YFLife 萬通保險

First Policy No.: 第一份保單編號：								

Second Policy No.: 第二份保單編號：								

CRITICAL ILLNESS & TOTAL DISABILITY BENEFIT CLAIM FORM
嚴重疾病及傷殘保障索償申請書 (C04)

Name of Insured : 受保人姓名	ID Card No. : 身份證號碼

The issue of this form is in no way constitute an admission of liability. No fee, commission or charge of whatever nature is required to pay to the employees or Consultants of YF Life Insurance International Ltd ("the Company") with respect to this claim. All parts must be completed before we will process the claim. In the event of the claim involving any payment to be made by the Company, the Policy Owner / Insured / Assignee must provide valid documentation proofs (such as identity document and address proof) to the satisfaction of the Company for the Company to conduct due diligence pursuant to the Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance, Cap.615.

發出此申請書並不表示萬通保險國際有限公司("本公司")已承認是次賠償責任。在此索償過程中，索償人無需支付任何費用予本公司之僱員或顧問。本索償申請書所有部份必須填妥。於處理任何索償而涉及本公司需要付款予客戶的情況下，有關之保單持有人 / 受保人 / 承讓人必須提交符合本公司要求之有效証明文件(例如其身份證明及地址證明)，讓本公司能按照於「打擊洗錢及恐怖分子資金籌集(金融機構)條例」第 615 章所載進行客戶盡職審查。

PART I : CLAIMANT'S STATEMENT 第一部份 : 索償人聲明

Questions 問	Answers 答
1. Type of claimed benefits (Please tick the appropriate box) : 索償保障類別 (請剔上適當的空格) :	☐ Critical Illness Benefit 嚴重疾病保障 ☐ Comprehensive Cancer Benefit 癌症全面保障 ☐ My Health Benefit 今日女性健康保障 ☐ LADY Health Benefit 「妳的健康」保障計劃 ☐ Update JR Health Benefit 兒童健康保障 ☐ Other 其他 : _____ ☐ Total & Permanent Disability 完全及永久傷殘保障 ☐ Waiver of Premium / Payor's Benefit 豁免保費/繳款人保障
2. If this claim is due to accident, please provide the following information: 若是次索償由意外導致，請填寫以下資料。 a. When did the accident happen? 是次意外發生日期及時間? b. How did it happen? 是次意外如何發生? c. Which part(s) of body injured? 受傷部位? d. Which police station had the case been reported to and what was the police reference number? 報案警署名稱及檔案編號。	2a. 2b. 2c. 2d.
3. If this claim is due to illness, please provide the following: 若是次索償由疾病導致，請填妥以下資料： a. What were the symptoms presented? 有何病徵呈現? b. How long had the symptoms been appeared? 上述病徵已持續多久? c. Give the details of the attending doctor that you first consulted for this illness. 最初診治此症之醫生資料。	3a. 3b. 3c. Date 日期 Name and Address 姓名及地址
4. When did you become completely unable to engage in any business or occupation due to the illness / disability? 閣下何時開始因是次疾病/傷殘而完全不能工作?	4.
5. Have you been wholly confining to bed at home or in hospital since the disability? Please name the daily activity(ies) you can perform. 閣下是否自傷殘後需要完全躺臥在家中或在醫院的床上? 請列出閣下日常可進行之活動。	5.
6. Give the name(s) of all attending doctor who treated you for similar or related illness. 曾因是次或同類受傷/疾病而求診之所有醫生資料。	6. Name and Address 姓名及地址 / First Consultation Date 求診日期 / Cause 原因 / Follow up Card No. 覆診卡編號
7. If you have been treated in hospital, please give details. 如閣下曾留院接受治療，請列明有關資料。	7. Name of Hospital 醫院名稱 / Admitted on 入院日期 / Discharge on 出院日期 / Diagnosis 病因 / Ward/Ref. No. 檔案編號
8. Have you ever suffered from the same or similar or related symptom? Please give details of each episode of attack. 閣下以往曾否患有同類形相似或有關病徵? 請詳述每次發病情況。	8. Onset Date 最初病發日 / Exact Cause of Loss 病因 / Period absent from work 停止工作之時期 / Doctor attended and address 主診醫生姓名及地址
9. Has your mother, father or any brother or sister suffered from diabetes, heart disease, stroke or cancer? Please give date and full particulars. 閣下之父母、兄弟或姊妹中，有否患有糖尿病、心臟病、中風或癌症? 如有，請詳述患病日期及詳情。	9.

