滙豐保險
HSBC Life

EB36

CLAIM FORM 索償表格

Group Life Scheme - Dismemberment 團體人壽計劃 - 傷殘

Claim for 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. 傷殘的索償。由僱員或病人和諮詢醫生填寫，所產生的費用由僱員或病人承擔。

HOW TO SUBMIT THIS FORM 如何提交此表格

After completing the form please send back to us:
填妥表格後，請寄送給我們：

BY MAIL

Employee Benefits Claims, HSBC Life, 18/F, Tower 1, HSBC Centre, 1 Sham Mong Road, Kowloon, Hong Kong

郵寄

滙豐保險僱員福利索償部 — 香港九龍深旺道1號滙豐中心1座18樓

IMPORTANT NOTES 重要事項

1. All claims must be submitted within 90 days of completion of treatment.
   所有索償必須在治療完成後90天內提交。
2. 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 employee or 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，我們會盡快與您聯絡。這可能會導致您的索償延遲。僱員或病人亦有可能需要支付索償期間產生的相關費用。
3. 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。

CLAIMS DOCUMENT CHECKLIST 索償文件清單

What you need to submit with this claim:
請連同此索償一併提交以下文件：

- ☐ 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 Drug list (include drug name, dosage, quantity and amount)
  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 or Laboratory Test Report, Endoscopic, Ultrasonogram, X-Ray, CT Scan, MRI etc., Diagnostic Written Report(s) and Operating theatre summary (if applicable)
  病理學或化驗報告，內窺鏡檢查，超聲檢查，X 射線，CT 掃描，磁力共振等診斷之書面報告及手術室摘要副本（如適用）
- ☐ Copy of Police Report (if applicable)
  警察事故報告副本（如適用）
- ☐ Copy of Employee/Patient's Identity Proof such as ID Card, Passport or Birth Certificate etc.
  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 Employee/Patient's name and bank account details (if applicable)
  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 由僱員或病人以正楷填寫

1. GROUP LIFE SCHEME INFORMATION 團體人壽保險資料

1A. EMPLOYER DETAILS 僱主資料

Group life policy no. 團體保單編號		Employer name 僱主名稱	

1B. EMPLOYEE DETAILS 僱員資料

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

English Full Name 英文姓名	Contact Number 聯絡電話號碼	Email 電郵

1C. PATIENT DETAILS 病人資料

English Name of Patient (if different from above) 病人英文姓名（如與上述不同）	HK/Macau ID card no. 香港／澳門身份證號碼	Membership no. (Refer to E-medical card/Physical Medical Card) 成員編號（請參閱您的電子醫療卡／實體醫療卡）

2. DISMEMBERMENT INFORMATION FOR YOUR CLAIM 肢體傷殘的資料

2A. IF YOUR DISMEMBERMENT WAS CAUSED BY AN ILLNESS 如閣下因疾病而導致肢體傷殘

If your disability was caused by an accident, please proceed to section 3F. 如閣下因意外而喪失工作能力，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

2B. CONSULTING DOCTOR'S INFORMATION 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 醫院名稱	Address 地址	Date of consultation 求診日期
			_____ – _____ – _____ DD日 MM月 YYYY年

2C. REFERRING DOCTOR'S INFORMATION 轉介醫生資料
Doctor who referred you to hospital 為閣下轉介入院的醫生

Referring doctor's name 轉介醫生姓名	Address of referring doctor's clinic 轉介醫生的診所地址	Name of hospital you were referred to 被轉介的醫院名稱	Date of admission 住院日期
			_____ – _____ – _____ DD日 MM月 YYYY年

2D. 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 and address (if you were admitted to a hospital) 醫院名稱和地址(如果您曾住院)	Admission no. 求診或住院號碼	Date of admission 求診或住院日期
			_____ – _____ – _____ DD日 MM月 YYYY年

2E. 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

2F. IF YOUR 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 _____ : _____ ☐ A.M 上午 ☐ P.M 下午 HR時 MIN分			
Was the accident reported to the police? 您是否已向警方申報是次意外？ ☐ Yes 是 ☐ No 不是	If 'yes', please provide details. 如'是'，請提供詳情。	Police station address 報案警署地址	Police report no. 報案號碼
Was the accident reported to your employer? 您是否已向僱主申報是次意外？ ☐ Yes 是 ☐ No 不是	If 'yes', please provide details. 如'是'，請提供詳情。		

3. CLAIMS SUBMITTED TO OTHER INSURER(S) 已向其他保險公司索償

Do you have similar benefits with any other insurance company?
有關此次疾病或意外，您有否申請其他保障賠償？

