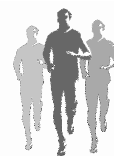
Crisis Insurance Claim Form
嚴重疾病賠償申請表



To be completed by Insured / Claimant 由被保人/病者或索償人填寫

(I) Insured's Particulars / 被保人資料

Policy No. 保單編號	Name of Insured 被保人姓名	I.D. No. 身份証編號
Sex 姓別	Age 年齡	Date of Birth (dd/mm/yy) 出生日期
Mailing Address 郵寄地址		Telephone No. 聯絡電話 :
E-mail Address 電郵地址 :		Mobile Phone No. 手提電話:
Name of Employer and Address 僱主名稱及地址		Occupation 職業

(II) Medical Details 醫療的詳情

1. Please give a brief description of the Insured's symptoms / Illness.
   請描述被保人之病徵及病因。

2. On what date did the Insured first consult a medical practitioner in connection with the Insured's Illness?
   被保人就有關疾病之首次求診日期？

3. Has the Insured previously suffered from or received treatment for a similar or related illness? If yes, please give 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. (a) Details of any medical practitioners who have been consulted in connection with the Insured's Illness. *(Please attach the relevant patient card copy)*
   被保人就有關疾病之求診紀錄。(請附上有關之覆診咭副本)

Doctor's Name 醫生姓名	Address & Telephone No. 地址及電話號碼	Patient No. 病歷編號	Date of Consultation 求診日期

(b) Details of any hospitalizations in connection with the Insured's illness.有關疾病之住院紀錄。

Name of Hospital 醫院名稱	Date of Admission (dd/mm/yy) 入院日期 (日/ 月/ 年)	Date of Discharge (dd/mm/yy) 出院日期 (日/ 月/ 年)

(c) Please give the name and address of the Insured's usual medical attendant. *(Please attach the patient card copy)*
請提供被保人過往慣常求診之醫生名稱及地址。(請附上覆診咭副本)

5. Has any of the Insured's blood relatives suffered from a similar or related illness? If yes, state relationship of the relative, nature of the illness and the date when the illness was first diagnosed. 被保人之直系親屬曾否患上此病或相關疾病？如有，請列明親屬與被保人之關係，疾病性質及首次診斷患上該病之日期。

6. Does the Insured smoke cigarettes or drink alcohol? If yes, please give the details including the daily consumption and the duration of the hobby.
被保人有否吸煙或飲酒習慣？如有，請提供此習慣之詳情包括每日之數量及多久。

7. Does the Insured have any other disability benefits or similar benefits with any other insurance company? If yes, please give the details.
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。

Name of the Insurance Company & Address 保險公司之名稱及地址	Policy Nos. 保單號碼	Benefit & Coverage 投保種類及投保總額

(IV) 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。

Date (DD/MM/YY) 日期 (日/月/年)	Place 簽署地	Signature of Claimant 索償人簽署	Signature of Close Relative of Insured (if applicable) 被保人近親簽署

Please make sure that the above signature of Insured is consistent with that in policy application. In the event of the Insured being unable to sign the form, it should be completed and signed by a close relative or other responsible person in charge of the Insured during his disability.
被保人請確保以上簽名與保單申請書上之簽名一致。 倘若被保人不能親自簽署表格，可由其近親或其他受委托之可靠人士在被保人失去能力期間代為填報及簽署。

For Adviser's Use Only 理財顧問專用

Adviser Name 理財顧問姓名	Adviser code & Location 理財顧問編號及地區