請掃二條碼登入客戶專頁，隨時提交索償申請及查閱進度。
https://cs.chinalife.com.hk

中國人壽 CHINA LIFE 海外

危疾賠償申請表-其他
CRITICAL ILLNESS CLAIM FORM - OTHERS

保單持有人姓名 Name of Policyholder	受保人姓名 Name of Insured	保單編號 Policy No.

受保人身份證/ 護照號碼 I.D. / Passport No. of Insured

保險中介資料 INSURANCE INTERMEDIARY INFORMATION

保險中介名稱 Name of Insurance Intermediary

保險中介編號 Insurance Intermediary Code

聯絡電話 Contact No.

重要須知 IMPORTANT NOTE

- 此表格適用於「危疾」或「嚴重病症」附加保障的賠償申請。This form is applicable for Dread Disease or Major Diseases benefit riders.
- 請以正楷填寫本申請表。任何資料如有更改，受保人/保單持有人/索償人必須在更改的位置簽署作實。Please complete this form in BLOCK LETTERS. All amendments should be endorsed by the Insured / Policyholder / Claimant in full signature.
- 本申請表中所用之「本公司」或「貴公司」之表述指中國人壽保險(海外)股份有限公司。The expressions "the Company" or "our Company" used in this form refers to China Life Insurance (Overseas) Company Limited.
- 本申請表第一部分必須由受保人/保單持有人/索償人填寫，並需於出院後三十天內連同有關之單據及出院證明書之正本呈交本公司。Part I of this form must be completed by Insured/Policyholder/Claimant and returned to the Company within 30 days from date of discharge with original receipts and discharge note.
- 如受保人為十八歲或以上，受保人及保單持有人必須親自填寫及簽署本申請表，如受保人為十八歲以下，本申請表應由保單持有人及受保人之家長或合法監護人填寫及簽署。如受保人/保單持有人因傷殘不能書寫，其直系親屬可代為填寫本申請表及簽字，並提供關係證明及醫生證明。If the insured is at or above age 18, the Insured and policyholder must complete and sign this form by his or her good self. If the insured is under age 18, this form should be completed and signed by policyholder and the insured's parent/ legal guardian. In the event that the Insured/ policyholder is physically incapacitated and prevented from signing, this form may be completed and signed by an immediate family member with relevant relationship proof and physician's statement provided.
- 若受保人/保單持有人/索償人以圖章蓋印簽署，必須由一位見證人予以見證。見證人之個人資料只會用於處理本索償申請及核實和確認本申請表簽署人的身份之用。If the Insured/Policyholder/Claimant uses a signature stamp, it must be witnessed by a witness. The personal particulars of the witness will only be used for the purpose of processing this claim and verifying and confirming the identity of the signatory of this form.
- 受保人/保單持有人/索償人之簽署必須與本公司之紀錄相同。The signature of the Insured / Policyholder / Claimant must be the same as the Company's record.
- 保險中介人或銀行營業員收到本申請表並不代表本公司已收到。Receipt of this form by your Insurance Intermediary or bank officer does not constitute receipt by the Company.
- 如有任何查詢，請與 閣下的保險中介人聯絡或致電本公司客戶服務熱線(853) 2859 5519 查詢。填妥的表格及所需文件請寄往澳門新口岸宋玉生廣場 263 號中土大廈 22 樓 A、B、K-P 座。If you have any queries, please feel free to contact your insurance intermediary or our Customer Service Hotline at (853) 2859 5519 for details. Completed form(s) and required document(s) should be sent to China Life Insurance (Overseas) Co. Ltd., Alameda Dr. Carlos D' Assumpção No. 263, 22 Andar A, B, K-P, Edif. China Civil Plaza, Macau.
- 本公司有權隨時更新此申請表，並接受或拒絕未符合本公司要求的申請表。請登入本公司網站 www.chinalife.com.mo 瀏覽及下載最新版本。The Company has the right to update this form from time to time and to accept or to reject the form if the Company's requirements are not fulfilled. Please visit our website www.chinalife.com.mo to view and download the latest version of the form.
- 如中英文版本有任何抵觸或不符之處，概以中文本為準。If there is any discrepancy or inconsistency between the English version and the Chinese version of this form, the Chinese version shall prevail.

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保單編號 Policy No.										

第一部份 – 索償資料 (由受保人填寫，如受保人未滿 18 歲，則由保單持有人填寫)
PART I – PARTICULARS OF CLAIM (To be completed by Insured/Policyholder if insured is below 18 years old)

A. 受保人資料 PARTICULARS OF INSURED

1 年齡及性別 Age and Sex of Insured

2 聯絡電話 Contact phone no.