Signed by Policy Owner 保單持有人簽署 X _____

Questions 問	Answers 答
10a. Do you smoke? 閣下是否吸煙人仕?	10a.
10b. If you are/had been smoker, please answer the following questions : 倘閣下是/曾為吸煙人仕，請回答以下問題 :	10b.
i. When did you start smoking? 閣下何時開始吸煙?	i.
ii. What type (e.g. cigarettes, cigars, etc.) and how many do / did you smoke per day? 香煙種類及每天吸煙數量?	ii.
iii. If you have ceased smoking, when did you last smoke? What was the reason of ceased smoking? 若閣下已停止吸煙，何時停止吸煙? 戒煙理由?	iii.
11. Have you ever been or are you at present insured by some other insurance company(ies)? Please give details. 閣下曾否投保於其他保險公司? 請列明有關資料。	11.
12a. What is your occupation (including any part-time employment) and duty involved prior to disablement / accident? 閣下於傷殘/意外前之職業及職責(包括兼職之工作)。	12a.
12b. In relation to your current loss, are you entitled to receive any form of group insurance benefit granted by your employer? Please give details. 就是次損失，閣下會否獲得僱主發出之團體保險賠償? 請詳述。	12b.
12c. Please give name and address of your employer. If you were self-employed, please tell us your company's name and usual place of business. 閣下現時僱主名稱及地址?如屬自僱，請提供閣下公司名稱及慣常工作地點。	12c.
13. When did you return to work and in what profession? To what extent had the loss been prevented you from returning to work if you are still ceasing work. 閣下恢復工作之日期及職業為何?如閣下仍未能恢復工作，請詳述閣下未能工作之原因。	13.

PERSONAL INFORMATION COLLECTION STATEMENT

I/We understand and agree my/our personal information (including a record of my/our image or voice by whatever means and my/our health information) collected by or held by YF Life Insurance International Ltd ("the Company") may be used for the purposes of: (1) approving, evaluating or processing my/our insurance application/policy service request; (2) administering, maintaining or reinsuring my/our policies; (3) adjudicating my/our claims, or conducting any investigation or analysis of my/our claims; (4) data matching; (5) investigation or prevention of crime; or (6) fulfilling legal or regulatory requirements. I/We understand and agree that failure to provide any information requested by the Company may result in the Company not being able to process my/our insurance application/policy service request.

I/We understand and agree my/our personal information collected by or held by the Company may be transferred or disclosed by the Company to any of the following persons (whether within or outside Hong Kong) for the purposes as specified above or to governmental/regulatory bodies (whether within or outside Hong Kong) for them to carry out their governmental/regulatory functions: (1) YF Life group companies and their associated/affiliated companies; (2) financial institutions, insurance companies, intermediaries and reinsurers; (3) claims investigation companies or any companies/persons necessary for claims assessment/investigation; (4) industry associations/federations and their members; (5) governmental/regulatory bodies and law enforcement agencies; (6) crime prevention organizations and their members/participants; and (7) service providers and selected persons which are under a duty of confidentiality to the Company.

I/We understand that I/we have the right to access to, and to correct, any of my/our personal information held by the Company by writing to the Personal Data Protection Officer of the Company. (Address : 27/F, YF Life Tower, 33 Lockhart Road, Wanchai, Hong Kong (applicable to policies issued in Hong Kong) or Avenida Doutor Mario Soares No. 320, Finance and IT Center of Macau, 8 Andar A, Macau (applicable to policies issued in Macau)). The Company may charge a reasonable fee for the processing of such request.

DECLARATION

I/We, the undersigned, hereby declare that all information deposed hereinabove, whether they are written by me/us or not, is true and complete to the best of my/our knowledge and belief and I/we have not withheld any material information connected with this claim. I/We also have read and understood the Personal Information Collection Statement stated above. I/We provide the information herein on a voluntary basis. However, I/we understand that failure to provide information as per the Company request may result in the Company being unable to process with this claim. This claim form and all other documents submitted to the Company for this claim shall be the property of the Company, and will be non-returnable under all circumstances.

