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危疾索償表格

Critical Illness Claim Form

Please complete and return this form with the supporting documents (see "Claims Document Checklist" on page 2) to **Metropolitan Life Insurance Company of Hong Kong Limited at Level 20, Cityplaza 3, 14 Taikoo Wan Road, Taikoo Shing, Hong Kong**
請填妥本索償表格，連同其他所需文件(見第二頁之「索償文件參考表」)，寄回**香港太古城太古灣道 14 號太古城中心 3 期 20 樓，美商大都會人壽保險香港有限公司**。

PART I 第一部份 (To be completed by Insured / Claimant 由受保人或索償人填寫)

A. INSURED INFORMATION 受保人資料

Policy No 保單編號	Name of Insured 受保人姓名	ID Card No 身份證號碼	Age 年歲 Sex 性別	Tel No 聯絡電話
Correspondence Address 通訊地址				☐ New Claim 首次索償 ☐ Reply Document 回覆文件 ☐ Review / Appeal 重審/覆核
Present Occupation 現職	Name & Address of employer 僱主名稱及地址			

B. DETAILS OF MEDICAL CONSULTATION / HOSPITALIZATION 求診/住院詳情

Critical Illness claimed 索償之危疾名稱

Consultation details 就診詳情	Consultation Date (MM/DD/YY) 就診日期 (月/日/年)	Name and address of doctor / hospital 醫生 / 醫院名稱及地址
(a) The doctor / hospital first consulted for this Critical Illness 首次就診此危疾之醫生/醫院資料		
(b) Other doctor / hospital seen for this Critical Illness 其他曾診治此危疾之醫生/醫院資料		
(c) Usual doctor / hospital for general illnesses 慣常求診一般疾病的醫生/醫院資料		

Are there any other illness treated for or suffered other than this Critical Illness claimed 除患有是次索償之危疾外，有否患有其他疾病

☐ No 沒有 ☐ Yes 有, Please provide 請提供

Illness 病患	Date of Diagnosis (MM/DD/YY) 診斷日期(月/日/年)	Name & Address of Doctor / Hospital 醫生 / 醫院名稱及地址

CRITICAL ILLNESS DUE TO ILLNESS 危疾(因病患)

1. Describe the symptoms 詳述病徵

2. When did the symptoms first appear 上述徵狀何時首次出現

   MM/DD/YY 月/日/年

3. Has the Insured previously suffered from, been tested / treated for the above / related condition
   以往曾否患上上述 / 有關病患並作檢驗 / 治療
   ☐ No 否
   ☐ Yes 有, Please provide 請提供

Illness 病患	Date of Diagnosis(MM/DD/YY) 診斷日期(月/日/年)	Name & Address of Doctor/Hospital 醫生/醫院名稱及地址

CRITICAL ILLNESS DUE TO ACCIDENT 危疾(因意外)

1. Date, time and place of accident 意外日期、時間及地點

   MM/DD/YY 月/日/年 ☐ AM 上午 ☐ PM 下午 Place 地點

2. How did the accident happen 意外發生經過

3. Part of body injured and injury severity 受傷部位及傷勢

4. Was the accident reported to the Police 有否就是次意外報警
   ☐ No 沒有
   ☐ Yes 有, Please provide name of police station and reference number
   請提供報案警署名稱及報案號碼

   Please provide copy of police report / statement
   請提供警察報告/口供紙

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C. OTHER INFORMATION 其他資料

1. Has any of Insured's blood relatives suffered from, been tested / treated for a similar or related illness 直系親屬中，有否曾患類同或有關之危疾，並曾作出檢驗 / 治療

☐ No 沒有 ☐ Yes 有, Please provide 請提供

Relationship of relative 親屬關係 | Illness 病患 | Date of Diagnosis (MM/DD/YY) 診斷日期(月/日/年) | Name & Address of Doctor/Hospital醫生/醫院名稱及地址

2. Are you making any other insurance claim regarding this critical illness 有否向其他保險公司就是次危疾提出索償

☐ No 沒有 ☐ Yes 有, Please provide 請提供

name of insurance company 保險公司名稱 policy number(s) 保單號碼

CLAIMS DOCUMENT CHECKLIST 索償文件參考表

(To facilitate our assessment of your claims, please complete and provide the following basic documents to us.)

(以便本公司盡快審核閣下的索償個案，請完成及提交以下之基本所需文件。)

Basic Document Required 基本所需文件	Claimed Benefit 索償保障
	Critical Illness Benefit 危疾保障
Fully completed Critical Illness Claim Form Part I 危疾索償表格第一部份	✓
Fully completed Critical Illness Claim Form Part II 危疾索償表格第二部份	✓
Policyowner's ID Copy 保單持有人身份証副本	✓
Pathology Report & Laboratory Report 病理及化驗報告	✓
Police Report / Police Statement 警察報告/口供紙	✓ (if applicable 如適用)

Note: (i) Supplementary documents / information may be further required from you or other related parties for claims assessment.