4 職業/行業(必須填寫) Occupation/Business (Compulsory)

5 索償申請類別 Type of claim
☐ 首次索償 New Claim ☐ 再度索償 Further Claim
☐ 待決賠案 Pending Claim ☐ 重批/覆核 Review / Appeal

6 通訊地址 Mailing Address

城市 City 國家 Country

B. 病症性質及有關資料 NATURE OF ILLNESS AND RELATED INFORMATION

1 病症名稱 Name of illness

2 請描述症狀 Please describe symptoms

3 症狀何時開始出現? When did these symptoms first appear? 年 Year 月 Month 日 Day

4 初診醫生/醫院的資料 The physician/hospital first consulted for this injury or illness.
求診日期 Date of consultation: 年 Year 月 Month 日 Day
醫生/醫院名稱及地址 Name & Address of Physician/Hospital

5 其他曾診治此症或過往類似病況的醫生/醫院資料: Other physicians/hospital consulted for this or similar conditions:
求診日期 Date of consultation: 年 Year 月 Month 日 Day
醫生/醫院名稱及地址 Name & Address of Physician/Hospital

6 閣下是否在其他保險公司投保類似的保障? 若有，請提供詳細資料。Are you insured with other insurance company for similar benefits? If yes, please give details. ☐ 是 Yes ☐ 否 No
保險公司名稱 Name of Insurance Company 保單號碼 Policy No. 保障類別及保障金額 Type & Amount of benefit

C. 領款方式 PAYMENT METHODS

1 ☐ 「銀企直聯」(ERP Integration)

1. 銀行賬戶持有人必須為保單持有人。Bank account holder must be the Policyholder.
2. 「銀企直聯」只適用於本地開立，並已完成及成功辦理登記「銀企直聯」綁定服務的銀行賬戶，申請詳情請向所屬銀行查詢。ERP Integration is only applicable to the local bank account which registration is completed successfully for ERP Integration binding service. Please enquire to the bank for application details.
3. 「銀企直聯」的實際到賬時間會因應個別銀行而有差異，申請前請先向有關銀行查詢。The actual time to receive the payment may vary among banks. Please enquire to the bank before application.

保單編號 Policy No.										

C. 領款方式(請選擇一種理賠支付方式) (續) PAYMENT METHOD (Please select only one of the settlement options) (Continued)

2 ☐ **自動入賬申請 Direct Payment Application**

請提供賬戶證明文件，如印有賬戶持有人姓名/名稱及賬戶號碼的銀行卡/月結單/存摺。倘未有足夠資料顯示銀行賬戶持有人為保單持有人/索償人或因故未能成功自動入賬，有關款項將以劃線支票形式發出。Please provide bank account document(s), such as bank card/monthly statement/ passbook with account holder name and account no. If there is insufficient information to identify the ownership of bank account belongs to Policyholder/Claimant or direct credit is failed for any reason, the payment will be issued by cheque.

本人/我們現申請以上理賠匯款方式領取金額，並同意銀行於匯款中扣除相關手續費 (如有)

I/We agree to apply the captioned Claims Remittance Service and bank charge would be deducted from the payment amount. (If applicable)

至保單持有人/索償人於本公司指定的澳門開立銀行戶口 To a bank account set up in Macau designated by the company held by the Policyholder/Claimant.

銀行名稱 Name of Bank	銀行編號 Bank No.	分行編號 Branch No.	銀行賬戶號碼 Account No.

賬戶持有人姓名(中文) (必須為保單持有人/索償人) Name of bank account holder (Chinese) (Policyholder/Claimant Only)	賬戶持有人姓名(英文) (必須為保單持有人/索償人) Name of bank account holder (English) (Policyholder/Claimant Only)

2 本地銀行劃線支票 MACAU LOCAL CROSSED CHEQUE

賠款貨幣選擇 Preferred Settlement Currency

☐ 保單貨幣 Policy Currency ☐ 港幣(按中國人壽保險(海外)股份有限公司每月之固定兌換率計算)
Hong Kong Dollar (at monthly fixed rate of China Life Insurance (Overseas) Company)

☐ 親自到客戶服務中心提取 Collect Cheque at Customer Service Centre in person
(請保單持有人/索償人帶同身份證明文件親臨本公司的澳門客戶服務中心收取支票。) (The Policyholder/Claimant should collect the cheque at our Macau Customer Service Centre by presenting the identity document.)

☐ 授權第三者(代領人)領取 Pick up cheque in person by authorized person

代領人姓名 Name of authorized person	代領人聯絡電話 Contact no. of authorized person	代領人身份證明文件號碼 I.D. no. of authorized person

☐ 郵寄至保單登記的通訊地址 Mail to correspondence address registered in our Company

☐ 經保險中介轉遞 Deliver via Insurance Intermediary

☐ 經銀行營業員轉送 (請指定銀行分行及經辦人員) Deliver by bank officer (Please state the branch and bank officer)

銀行分行 Branch _____ 經辦人員 Bank Officer _____

3 其他領款方式 OTHER PAYMENT METHODS

☐ 抵付保費 (僅適用於同一保單持有人名下生效之保單，請指定保單號碼。) Offset the premium (only applicable to inforce policy under same Policyholder, please specify the policy no..)

