HSBC Life
滙豐保險

EB32

CLAIM FORM 索償表格

Group Life Scheme - Total And Permanent Disability/Accidental Dismemberment
團體人壽計劃 – 完全及永久喪失工作能力/意外傷殘索償

Claim for total and permanent disability or accidental dismemberment. To be filled in by the employee or patient and the consulting doctor, any expense incurred will be borne by the employee or patient. If this is a disability claim, please complete this form with respect to the disabled person instead of the insured employee. 完全及永久殘疾或意外傷殘的索償。由受保僱員或病人和主診醫生填寫，所產生的費用由受保僱員或病人承擔。如果這是一項傷殘索償，請以傷殘人士資料回答。

HOW TO SUBMIT THIS FORM 如何提交此表格

After completing the form please send back to us:
填寫表格後，請發回給我們：

BY MAIL
Post the fully completed and signed claim form (sections 1 & 2), plus all the items in the checklist, to Employee Benefits Claims, HSBC Life, P.O. Box 70451, Kowloon Central Post Office, Kowloon, Hong Kong

郵寄
將填妥並簽署的索償表格（第 1 及第 2 部分）連同清單中的所有項目郵寄至香港滙豐保險僱員福利索償部 — 香港九龍中央郵政信箱70451號

WHAT HAPPENS NEXT 下一步

The process after you send in the claim form
提交此表格後的流程

1. We'll contact you as soon as possible if we need more information, or if we need to have your claim assessed by a third party such as an impartial doctor or hospital. This could cause a delay to your claim. The patient is responsible for any expenses incurred while the claim is being processed.
   如果我們需要更多資料，或者需要讓第三方（例如公正的醫生或醫院）評估您的索償，我們會盡快與您聯繫。這可能會導致您的索償延遲。索償人需要支付索償期間產生的任何費用。
2. If you have any questions about your claim, please call (852) 3128 0153.
   如果您對索償有任何疑問，請致電 (852) 3128 0153。

CHECKLIST 索償文件清單

What you need to submit with this claim
您需要與此索償一起提交的文件

- ☐ Copy of Sick leave certificate with diagnosis and/or proof of consultation
  列有診斷證明之病假證明書及/或治療詳情副本
- ☐ Copy of Physiotherapy and/or occupational therapy reports (if applicable)
  物理治療/職業治療報告副本 (如適用)
- ☐ Copy of Prescription medication list (including name, quantity and dosage)
  藥物詳情副本（包括藥物名稱、劑量及數量）
- ☐ Copy of Referral letter(s) from any medical specialists
  任何專科轉介信副本
- ☐ Copy of Histopathology, Laboratory Test Report, Endoscopic, Ultrasonogram, X-Ray, CT Scan, MRI, Diagnostic Written Report(s) and Operating theatre summary (if applicable)
  病理學、化驗報告、內窺鏡、超聲波、X-光、電腦掃描、磁力共震、手術室摘要及診斷之書面報告副本（如適用）
- ☐ Copy of Police Report (if applicable)
  警察事故報告副本（如適用）
- ☐ Copy of Insured Employee / Patient's Identity Proof such as ID Card, Passport or Birth Certificate etc.
  受保僱員/病人之身份證明文件副本例如身分證、護照或出生證明書等
- ☐ Copy of document with the Insured Employee / Patient's name and bank account details (if applicable)
  受保僱員/病人之個人本地銀行戶口證明文件副本（如適用）
- ☐ Copy of the latest employment pay slip as proof for the sum assured issued by Policyholder
  由保單持有人發出之最近入息證明副本以作保額計算用途

SECTION 1: CLAIM INFORMATION 甲部 – 索償資料

To be completed in BLOCK LETTERS by the employee or patient 由受保僱員或病人填寫

1. MEMBERSHIP INFORMATION 成員資料

1A. EMPLOYER DETAILS 僱主資料

Group medical policy no. 團體保單編號	Refer to e-medical card on your Benefits+ App / Physical Medical Card 請參閱您的 Benefits+ App / 實體醫療卡上的成員編號	Employer name 僱主/團體保單投保公司名稱	

1B. EMPLOYEE DETAILS 僱員資料

Mandatory fields, otherwise, claim will not be processed 必須填寫，否則索償將不予處理

Full name 姓名	Phone no. 電話	Email 電郵
	852–	

1C. PATIENT DETAILS 病人資料

Name of Patient (if different from above) 病人姓名(如與上述不符)	HK/Macau ID card no. 香港/澳門身份證號碼	Membership no. 成員編號
	–	Refer To E-Medical Card On Your Benefits+ App / Physical Medical Card 請參閱您的 Benefits+ App / 實體醫療卡上的成員編號