If there is any subsequent change to the information provided, I/we undertake to notify the Company as soon as possible.

I/ We hereby agree and authorize the Company, according to the Insurance (Levy) Regulation, to deduct (1) corresponding levy on unpaid premium (if any); and (2) outstanding levy of the policy(ies) (if any) from the claim payment of the policy(ies) payable to me/us. The levy will be remitted to the Insurance Authority by the Company. (Applicable to policy issued in Hong Kong)

AUTHORIZATION

I/We hereby on behalf of myself/ourselves irrevocably authorize (1) any individual or organization (including but not limited to my/our employer, registered medical practitioner, hospital, clinic, insurance company, bank, police, governmental department, public or private institution) that has any record, statement, information of mine/us (whether medical or otherwise) to release, disclose or transfer all the information to the Company or its representatives for the purposes of assessing and processing any insurance claim. (2) The Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and/or tests to evaluate my/our health status in related to this claim. I/We hereby acknowledge that (1) this authorization shall be binding on my/our successors and assignees and remain valid and subsisting notwithstanding my/our death or incapacity for whatever reasons; (2) A photocopy of this authorization shall be as valid as its original. I/We hereby grant my/our consent to the Company to collect, use and transfer the above health information in accordance with the Personal Information Collection Statement.

個人資料收集聲明

本人/我們明白及同意萬通保險國際有限公司("貴公司")所收集或持有本人/我們的個人資料(包括任何形式的肖像、聲音及與健康有關的資料)可能會被用於下列目的：(1) 批核、評審及處理本人/我們之投保計劃申請/保單服務要求；(2) 就本人/我們之保單提供行政、持續或再保險的服務；(3) 評核本人/我們索償，或就本人/我們之索償進行調查或分析；(4) 資料核對；(5) 偵測或防止罪行；或(6) 符合法律或合規要求。本人/我們明白及同意必須提供貴公司所需的個人資料，否則，貴公司將不能處理本人/我們之投保申請或就本人/我們之保單提供服務。

本人/我們明白及同意貴公司可能為達到上述目的或讓政府/監管機構(不論在香港或海外)執行其職務而向以下任何一方(不論在香港或海外)轉移或透露由貴公司收集或持有屬於本人/我們的個人資料：(1) 萬通保險集團成員公司及其關聯或相關公司；(2) 金融機構、保險公司、中介人或再保險公司；(3) 賠償調查公司及所需有關評核索償之公司及/或人士; (4) 行業組織/聯會及其成員；(5) 政府部門或監管機構和執法機構；(6) 防犯罪組織及其會員/參與者；及 (7) 與貴公司有保密協議的服務提供者及其他人士。

本人/我們明白本人/我們有權查閱和更改任何由貴公司持有屬於本人/我們的個人資料。如有需要，本人/我們可與貴公司的資料保護主任提出有關要求、並以書面方式呈交(地址：香港灣仔駱克道 33 號萬通保險大廈 27 樓(適用於香港簽發的保單) 或澳門蘇亞利斯博士大馬路 320 號澳門財富中心 8 樓 A 座(適用於澳門簽發的保單))。處理上述要求時，貴公司可能會收取合理費用。

聲明

本人/我們，即下方簽署者，謹此聲明上述披露之一切資料，不論是否由本人/我們手寫，就本人/我們等所深知及確信均屬完整並真確無訛。本人/我們就此索償申請並無隱瞞任何重要資料。本人/我們等亦已閱讀及明白上述的個人資料收集聲明。本人/我們在此提供的資料均屬自願。若未能依據貴公司要求提供資料，本人/我們明白會導致貴公司不能處理此索償。此索償申請書及一切其他文件在遞交給貴公司後便會成為貴公司的財產。在任何情況下均不會獲得退回。

若本人/我們所提供的資料有任何更改時，本人/我們確保盡快通知貴公司有關的更改。

本人/我們謹此同意及授權貴公司按《保險業(徵費)規例》從支付予本人/我們之賠償金額中扣除保單 (1) 未繳保費的相關徵費(如適用)；及 (2) 尚欠的徵費(如適用)，並由貴公司把徵費轉付至保險業監管局。(只適用於香港簽發之保單)