保單號碼 Policy No.

4 其他方式 Other Methods

☐ 其他(請列明) Others (Please specify) _____

D. 索償所需文件清單 CLAIM DOCUMENT CHECKLIST

- ✓ 基本文件 Basic Documents；● 附加文件 Additional Documents；× 不適用 Not Applicable

索償所需文件(文件的核實副本可於本公司的客戶服務中心辦理) Claim Document (Documents can be certified at our Company's Customer Service Centre)	危疾賠償 Critical illness claim
☐ 由閣下填妥並簽署之本申請表第一部分 Part I of this form completed and signed by your good self	✓
☐ 由主診醫生填寫之賠償申請表第二部份主診醫生報告書 Claim Form Part II - Attending Physician's Statement to be completed by the attending physician	✓
☐ 受保人身份證明文件之核實副本 The certified true copy of identity document of the Insured.	✓
☐ 投保人之身分證文件之核實副本 (受保人非投保人) The certified true copy of identity document of Owner (Insured is not Owner).	✓
☐ 化驗/ X 光/ 電腦掃描/ 磁力共振/ 心電圖/ 相關病理檢驗報告 (如適用者) Laboratory/ X-ray / CT Scan / MRI/ E.C.G. / Pathological Reports (if applicable)	●
☐ 保單正本或保單遺失聲明書(如未能提供保單正本) Original Policy or Policy Lost Declaration (if unable to provide original Policy)	●
☐ 稅務信息交換之自我證明表格(理賠適用) Self-Certification Form (For Claims) for Automatic Exchange of Financial Account Information	●

保單編號 Policy No.										

E. 個人資料收集聲明 PERSONAL INFORMATION COLLECTION STATEMENT

本人/我們確認已閱讀及明白「中國人壽保險（海外）股份有限公司」的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於 https://www.chinalife.com.mo/zh-hant/personal-information-collection-statement 下載或向中國人壽保險（海外）股份有限公司索取。

I/We confirm that I/we have read and understood the Personal Information Collection Statement ("PICS") of China Life Insurance (Overseas) Company Limited. For the latest version of the PICS, it can be downloaded from https://www.chinalife.com.mo/zh-hant/personal-information-collection-statement or is made available upon request.

F. 聲明及授權 DECLARATION AND AUTHORIZATION

授權 Authorization

本人/我們，受保人/保單持有人/索償人，代表本人/我們及尚未成年之受保人(如有)謹此授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、政府部門，或其他機構、組織或人士，凡知道或具有任何有關本人/我們/尚未成年之受保人之紀錄、認識或資料者，均可將該等資料提供、發放及轉交給中國人壽保險（海外）股份有限公司（以下簡稱「貴公司」）； (2) 貴公司或任何其指定之醫療/輔助醫療檢查員或化驗所，可就本索償申請替本人/我們/尚未成年之受保人進行所需之醫療評估及測試，作為審核本人/我們/尚未成年之受保人之健康狀況。此授權對本人/我們之繼承人及授讓人具有約束力；即使本人/我們死亡或無行為能力時，此授權書仍具效力。此授權書的影印本與正本均有同等效力。I/We, the Insured/Policyholder/Claimant, represent me/ us/ the Insured under 18 years old (if any) HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, government department, or other organization, institution or person, that is aware of or has any records, knowledge or information of me/us/the insured under 18 years old to disclose, release and transfer such information to the Company; (2) the Company or any of its appointed medical / para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ ourselves/ the insured under 18 years old in relation to this claim. This authorization shall bind the successors and assignees of me/us and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

聲明 Declaration

本人/我們，受保人/保單持有人/索償人，謹此聲明及同意(1)上述一切陳述及問題的所有答案，不論是否本人/我們親手所寫，就本人/我們所知所信，均為事實之全部並確實無訛； 本人/我們明白倘未知任何一項是否重要，本人/我們均須將其事實在本申請表上說明；(2) 本人/我們對任何人所作出之任何聲明，除在本申請表上填寫或印出及經 貴公司發表和批准外，貴公司不須受其約束。若相關人士不能提供任何本申請表所需的資料，貴公司可能因此不能審核及處理本索償申請。

I/We, the Insured/Policyholder/Claimant HEREBY DECLARE and AGREE that (1) all the foregoing statements and answers to all questions whether or not written by my/our own hand are to the best of my/our knowledge and belief complete and true; I/We also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. (2) The Company is not bound by any statement which I/we may have made to any person unless it is written or printed here and is presented and approved by the Company. If any relevant persons fail to provide any information requested in this claim form, it may result in the Company's inability to process and deal with this claim.

