Declaration and Authorization for Disability Claims
在生權益之聲明及授權書(適用於傷殘索償)

Policy No. :_____

Insured : _____

Declaration

I HEREBY DECLARE AND AGREE that :

1. Any personal data of 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) assess and evaluate this claim; (ii) provide all services related to this claim; (iii) any promotion of service by the Company and its affiliated companies and (iv) communicating with me or the Insured (if different) for such purpose.
2. I understand that I have or the Insured (if different) has the right to request access to and 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.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，以作為(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。

2.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。]

Authorization

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

1. any registered practitioner, hospital, clinic insurance company, government institution or other organization that has record or knowledge of my or the Insured's (if different) employment and salary information; health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclosed 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.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)的受僱資料；入息資料；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 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 :
I.D. No. :
Relationship :