CHUBB

Agent's/Intermediary's name 保險代理 / 中介人姓名
Agent's/Intermediary's contact phone no. 保險代理 / 中介人聯絡電話
Agent's/Intermediary's code 保險代理 / 中介人代號
Agency 組別 –

Claim Form - Disability

傷殘保障申請書

Claim Type 賠償類別

☐ Waiver of Premium (WP) 豁免保費
☐ Income Protection (DI/PIP/PIPS) 傷殘入息保障
☐ Child's Protection Benefit (CPB) 兒童保障利益
☐ Disability of CPB payor 兒童保障利益付款人傷殘
☐ Death of CPB payor 兒童保障利益付款人死亡
Date of death 死亡日期 ____________________ Place of death 死亡地點 ____________________

☐ New claim 首次索償	☐ Pending claim 待決索償	☐ Further claim 再度索償	☐ Review/appeal 重批/覆核
	Please provide claim no. for reference 請提供賠償編號以作參考		

Part I (To Be Completed by Claimant/Insured) 甲部（由索償人 / 受保人填寫）

A. Insured's Particulars 受保人資料

Policy no. 保單編號	Insured's name (WP)/payor's name (CPB) 受保人姓名（豁免保費）/ 付款人姓名（兒童保障利益）	HKID card/passport no. 香港身份證 / 護照號碼	Date of birth 出生日期 DD日MM月YYYY年 / /	Sex 性別	Age 年齡	Tel. no. 電話號碼

B. Employment Particulars 就業詳情

1. Present occupation 現時職業	Duties 工作範圍	Employer's name, address & tel. no. 僱主名稱、地址及電話

If more than one occupation, state all and exact nature of occupational duties. 若有兼職請全部列明，並詳述職位及職責。

2. Did the insured file any medical leave certificate to his/her employer? 有否向僱主遞交病假證明書？ ☐ Yes 有 ☐ No 沒有

3. Did the insured submit any claim for workmen's compensation for this accident? 有否就此意外申請勞工賠償？ ☐ Yes 有 ☐ No 沒有

Submission date 遞交日期：(/ /)
DD日 MM月YYYY年

4. The insured's average monthly earned income during the period one year prior to the commencement of disability (Please provide income statement) - applicable to DI/PIP/PIPS claim only 開始傷殘前一年內的平均收入？（請遞交入息證明）- 只適用於入息保障賠償

As part of our endeavour to keep our records updated and to maintain high quality of service, we sincerely invite you to provide us your email address. Please visit our website https://eservice.chubblife.com.hk to update your email address.

為使能為閣下提供更完善的服務及本公司可不時更新客戶個人資料，本公司現誠邀閣下使用本公司網上服務 https://eservice.chubblife.com.hk，以提供閣下的電郵地址。

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C. Other Insurance Coverage 其他保險資料

Does the Insured have any other insurance policy covering this case? 受保人會否就是次索償獲得其他保險賠償？ ☐ Yes 有 ☐ No 沒有

If “Yes”, please complete below particulars. 若有，請詳細填寫以下資料。

Name of insurer 投保公司	Policy no. 保單號碼	Benefit type 保障類別	Benefit amount 保障金額

D. Disability Particulars 傷殘詳情

1. Disability due to accident 因意外導致傷殘

a. When (date and time) did the accident occur? 意外在何時（日期及時間）發生	(/ /) DD日 MM月 YYYY年 (:) HR時 MIN分 ☐ AM 上午 ☐ PM 下午
b. Where did the accident occur? 意外在何地發生	
c. How did the accident occur? (Please describe in details) 意外如何發生？（請描述詳情）	
d. Which part of the body injured and type of injury? 受傷部位及傷勢？	
e. Any hospital confinement incurred? 有否住院 If Yes, please provide the date of admission. 如有，請提供入院日期	☐ Yes 有 ☐ No 沒有 (/ /) DD日 MM月 YYYY年

