時及何處發生? Date 日期 _____ Time 時間 _____ am/pm 上午/下午 Place 地點 _____
 (b) How did it occur? 意外如何發生 _____
 (c) What were you doing at the time of accident? 當意外發生時, 你作何事? _____
 (d) Which part of body was injured? Describe in detail 詳述身體受傷部位及情況 _____

2.2 Details of sickness 疾病資料

(a) State date of onset 病發日期 _____
 (b) Diagnosis 病症 _____
 (c) Symptom 症狀 _____

3. (a) Give name and address of all medical practitioners who have attended you for the injury or sickness 請提供診治受傷或疾病之醫生名稱及地址 _____
 (b) If confined to hospital, please state 如須要住院, 請列明
 Name of Hospital 醫院名稱 _____
 Date of Admission 入院日期 _____

4. How long have/will you been/be away from work after disability? 殘疾以後, 你不能工作之時間有多少?
 Totally Disabled 完全傷殘
 From 由 _____ To 至 _____

DECLARATION AND AUTHORIZATION 聲明及授權

The claimant (I/We) hereby declare, agree and understand, as the case may be, as evidenced by my/our signature(s) hereunder, that: 索償人(本人/吾等)聲明、同意及明白以下各項(視乎情況適用而定), 並在此賠償申請書簽署作實:

- All the foregoing statements and answers in this claim form together with those in any required medical examination, questionnaire, amendment or other document signed by me/us in connection with this claim application are full, complete and true. I/We also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. Sun Life Hong Kong Limited (including its successors or assigns, the Company) may be unable to process this claim application if I/we fail to provide any information required to this application. 此賠償申請書上所載的聲明及答案, 以及經本人/吾等簽署之所需之表格檢驗、問卷、修改書及其他文件, 均屬真確無訛, 詳細完整, 並構成賠償申請的依據及其中部份, 本人/吾等明白倘有任何未知是否屬於重要事項的資料均須在此透露。倘本人/吾等未能提供此賠償申請所需資料, 可導致香港永明金融有限公司(包括繼承人或承讓入, 公司)未能處理此賠償申請。
- I/We fully understand that the Company is not bound by any statement which I/we may have made to any person if not written or printed here. 本人/吾等完全明白公司不受一些本人/吾等沒有在此賠償申請書上提及或刊印向任何人土定立的聲明所約束。
- The personal information of employees, members and dependents held by or on behalf of the Company (whether contained herein or otherwise obtained and including personal information obtained after the date of this Application) may be held, used, disclosed, released and transferred by the Company to the parties and for the purposes mentioned in the Personal Information Collection Statement below: 由公司所持有及由本人/吾等提供有關僱員、成員及配偶或子女的個人資料, 公司(不論是否從此申請書或其他途徑, 包括在此申請後所得)可持有、使用、發放或轉交予有關人等作以下《個人資料收集聲明》中提及的用途:

Personal Information Collection Statement
 Any personal information collected or held by or on behalf of the Company (whether contained in this Application or otherwise obtained) may be held, used, disclosed and transferred by the Company to individuals, companies or organizations associated with the Company or any selected third parties that the Company may consider necessary or advisable, including those carrying on financial services, insurance or related businesses (within or outside of Hong Kong, including reinsurance and claims investigation companies, professional advisors, intermediaries and industry associations / federations), for the purposes of processing this Application and providing insurance services, other financial products and services and other services that may be of interest to me/us, direct marketing, data matching, carrying out regulatory functions and communicating with me/us for such purposes and all other directly related purposes. The Company is hereby authorized to obtain access to and/or to verify any of my/our data with the information collected from the insurance industry by any association, federation or similar organization of insurance companies. I/We understand that the information I/we give is on a voluntary basis. However, failure to supply information may result in the Company being unable to process my/our application. In accordance with the terms of the Personal Data (Privacy) Ordinance, the Company has the right to charge a reasonable fee for the processing of any data access request. I/We have the right to obtain access to and to request correction of any personal information concerning me/us held by the Company. Request for such access can be made in writing and addressed to: Customer Service Centre, 8/F, Sun Life Tower, The Gateway, 15 Canton Road, Kowloon.

