宏利 Manulife

CLAIM FORM FOR MAJOR DISEASE - HEART VALVE SURGERY/LESS INVASIVE TREATMENTS OF HEART VALVE DISEASE

重病保障索償表格 – 心瓣手術/心瓣膜疾病的次級創傷性治療

Branch code 分行編號 _____ Location 地點 Macao

Advisor code 保險顧問編號 _____

Advisor's name 保險顧問姓名 _____

Contact no. 聯絡電話 _____

1. Policy No. 保單編號	2. Name of Insured 受保人姓名	3. I.D. Card No. 身份證號碼	4. Age 年齡
5. Residential Address 住宅地址		6. a) Business Tel. No. 辦公電話號碼	b) Residential Tel. No. 住宅電話號碼
7. Occupation 職業		8. Name and Address of Employer 僱主名稱及地址	

9. Describe the nature of your illness
疾病性質

10. a) When did the symptoms first occur? 何時開始出現病徵？

b) On what date did you first consult a doctor for the illness? 首次因該疾病向醫生求診之日期。

11. Give details of hospitals confined and/or physicians consulted for the illness. 因該疾病入住醫院詳情及/或主診醫生資料

Name of Physician(s) and/or Hospital(s) 醫生姓名及/或醫院名稱	Address(es) 地址	Date of Consultation(s) and/or Period of Confinement(s) 診治及/或留院日期

12. What kinds of treatment have you received? 閣下曾接受甚麼治療？

13. Have you previously suffered from or received treatment for a similar or related illness? 閣下過往曾否患有相似或有關之疾病或因而接受治療？

☐ No 否 ☐ Yes 有 If "Yes", give details 若「有」，請填寫有關資料。

Name of Physician(s) and/or Hospital(s) 醫生姓名及/或醫院名稱	Address(es) 地址	Date 日期	Reason(s) 原因

14. Have any of your blood relatives suffered from a similar or related illness? 閣下之血緣親屬曾否患有相似或有關之疾病？

☐ No 否 ☐ Yes 有 If "Yes", give details 若「有」，請填寫有關資料。

Relationship 關係	Nature of Illness 疾病性質	Date when First Diagnosed 首次被斷定患有該疾病之日期

15. Give the name and address of your usual medical attendant if different from above. 若閣下之私人醫生並非上述之醫生，請填寫醫生之姓名及地址。

16. Are you insured for similar benefits with any other company? 閣下是否受保於其他保險公司並獲類似之保障？

☐ No 否 ☐ Yes 是 If "Yes", give details 若「是」，請填寫有關資料。

Name of Insurance Company 保險公司名稱	Policy No. 保單編號	Issue Date 保單簽發日期	Amount of Benefits 保障額

17. Please provide copies of all surgical / histopathology reports, blood test results, X-rays, CT Scans, and any other imaging studies, laboratory evidence, angiograms, echocardiogram, etc and any relevant hospital reports that are available. 請提供所有手術/病理化驗報告，驗血結果，X-光檢查，電腦掃描，及其他影像報告，化驗報告，血管造影術報告及超聲心動圖等，或任何有關的醫院報告。

18. Continuation of Supplementary Benefit(s) Upon Plan Termination by Claim Payment 因賠付計劃終止後延續附加保障

Please put a "✓" in the box if applicable. 請於適當方格內填上 "✓" 號。

☐ I would like to apply for continuation of eligible Supplementary Benefit(s) upon Plan Termination by Claim Payment.
本人欲申請因賠付致計劃終止後延續合資格的附加保障

Remarks: Please contact your Insurance Advisor to obtain the relevant application form(s) and submit together with this Claim
備註： 請聯絡閣下的保險顧問索取所需申請表格並連同此索償申請一併遞交

☐ I do not need this option
本人並不需要此選項

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。

Payment Instructions 付款指示

☐ 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)

☐ MOP Cheque[a] 澳門元支票 [a]

☐ HKD Cheque [b] 港元支票 [b]

☐ Same as Policy Currency 與保單幣值相同

For USD policy only [c] 只適用於美元保單 [c]

☐ 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)

Notes 註:

(a) The MOP 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.
相等之澳門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。

(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。

(c) In general, it takes a long settlement period to clear a foreign cheque in Macao. 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澳門兌現外幣支票；另銀行或會向客戶徵收兌現支票的相關手續費。

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 Macao) 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 Macao) 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, Macao Administration Office, Avenida De Almeida Ribeiro No.61, Circle Square, 14 andar A, Macao.

