

死亡索償表格

Death 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 Claimant 由索償人填寫)

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	Date of Birth 出生日期
Correspondence Address at Death 生前通訊地址				Tel No 聯絡電話
Last Occupation 生前職業	Name, Address & Tel no. of last employer 生前僱主名稱、地址及電話			

B. DETAILS OF DEATH 身故詳情

Date of death (MM/DD/YY) 身故日期 (月/日/年)	Place of Death 死亡地點	Cause of Death 死亡原因			
DEATH DUE TO ILLNESS 因病患身故		DEATH DUE TO ACCIDENT 因意外身故			
1. Describe the symptoms 詳述病徵		1. Date, time and place of accident 意外日期、時間及地點 <table border="1"> <tr> <td>MM/DD/YY 月/日/年</td> <td><input type="checkbox"/> AM 上午 <input type="checkbox"/> PM 下午</td> <td>Place 地點</td> </tr> </table>	MM/DD/YY 月/日/年	<input type="checkbox"/> AM 上午 <input type="checkbox"/> PM 下午	Place 地點
MM/DD/YY 月/日/年	<input type="checkbox"/> AM 上午 <input type="checkbox"/> PM 下午	Place 地點			
2. (a) When did the symptoms first appear 上述徵狀何時首次出現 <table border="1"> <tr> <td>MM/DD/YY 月/日/年</td> </tr> </table> (b) Consultation history for the illness 就診該病詳情 Consultation Dates (MM/DD/YY) 診治日期(月/日/年) Name & Address of Doctor / Hospital 醫生/醫院名稱及地址 Patient No. 病人編號		MM/DD/YY 月/日/年	2. How did the accident happen 意外發生經過		
MM/DD/YY 月/日/年					
		3. 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. OTHER INFORMATION 其他資料

1. Has there been or will there be a death inquest 是否已經或將進行死因研究 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide us a copy of the death inquest report 是，請提供死因研究報告	3. Are you making any other insurance claim regarding this incident 有否向其他保險公司就是次事故提出索償 <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
2. Has there been or will there be any autopsy 是否已經或將進行解剖驗屍 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide us a copy of the autopsy report 是，請提供解剖驗屍報告	
4. Name and details of all doctors, hospitals or institutions where the insured was treated during the 5 years preceding death 在死者身故前五年內為死者治病之所有醫生、醫院或醫療機構的名稱及詳情 Consultation Dates (MM/DD/YY) 診治日期(月/日/年) Name & Address of Doctor / Hospital 醫生/醫院名稱及地址 Illness/Injury 傷病 Patient No. 病人編號	

D. CLAIMANT INFORMATION 索償人資料

Chinese Name of Claimant 索償人中文姓名	English Name of Claimant 索償人英文姓名	ID Card No 身份證號碼	Tel No 聯絡電話
Correspondence Address 通訊地址			Relationship with Insured 與受保人關係
Claimant Capacity 索償人身份 <input type="checkbox"/> Beneficiary 受益人 <input type="checkbox"/> Policyowner 保單持有人 <input type="checkbox"/> Others (please specify) 其他(請註明) _____			

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
	Life Benefit 人壽保障
Fully completed Death Claim Form Part I 死亡索償表格第一部份	✓
Fully completed Death Claim Form Part II 死亡索償表格第二部份	✓
Original / Certified true copy of Death Certificate 死亡證書正本/核實副本	✓
Original / Certified true copy of Insured's ID 受保人身份證正本/核實副本	✓
Original / Certified true copy of beneficiary's ID 受益人身份證正本/核實副本	✓
Original / Certified true copy of relationship proof of beneficiary & Insured 受益人與受保人之關係證明正本/核實副本	✓
Original Policy 保單正本	✓
Address proof of beneficiary 受益人住址證明	✓
Death Inquest Report 死因研究報告	✓ (if applicable 如適用)
Autopsy Report 解剖驗屍報告	✓ (if applicable 如適用)
Police report / 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。

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) is provided and 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 and 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 or the deceased's 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 or the deceased 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或死者的個人資料(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予予聯會的其他功能。此外，貴公司獲授權向聯會查閱及/或核實該會已搜集本人或死者之資料。

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或死者的任何資料，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，如具有本人或死者的任何紀錄、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

Name of Claimant 索償人姓名

Claimant ID Card No 索償人身份證號碼

Date (MM/DD/YY) 日期(月/日/年)

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

MLHK-CLM-DTH-CF-032008

死亡索償表格 - 主診醫生報告

Death Claim Form – Attending Physician Statement

PART II 第二部份 (To be completed by attending physician at the Claimant's expense 由主診醫生填寫，費用由索償人支付)

Name of Deceased 死者姓名	ID Card No. 身份證號碼	Date of Birth 出生日期	Age & Sex 年齡及性別
Date of Death (MM/DD/YY) 身故日期 (月/日/年)		Place of Death 死亡地點	Cause of Death 死亡原因