2. EMPLOYMENT AND EDUCATION INFORMATION 就業及學歷資料

2A. CURRENT OCCUPATION AND EDUCATION 現時就業及學歷詳請

Occupation 職業	Job title 職位	Occupation industry 行業	Duties you performed in your role 工作範圍

What are your academic qualifications / training credentials? 請提供您的學歷或訓練憑證	Type of work environment 工作地點類型
	☐ Indoors 戶內 ☐ Outdoors 戶外 ☐ Both indoors & outdoors 戶內及戶外

2B. PREVIOUS OCCUPATION 過往就業資料

Have you previously worked in a different type of occupation? 您過往是否曾任職於不同行業?	☐ Yes 是 ☐ No 不是 If yes, please provide information below. 如是，請詳述之。

Occupation type 工作類型	Duration of occupation 就業時期	Name of employer 僱主名稱	Duties performed 工作範圍

3. DISABILITY INFORMATION 喪失工作能力的詳情

3A. IF YOUR DISABILITY WAS CAUSED BY AN ILLNESS 如閣下因疾病而導致喪失工作能力

If your disability was caused by an accident, please proceed to section 3F. 如閣下因意外而導致喪失工作能力，請跳至3F。

Description of illness and its symptoms 疾病症狀之描述	Duration of symptoms 病症持續時間

3B. INITIAL CONSULTING DOCTOR'S INFORMATION 首次應診醫生資料

Initial doctor who treated you for your illness 首次應診的醫生

Doctor's full name 醫生姓名	Name of hospital / clinic 醫院 / 診所名稱	Address 地址	Date of consultation 求診日期
			DD日 MM月 YYYY年

3C. INFORMATION FOR ALL OTHER DOCTOR CONSULTATIONS OR HOSPITAL ADMISSIONS DURING YOUR ILLNESS 曾診治此病的其他醫生或住院資料

Doctor's full name 醫生姓名	Hospital name (if you were admitted to a hospital) 醫院名稱 (如果您曾經住院)	Admission no. (if applicable) 住院號碼 (如適用)	Date of consultation / admission 求診或住院日期
			DD日 MM月 YYYY年

3D. REFERRAL DOCTOR'S INFORMATION (IF YOU WERE ADMITTED TO A HOSPITAL) 轉介醫生資料 (如果您曾經住院)

Doctor who referred you to hospital 為閣下轉介入院的醫生

Referral doctor's name 轉介醫生姓名	Address of referral doctor's clinic 轉介醫生的診所地址

3E. REGULAR DOCTOR'S INFORMATION 慣常醫生資料

Details for your regular doctor 慣常醫生的詳細資料

Doctor's full name 醫生姓名	Clinic address 診所地址	Initial consultation date 首次求診日期
		DD日 MM月 YYYY年

3. DISABILITY INFORMATION (CONTINUED) 喪失工作能力資料 (續)

3F. IF THE DISABILITY WAS CAUSED BY AN ACCIDENT 如閣下因意外而導致喪失工作能力

Date / time of accident 意外日期及時間	Location of accident 意外地點	How did the accident occur? 意外發生經過	Specify part(s) of the body that were injured and the type of injury(ies) 請簡述受傷部位及傷勢
DD日 MM月 YYYY年 HR 時 : MIN 分 ☐ A.M 上午 ☐ P.M 下午			

Was the accident reported to the police? 您是否已向警方申報是次意外？	If yes, please provide details. 如是，請詳述之。	Police station address 報案警署地址	Police report no. 報案號碼
☐ Yes 是 ☐ No 不是			

Was the accident reported to your employer? 您是否已向僱主申報是次意外？	If yes, please provide details. 如是，請詳述之。
☐ Yes 是 ☐ No 不是	

3G. JOB PERFORMANCE AFTER DISABILITY 喪失工作能力後的工作情況

Did you provide your employer with a sick leave certificate?
您是否向您的僱主提供了病假證明？

☐ Yes 是 ☐ No 不是

Last day of work 最後工作日期	Estimated date of return to work 預計何時可以恢復工作	How long have you worked in this occupation? 您從事這個職業多久？
DD日 MM月 YYYY年	DD日 MM月 YYYY年	

Have you been able to work since your condition began? 自從您喪失工作能力後，您是否能夠從事任何行業的工作?	If Yes, please provide more details (i.e. types of duties performed, total number of hours per week). 如是，請詳述之 (包括工作類型 , 每週工作時數)。	
☐ Yes 是 ☐ No 不是	If No, have you sought alternative employment or voluntary work? 如否，您是否尋求過其他或志願的工作？ ☐ Yes 是 ☐ No 不是	Please provide details of any alternative or voluntary work. 如有，請詳述之。

