滙豐保險 HSBC Life

HSBCDIS

CLAIM FORM 索償表格

Total & Permanent Disability/Disability/Accidental Dismemberment Claim Form

完全及永久傷殘／傷殘／意外傷殘賠償索償表

HSBC Life (International) Limited, incorporated in Bermuda with limited liability (the "Company" or "HSBC Life")
滙豐人壽保險(國際)有限公司(註冊成立於百慕達之有限公司)(「本公司」或「滙豐保險」)

PLEASE SUBMIT THE FORM AND RELEVANT DOCUMENTS TO ONE OF THE AVAILABLE CHANNELS BELOW. 請將表格和相關文件用以下其中一種方式遞交。

- Scan the QR code on your right hand side to upload documents to" Document Upload Service" on HSBC website 您可以掃瞄右方的二維碼上載相關文件到滙豐網站上的「文件上載服務」; OR 或
- Mail to 18/F, Tower 1, HSBC Centre, 1 Sham Mong Road, Kowloon, Hong Kong 郵寄至香港九龍深旺道1號滙豐中心1座18樓; OR 或
- Submit to any HSBC Branch 可於任何滙豐分行遞交

WHAT HAPPENS NEXT 下一步

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

1. We'll let you know the outcome of this claim within 7 business days. 我們將在7個工作日內通知您此索償的結果。
2. If you have any questions about your claim, please call (852) 3128 0122. 如果您對索償有任何疑問，請致電(852) 3128 0122。

CLAIMS DOCUMENT CHECKLIST 索償文件清單

- ☐ Part I is fully completed & signed by the Policyholder/Claimant/Life Insured 索償表甲部經由保單持有人／索償人／受保人填寫並簽署
- ☐ Part II is fully completed & signed by the Attending Physician with chop 索償表乙部經由主診醫生填寫，簽署並蓋印
- ☐ 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 Sick Leave Certificate with diagnosis and/or Consultation Proof 列有診斷證明之病假證明書及／或治療詳情副本
- ☐ Copy of Physiotherapy/Occupational Therapy Report(s) (if applicable) 物理治療／職業治療報告副本(如適用)
- ☐ Copy of Police Report (if applicable) 警察事故報告副本(如適用)
- ☐ Copy of Policyholder & Insured's Identity Card 保單持有人及受保人之身份證明文件副本
- ☐ Copy of Bank Account Proof (applicable for Policyholder's sole or joint name bank account other than Policyholder's premium deduction account) 銀行戶口證明文件副本(適用於保單持有人之個人或聯名非保費轉賬戶口)

Notes 注意：

1. A claim must be made as soon as possible after the insured becoming aware that he/ she is suffering from disability whilst this Policy is in force. 索償人需於受保人已獲悉或被診斷傷殘時盡快在保單有效期內提出索償。
2. Please ensure completion of the above procedures to avoid unnecessary delay in claim process. 請確保完成以上各項，以免延緩索償進程。
3. We will inform you as soon as possible if we require additional information from you or we consider that your claim has to be assessed from third parties (such as doctor, hospital, etc.). As the time required for obtaining the information is variable, the processing time of your claim will likely be lengthened. 若我們有需要就審核是次賠償申請而向您或其他人士(如醫生、醫院等)索取額外資料，我們會盡快通知您。因索取有關資料需時，賠償申請的審核時間會較長。

PART I – TO BE COMPLETED BY THE INSURED PERSON OR CLAIMANT IN ENGLISH OR CHINESE
甲部 – 由受保人或索償人以英文或中文填寫

DETAILS OF INSURED* 受保人資料*

Policy No. 保單號碼	Name of Insured* 受保人姓名*	I.D. Card/Passport No. 身份證／護照號碼

Contact Number 聯絡電話	Email Address 電郵地址

Correspondence Address 通訊地址

DETAILS OF EMPLOYMENT 就業資料

Position 職位	Employer/Business Industry 僱主／公司行業	Job Activities 工作範圍

Employer's Name, Address & Telephone No. 僱主名稱、地址及電話號碼

Date of last worked 最後工作日期(DD 日／MM 月／YYYY 年)	Date of returned to work (Or expected date of return) 復工日期(或預計復工日期)(DD 日／MM 月／YYYY年)

REASON FOR CLAIM 賠償原因 Please ✓ the appropriate box. 請在適當的方格內加上✓號。

☐ Disability was due to accident 因意外而導致傷殘：

(a) Date and time of accident 意外日期及時間(DD 日／MM 月／YYYY 年 and am 上午／pm 下午)