(ii) Company reserves the right to request for original documents if the company deemed necessary.

注意: (i) 本公司或需於稍後向閣下/其他有關人士索取額外文件/資料以作理賠審核之用。

(ii) 如有需要，本公司保留權利要求閣下提交文件正本。

REQUEST FOR RETURN OF ORIGINAL DOCUMENTS 退回正本文件

If you want to get back the original documents submitted, please put a tick beside the corresponding box(es) below:

如閣下欲退回已呈交之正本文件，請於下列有關文件欄內劃上"✓"號:

☐ Original Pathology Report & Laboratory Report 病理及化驗報告

☐ Others (please specify) 其他(請註明) ______________________

DECLARATION AND AUTHORIZATION 聲明及授權

I hereby declare that the above information given on this claim application form is true and complete to the best of my knowledge.

I understand and agree that any personal data collected or held by Metropolitan Life Insurance Company of Hong Kong Limited ("the Company") (whether contained in this claim form or otherwise) may be (i) used or stored, (ii) disclosed or transferred (whether within or outside Hong Kong) by the Company to its affiliated companies, reinsurance and claims investigation company, industry association / federation, any members of the federation or any individuals / organizations associated with the Company or any third party to (i) process the claim; (ii) provide all services related to this claim or to promote other financial products and services, direct marketing, and data matching, and to communicate with me for such purposes; or (iii) enable the federation to carry out its regulatory functions or such other functions that may be assigned to the federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the federation. Moreover, the Company is hereby authorized to obtain access to and / or to verify any of my data with the information collected by the federation from the insurance industry.

I understand that I have the right to obtain access to and to request correction of any personal information held by the Company or be given reasons for any refusal of access. I also understand that a reasonable fee may be charged by the Company for process of any access.

I hereby irrevocably authorize any employer, doctor, hospital, clinic, insurance company, government office or any organization, or persons who have any records, knowledge or information (whether medical or otherwise) of me to disclose, release or transfer to the Company or its representative such information pertinent to this claim. The authorization shall bind my successors and assignees and remain valid notwithstanding my death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as original.

本人就此聲明在索償表格上所提供的資料均屬本人所知的事實。

本人明白及同意美商大都會人壽保險香港有限公司(貴公司)，可以(i)使用或儲存，(ii)透露或轉移(論在本港或海外)，任何貴公司所收集或持有之任何本人的個人資料(不論是否此索償表格所載或從其他途徑所取得)給貴公司之任何關聯公司，再保公司及理賠調查公司，行業協會/聯會，聯會之成員及與貴公司有關之人士或機構，以(i)辦理此索償；(ii)提供所有有關此索償之服務及推廣其他財務產品及服務，直接促銷及資料核對等用途，及因此等用途而與本人聯絡；或(iii)執行聯會的監察功能；或執行本著保險業或任何聯會會員利益而付予聯會的其他功能。此外，貴公司獲授權向聯會查閱及/或核實該會已搜集本人之資料。

本人明白本人有權自貴公司查閱及申請更改所有貴公司持有之有關本人的任何資料，或獲得任何被拒絕查閱的理由。貴公司有權酌情收取任何查閱資料的行政費用。

本人授權任何僱主、醫生、醫院、診所、保險公司、政府部門或其他機構及人士，如具有本人的任何紀錄、知識或資料，可將該等資料向貴公司代表透露，發放或移交，用以作爲該份索償申請的參考。此授權書對本人的繼承讓人均有約束力，即使在本人死亡或喪失行爲能力後仍然有效。此授權書的影印本具有與正本同等的效力。

Signature of Claimant 索償人簽署	# Signature of Insured 受保人簽署
Claimant Name & ID Card No 索償人姓名及身份證號碼	#Insured Name & ID Card no 受保人姓名及身份證號碼
Date (MM/DD/YY) 日期(月/日/年)	#Date (MM/DD/ YY) 日期(月/日/年)
Relationship with insured 與受保人關係	# not required if insured is the claimant 如受保人同爲索償人，此欄無須簽署或填寫

ENQUIRIES 查詢

For enquiries, please call our Customer Services Hotline on 2199 1000 during office hours, from Monday to Friday, 9:00am to 5:30pm and Saturday 9:00am to 1:00pm (except public holidays)

如有任何查詢，請於辦公時間內，星期一至星期五，上午九時至下午五時半，及星期六上午九時至下午一時(公眾假期除外) ，致電客戶服務熱線 2199 1000。