3H. CIGARETTE AND ALCOHOL CONSUMPTION 吸煙及喝酒習慣

Do you smoke cigarettes? 您是否有吸煙習慣？	How long have you smoked for (in years) and how many on average per week? 如是，請詳述之。(吸煙年期及平均一星期吸煙數量)
☐ Yes 是 ☐ No 不是	

Do you drink alcohol? 您是否有喝酒習慣？	How long have you been drinking alcohol for (in years), what type of drinks, and how many on average per week? 如是，請詳述之。(喝酒年期, 酒類, 平均一星期喝酒數量)
☐ Yes 是 ☐ No 不是	

4. PAYMENT INSTRUCTIONS 付款指示

☐ Cheque - made payable to the employee and mailed to employee's address.
支票 – 以支票支付受保僱員，並將支票寄往其通訊地址。

☐ Via transfer to bank account (The employee must hold or jointly hold the bank account. Otherwise a cheque made payable to the employee will be sent by mail to their address.) Please fill in the detail below
轉賬至銀行戶口（必須為受保僱員之個人或聯名銀行戶口，否則付款將以支票形式寄予受保僱員通訊地址。）請填寫以下戶口資料

Account no. 戶口號碼	Account holder name 戶口持有人姓名
☐☐☐ – ☐☐☐ – ☐☐☐☐☐☐☐☐☐ Bank Code 銀行編號 Branch Code 分行編號 Account Number 戶口號碼	

We require a document including the Insured Employee's full name and bank account details attached to this claim as proof, otherwise we will mail a cheque instead. If you do not provide the bank proof, payment will be made by cheque payable to the Insured Employee and mailed to the Insured Employee's correspondence address.
請提供受保僱員本地銀行戶口證明文件副本並清楚顯示受保僱員全名和銀行戶口詳細信息作為索償的證明。若您未能提供銀行證明，我們將通過支票支付予受保僱員並郵寄到其通訊地址。

5. EMPLOYEE / PATIENT'S DECLARATION & AUTHORISATION 員工/病人的聲明及授權

I/We hereby certify that the answers and statement given above are true and complete to the best of my/our knowledge and that I/We have withheld no material fact. I/We authorise any physician, hospital, clinic, insurance company or other individual organisation or government office that has any records or knowledge of my/our health, to disclose to HSBC Life (International) Limited or its representative any information relevant to this claim. This authority shall remain valid notwithstanding my death or incapacity and a copy of this authorisation shall be as effective and valid as the original. By signing below, I/we confirm the above application and agree that the Company may use and disclose all personal data about me/us that the Company currently or subsequently hold for the purposes as set out in the Notice relating to the Personal Data (Privacy) Ordinance (which may otherwise be referred to as 'Personal Information Collection Statement') that the Company, HSBC Life (International) Limited, have most recently notified me of, and I understand I can scan the QR code on the right for review, or contact the Medical Services Hotline for details. The Company will collect, use, disclose and transfer my/ our and/or beneficiary's personal information, for the purposes necessary to detect and prevent fraud (whether or not relating to the policy mentioned in this form) to the following persons who may collect and use this information only as reasonably necessary to carry out the purposes described above: organisations that consolidate claims and underwriting information for the insurance industry; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information.
本人（等） 在此聲明以上所提供的資料均屬正確無訛且並無缺漏。本人謹此聲明，本人已細閱並完全明白以上內容及本表格後頁的個人資料收集聲明 。本人(等)授權任何知道本人健康情況及據知任何紀錄之醫生，醫院 ，診所，保險公司或其他私人，政府機構向滙豐人壽保險(國際)有限公司或其代表提供本人(等)之有關資料 。此授權書於本人(等)死亡或喪失能力後依然生效 。本授權書之影印本亦屬有效。本人(等)在下方簽署即同意；滙豐保險可按本表格隨附的關於個人資料(私隱)條例的通知內列出的用途使用及披露貴公司現時或其後持有有關本人(等)及／或受益人的全部個人資料 。貴公司將收集，使用，披露及轉移本人(等)及／或受益人的個人資料給以下人士，以用作偵測和防止欺詐行為(無論是否與就本表格而發出的保單有關)所需的目的，而他們只能在有合理需要履行上述目 的之情況下才可收集和使用這些資料：整合保險業申索和承保資料的組織；防欺詐組織；其他保險公司(無論是直接地，或是通過防欺詐組織或本段中指名的其他人士)；和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊(及其運營者)。

Personal Information Collection Statement (English)

個人資料收集聲明 (中文)

