Group Insurance Disability Preliminary Claimant Statement
團體傷殘保障賠償申請表

Policy No. 保單編號: _____ Name of Policyowner 保單持有人名稱: _____

1. Personal particulars of the employee 僱員個人資料:

   Name of Employee 僱員名稱: _____ I.D. Card No. 身份証編號: _____

   Date of Birth 出生日期: _____ Age 年齡: _____ Sex 性別: _____

   Residential Address 住宅地址: _____

   Date of employment 受僱日期: _____ Present occupation/position 現在職業: _____

   Exact nature of occupational duties 實際職責: _____

2. Please complete if Disability was caused by accident 如由意外引起請詳述:

   (a) Date and time of accident. 意外發生日期。

   _____

   (b) Where and how did it happen? 描述意外發生的經過及地點。

   _____

   (c) Part of body injured and type of injury. 描述受傷的部位及種類。

   _____

   (d) Was the accident related to your occupation? 意外是否與工作有關？

   _____

3. Please complete if Disability was caused by illness 如由疾病引起請詳述:

   (a) Please describe fully the nature and symptoms of your illness. 所患何病，病徵是什麼？

   _____

   (b) How long had you been having these symptoms prior to the first consultation? 閣下首次就診前病徵已存在多久？

   _____

   (c) When did you first consult a doctor for this illness? 閣下何時首次因此病就診？

   _____

   (d) Have you previously suffered from, or received treatment for, a similar or related illness? If yes, please give full details. 被保人過往曾否患上此類疾病或相關之疾病或因該病而接受治療？如'是'，請詳述。

   _____

4. Medical Consultations 醫療的詳情:
   Details of hospitals confined or physicians consulted for the injury/illness 就有關意外/疾病之求診紀錄。

Name of Physician(s) 醫生姓名 And / or Hospital(s) 醫院名稱	Address(s) 地址	Date of consultation(s) And / or period of Confinement(s) 求診日期

5. What treatment have you received and you are currently receiving in connection with you injury/illness?
   閣下是否仍然須要接受治療？請詳述。

   _____

6. When were you first absent from work due to your disability? 請詳述閣下何時開始停止工作？

   _____

7. Date on which you returned to work or you expect to do so? 閣下何時或預期何時可恢復工作？

   _____

8. Had you absent from work due to injury/illness during the 3 months immediately preceding or on the last review date of this Group Insurance. (If yes, please give the full details) 閣下曾否於參予此團體保險前 3 個數月內因疾病或意外而申請病假？

_____

9. Are you insured for similar benefits with any other insurance company? If yes, state name of Companies, type of insurance and the amount of benefit insured. 被保人是否受保於其他殘疾或類似保障於其他保險公司？如是，請提供有關資料，如有，請提供保險公司名稱及地址、投保種類及投保總額。

_____

Declaration and Authorization 聲明及授權

I HEREBY DECLARE AND AGREE THAT:

1. The answers to all the above questions are complete, true and accurate and are given to the best of my knowledge and belief;
2. Any personal data concerning myself or the Insured (if different) collected and held by the company may be used, stored, disclosed and transferred (whether within or outside Hong Kong) to such individuals/organizations associated with the Company. These include reinsurers, claims investigators and industry associations/ federations for the purposes of (i) underwriting and evaluating this application; (ii) dealing with any matters arising from any policy issued pursuant to this application; (iii) providing all services related to this application; (iv) any promotion of financial products and services by the company and its affiliated companies and (v) communicating with me or the Insured (if different) for such purposes;
3. I understand that I have or the Insured (if different) has the right to request access to and, following such access, to request correction (if appropriate) of any personal information concerning myself or the Insured (if different) held by the company or be given reasons for any refusal of access. I also understand that the Company has the right to charge a reasonable fee for process of any access. [Note: Any request for access or correction can be made in writing and addressed to the head of Claims Department at 1/F., FWD Financial Centre, 308 Des Voeux Road Central, Hong Kong.]

本人謹此聲明並同意：

1. 上述所有問題的答案均是完整，真實及準確，並且是盡本人所知及所信而作答的；
2. 由公司收集及持有本人或被保人（如有不同）的任何個人資料，可使用、儲存、透露及轉予(無論本港或海外)公司有關聯的人仕/或機構團體，包括再保公司，賠償調查員及保險業協會/聯盟，以作爲(i)承保及評估本申請；(ii)處理本申請所發出的任何保單引起的任何事件；(iii)提供有關本申請的所有服務；(iv)任何公司及其附屬公司之財經計劃商品及服務之推廣活動；以及(v)因上述目的與本人或被保人（如有不同）聯絡。
3. 本人明白，本人或被保人（如有不同）有權要求查閱及於查閱後有權要求更正（如適當時），公司所持有之有關本人或被保人（如有不同）的任何個人資料，或獲得任何拒絕查閱的理由；本人亦明白公司有權就處理任何查閱資料的要求，收取合理費用。[注意：任何查閱及更正要求可以書面方式寄往香港中環德輔道中308號富衛金融中心1樓賠償部收。]

I hereby authorize or authorize on behalf of the Insured (if different);

1. any registered medical practitioner, hospital, clinic, insurance company, government institution or other organization that has record or knowledge of my or the Insured's (if different) heath and medical history or any treatment or advice or that has been or may hereafter be consulted to disclose to the Company such information as required by the Company in relation to this claim; and
2. the Company or any of its approved medical examiners or laboratories to perform the 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.當公司有需要時，公司可要求持有或瞭解本人或被保人(如有不同)的健康及醫療記錄；或任何治療或忠告或曾向其求診或以後向其求診之任何註冊醫生，醫院，診所，保險公司，政府機構或其它團體透露有關被保人資料。

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 or 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爲能力，本授權仍然有效。本授權的影印本與正本同樣有效.)

Data Protection - The Company has appointed a Data Protection Officer to handle any enquiries relating to your personal information. If you would like to obtain a copy of the FWD Life Insurance Company (Bermuda) Limited Personal Data Policy and Practices, please write to the Corporate Data Protection Officer at 1/F., FWD Financial Centre, 308 Des Voeux Road Central, Hong Kong.

資料保護 - 公司已委任一位資料保護主任,處理有關閣下個人資料的任何書面查詢。如閣下對資料保護有任何查詢，請來信寄香港中環德輔道中 308 號富衛金融中心 1 樓富衛人壽保險(百慕達)有限公司 資料保護主任收。

Signature of Employee (Insured) 僱員簽署 ：_____ Date 日期: _____