(個人資料收集聲明)
 任何公司收集或持有(無論此申請書所載或由其他途徑所獲取)之任何個人資料並可由公司持有、使用、披露及轉移予與公司有關之個人、公司或機構或任何公司認為必須或合適之指定第三者, 包括提供金融服務、保險或相關業務(本港或海外之再保險及索償調查公司、專業顧問、中介人及同業協會或聯會), 以用作處理此申請及提供與之及其他金融產品及服務有關之售後服務、直銷推廣、數據核對、執行監管職能及因此等用途與本人/吾等聯絡或其他直接有關之用途。本人/吾等在此授權公司索取及/或核實由任何保險業協會或聯會或從事與保險業務有關之公司所提供關於本人/吾等的資料。本人/吾等明白本人/吾等所提供之資料均屬自願, 惟若不能提供該等資料有機會導致公司無法處理本人/吾等之申請。根據個人資料(私隱)條例, 公司可能就任何資料查詢要求收取合理費用。本人/吾等有權查閱及要求更正公司持有有關本人/吾等的個人資料, 有關要求可以書面形式郵寄香港九龍廣東道15號港威大廈永明金融大樓8樓香港永明金融有限公司客戶服務中心。

- I/We further authorized: (a) any doctor, hospital, clinic, insurance company, government office or any organization or person who has any record, knowledge or information of me/the insured (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to this Application; and (b) the Company or any of its appointed medical/paramedical examiners or laboratories to perform necessary medical assessments and tests to evaluate the health status of me/the insured in relation to this Application. This authorization shall bind the successors and assignees of me/the insured and shall remain valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original. 本人/吾等同時授權:(甲)任何擁有任何本人/受保人之記錄、詳情或資料(醫療或其他資料)之醫生、醫院、診所、保險公司、政府部門、機構或人士就此賠償申請向公司或其代表披露、透露或轉移此等記錄、詳情或資料;及(乙)公司或公司指定之醫生/護理人員或化驗所進行必要之健康評估及檢驗, 以評估與此賠償申請之本人/受保人的健康情況。此授權書對本人/受保人之繼承人及受讓人有約束力, 並於本人/受保人身故後或喪失能力後仍然有效。此授權書的正本及影印本均屬有效。

Date 日期 _____ Witness 見證人 _____ Signature of Employee 僱員簽署 _____ Signature of Employer/Policy Owner 僱主/保單持有人簽署 _____

In the event that the employee is unable to sign the form, it should be filled up and signed by the Policy Owner/Employer during disability. 如僱員因傷殘不能填寫此申請書, 可由僱主代為填寫及簽署。
 The furnishing or investigation of this or other claim forms does not constitute an admission of the Company's liability and will not be considered as a waiver of any of the Company's right. 本公司提供此賠償申請書及對賠償之申請進行調查, 並不表示本公司放棄任何權利或同意任何責任。

Attending Physician Report 主診醫生報告

Part B - To be completed by attending physician 乙部 - 由主診醫生填寫

1. PARTICULARS OF THE PATIENT 病人資料	
Name of Patient 病人姓名 _____	I.D.Card No. 身份證號碼 _____ Age 年齡 _____
2. Date of accident/onset of sickness 意外發生 / 病發日期 _____	
3. a) Describe and locate accurately cause, character and extent of injury of sickness 請敘述受傷或疾病之原因、性質及程度 _____	
b) Describe the present condition 請敘述現時狀況	
i) Are the symptoms progressive, stationary or improving? 症狀是否惡化、穩定或好轉? _____	
ii) Does the disability render the patient totally disabled or partially disabled? 殘疾是否會導致病人完全傷殘或部份傷殘? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 Please state cause of disability 請註明傷殘原因 _____	
4. When did symptoms first appear? 病症何時首次出現? _____	
5. Date of first and latest consultation 首次及最近診治日期	
First Date 首次日期 _____	Latest Date 最近日期 _____
6. Describe type of treatment, surgical procedure or operation performed 請敘述接受何種治療、手術步驟或外科手術 _____	
7. Give details of any history of physical impairments which may have contributed directly or indirectly to the accident or sickness or which may likely to retard his recovery 請詳述有關病人身體殘缺病歷而會直接或間接阻慢受傷或疾病痊癒程度 _____	
8. Is condition due to pregnancy? 上述情況是否因懷孕引致? _____	
9. a) In your opinion, could the patient resume any work for which he is fitted by nature, training and experience? 據閣下意見，病人是否可以利用其訓練及經驗重新從事任何適當工作? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 Please give date to resume work 請提供重新工作日期 _____	
b) If the patient is continuously totally disabled, how long will such total disability continue? 如病人是繼續完全傷殘，此傷殘會維持多久? _____	
10. Details of Hospitalization 醫院資料	
a) Name of Hospital where treatment was received 入住醫院名稱 _____	
b) Was the patient admitted as an inpatient or was treatment received as an outpatient? 病人是否需住院或只需在門診接受治療? <input type="checkbox"/> Inpatient 住院 Period of Hospitalization 住院時期 From 由 _____ To 至 _____ <input type="checkbox"/> Outpatient 門診	
I hereby certify that having personally examined the above named patient, the facts as set forth are true and correct 本人茲證明以上有關病人之資料乃真實及正確	
Name of attending Physician: _____ 主診醫生姓名	Signature of attending Physician with Official Chop 主診醫生簽署及蓋章
Qualifications: _____ 資歷	
Address: _____ 地址	
Telephone: _____ 聯絡電話	Date 日期: _____