

## 殘疾索償表格

### Disability 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				<input type="checkbox"/> New Claim 首次索償 <input type="checkbox"/> Further Claim 再度索償 <input type="checkbox"/> Reply Document 回覆文件 <input type="checkbox"/> Review / Appeal 重審/覆核

##### B. DETAILS OF DISABILITY 殘疾詳情

Hospitalization Period for this disability 因殘疾之住院日期 From 由 MM/DD/YY 月/日/年 To 至 MM/DD/YY 月/日/年 Name of Hospital 醫院名稱	Are you making any other insurance claim regarding this disability 有否向其他保險公司就是次殘疾提出索償 <input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有, Please provide 請提供 name of insurance company 保險公司名稱 policy number(s) 保單號碼
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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 disability 首次就診此殘疾之醫生/醫院資料	_____	_____
(b) The doctor / hospital which referred the Insured to hospital 建議入院之醫生/醫院資料	_____	_____
(c) Other doctor / hospital seen for this disability 其他曾診治此殘疾之醫生/醫院資料	_____	_____
(d) Usual doctor / hospital for general illnesses 慣常求診一般疾病的醫生/醫院資料	_____	_____

DISABILITY DUE TO ILLNESS 殘疾(因病患)	DISABILITY DUE TO ACCIDENT 殘疾(因意外)
1. Describe the symptoms 詳述病徵	1. Date, time and place of accident 意外日期、時間及地點 MM/DD/YY 月/日/年 <input type="checkbox"/> AM 上午 <input type="checkbox"/> PM 下午 Place 地點
2. When did the symptoms first appear 上述徵狀何時首次出現 MM/DD/YY 月/日/年	2. How did the accident happen 意外發生經過
3. Was the condition a recurrent episode or a chronic disease 上述之情況是否舊病復發或慢性疾病 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, Date of first attack 首次發病日期 MM/DD/YY 月/日/年 Disease details 病況資料	3. Part of body injured and type of injury 受傷部位及傷勢
	4. Was the accident reported to the Police 有否就是次意外報警 <input type="checkbox"/> No 沒有 <input type="checkbox"/> 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

## C. EMPLOYMENT PARTICULARS 就業資料

Employment before Disability 殘疾前之就業情況	<input type="checkbox"/> Full-time 全職	<input type="checkbox"/> Part-time 兼職
Occupation (if more than one, please state all) and exact nature of occupational duties 所有職位及職責		
Name and Address of business or employer 公司或僱主名稱及地址		
Any sick leave certificate(s) with your employer 有否向僱主遞交病假證明書	<input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有
Date of last worked (MM/DD/YY) 最後工作日期 (月/日/年)		
Date returned to work / expected date of return (MM/DD/YY) 恢復工作日期 / 預計復工日期 (月/日/年)		

## 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
	Waiver of Premium / Payor Benefit / Total & Permanent Disability 保費豁免 / 付款人保障 / 完全及永久殘疾保障
Fully completed Disability Claim Form Part I 殘疾索償表格第一部份	✓
Fully completed Disability Claim Form Part II 殘疾索償表格第二部份	✓
Original / Certified True Copy of Sick Leave Certificate 病假證明書正本/核實副本	✓
Policyowner's ID Copy 保單持有人身份証副本	✓
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 sick leave certificates 病假證明書正本

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；或執行本署保險業或任何聯會會員利益而予聯會的其他功能。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，用以作為該份索償申請的參考。此授權書對本人的繼承人均有約束力，即使在本人死亡或喪失行為能力後仍然有效。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 如受保人同為索償人，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。

MetLife Limited 大都會人壽保險有限公司

Metropolitan Life Insurance Company of Hong Kong Limited 美商大都會人壽保險香港有限公司

Level 20, Cityplaza 3, 14 Taikoo Wan Road, Taikoo Shing, Hong Kong 香港太古城太古灣道14號太古城中心3期20樓

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