☐ Yes, please provide information below and attach all related settlement forms or documents.
是，請提供下列資料並附上所有相關賠償表或文件。
☐ No 不是

Name of insurance company 保險公司名稱	Amount of sum assured 保障金額	Type of benefit 保障類別	Policy no. 保單號碼

4. PAYMENT INSTRUCTIONS 付款指示

☐ Via Cheque – made cheque payable to the employee and will be sent by mail to employee's address.
支票 – 以支票支付僱員，並將支票寄往其通訊地址。

☐ Via transfer to bank account (The beneficiary must hold or jointly hold the bank account. Otherwise a cheque made payable to the beneficiary will be sent by mail to their address.) Please fill in the details below.
轉賬至受益人之本地銀行戶口(不適用於非受益人之個人或聯名銀行戶口。若該戶口並非受益人之個人或聯名銀行戶口，付款將以支票形式寄予受益人通訊地址。)請提供下列資料。

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 employee's full name and bank account details attached to this claim as proof. If you do not provide the bank proof, payment will be made by cheque payable to the employee and mailed to the employee's correspondence address.
請提供僱員本地銀行戶口證明文件副本並清楚顯示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僱員並郵寄到其通訊地址。

5. EMPLOYEE'S / PATIENT'S DECLARATION AND AUTHORISATION 僱員/病人聲明和授權

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'). I understand I can view such notice by scanning the QR code on the right, or else I can request a copy by visiting my local HSBC Branch or by calling the Life Insurance Service Hotline: (852) 2583 8000. 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。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 病人簽署	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	_____ – _____ – _____ DD日 MM月 YYYY年 Date signed 簽署日期

SECTION 2: DOCTOR SECTION 乙部 – 由醫生填寫

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

1. PATIENT DETAILS 病人資料

English Full Name 英文姓名	Date of birth 出生日期	HK/Macau ID card no. 香港/澳門身份證號碼	Patient's membership no. (required for the claim to be processed) 病人成員編號（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

Date of diagnosis 診斷日期	Please specify part(s) of body dismembered/loss of function. 請具體說明傷殘的部位。
_____ – _____ – _____ DD日 MM月 YYYY年	

What is the cause of the dismemberment/loss of function? 傷殘原因是什麼？	☐ illness, please provide details below. 疾病，請在下方提供詳情。 ☐ accident 事故

Date of first consultation 首次看診日期	Description of patient's symptoms at the first consultation 病人首次看診時的病徵	How long has the patient shown these symptoms? 病人在首次求診前患有該病徵有多久?
_____ – _____ – _____ DD日 MM月 YYYY年		

Please provide details of the illness/accident and how does it cause the dismemberment/loss of function.
請提供疾病/事故的詳情以及如何導致肢解/喪失功能。

3. DISMEMBERMENT DETAILS 傷殘詳情

What is the present condition of the patient's dismemberment/loss of function?
目前病人的傷殘狀況如何？

Do you think the dismemberment or loss of function mentioned would be temporary or permanent?
您認為病人傷殘或喪失功能是暫時性的還是永久性的？

☐ Temporary 暫時性的 ☐ Permanent 永久性的

How is the conclusion supported? Please provide the date and result of any tests performed.
如何得出上述結論？請提供任何相關測試的日期和結果以支持您的診斷。

Date of test 測試日期	Test name 測試名稱	Test result 測試結果
_____ – _____ – _____ DD日 MM月 YYYY年		
_____ – _____ – _____ DD日 MM月 YYYY年		
_____ – _____ – _____ DD日 MM月 YYYY年		
_____ – _____ – _____ DD日 MM月 YYYY年		

4. TREATMENT AND PROGNOSIS 治療

Please provide a detailed description of the type of prescribed treatment, including medication, surgical treatments, chemotherapy or radiotherapy, duration, quantity and frequency. Please use a separate piece of paper and attach it if you need more space. 請詳細描述您處方的治療類型，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。	

What is the prognosis?
預期進展為何?

Would there be any chance of recovery or improvement?
會有任何恢復或改善的機會嗎？

☐ Yes 是 ☐ No 不是

5. SUPPORTING INFORMATION 補充資料

Please provide any further information that will assist us in assessing this claim.
請提供任何進一步的資料，以幫助我們評估這項索償。

6. 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	Contact no. 電話號碼

DOCTOR'S SIGNATURE 醫生簽署

_____ – _____ – _____
DD日 MM月 YYYY年

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

Date signed
簽署日期