授權書

本人/我們現授權(1) 任何擁有本人/我們等任何記錄、供詞、資料(不論是否醫學資料)之人士或機構(包括但不限於本人/我們的僱主、註冊醫生、醫院、診所、保險公司、銀行、警察、政府部門、公共或私營機構)向貴公司或其代表發放、披露或轉交任何與評核及處理保險索償申請有關的資料。(2) 貴公司或任何由貴公司指定的醫務人員或化驗所可就此索償對本人/我們等進行有需要之醫療評估及測試，以審核本人/我們的健康狀況。本人/我們現確認 (1) 此授權書對本人/我們之繼承人及受讓人具有約束力，即使本人/我們死亡或無行為能力(不論任何原因)，此授權書仍然生效及具效力; (2) 本授權書之副本與正本具有同等效力。本人/我們謹此授權貴公司可按「個人資料收集聲明」的規定收集、使用及轉移上述有關本人/我們健康方面的資料。

Signature of Consultant 顧問簽署	Signature of Policy Owner 保單持有人簽署	Signature of Insured 受保人簽署 (only if age is over 18 若年齡超過 18 歲)
Name and Code of Consultant 顧問姓名及編號	Name of Policy Owner 保單持有人姓名	Name of Insured 受保人姓名
Date 日期	Policy Owner's ID No. 保單持有人身份證號碼	Insured's ID No. 受保人身份證號碼

PART II : ATTENDING PHYSICIAN'S STATEMENT 第二部份 ： 醫生報告

病者姓名 ：
Patient's Name : _____

年齡:
Age : _____

身份證號碼.:
ID Card No. : _____

NOTE 注意 ： No claim will be admitted unless the report below is duly completed by the medical attendant of the Patient. YF Life Insurance International Ltd will not be responsible for any fee for the completion of this report.
本報告必須由病者之主診醫生填寫。 萬通保險國際有限公司不會負責填寫此報告之費用。

Questions 問	Answers 答
1. How long have you known the patient? If you know this patient prior to the consultation of the claimed illness / injury, how did you know this patient? 閣下與病者相識多久？若閣下並非因此疾病/受傷而與病者相識，請詳列認識之經過。	1.
2. Was the patient referred to you by another doctor? If yes, please give us his / her name and address. 病者是否由其他醫生轉介予閣下？如是，請提供該醫生的姓名及地址。	2. ☐ No 否 ☐ Yes 是
3a. When did you first attend that patient for the claimed illness / injury? 閣下於何時首次因是次疾病/受傷首次與病者會面？	3a.
3b. What were the complaints and symptoms presented? How severe was the condition? How frequent was the attack? 請列明病者之症狀？嚴重程度？病發頻率？	3b.
3c. How long has the patient been experienced such symptoms prior to first consultation? How did you know this information? 於首次求診前，病者的症狀持續多久？閣下如何得悉有關資料？	3c.
3d. How long do you think the symptoms has lasted prior to the first consultation to you? Did you inform the patient of your opinion? 閣下認為此症狀於首次求診前可能已持續多久？有否將閣下之意見知會病者？如有，於何時？	3d.
4. Had any laboratory test such as cytological studies, x-ray, electrocardiography (ECG), cardiac enzyme levels (CK-MB / Troponin I / Troponin T / AccuTnI), pathology or serological studies been performed? Please give details and provide us with a set of the results if available. 病者曾否接受化驗檢查，如細胞檢查、X 光檢查、心電圖測試、心臟酵素的水平 (CK-MB / Troponin I / Troponin T / AccuTnI)、病理檢查或血清檢驗？請詳細列明及提供有關報告予本公司。	4. Date Performed 檢查日期 / Details of Procedure 詳細過程 / Results of the test(s) 報告結果
5. Please list down the date and details of each visit of the patient to your clinic / hospital in the order of dates. 請詳列病者過往求診的日期及詳情。	5. Date 日期 / Symptom 病徵 / Diagnosis 診斷 / Treatment / Physiotherapy and Length of Course 治療 / 物理治療及療程時段
6. Please list down all hospitalization record(s) of the patient. 請列出病者所有住院紀錄。	6. Admitted on 入院日期 / Discharged on 出院日期 / Diagnosis 診斷 / Treatment 治療 / Name of Hospital 醫院名稱
7. Are there any plan for chemotherapy, radiotherapy or surgical operation? Please provide the details. 是否已計劃進行化療 / 電療治療 / 手術？請提供詳情。 a. Chemotherapy 化療 b. Radiotherapy 電療 c. Surgical operation 手術	7. No 否 / Yes 是 / Date 日期 / Details 詳情 ☐ ☐ _____ _____ ☐ ☐ _____ _____ ☐ ☐ _____ _____