G. 簽署(請勿在空白表格上簽署) SIGNATURE (Please DO NOT sign on BLANK form)

	受保人(年齡 18 歲或以上) Insured(whose age is 18 or above)			保單持有人 / 索償人* Policyholder / Claimant*			見證人 Witness		
簽署 Signature									
姓名 Name									
身份證/護照號碼 I.D. Card / Passport No.									
日期 Date	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day
*索償人與受保人/保單持有人關係 *Relationship with Insured/Policyholder									

保單編號 Policy No.										

第二部份 – 主診醫生報告書 (由主診醫生填寫，所有費用由受保人/保單持有人/索償人自行承擔)
PART II – ATTENDING PHYSICIAN'S STATEMENT (To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)

A. 病人資料 PARTICULARS OF PATIENT

1 病人姓名 Name of Patient

2 年齡及性別 Age and Sex

3 身份證/ 護照號碼 I.D. Card / Passport No.

B. 臨床資料 CLINICAL DETAILS

1 病人之醫療記錄可追溯至 We can trace the medical record of patient back to
年 Year 月 Month 日 Day

2 首次出現病徵日期發生日期 Date of the symptoms first appeared
年 Year 月 Month 日 Day

3 病人首次有關此病症之求診日期 Date of first consultation for this condition or related illness
年 Year 月 Month 日 Day

4 請詳細說明首次會診時之徵狀和病症 Please describe the symptoms and complaints at first consultation.

5 病人是否由其他醫生轉介？如是，請提供該醫生之姓名及地址。Is the patient referred by other physician? If yes, please give the name and address of the referring doctor. ☐ 是 Yes ☐ 否 No

6 診斷 Diagnosis

7 何時確診 When was the diagnosis made 年 Year 月 Month 日 Day

8 所有關於是項診斷之治療、檢查及其結果、有否任何併發症及出院後之覆診或跟進計劃 Any treatments, investigation procedures, results, and/or any complications and follow up plan regarding the subject diagnosis.

C. 閣下之專業意見 PROFESSIONAL COMMENT

1 是次病症是否復發個案，或與過往其他病況有關？如是，請提供有關診治日期及治療詳情。Is the sickness a recurrent episode or related to any previous conditions? If so, please provide details of the diagnosis and treatments. ☐ 是 Yes ☐ 否 No

診治日期 Date of diagnosis/treatments 年 Year 月 Month 日 Day

詳情(包括診斷/治療/檢查及結果) Details(including diagnosis/ treatments/ investigations and results)

保單編號 Policy No.										

C. 閣下之專業意見(續) PROFESSIONAL COMMENT(Continued)

2 病人之家族史有否增加病人患上此症的風險? **Is there any patient's family history which would increase the risk of this illness?**

3 病情預測 **The prognosis of the condition**

4 是否與人體免疫缺損病毒有關? **Is it HIV related?**

D. 其他醫療病史 OTHER MEDICAL HISTORY

1 病人過往有否以下病症/習慣。**Does the patient have any medical history or habit as indicated below?**

- ☐ 哮喘 Asthma
- ☐ 心臟病 Cardiac problem
- ☐ 糖尿病 Diabetes Mellitus
- ☐ 乙型肝炎 Hepatitis B
- ☐ 高血壓 Hypertension
- ☐ 曾接受手術 Previous operation
- ☐ 濫藥 Drug abuse
- ☐ 家族性癌症 Family history of cancer
- ☐ 家族病史 Unfavorable family history
- ☐ 飲酒習慣 Drinking
- ☐ 吸煙習慣 Smoking
- ☐ 以上皆沒有 None
- ☐ 其他疾病，請說明 Other disease, please specify

2 該病人曾否因患上述疾病或其他嚴重疾病接受醫生或醫院治療 ? 如是者，請述詳情。**Had the patient previously been treated or hospitalized for the above disease or other major disease? If so, please give details.**

日期 Dates			疾病 Disease	治療/住院詳情 Details of treatment/hospitalization	醫生姓名/醫院名稱 Name of Physician/Hospital
年 Year	月 Month	日 Day			

3 請提供飲酒/吸煙習慣詳情 **Please provide details of Drinking & Smoking habit.**

習慣始自 **Drinking/ Smoking start date since** 年 Year ____ 月 Month ____ 日 Day ____

每日用量 **Daily consumption** _____ (支/包/樽/罐 piece/ pack/ bottle/ can)

E. 主診醫生資料 ATTENDING PHYSICIAN'S INFORMATION

主診醫生姓名 Name of Attending physician		資歷 Qualification	
地址 Address		聯絡電話 Contact No.	
主診醫生簽署/醫院蓋章 Signature & Stamp of Attending Physician/ Hospital		日期 Date	年 Year / 月 Month / 日 Day