Manulife 宏利

Branch code 分行編號 _____ Location 地點 _____
Advisor code 保險顧問編號 _____
Advisor's name 保險顧問姓名 _____
Contact no. 聯絡電話 _____

Claimant's Statement of Disability
索償人聲明 — 傷殘

For more efficient processing of claim, please submit 1) Employer confirmation, 2) Sick leave certificate from your doctor(s), 3) Doctors's notes if any.
為加快進行索償審核程序，敬請一併遞交1）僱主證明書；2）由閣下之醫生簽發之病假證明；3）醫生報告（如適用）。

1. Insured's Name: 受保人姓名：	2. Policy Number : 保單編號：
3. Contact Phone Number: 聯絡電話號碼：	4. Birthdate (mm/dd/yy): 出生日期（月/ 日/ 年）：
5. Residential Address : 住宅地址：	
6. Occupation at Disability : 傷殘前從事之職業：	7. Describe your duties fully : 詳細列出職務：
8. Employer's Name: 僱主名稱：	9. Employer's Phone Number: 僱主電話號碼：
10. Employer's Address: 僱主地址：	
11. Is Disability due to : Injury ☐ 受傷 Accident Date 意外發生日期： _____ 導致傷殘之原因是： Sickness ☐ 疾病 Symptom First Noted Date 首次發現病徵之日期： _____	12. Describe Nature of Injuries/Sickness: 指出受傷/ 疾病性質：

13. Give date on which you last worked at your present regular occupation: (mm/dd/yy) _____ 閣下最後從事現職之日期（月/ 日/ 年） ☐full time 全職 ☐part time 兼職 **Average monthly salary $ 每月平均收入 $** _____	14. If you have returned to work, give date of return: (mm/dd/yy) _____ 若閣下已復工，填寫復工日期（月/ 日/ 年） ☐ full time 全職 ☐ Part time 兼職 **Average monthly salary $ 每月平均收入 $** _____	15. If you have not returned to work, when do you expect to? (mm/dd/yy) _____ 若閣下仍未復工，估計可於何時復工（月/ 日/ 年） ☐ full time 全職 ☐ Part time 兼職

16. When were you first treated by physician for the disability described above? (mm/dd/yy)
閣下於何時首次因上述傷殘而接受醫生治療？（月/ 日/ 年）

17. Name, address & phone no. of first physician attended in Item no. 16 第16項所指之應診醫生姓名，地址及電話號碼	18. Name, address & phone no. of present attending physician (if other than physician mentioned above). 現時主診醫生（如非前述之醫生）之姓名、地址及電話號碼

19. Have you consulted any other doctor because of your present disability or for any other reason during the last two years?
於過往兩年內，閣下曾否由於現時之傷殘情況或任何其他原因向任何其他醫生求診？

Name of Doctor 醫生姓名	Address & Phone No. 地址及電話號碼	Date Consulted 求診日期	Reasons 原因

20. Has or will a Claim be filed with any other insurance company, Workmen's Compensation, Unemployment Insurance Commission, etc?
閣下曾否或會否向任何其他保險公司，勞工賠償計劃，失業保障部門等提出索償？

Company 公司名稱	Policy No. 保單編號	Issue Date 簽發日期	Amount of Income Benefits 入息賠償金額	Weekly/Monthly 每週/ 每月支付

21. Information about other Disability Income. Do you have any other Income Protection Cover? Overhead Expenses Cover?
其他傷殘入息資料。閣下是否受保於任何其他入息保障計劃？經費開支保障計劃？

Source of Income: (Salary,Insurance, Government Benefits,Others) 入息來源：（薪金、保險、政府保障、其他）	Are you now receiving? 是否現正收取？	Do you expect to receive? 是否將會收取？	Date claim was filed? mm/dd/yy 提出索償之日期 月/ 日/ 年	Date payments began 開始獲支付款項之日期	Date payments ended 停止獲支付款項之日期	Amount per week or month: (Please specify currency) 每週或每月獲支付金額（請註明貨幣）
	☐Yes 是 ☐No否	☐Yes 是 ☐No否	/ /	/ /	/ /	/ wk 每週 / mth 每月
	☐Yes 是 ☐No否	☐Yes 是 ☐No否	/ /	/ /	/ /	/ wk 每週 / mth 每月
	☐Yes 是 ☐No否	☐Yes 是 ☐No否	/ /	/ /	/ /	/ wk 每週 / mth 每月

Payment Instructions 付款指示

☐ By Direct Credit to one of my following bank accounts (only applicable to policyowner's bank account in HKD currency)
直接存入本人下列其中一個銀行帳戶（只適用於保單持有人之港元戶口）：
- ☐ Current autopay bank account for premium payment 現時繳付保費之自動轉帳銀行帳戶
- ☐ Last bank account for receiving claims payment or policy payment (including dividend, loan payment, regular withdrawal, etc.)
上一次收取理賠金額或保單款項（包括紅利、貸款金額、定期提取金額等）之銀行帳戶
- ☐ Bank account specified below 以下指定的銀行帳戶：