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 (無論在澳門境內還是境外) (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 (無論在澳門境內還是境外) 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，澳門分行行政部，澳門新馬路61號永光廣場十四樓A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

NOTE : This form must be completed by a qualified and registered physician at the insured's expense. 註：本表格必須由受保人自費聘請之合資格註冊醫生填寫。

1. Name of Patient 病人姓名	2. I.D. Card No. 身份證號碼	3. Age 年齡

4. Are you the patient's usual medical attendant? 閣下是否病人之私人醫生？
☐ No 否 ☐ Yes 是 If "Yes", give details 若「是」，請填寫有關資料。

Period of Consultation 應診期間	Past Health History 病人過往健康情況

5. a) Date on which the patient first consulted you related to the condition (Heart Valve Surgery/Less Invasive Treatments of Heart Valve Disease). 病人就是項疾病（心瓣手術/心瓣膜疾病的次級創傷性治療）首次向閣下求診的日期（DD日/ MM月/YY年）。

b) What were the symptoms? 病人之病徵？

c) How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前已患有此病徵多久？

d) When was the patient informed of the diagnosis? (Please give exact date) 何時通知病人診斷結果?（請填寫準確日期）

6. Give full and exact details of the diagnosis. 請詳盡填寫確實診斷資料。

7. Had the patient any past history of the disease specified above or related illness? 病人過往曾否患有上述疾病或有關疾病？
☐ No 否 ☐ Yes 有 If "Yes", give details 若「有」，請填寫有關資料。

Name of Attended Physician(s) 應診醫生姓名	Date of Consultation 診治日期	Address(es) 地址	Exact Diagnosis 確實診斷資料

8. Is there anything in the patient's family history which would have increased the risk of the disease specified above? 病人之家庭背景有否任何增加病人患上上述疾病機會之事項？

9. Please give details of the patient's habits in relation to alcohol, drugs and smoking. 請填寫病人飲酒、吸毒或吸煙習慣之詳情。

10. Has the patient undergone surgical correction for heart valve disease? 病人有否就其心臟瓣膜疾病接受矯正手術？
☐ Yes 有 ☐ No 沒有
If yes, the type of surgical correction performed? 如有，進行了何種矯正手術？

a) Through open-heart surgery to replace or repair heart valve defects/abnormalities 透過剖開心臟手術以置換心瓣或治療心瓣缺陷/異常
☐ Yes 有 ☐ No 沒有

b) Through Intravascular procedures to perform percutaneous valvuloplasty, percutaneous valvotomy or percutaneous valve replacement 透過血管介入的程序進行經皮穿刺瓣膜成形術，經皮穿刺瓣膜切除術或經皮穿刺瓣膜置換術
☐ Yes 有 ☐ No 沒有

c) If any one of the above 2 questions is "Yes", please specify the name of procedure done to correct the valvular problem: 如以上兩項任何一 項為 "有", 請列出矯正心臟瓣膜缺陷的手術程序的名稱：

d) If none of the above surgeries has been done, please state what other types of surgery was performed. 如沒有進行上述手術，請列出所進行之其他矯正手術。

e) Date and place of surgery 手術日期及地點

Date of surgery 手術日期 : (/ /) DD日/MM月/YY年

The hospital where the surgery was performed 手術醫院：

Name of Surgeon 手術醫生姓名：

11. Please enclose copies of all surgical reports, X-rays, CT scans, and any other imaging studies, laboratory evidence, angiograms, echocardiogram, etc and any relevant hospital reports that are available. 請提供所有手術報告、X 光檢查、電腦掃描、及其他影像報告、化驗報告, 血管造影術報告及超聲心動圖等，或任何有關的醫院報告。

12. Please provide details of physicians to whom the patient has been referred or attended for this disease. 請提供曾為病人診治是項病症之醫生資料。
(We would be grateful for copies of any relevant medical report that are available) （敬請提供任何有關醫療報告副本）

Name of Physician(s) and/or Hospital(s) 醫生姓名及/ 或醫院名稱	Address(es) 地址	Date of Consultation(s) and/or Period of Confinement(s) 診治及/ 或留院日期

13. If there is any further information which, in your opinion, will assist us in assessing this claim, please furnish such information below.
閣下認為有否其他資料可協助本公司審核是項索償申請？請提供有關資料。

Signature 簽署 X _____ Name of Physician (with stamp) 醫生姓名 (連印章) _____

Date 日期 _____ Address 地址 _____

Qualification 資格 _____ Tel. No. 電話號碼 _____