(b) Where and how did it happen? 意外地點及經過？

(c) Part of body injured and type of injury 受傷部位及傷勢

☐ Disability was due to illness 因疾病而導致傷殘：

(a) Describe the illness and give a brief description of the symptoms 所患病症及其病徵

(b) How long had the insured been having these symptoms prior to visiting physician? 受保人在首次就診前該等病徵已存在多久？

* If a claim is made on the Policyholder's disability, please complete this form with respect to the disabled Policyholder instead of Insured. 若此為保單持有人傷殘之賠償申請，請以保單持有人資料回答。

Details of consultation 診治詳情

(i) Please give details of all physician(s) consulted or hospital(s) to which Insured was admitted during this illness 受保人曾診治此病的醫生資料：

Physician/Hospital 醫生／醫院		Admission No. 求診或住院號碼	Admission Date 求診或住院日期
Name 姓名	Address 地址		

PAYMENT INSTRUCTION 付款指示

☐ By Bank Account 經銀行戶口

☐ Transfer to the policyholder's premium deduction account (not applicable if the bank account is held by someone other than the policyholder's sole or joint name) 轉賬至保單持有人之保費轉帳戶口（不適用於非保單持有人之個人或聯名銀行戶口）

☐ Transfer to the Policyholder's sole or joint name bank account below 轉賬至以下保單持有人之個人或聯名銀行戶口

Bank Name and Branch 銀行及分行之名稱	Bank No. 銀行編號	Branch No. 分行編號	Account No. 賬戶號碼

Notes 註:
Please also submit adequate proof showing the full name and the bank account number of Policyholder's sole or joint name bank account (such as copy of bank book, ATM card, bank statement, etc.) to the company. If we do not receive the copy of the required document(s), the payment will be made by cheque payable to the Policyholder and mailed to the Policyholder's correspondence address. 請同時提交印保單持有人之個人或聯名戶口全名及銀行戶口號碼之充足證明（如銀行存摺或自動櫃員機卡或月結單副本等）。若您沒有提供上述所需文件，款項將以支票形式寄予保單持有人之通訊地址。

☐ By Cheque 以支票形式 (Mail to the Policyholder's correspondence address 寄往保單持有人之通訊地址)

☐ In policy currency (Only applicable for HKD/USD/CNY) 以保單貨幣付款（只適用於港幣／美元／人民幣）　☐ In HKD 以港幣付款

For your attention 請注意：

1. If policy has outstanding levy, The Company will deduct all of the outstanding levy from the claim payment. 如保單有逾期保費徵費，本公司會從賠償金額中扣除有關保單的保費徵費。
2. If the benefit payments are settled in currencies other than the policy currencies/currency of levy cap i.e. HKD as provided by the Insurance Authority, the benefit payments would be subject to the change according to the prevailing exchange rate of policy currencies/HKD to payment currencies to be determined by the Company from time to time. The fluctuation in exchange rates may have impact on the amount of payments. By choosing the payment currency(ies) other than policy currency, you are subject to the exchange rate risks. Exchange rate fluctuates from time to time. You may suffer a loss of your benefit values as a result of the exchange rate fluctuations. 如利益支付款項的貨幣不是以保單貨幣或保險業監管局訂定徵費上限的貨幣（即港幣）支付，該利益支付款項將會受本公司不時釐定的保單貨幣對支付貨幣／港幣的匯率而改變。匯率之波動會對款額構成影響。選擇非保單貨幣結算支付款項，您須承受匯率風險。匯率會不時波動，您可能因匯率之波動而損失部分的利益價值。
3. If the receiving bank account is a non-HSBC bank account, bank charges may incur which will be deducted from the amount payable by the said receiving bank and/or HSBC, if applicable. If you provide a bank account in currency different from the payment currency, the amount payable is subject to exchange rates difference. The Company will not be liable for any charges or loss due to payment settled via non-HSBC bank, currency exchange or rejection of transaction by the receiving bank as a result of incorrect bank account details. 如收款戶口非滙豐銀行之戶口，該銀行及／或滙豐銀行可於款項中收取服務費用，如適用。如您提供與利益支付款項的貨幣不同貨幣的戶口，請留意匯率的兌換差價。本公司將不會承擔任何因不同銀行或貨幣而導致被收取之費用或損失或因銀行戶口資料不乎而被拒絕轉賬之責任。
4. Unless otherwise specified, claim payment will be made according to the current payment instruction (if any) registered with the Company. 如無明確指示，賠償會按本公司的現有記錄轉賬（如有）。