2. Disability due to illness 因病導致傷殘

a. Describe the symptom & abnormalities which led to Disability 請描述導致受保人是次傷殘病徵及不適	
b. Details of first consultation for the illness 初診詳情	Date of first consultation 初診日期 (/ /) DD日 MM月 YYYY年 Doctor’s name 醫生姓名 __________ Address of the doctor 醫生地址 __________ Details 詳細情形 __________
c. Since when the insured had the symptom first appeared? 受保人何時出現上述徵狀？	(/ /) DD日 MM月 YYYY年
d. Has the insured been treated by other doctor(s) for similar or related illness in the past? 受保人有否因同一或有關病症而求診於其他醫生？	☐ Yes, please state 如有，請詳述 ☐ No 沒有 Date of first consultation 初診日期 (/ /) DD日 MM月 YYYY年 Doctor’s name 醫生姓名 __________ Address of the doctor 醫生地址 __________ Details 詳細情形 __________

3. When did the insured become totally disabled so as to prevent from doing any work? 何時開始完全傷殘並導致完全喪失工作能力？	(/ /) DD日 MM月 YYYY年
4. If still disabled, when does the insured expect to be able to return to full time work? 若仍然傷殘，估計何時可以回復全職工作？	(/ /) DD日 MM月 YYYY年
5. If the insured has recovered, when was the insured able to perform part of the duties of his/her occupation or light work of any sort? (Please describe full job duties) 若現在已康復，受保人何時開始可以執行其日常工作的部份職責或任何其他非勞動性工作？（請詳述工作性質）	(/ /) DD日 MM月 YYYY年 Details 詳細情形 ______

E. Treatment Particulars 治療詳情

Details of hospital confined or physicians consulted for this injury or illness 詳列出此次受傷或疾病而就診之醫生／醫院詳情

Name of physician(s) and/or hospital(s) 醫生／醫院名稱	Address(es) 地址	Date of consultation(s) and/or period of confinement 就診／住院日期

F. Income Benefits Particulars 收入詳情 (Applicable To Income Protection Claim Only 只適用於傷殘入息保障賠償)

Income benefits 收入資料	Is the insured now receiving? Yes/No 受保人有否接受？是／否	Does the insured expect to receive? Yes/No 受保人期望接受？是／否	Date of benefits start(ed) 收入開始日期	Amount and frequency (weekly, monthly, etc.) please state currency 確實金額及頻率（每星期／每月）請提供貨幣
a. Salary 工資 Income, wages, salary or other monetary remuneration from: 從以下所得之收入、工資、薪金、金錢回報				
i) The insured's present employer 僱主	☐ ☐	☐ ☐	______	$ ______ Per ______
ii) The insured's business (if self-employed) or partnership 自僱／合作伙伴	☐ ☐	☐ ☐	______	$ ______ Per ______
iii) Any other sources 其它來源	☐ ☐	☐ ☐	______	$ ______ Per ______
b. Insurance 保險 Disability benefits under any 從以下所得之傷殘入息保障利益				
i) Individual disability income policy 個人傷殘入息保障	☐ ☐	☐ ☐	______	$ ______ Per ______
ii) Group life insurance policy 團體人壽保障	☐ ☐	☐ ☐	______	$ ______ Per ______
iii) Group disability income policy 團體傷殘入息保障	☐ ☐	☐ ☐	______	$ ______ Per ______
iv) Retirement plan 退休金	☐ ☐	☐ ☐	______	$ ______ Per ______

c. Government benefits/disability benefits under 從以下所得之傷殘入息保障 i) Social security 社會保障 ii) Workers' compensation 勞工賠償 iii) Unemployment benefit scheme 失業救濟金 iv) Any other governmental agency scheme 其它政府機構計劃	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	____ ____ ____ ____	$ ____ Per ____ $ ____ Per ____ $ ____ Per ____ $ ____ Per ____
d. Others (please specify) 其它 ____	☐ ☐	☐ ☐	____	$ ____ Per ____

e. If the insured is eligible for any income benefits on account of his/her disability, but have not yet applied for them, when does the insured intend to apply for them? 如受保人仍未申請以上入息保障賠償，受保人會在何時申請？
(/ /) DD日 MM月 YYYY年

