CHINA MERCHANTS INSURANCE COMPANY LIMITED
招商局保險有限公司

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CRITICAL ILLNESS / MEDICAL CLAIM FORM

危疾 / 醫療保險索償申請表格

THIS FORM IS ISSUED WITHOUT ADMISSION OF LIABILITY. Completed Claim Form together with all the supporting medical reports and documents should be forwarded to us within one calendar month following the occurrence of an event likely to give rise to a claim. Otherwise, it may prejudice your claim under the Policy. 茲此聲明, 填寫本申請表格並不代表本公司已承諾賠償。 請於可能導至需要索償的事件發生後的一個月內填妥本表格連同一切有關醫療報告及文件交回本公司以便處理, 否則可能影響 台端的索償。

Part 1 – To be completed by the Insured/Claimant 第一部份 – 由受保人/索償人填寫

Name of the Insured: ______________________
受保人姓名

Policy No: ______________________
保單號碼

Name of the Claimant: ______________________
索償人姓名

ID Card No: ______________________
身份証號碼

Telephone No: ______________________
電話

Date of Birth: ______________________
出生日期

Address 地址: ______________________

Details of Your Claim 索償事由

Date, Time and Place of the accident: ______________________
意外發生日期、時間及地點

Full description of the accident/event 事件之詳細描述: ______________________

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Declaration and Authorization 聲明及授權書

I declare that to the best of my knowledge and belief the above statement and particulars contained are in all respects true and complete and are made without reservation of any kind. 本人謹此聲明本人確信以上所填報之資料及所列各項之事件乃屬完全真確並無對保險公司作任何資料之保留。

I hereby authorize any hospitals, physicians, or other person who has attended or examined me, to furnish to China Merchants Insurance Co Ltd or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.
本人茲授權任何醫院、醫師及其他曾替本人診治、護理或檢查之人士, 將部份或全部有關本人受傷或疾病之醫療診斷報告及藥方等資料供給與招商局保險有限公司或其代表人。 此授權書之影印本與正本俱同等效力。

Signature of the Insured: ______________________
受保人簽署

Date: ______________________
日期

(Please turn over 請轉背頁)

Note 注意

Please ask your attending physician to complete Part 2 of this Form.

請要求 台端的主診醫生填寫本表格的第二部份。

Any persons from whom the Company has collected information as aforesaid shall have the right of access to and to request correction of any personal information concerning themselves held by the Company. A request for such access may be made to the Data Protection Officer of the Company of 18th Floor, China Merchants Tower, Shun Tak Centre, 168-200 Connaught Road Central, Hong Kong.

就提供上述資料的任何人有權查閱及要求更改由本公司所持有有關他們的個人資料。 任何關於個人資料查閱或更改之要求, 可向本公司之資料保護主任提出, 地址爲香港干諾道中 168-200 號信德中心招商局大廈 18 樓。

Part 2 - To be completed by the Attending Physician 第二部份 - 由主診醫生填寫	
Name of Patient 病者姓名	HK ID No. 身份証號碼
Diagnosis and Treatment 診斷及治療	Cause and Pathology 病因及病理
The first consultation date for this condition 首次求診日期	How long the Patient had been experiencing the symptoms prior to this first consultation? 在首次求診前, 病者經歷了該病癥多久?
In your opinion, how long the symptoms had existed prior to the first consultation? Have you informed the Patient? 根据 閣下的意見, 該病癥在首次求診前出現了多久? 有否知會病者?	In your opinion, how long the illness would have been in existence before the symptoms surfaced? 根据 閣下的意見, 該病症在病癥首次出現前已存在了多久?
Was the Patient referred to you by another doctor? If yes, please state the name of the doctor. 病者是否由另一名醫生轉介? 如有者, 請提供該醫生姓名	Had the Patient been treated for the same or similar condition before? If yes, please give details 病者以往曾否因同樣或相類似之病症而接受治療? 如有者, 請提供詳情
Have you referred the Patient to another specialist? If yes, please state the name of the specialist. 閣下有否把病者轉介往另一名專科醫生? 如有者, 請提供該醫生姓名	Had the Patient been operated for the condition? If yes, please give details 病者可有進行外科手術治療? 如有者, 請提供詳情
I hereby declare that I am the Attending Physician of the above-named Patient and that the answers given by me as above are full, complete and true to the best of my knowledge. 本人謹在此聲明, 本人乃上述病者的主診醫生; 以上所述一切是根据本人所知正確填寫, 並爲完全和真確。 Date 日期	 Attending Physician's Signature & Official Stamp 主診醫生簽署及蓋章