DECLARATION AND AUTHORISATION 聲明及授權

I/we hereby certify that all the answers and statements given above are true and complete and that I/we have not withheld any 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。

I/we authorise any physician, hospital, clinic, insurance company or other individual organisation or government office that has any records or knowledge of me/us or 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. 本人（等）授權任何知道本人（等）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。

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'). I understand I can view such notice by scanning the QR code on your right hand side, or else I can request a copy by visiting my local HSBC Branch or by calling the Life Insurance Service Hotline: (852) 2583 8000. 本人（等）在下方簽署即確認上述申請，並同意貴公司可跟據本表格內有關個人資料（私隱）條例的通知書（也可稱為「個人資料收集聲明」）內列出的用途，使用及披露現時或其後持有有關本人（等）的所有個人資料。本人明白可以透過掃描右方的二維碼瀏覽該通知書，或可前往各滙豐分行或致電滙豐人壽保險服務熱線：(852) 2583 8000索取該通知書的副本。

Personal Information Collection Statement (English)

個人資料收集聲明（中文）

SIGNATURE 簽署

Signature of Life Insured 受保人簽署

Signature of Policyholder 保單持有人簽署

Name 姓名

Name 姓名

I.D. Card/Passport No. 身份證／護照號碼

I.D. Card/Passport No. 身份證／護照號碼

Date 日期

Date 日期

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PART II – ATTENDING PHYSICIAN'S REPORT – TOTAL & PERMANENT DISABILITY/DISABILITY/ACCIDENTAL DISMEMBERMENT CLAIM FORM
乙部– 醫療報告 – 完全及永久傷殘／ 傷殘／意外傷殘賠償索償表
(To be completed by Physician at Claimant's expense)（由主診醫生填寫，費用由索償人支付）

1. Name of Patient (Surname first)	2. HKID Card No./Passport No.

3. (a) Date and time of accident.

(b) Where and how did it happen?

(c) When were you last consulted for this condition and how long had the symptoms been present at that time?

4. (a) Please give the precise diagnosis.

(b) Please describe the symptoms currently disabling your patient.

(c) How long have the symptoms been present?

(d) Date when first absent from work.

5. Can the patient perform the right listed "Activities of Daily Living" without the use of mechanical equipment, special devices or other aids and adaptations?

Transfer (to get in bed and out of bed or chair):	☐ Yes	☐ No
Mobility:	☐ Yes	☐ No
Dressing:	☐ Yes	☐ No
Bathing & Washing:	☐ Yes	☐ No
Eating:	☐ Yes	☐ No
Toileting:	☐ Yes	☐ No

Remarks:

6. With the current health condition of the patient in mind, what would you rate the present working capacity of the patient?

- ☐ No limitation of functional capacity, capable of heavy work without restrictions
- ☐ Capable of medium manual activity
- ☐ Slight limitation of functional capacity, capable of light work
- ☐ Moderate limitation of functional capacity, capable of clerical / administrative activity
- ☐ Severe limitation of functional capacity, incapable of minimum activity

Remarks:

7. With the current mental status of the patient as described above, what would you rate the present ability for interpersonal relations and communication of the patient?

- ☐ Without Limitations: Able to engage in all interpersonal relations and communication
- ☐ Slight Limitations: Able to engage in most interpersonal relations and communication
- ☐ Moderate Limitations: Able to engage in only limited interpersonal relations and communication
- ☐ Marked Limitations: Unable to engage in interpersonal relations and communication
- ☐ Severe Limitations: Has significant loss of psychological, physiological, personal and social adjustment

Remarks:

8.	Is the patient now totally disabled?	In terms of his/her own job:	In terms of any other jobs:
		☐ Yes ☐ No	☐ Yes ☐ No

9.	Do you expect a fundamental or marked change of this present condition in the future?	☐ Yes If yes, how long do you expect the patient will take to perform duties? In terms of own job: ☐ Within 1 Mth ☐ 1-3 Mths ☐ 3-6 Mths ☐ 6-12 Mths ☐ >12Mths ☐ Never In terms of any other jobs: ☐ Within 1 Mth ☐ 1-3 Mths ☐ 3-6 Mths ☐ 6-12 Mths ☐ >12Mths ☐ Never
		☐ No If no, please explain.

10. Please state any further treatment/rehabilitation plan.

DECLARATION AND AUTHORISATION

I hereby declare and agree that all statements and answers to all questions are complete and true to the best of my knowledge and belief.

Name of Attending Physician/ Surgeon (with qualifications)	Address	Contact Telephone No.

Signature and name chop of Attending Physician/Surgeon

Date

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