Name of account holder 帳戶持有人姓名： _____

Bank Name 銀行名稱	Bank No. 銀行編號	Branch No. 分行編號	Bank Account No. 銀行帳戶號碼

Please provide account proof (e.g. bank statement or bank book copy showing the name of account holder and account number)
請提供帳戶資料證明（如列有帳戶持有人之姓名及帳戶號碼之銀行帳單或銀行存摺影印本）

Remarks 備註:
- Only applicable to payment with daily transaction limit of HKD100,000 per policy. If payment exceeds HKD100,000 or the instruction cannot be executed, it will be issued by cheque.
每份保單每日存款交易上限為港元100,000。如交易超逾港元100,000或無法執行有關付款指示，總額將以支票形式支付。
- The above instruction will **replace any existing bank account record/setup for receiving payment** including regular withdrawals (if any).
此帳戶資料將取代現時紀錄內/設立收取款項的帳戶包括用作定期提取的帳戶（如有）。

☐ By Cheque 以支票形式

Cheque Collection Method 支票交付方法
- ☐ Through my Insurance Advisor 由本人的保險顧問轉交
- ☐ By Mail to my latest correspondence address with Manulife 寄往本人於宏利紀錄的最新通訊地址

Cheque Currency [a] (for USD policy only) 支票幣值 [a]（只適用於美元保單）
- ☐ USD Cheque (drawn in Hong Kong) 美元支票（由香港的銀行付款）
- ☐ USD Cheque (drawn in United States) 美元支票（由美國的銀行付款）
- ☐ HKD Cheque [b] 港元支票 [b]

Notes 註:
(a) In general, it takes a long settlement period to clear a foreign cheque in Hong Kong. Bank charges may be incurred by client for clearing the cheque.
銀行通常需要較長的結算時間於香港兌現外幣支票；另銀行或會向客戶徵收兌現支票的相關手續費。
(b) The HKD equivalent will be based on the currency exchange rate provided by the Company at the time of issue of the cheque and it can be changed from time to time.
相等之港元將會以支票發出時的貨幣兌換率計算，而宏利將不時提供有關的貨幣兌換率。

The Chinese version of this claim form is for reference only. In the event of conflicts between the Chinese and English versions, the English version shall prevail. 此索償表格之中文譯本只供參考之用，若與英文有異，一概以英文為準。

Declaration and Authorization 聲明及授權

I/We hereby declare that the answers to the above questions are full and true to the best of my/our knowledge. I/We further authorize any physician, hospital, insurance company, claims investigation company, government authority or organization that has any record or knowledge of me/us, my/our health or my/our activities (including records relating to Social Welfare, Workers' Compensation, credit, financial, earnings and employment history) to furnish to Manulife (International) Limited ("Manulife") or its authorized representative such information including without limitation all information with respect to any illness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photostatic copy of this authorization shall be as effective and valid as the original.

本人/ 我們特此聲明填報於本表格內之資料已是本人/ 我們所知之全部並為真實無訛。本人/ 我們茲授權任何醫生、醫院、保險公司、賠償調查公司、政府有關部門或其他持有本人/ 我們個人資料、健康狀況或記錄（包括有關本人/ 我們所獲之社會福利及勞工賠償、本人/ 我們之存款、財政狀況、入息及就業記錄）之組織可以將該等資料，包括但不限於所有有關本人/ 我們之疾病或受傷，傷患之病歷、診斷報告、藥方或治療及所有醫院或醫療記錄副本等資料予宏利人壽保險（國際）有限公司（"宏利"）或其代理人。此授權書之複製本與正本具同等效力。