Signature of the attending physician / specialist (with chop) :
主診醫生簽署及蓋章

_____

Patient's Name
病者姓名 : _____

ID Card No.
身份證號碼 : _____

8a. Has the patient previously suffered from same or similar disorders? 病者過往是否患有相同或相似的疾病?	8a. ☐ No 否 ☐ Yes 是
8b. If yes, please give the date and details of each disorder. 若有，請提供日期及詳細疾病資料。	8b. Date of occurrence 發病日期 / Exact Nature / Cause of Attack 發病原因 / Test / Treatment Received 治療 / Duration of Disability 殘疾持續日期 / Doctor Attended 主診醫生
8c. If not, do you consider that the disability caused by any other disease or disorder? If yes, please provide name of the disease or disorder and how it relates to this illness / disorder. (If available, please provide the date and the details when the patient was aware of such pre-existing illness or disorder). 若沒有，閣下是否認為是次傷殘或疾病是由其他疾病/異常情況所導致? 若是，請提供該疾病/異常情況之名稱及列明該情況如何與是次疾病有關。 (請提供病者已知舊患之日期及詳情)	8c.
9a. What was your final diagnosis? Please also give the date of diagnosis. 閣下之最後診斷為何? 診斷日期?	9a. Final Diagnosis : 最後診斷 Date of Diagnosis : ____ / ____ / ____ 診斷日期 MM 月 / DD 日 / CCYY 年
9b. Was the diagnosis made before the patient first consulted to you (as mentioned in Question 3a)? If yes, please give details. 診斷日期是否早於初次向閣下求診日期 (問題 3a 註明之答案)? 若是，請提供詳情。	9b.
10a. Please provide the period of Total Disability of the patient (i.e., prevented the patient from engaging in any occupation, or performing any work for remuneration or profit). 請提供病者之完全傷殘時期 (使病者無法從事任何可獲報酬的職業或工作)。	10a. From 由 ____ / ____ / ____ MM 月 / DD 日 / CCYY 年 To 至 ____ / ____ / ____ MM 月 / DD 日 / CCYY 年
10b. Please provide the period of Partial Disability of the patient (i.e., prevented the patient from engaging in one or more major duties pertaining to his / her own occupation). 請提供病者之部份傷殘時期 (使病者無法從事本身職業內一項或多項主要職責)。	10b. From 由 ____ / ____ / ____ MM 月 / DD 日 / CCYY 年 To 至 ____ / ____ / ____ MM 月 / DD 日 / CCYY 年
10c. Would you expect that the patient remain in the same disability condition as above which continuously requires medical treatment? Please give reason. 閣下是否認為病者將維持上述傷殘情況，並需繼續接受醫療診治? 請列明原因。	10c.
10d. For how long would the patient remain in the above condition? Please let us know the rehabilitation plan to the patient. 上述之情況仍會持續多久? 請詳述提供予病者康復治療之計劃。	10d.
11a. When did you see the patient recently? 閣下最近於何時約見病者?	11a.
11b. What was the condition of the patient? 病者的情況如何?	11b.
12. Did you have any other information to supplement the above? If yes, please give us in details. 閣下有否其他資料補充? 若有，請詳述。	12.
13. Please give the name and address of other doctors who have treated the patient. 請提供有關曾經治療此病者之醫生姓名及地址。	13.

I hereby certify that I have personally attended the above named Patient and that all the information supplied by me on this form is true and correct to the best of my knowledge and belief.
本人現聲明本人曾提供治療予上述病者，就本人所知所信，上述的資料均為事實之全部，並確實無訛。

Signature of Medical Attendant (with chop) 主診醫生簽名及蓋章

Hospital Specialty / Unit / Department 醫院專科 / 單位 / 部門

Name of Medical Attendant/Qualification(s) 主診醫生姓名 / 專業資格

Date 日期