G. Payment Currency 賠款貨幣

Please issue the following currency for the claim payment 請以以下貨幣支付賠償金

☐ HK dollar 港幣 ☐ Policy currency 保單貨幣

H. Payment Instruction 賠款方式

☐ Cheque 支票

☐ Bank Draft 本票 (drawn in Mainland China 於中國內地兌現)

☐ Telegraphic Transfer (TT) 電匯

Remarks 備註：

1) For TT payment, please provide the SWIFT code, bank name, bank address and bank account number.
若選擇電匯，請提供銀行代號、銀行名稱、銀行地址及戶口號碼。
2) Bank charges may be incurred by client for clearing the bank draft and TT. Policyowner is recommended to check with the bank before applying this instruction.
銀行或會向閣下徵收兌現本票或電匯的相關手續費。建議保單持有人於遞交指示前先向銀行查詢。
3) If no option is selected or unclear information, the claim payment will be settled by cheque.
如沒有選擇或資料不清，賠償金額將以支票發出。

I. Agent's/Intermediary's Statement 保險代理 / 中介人聲明

I/We have verified the original HKID card/passport/residential address proof of the policyowner and confirmed the identity details in the HKID card/passport to be matched with the identity of the policyowner in this claim form. I/We will provide the required information and copies of the relevant documents to Chubb Life Insurance Hong Kong Limited without delay. 本人／吾等已核對保單持有人之香港身份證／護照／居住地址證明之正本，並確認香港身份證／護照之身份資料與此賠償申請書上保單持有人之資料一致。本人／吾等將會儘快遞交有關文件之副本予安達人壽保險香港有限公司。

Agent's/intermediary's name 保險代理 / 中介人姓名

Agent's/intermediary's code 保險代理 / 中介人代號

Agency 組別

Agent's/intermediary's signature 保險代理 / 中介人簽署

Sign date 簽署日期

J. Personal Information Collection Statement 個人資料收集聲明

I/WE HEREBY ACKNOWLEDGE, DECLARE AND AGREE THAT, by signing this form, any personal information collected or held by Chubb Life Insurance Hong Kong Limited (the "Company") is provided and may be used, processed, stored, disclosed, transferred by the Company to the transferees indicated in and in accordance with the Personal Information Collection Statement set out in my/our Application For Life Insurance, which may include without limitation, any branch, subsidiary, holding company, associated company or affiliates of the Company (the "Group Companies"), its authorized agents, reinsurers, claims investigators, loss adjudicators, medical advisors, recovery agents, insurance industry associations and federations, credit reference agencies, government or judicial or regulatory bodies or any person to whom the Company is under legal and/or regulatory obligation to make disclosure, and the Company's appointed third party agents, contractors and advisors, in each case whether within or outside of Hong Kong and Mainland China. Moreover, the Company is hereby authorized to obtain access to and/or to verify any of my/our personal information with the information collected by the insurance industry associations, the federations, the government and regulatory bodies and medical personnel or organizations. I/We am/are obliged to supply the information required from me/us under this form which is a condition precedent for me/us to apply for claims assessment, processing and other services. Failure to supply the required information may result in the Company being unable to process this form. For more details of the Company's policies on personal information and privacy protection, please read the Company's Privacy Notice available at https://www.chubb.com/hk-en/footer/chubb-life-privacy-policy.html. Any questions regarding personal information, access to or correction of personal information should be made in writing and forwarded to The Data Protection Officer of Chubb Life Insurance Hong Kong Limited at 35/F, Chubb Tower, Windsor House, 311 Gloucester Road, Causeway Bay, Hong Kong.