Personal Information Collection Statement 個人資料收集聲明

I/we acknowledge that the personal data provided in this Form will be used by Manulife for the purposes of processing, adjudicating and investigating claims application(s) and request(s) for credit service, approving and underwriting insurance applications, administering and reinsuring policies, complying with applicable laws and other related purposes and for such purposes, may be transferred to such persons or entities (whether within or outside Hong Kong) as: (a) any person in connection with any claims made by or against or otherwise involving customers in respect of any products and/or services; (b) any agent, contractor or third party service provider who provides administrative, telecommunications, computer, information technology, payment, data processing or storage, marketing, mailing, printing, telemarketing, customer satisfaction analysis, or other services to Manulife or any member of Manulife's group of companies in connection with the operation of business, including any custodian, administrator, investment manager, investment advisor or distributor; (c) any credit reference agencies or, in the event of default, any debt collection agencies; (d) any advisor (including his or her employees) or other intermediary (including their employees); (e) reinsurers and medical service providers; (f) employers of the customers; (g) any person which has undertaken to Manulife or any member of Manulife's group of companies to keep such data confidential; (h) any actual or proposed assignee, transferee, participant or sub-participant of the rights or business of Manulife or any member of Manulife's group of companies ; (i) any member of Manulife's group of companies; (j) any person to whom Manulife or any member of Manulife's group of companies is under an obligation or otherwise required to make disclosure under the requirements of any law, rules, regulations, codes of practice, guidelines or guidances binding on or applicable to Manulife or any member of Manulife's group of companies including but not limited to any local or foreign regulators, governmental bodies, or industry recognised bodies; (k) any person to whom Manulife or any member of Manulife's group of companies is under an obligation or otherwise required to make disclosure pursuant to any contractual or other commitment or arrangement with local or foreign regulators, governmental bodies, or industry recognised bodies (whether within or outside Hong Kong) that is assumed by or imposed on Manulife or any member of Manulife's group of companies by reason of its financial, commercial, business or other interests or activities in or related to the jurisdiction of the relevant local or foreign regulators, governmental bodies, industry recognised bodies. I/we understand that I/we am/are not obliged to provide such personal data as requested but if I/we refuse to provide such data, Manulife may not be able to proceed further on my/our application(s) and/or request(s) in this Form. I/we may request access to and correction of my/our personal data held by Manulife, by writing to Privacy Officer at Manulife (International) Limited, 22/F., Tower A, Manulife Financial Centre, 223-231 Wai Yip Street, Kwun Tong, Kowloon, Hong Kong.

本人/ 我們確認載於本表格內之個人資料將被宏利用以處理、判定及調查有關之索償及代繳費用服務申請，批核及承保保險申請，管理保單並安排分保，遵守適用法律及其他相關用途並就此等用途，該等個人資料可被轉送到下列人士或機構（無論在香港境內還是境外）(a) 與客戶、針對客戶或涉及客戶就任何產品及/ 或服務提起的任何索賠相關的任何人士；(b) 向宏利或宏利的公司集團任何成員提供與業務經營相關的行政管理、電信通訊、電腦、資訊技術、付款、資料處理或儲存、市場推廣、郵寄、列印、電話行銷、客戶滿意度分析或其他服務的任何代理、承辦商或第三方服務供應商，包括任何託管人，執行人，投資管理人，投資顧問或分銷商；(c) 任何信貸資料服務機構或（如出現付款違約）任何債務托收機構；(d) 任何顧問（包括其僱員）或其他中介人士/ 機構（包括其僱員）；(e) 再保險商和醫療服務供應商；(f) 客戶的僱主；(g) 已向宏利或宏利的公司集團任何成員承諾將對該等資料保密的任何人士；(h) 宏利或宏利的公司集團任何成員的權利或業務的任何實際或擬議受讓人、承讓人、參與人或次級參與人；(i) 宏利的公司集團任何成員；(j) 宏利或宏利的公司集團任何成員根據對其有約束力或適用的任何法律、法規、規章、守則、指引或指南的規定有義務或必須向其披露的任何人士，其中包括但不限於任何當地或外國的監管機構、政府機構或公認行業組織；(k) 根據由於宏利或宏利的公司集團任何成員在相關當地或外國監管機構、政府機構、或公認行業組織（無論在香港境內還是境外）所在司法管轄區的或涉及該等司法管轄區的財務、商業、業務或其他利益或活動而由宏利或宏利的公司集團任何成員承擔或施加給其的、與該等當地或外國監管機構、政府機構、公認行業組織之間的任何合同、其他承諾或安排，有義務或必須向其披露的任何人士。本人/ 我們明白本人/ 我們並無責任提供該等個人資料。但如果本人/ 我們拒絕提供該等資料，宏利可未能繼續處理本人/ 我們的申請及/ 或本表
格內之申請.本人/ 我們可去信個人資料主任於宏利人壽保險(國際)有限公司，香港九龍觀塘偉業街223-231號宏利金融中心A座22樓要求查閱及更改本人/ 我們在宏利之個人資料。

×		
Signature of Claimant (if Aged 18 or Above)* 索償人簽署（如十八歲或以上）	Name (In BLOCK LETTERS) & I.D. No. of Claimant 索償人姓名（請以正楷書寫）及身份証號碼	Date (DD/MM/YYYY) 日期（日/ 月/ 年）
×		
Signature of Policyowner 保單持有人簽署	Name (In BLOCK LETTERS) & I.D. No. of Policyowner 保單持有人姓名(請以正楷書寫)及身份証號碼	Date (DD/MM/YYYY) 日期（日/ 月/ 年）

* For patient aged below 18, signature of the policyowner must be provided for the application for the claim
十八歲以下病人之索償申請必須由保單持有人簽署。