6. PATIENT'S SIGNATURE 病人簽署

Signature of Patient/ Parent or Legal Guardian (if Patient below 18 years of age) 病人/家長或合法監護人簽署 (適用於十八歲以下之病人)	Full name (in BLOCK letters) 姓名（請以正階英文書寫）	HK/Macau ID card no. 香港/澳門身份證號碼	Date signed 簽署日期
		☐☐☐☐☐☐☐ – ☐	☐☐ DD日 ☐☐ MM月 ☐☐☐☐ YYYY年

SECTION 2: DOCTOR SECTION 乙部 – 由醫生填寫

To be completed in BLOCK LETTERS and signed by the consulting doctor 由主診醫生以正楷填寫並簽署

1. PATIENT DETAILS 病人資料

Full name 病人姓名	Date of birth 出生日期	HK/Macau ID card no. 香港/澳門身份證號碼	Membership no. (required for the claim to be processed) 成員編號（此欄必須填寫否則索償申請將不獲辦理）
	DD日 MM月 YYYY年	–	

2. MEDICAL HISTORY 病歷紀錄

Are you the patient's regular doctor? 您是否該病人的慣常醫生?	If yes, how long have you been treating the patient for? 如是，您為病人看診了多久？
☐ Yes 是 ☐ No 不是	

Date of first consultation 首次求診日期	Date of most recent consultation 最近求診日期	How long has the patient shown these symptoms before the first consultation? 病人在首次求診前患有該病徵多久?	Date when patient was first absent from work 病人首次缺勤日期
DD日 MM月 YYYY年	DD日 MM月 YYYY年		DD日 MM月 YYYY年

Are you currently issuing the patient with sick leave certificates? 您是否正在為病人簽發病假證明?	If yes, how long do you intend to issue them for? 如是，您預期為病人簽發多久的病假？
☐ Yes 是 ☐ No 不是	

3. CIGARETTE AND ALCOHOL CONSUMPTION 吸煙及喝酒習慣

Does the patient smoke cigarettes? 病人是否有吸煙習慣？	How long have they smoked for (in years) and how many on average per week? 請提供病人吸煙年期及平均一星期吸煙的數量。
☐ Yes 是 ☐ No 不是	
Does the patient drink alcohol? 病人是否有喝酒習慣？	How long have they been drinking alcohol for (in years), what type of drinks, and how many on average per week? 請提供病人喝酒年期，酒類及平均一星期喝酒的數量。
☐ Yes 是 ☐ No 不是	

4. DETAILS OF PATIENT'S DISABILITY 病人喪失工作能力詳情

Description of the illness/disability, e.g. location and size of tumours, histopathological findings, cancer stage level etc. 疾病/殘疾的描述，例如腫瘤的位置和大小、組織病理學結果、癌症期數等。	Medical diagnosis 診斷結果	Which symptoms are causing the patient to be disabled? 請提供導致病人喪失工作能力的症狀。

How long has the patient shown these symptoms? 病人出現了這些症狀多久？	
Does the patient suffer from any other conditions? 病人是否有其他病徵？	Are any other conditions having an effect on the condition listed under 'medical diagnosis' above? Please give details. 上述診斷有否引至其他病徵？如有，請詳述之。
☐ Yes 是 ☐ No 不是	
Has the patient been diagnosed with cancer? 病人有否被診斷患上癌症?	If yes, has the cancer metastasised to other areas of the body? Please provide details. 如有，癌症有否擴散到身體其他部位? 請詳述之。
☐ Yes 是 ☐ No 不是	

5. TREATMENT 治療

Please describe in detail the type of treatment you have prescribed; including medication, surgical treatments, chemotherapy or radiotherapy, period, quantity and duration. Please go ahead and use a separate piece of paper and attach if you need more space. 請詳細描述您提供的治療類型；包括藥物治療、手術治療、化療或電療、週期、數量和持續時間。如果空間不足，您可附上額外紙張。	
How has the patient responded to the treatment? 病人對治療的反應如何？	
Is the patient still being cared for in hospital? 病人是否仍在住院？ ☐ Yes 是 ☐ No 不是	If yes, please provide details. 如是，請詳述之。

6. PHYSICAL AND PSYCHOLOGICAL IMPAIRMENT 體能及心理受損

In your opinion, how limited is the patient's physical capability? 您認為病人活動能力的級別是：	Please provide more details. 請詳述之。
☐ No physical impairment: capable of heavy physical work 無活動能力受阻：可應付費力的工作 ☐ Minor physical impairment: capable of moderate physical work 活動能力輕微受阻：可應付中量體力勞動工作 ☐ Moderate physical impairment: capable of light physical work only 活動能力中度受阻：可應付輕便的工作 ☐ Significant physical impairment: capable of sedentary work only. 活動能力明顯受阻：可應付文書工作 ☐ Severe physical impairment: incapable of any physical activity or sedentary work 活動能力嚴重受阻：不能應付勞動或文書工作	