MEDICAL INFORMATION 醫療資料

<p>1. (a) Was the death caused by an accident 死亡原因是否由意外導致</p> <p><input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Yes, please provide details how and where the accident happened 是，請提供意外發生經過及地點</p> <p>(b) Date of accident 意外日期</p> <p>____/____/____ MM/DD/YY 月/日/年</p>	<p>5. Was the cause of death secondary to a recurrent or chronic condition 身故原因是否與舊病復發或慢性疾病有關</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please give details 是，請提供詳情</p> <table border="1"> <thead> <tr> <th>Illness/ Injury 疾病/傷患</th> <th>Symptom Onset 首次出現徵狀日期</th> <th>First Consultation 首次求診日期</th> <th>Name & Address of Doctor / Hospital 醫生/醫院名稱及地址</th> </tr> </thead> <tbody> <tr> <td colspan="4">____ (MM/DD/YY 月/日/年) ____ (MM/DD/YY 月/日/年) _____</td> </tr> </tbody> </table>	Illness/ Injury 疾病/傷患	Symptom Onset 首次出現徵狀日期	First Consultation 首次求診日期	Name & Address of Doctor / Hospital 醫生/醫院名稱及地址	____ (MM/DD/YY 月/日/年) ____ (MM/DD/YY 月/日/年) _____			
Illness/ Injury 疾病/傷患	Symptom Onset 首次出現徵狀日期	First Consultation 首次求診日期	Name & Address of Doctor / Hospital 醫生/醫院名稱及地址						
____ (MM/DD/YY 月/日/年) ____ (MM/DD/YY 月/日/年) _____									
<p>2. (a) Signs and symptoms related to the cause of death 導致死者身故的傷病病況或徵狀</p> <p>(b) Date of symptoms first appeared 首次出現徵狀日期</p> <p>____/____/____ MM/DD/YY 月/日/年</p>	<p>6. Were there any precipitating factors (e.g. habits, occupation, residence), direct or indirect, which may have contributed to or hastened the death of the deceased 有否其他因素(如習慣、職業或居住環境)直接或間接加速 / 促使死者死亡</p> <p><input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Yes, please give details of the conditions and indicate the duration of each condition 是，請提供各因素及持續的時段</p>								
<p>3. When and by whom was the cause of death first diagnosed 何時及由誰首次診斷出導致死者身故之原因</p> <p>First Consultation Date (MM/DD/YY) Name & Address of Doctor / Hospital 首次求診日期 (月/日/年) 醫生/醫院名稱及地址</p> <p>____ (MM/DD/YY 月/日/年) _____</p>	<p>7. Did the deceased use alcohol or narcotics 死者有否飲酒或服藥</p> <p><input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Yes, please state how they contributed to the fatal cause 有，請詳述與死因之關係</p>								
<p>4. (a) Date of your first consultation for this condition 首次就是次原因向閣下求診日期</p> <p>____/____/____ MM/DD/YY 月/日/年</p> <p>(b) Was the deceased referred to you by another doctor / hospital 有否經其他醫生/醫院轉介</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please give details 是，請提供詳情</p> <p>Consultation Date 求診日期 Name & Address of Doctor / Hospital (MM/DD/YY 月/日/年) 醫生/醫院名稱及地址</p> <p>____ (MM/DD/YY 月/日/年) _____</p>	<p>8. Patient's past medical history, if any 病人的過去病歷，如有</p> <table border="1"> <thead> <tr> <th>Illness/ Injury 疾病/傷患</th> <th>Consultation Date 求診日期</th> <th>Name & Address of Doctor / Hospital 醫生/醫院名稱及地址</th> </tr> </thead> <tbody> <tr> <td colspan="3">____ (MM/DD/YY 月/日/年) _____</td> </tr> </tbody> </table>	Illness/ Injury 疾病/傷患	Consultation Date 求診日期	Name & Address of Doctor / Hospital 醫生/醫院名稱及地址	____ (MM/DD/YY 月/日/年) _____				
Illness/ Injury 疾病/傷患	Consultation Date 求診日期	Name & Address of Doctor / Hospital 醫生/醫院名稱及地址							
____ (MM/DD/YY 月/日/年) _____									

I hereby certify that I have personally examined and treated the Deceased and that the answers given above are all true to the best of my knowledge and belief.
本人謹此聲明曾為死者作出檢查及治療，而據本人所知所信，以上填報各項答案均屬正確。

Name of Physician 醫生姓名 _____ Signature 簽署 _____ Hospital Stamp 醫院蓋章 _____

Qualification 資格 _____ Date 日期 _____

Address 地址 _____ Tel No 電話 _____

Note: In case of inconsistency between the Chinese and English version, the English version shall prevail 如中文版本的内容與英文版本有任何差異，均以英文版本為準。