Attending Physician's Statement 應診醫生報告

I hereby, authorize the release to my insurer of any information requested in respect of this claim.
本人謹此授權應診醫生把任何與本索償有關之資料交予本人之保險公司。

Date 日期 _____ Signature of patient 病人簽署 _____

The patient is responsible for securing this form and for charges made for its completion. 病人須自行索取本表格及支付因填寫本表格而招致之費用。

ATTENDING PHYSICIAN'S STATEMENT 應診醫生報告

Patient's Name 病人姓名 _____ Age 年齡 : _____

Address 地址 _____

1. History, to the best of my knowledge 據本人所知，病人之過往病歷為 :

a) Symptoms first appeared or accident happened 首次出現病徵或意外發生之日期 .....mm 月/.....dd 日/.....yy 年

b) Date of first visit 首次求診日期 .....mm 月/.....dd 日/.....yy 年

c) Date of last attendance 上次求診日期 .....mm 月/.....dd 日/.....yy 年

d) Were you actively supervising this patient's care during the full period? 閣下是否於病人整個傷殘期間負責監察病人之情況？
☐ Yes 是 ☐ No, please comment 否，請解釋
_____
_____

e) Patient has had same or similar condition ☐ Yes 是 ☐ No 否
病人是否曾處於相同或相似之狀況？
If yes, please state when and describe:
若「是」請指出時間及有關資料。
_____
_____

f) Are you the patient's usual medical attendant? ☐ Yes ☐ No. If yes, give details:
閣下是否病人，慣常求診之醫生？ ☐是 ☐ 否，若「是」，請填寫有關詳情。
Period of Consultation 應診期間

Past Health History 過往健康記錄
_____
_____

2. Diagnosis 診斷資料:

a) Diagnosis (including any complications) 診斷結果（包括任何併發症） _____

b) Subjective symptoms 主觀徵狀 _____

c) Objective findings (including current X-rays, ECG's Laboratory Data and any clinical findings)
客觀所見（包括最近之X光、心電圖、化驗報告及任何病理所見） _____

3. Nature of treatments 治療性質:

a) If hospitalized, please give name of hospital 若病人曾留院治療，請填寫醫院名稱 _____

b) If surgery performed, please describe & date 若病人曾按受手術，請提供有關資料及日期 _____

c) If referred to you, please give name, address, phone # of referring physician _____
若病人是由其他醫生轉介序閣下，請填寫其姓名、地址及電話號碼

4. Physical Impairment (If applicable) 體能受損（如適用）

☐ No limitation of functional capacity: capable of heavy work. No restrictions. 無活動能力受阻：可應付費力的工作。無限制。
☐ Capable of medium manual activity. 可應付中量體力勞動工作
☐ Slight limitation of functional capacity; capable of light work. 活動能力輕微受阻：可應付輕便的工作。
☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. 活動能力中度受阻：可應付文書/ 行政（案頭）工作
☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity. 活動能力嚴重受阻：不能應付最低限度（案頭）工作

☐ Remarks : 附註 _____

5. Prognosis, to the best of my knowledge, 本人所知之預斷為 :

a) Is patient now totally disabled? ☐No 否 ☐Yes是
病人現時是否完全傷殘？

b) The patient has been TOTALLY DISABLED (unable to work)
病人已完全傷殘（不能工作）的時間
FROM 由 ____ 月mm/ ____ 日dd/ ____ 年 yy TO ____ 月mm/ ____ 日dd/ ____ 年yy

c) How long was or will patient be PARTIALLY DISABLED?
病人曾經或將會部份傷殘的時間
FROM 由 ____ 月mm/ ____ 日dd/ ____ 年 yy TO ____ 月mm/ ____ 日dd/ ____ 年yy

d) If still disabled, give approximate date patient should be able to return to work
若病人仍然傷殘，大約可於何時復工？
____ 月mm/ ____ 日dd/ ____ 年yy

e) What duties of patient's job is he/she incapable of performing?
病人現不能從事工作內哪些職務？
_____

f) Does patient's condition prevent them from caring for themselves? ☐Yes ☐No
If yes, please explain _____
病人之狀況是否令其不能照顧自己？ ☐是 ☐否
若「是」，請解釋 _____

6. Remarks : 注意事項
_____
_____

After you have fully completed this form, if you have the following materials, please attach copies 若有下列文件，請一併附上副本 :

- **Office notes for the period treatment or the last two years**
  過往兩年或治療期間之診所記錄
- **Test results showing objective findings**
  顯示客觀所見之檢驗結果
- **Hospital discharge summaries**
  出院報告
- **Consulting physician reports**
  顧問醫生報告

Name of Attending Physician 應診醫生姓名 : _____ Telephone No 電話號碼 : _____

Degree/Specialty 學位/ 專科 : _____ Date 日期 : _____

Address 地址 : _____

_____ Signature (with stamp) 簽署（連印章）: _____