6A. PSYCHOLOGICAL IMPAIRMENT 心理受損

Does the patient suffer from stress, emotional or psychological conditions as a result of their condition? 病人是否因為病症而出現壓力、情緒化或任何心理問題？ ☐ Yes 是 ☐ No 不是	If yes, please provide details. 如是，請詳述之。
In your opinion, does the patient suffer from any psychological conditions that would prevent them from working? 您認為該心理狀況是否導致病人不宜工作? ☐ Yes 是 ☐ No 不是	If yes, please provide details. 如是，請詳述之。

7. PROGNOSIS 預期進展

Current status of patient's condition 病人現時狀況	In your opinion, is it possible for the patient's condition to be reversed or improved? 您認為病人狀況是否有可能康復或改善?	Is there anything else that could stop the patient from returning to work? 是否有其他原因使病人不宜恢復工作?
☐ Recovered 已康復 ☐ Improved 有改善 ☐ Not improved 維持不變 ☐ Deteriorating 惡化 ☐ Other 其他 _____		

PATIENT'S CURRENT OCCUPATION 病人現時的就業詳請

Occupation 職業	Job title 職位	Occupation industry 行業	Duties you performed in your role 工作範圍

In your opinion, is the patient capable of returning to work? Please respond yes or no in the table below.
您認為病人是否有能力重返工作崗位? 請在以下表格回答是或不是。

	Their current occupation? 病人現在的職業	Another occupation (including sedentary office/clerical work)? 其他職業 (包括久坐辦公室的/文書的工作)?
Is your patient totally incapable of performing: 您的病人是否完全無法執行：	☐ Yes 是 ☐ No 不是	☐ Yes 是 ☐ No 不是
Do you think the patient's condition could improve enough for them to be able to perform: 您認為病情可以改善到足以使患者能夠執行：	☐ Yes 是 ☐ No 不是	☐ Yes 是 ☐ No 不是
If yes, please provide a date your patient might be able to return to work: 如是，請提供病人可能重返工作崗位的日期：		

7. PROGNOSIS (CONTINUED) 預期進展(續)

In your opinion, is the Patient not able to engage in a gainful occupation or work for compensation or profit for which the Patient is reasonably qualified by reason of education, training or experience, for the remainder of the Patient's lifetime as a result of the Patient's condition/disability?
您是否認為病人的情況/殘疾導致病人無法在餘生中從事因其教育、培訓或經驗而合理勝任的有酬職業或有報酬的工作？

☐ Yes 是 ☐ No 不是

8. HISTORY OF THE CONDITION 病歷紀錄

Has the patient previously suffered from related conditions to this illness? 病人曾否出現與此疾病相關的徵狀?	☐ Yes 是 ☐ No 不是 If yes, please provide information below. 如是，請詳述之。

Date of doctor's consultation or hospital admission DD/MM/YYY 醫生就診或住院日期 DD/MM/YYYY	Name of doctor 醫生姓名	Name of hospital 醫院名稱	Details of treatment 治療詳情

9. SUPPORTING INFORMATION 補充資料

If there is any further information that will assist us in assessing this claim? e.g. hospital records 是否有其他資料可以幫助我們評估此索償？例如：醫院記錄 ☐ Yes 是 ☐ No 不是	If yes, please provide details. 如是，請詳述之。

10. REHABILITATION 康復治療

Is your patient currently undergoing any form of rehabilitation? 病人目前是否正在接受任何形式的康復治療？ ☐ Yes 是 ☐ No 不是	If yes, please provide details. 如是，請詳述之。
Can you recommend any further rehabilitation that could improve the patient's condition? 您能推薦任何可以改善病人病情的康復治療嗎？	

11. DOCTOR'S DECLARATION AND AUTHORISATION 醫生聲明及授權書

I declare that all information provided is true and complete to the best of my knowledge.
本人謹此聲明及同意上述一切陳述及問題的所有答案，就本人所知所信，均為事實全部並確實無訛 。

Name of attending doctor (Please add your qualifications) 主診醫生姓名 (請提供您的專業資格)	Address 地址	Phone no. 電話號碼

DOCTOR'S SIGNATURE 醫生簽署

Signature and stamp of attending doctor
主診醫生簽名及蓋章

☐☐ DD日 ☐☐ MM月 ☐☐☐☐ YYYY年

Date signed
簽署日期