就簽署此表格，本人/吾等確認、聲明及同意安達人壽保險香港有限公司（「貴公司」）可以使用、處理、儲存、披露、轉移任何貴公司所收集或持有任何本人/吾等的個人資料至在本人/吾等的人壽保險申請書中的個人資料收集聲明所訂明的資料轉移接收方，包括但不限於，貴公司的任何分行、附屬公司、控股公司、聯營公司或聯繫公司(「集團公司」)、其獲授權的代理人、再保險公司、理賠調查公司、理賠調查員、醫療顧問、索償代理、保險行業協會及聯會、信貸資料機構、政府或司法或監管機構或對貴公司具有法律及/或監管責任而須予以披露的任何人士，及貴公司指定的第三方代理、承包商及顧問，不論在香港及中國大陸境內或境外。此外，貴公司獲授權向保險行業協會及聯會、政府及監管機構、及醫務人員或機構取閱及/或核實任何該等機構向本人/吾等收集之個人資料。本人/吾等有責任提供此表格上所需資料，以作為索償評估,處理及其他服務之先決條件。如未能提供所需的資料，可能會導致貴公司無法處理本表格。有關安達人壽保險香港有限公司個人資料及私隱保障政策的詳情，請參閱安達人壽保險香港有限公司的私隱政策，網址為https://www.chubb.com/hk-zh/footer/chubb-life-privacy-policy.html。如欲查詢有關個人資料事宜，查閱或更正個人資料必須以書面形式向安達人壽保險香港有限公司的資料保護主任提出，並送交至香港銅鑼灣告士打道三一一號皇室大廈安達人壽大樓三十五樓 。

K. Authorization 授權

I hereby irrevocably authorize or authorize on behalf of the Insured (if different) (i) any employer, doctor, hospital, clinic, insurance company, government office or any organizations or persons who have any records, knowledge or information (whether medical or otherwise) of me or the Insured (if different) to disclose, release or transfer to Chubb Life Insurance Hong Kong Limited "the **Company**" or its representative such information pertinent to this claim; (ii) the Company or any of its appointed medical/para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate my or the Insured (if different) health status in relation to this claim. This authorization shall bind my and the Insured's successors and assignees 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 valid as the original. 本人或受保人授權（如有不同）(i) 任何僱主、醫生、醫院、診所、保險公司、政府部門，或其他機構及人士，如具有本人／受保人（如不同）的任何紀錄、知識或資料，可將該等資料向貴公司或貴公司代表透露、發放或移交，用以作為該份索償申請的參考；(ii) 貴公司或貴公司委任的醫療／輔助醫療檢查員或檢驗所，就有關索償的申請，進行醫療評估或測驗，以檢定本人／受保人（如有不同）的健康狀況。該授權書對本人／受保人的繼承人及承讓人均有約束力，即使在本人／受保人（如有不同）死亡或喪失行為能力後仍然有效。該授權書的影印本具有與正本同等的效力。

______ / ______ / ______
Day 日 Month 月 Year 年

Signature of Policyowner (if other than Insured)
保單持有人簽名（如並非受保人）

Name of Policyowner
保單持有人姓名

Identity Document Number of Policyowner
保單持有人身份證明文件號碼

______ / ______ / ______
Day 日 Month 月 Year 年

Signature of Insured
受保人簽名

Name of Insured
受保人姓名

Identity Document Number of Insured
受保人身份證明文件號碼

* In compliance with the Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance and the Guideline on Anti-Money Laundering and Counter-Terrorist Financing which is issued by the Office of the Commissioner of Insurance as amended from time to time, Chubb Life Insurance Hong Kong Limited is required to collect the identity information for the above items with asterisk (*) and verify the identity of the Policyowner. Your agent/intermediary, therefore, is needed to verify the original identification documents and collect the copies of the relevant and other documents as deemed necessary of the Policyowner.

* 根據打擊洗錢及恐怖分子資金籌集（金融機構）條例及保險業監理處所發出及不時修訂之「打擊洗錢及恐怖分子資金籌集指引」，安達人壽保險香港有限公司必須收取以上註有星號 (*) 項目之保單持有人身份資料並核實保單持有人之身份。閣下之保險代理／中介人必須核實保單持有人之正本身份證明文件，並收取有關及其他所須文件之副本。

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