Authorization for Living Claims
在生權益授權書

Policy No. 保單號碼 :_____

Name of Insured 被保人姓名 :_____

Authorization

I HEREBY AUTHORIZE AND AUTHORIZE ON BEHALF OF THE INSURED (if different):

1. any registered practitioners, hospitals, clinics, insurance companies, government institution, organizations or persons that possess any medical history or records or employment and salary information or other information of me/the insured or whom I have attended or may hereafter attend, to disclose any of my or the insured's medical information or other information to FWD Life Insurance Company (Bermuda) Limited in relation to this claim.
2. the Company or any of its approved medical examiners or laboratories to perform necessary medical assessment and tests to evaluate my or the Insured's health status in relation to this claim.

本人在此授權或代表被保人（如有不同）授權：

1. 任何持有本人/ 被保人的醫療病歷、記錄或職業及薪酬記錄或其他資料或本人曾求診或其後將會求診的醫生、醫院、診所、保險公司、政府機構、機構或人士向富衛人壽保險（百慕達）有限公司披露本人/ 被保人的任何醫療資料或其他資料，作為評估或處理此索償之用。
2. 公司或公司許可的醫療人員或化驗所，就本賠償申請，進行必要的醫學評估及測試，以評估本人或被保人的健康狀況。

[Note : This authorization shall bind my and the Insured's successors and assigns and remain valid notwithstanding my or the Insured's death or incapacity in so far as legally possible. A photocopy of this Authorization shall be as valid as the original].

(注意:本授權對本人或被保人的承繼人及轉讓人均有約束力，並且如法律上可行時，不論本人或被保人死亡及失去行為能力，本授權仍然有效。本授權的影印本與正本同樣有效。)

_____
Date (DD / MM / YY)
日期 (日 / 月 / 年)

_____
Signature of Claimant 索償人簽署

_____
Name of Claimant 索償人姓名

_____
ID Card No. 身份證號碼

_____
Relationship with Insured 與被保人之關係