中銀集團保險有限公司
BANK OF CHINA GROUP INSURANCE COMPANY LIMITED

索償編號（公司專用）
Claim No. (for office use)

香港中環德輔道中 71 號永安集團大廈九樓 9/F., Wing On House, 71 Des Voeux Road Central, Hong Kong. 電話 Tel：28670888 傳真 Fax：3906 9906

CRITICAL ILLNESS CLAIM FORM 危疾保障索賠申請書

Please complete and sign this claim form and make sure the original copies of invoices and receipts are attached 請填妥本申請書及簽署後連同有關單據正本一併遞交。

Note : ORIGINAL DOCUMENTS submitted would be retained by Bank of China Group Insurance Company Limited. You are advised to keep a copy for reference. Only CERTIFIED TRUE COPY would be returned upon request.

注意：所遞交之正本文件將會存留於中銀集團保險有限公司，請自備副本參考。如要求退回文件，只會退還文件之核實正本。

PART I – CLAIMANT'S STATEMENT (IN BLOCK LETTER) 第一部份 – 索償人資料 (請用正楷填寫)

Policy No. 保單號碼	Policyholder Name 投保人姓名

Insured/Claimant Must Complete The Following • 由受保人/索償人填寫以下部份

Name of Insured (in full) 受保人姓名	Insured's HKID / Passport No. 受保人香港身分證/護照號碼

Nature of Claim and Related Details 索償性質及有關資料

1. Name of critical illness you are claiming for 索償的危疾名稱

2. Date of first consultation (DD/MM/YY) 首次求診日期 (日/月/年)

3. Describe the symptoms from date of onset. 詳述病發日起所患之一切病徵。

4. The name, address and contact phone no. of the doctor you first consulted for this illness. 首次就此病求診之醫生姓名、地址及聯絡電話。

5. How long have you been having these symptoms form the date of your first consultation? 由首次求診日起，以上病徵已存在多久？

6. The name, address and contact phone no. of your usual doctor. 閣下慣常求診之醫生姓名、地址及聯絡電話。

7. Please give below details of any doctor(s) who have been consulted in connection with this illness. 請提供曾診治此病的其他醫生或專科醫生資料。

Consultation Date(MM/DD/YY) 求診日期 (日/月/年)	Doctor Name 醫生姓名	Address 地址

8. Please give below details of any hospitalization in connection with this illness. 請提供與此病有關之住院記錄。

Hospital Name 醫院名稱	Admission Date(MM/DD/YY) 入院日期 (日/月/年)	Discharge Date (MM/DD/YY) 出院日期 (日/月/年)	Diagnosis 診斷

9. Are there any other illnesses/complaints treated for or suffer by you prior to this critical illness you are claiming for? If so, please give full details. 閣下在患有是次索償之疾病前是否患有其他疾病? 如"有"，請詳細提供有關資料。

Hospital Name 醫院名稱	Admission Date(MM/DD/YY) 入院日期 (日/月/年)	Discharge Date (MM/DD/YY) 出院日期 (日/月/年)	Diagnosis 診斷

10. Are you insured for similar bnenefits with any other Company? If "yes", please state. 閣下是否在其他公司投保類似危疾保障？如"有"，請提供有關資料。

Insurer Name 保險公司名稱	Type / Amount of Benefit 投保類別/金額	Policy Number 保單號碼	Claim Status 賠償結果

轉背頁 P.T.O.

11. 請提供銀行自動轉帳戶口號碼及電郵地址作理賠賠款之用。指定之銀行自動轉帳戶口號碼及電郵地址將適用於以後的理賠，特別註明除外。
Please provide bank autopay account number and email address for claim settlement purpose. Unless otherwise specify, the designated account number and email address shall be applied to all future claim settlements.

戶口持有人 Bank Account Holder	銀行及分行編號 Bank and Branch Code								自動轉帳戶口號碼 Bank Autopay Account Number								電郵地址 Email Address
投保人 Insured				--				--									
配偶 Spouse				--				--									

Declaration and authorization 聲明及授權

Authorization
I act on behalf of myself and my dependents hereby authorize any medical practitioner, hospital, clinic, insurance company to disclose to the Bank of China Group Insurance Co., Ltd. all information concerning the above disability and any prior medical history for the purpose of proceeding the medical claim. A photostat of this authorization shall be as valid as the original.

Declaration
1. I hereby declare that the above statement and answers are true and correct. I understand that any misrepresentation of the above statement and answers will cause my/our claim invalid.
2. I understand that the information provided by me to Bank of China Group Insurance Company Limited ("BOCG Insurance") is collected to enable BOCG Insurance to carry on insurance business and may be used for the purpose of:
(i) processing and evaluating my insurance application and any future insurance application I may make; (ii) administering my insurance policy and providing services in relation to my insurance policy; (iii) analysis or investigating, processing and paying claims made under my insurance policy; (iv) invoicing and collecting premiums and outstanding amounts from me; (v) any alterations, variations, cancellation or renewal of any insurance related product or service; (vi) contacting me for any of the above purposes; (vii) exercising any right of subrogation by BOCG Insurance; (viii) other ancillary purposes which are directly related to the above purposes; and (ix) complying with applicable laws, regulations or any industry codes or guidelines.
BOCG Insurance may disclose my and/or the Insured Person(s)'s personal data for the above purposes to the following classes of transferees:
(a) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist BOCG Insurance to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors); (b) in the event of a claim, loss adjudicators, claims investigators and medical advisors; (c) in the event of default, debt collectors and recovery agents; (d) insurance reference bureaus or credit reference bureaus; (e) reinsurers and reinsurance brokers; (f) my insurance broker (if any); (g) BOCG Insurance's legal and professional advisors; (h) BOCG Insurance's related companies (as that term is defined in the Companies Ordinance); (i) any association, federation or similar organization of insurance companies ("Federation") and its members that exists or is formed from time to time for any of the above or related purposes or to 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; (j) any member(s) of the "Federation" by the "Federation" for any of the above or related purposes; (k) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; (l) the Insurance Claims Complaints Bureau and similar industry bodies; and (m) government agencies and authorities as required or permitted by law.
BOCG Insurance is hereby authorized to obtain access to and/or to verify any of my and/or the Insured Person(s)'s data with the information collected by the Federation from the insurance industry.
Moreover, BOCG Insurance may also use and disclose my and/or the Insured Person(s)'s personal data otherwise with my consent.
I have the right to obtain access to and to request correction of any personal information concerning myself and/or the Insured Person(s) held by BOCG Insurance. Requests for such access can be made to BOCG Insurance's Legal and Compliance Department (Tel: 2867 0888 / Fax: 3906 9939).

授權
本人現授權任何西醫、醫院、診所、保險公司及其他人士，均可向**中銀集團保險有限公司**提供本人或本人家屬之健康情況、傷病資料及病歷記錄，作爲審核有關醫療保險索賠之用。本授權書之影印本與正本有同等效力。

聲明
1、本人聲明上述所填報之資料均屬真實無訛，本人清楚明白如上述資料有誤或不實，可能導致本人或本人家屬的保障無效。
2、本人明白本人提供予中銀集團保險有限公司("中銀集團保險")的資料，爲中銀集團保險提供保險業務所需，並可能使用於下列目的:
(i) 處理及審批本人的保險申請或本人將來提交的保險申請；(ii) 執行本人保單的行政工作及提供與本人保單相關的服務；(iii) 分析或調查、處理及支付本人保單有關的索償；(iv) 發出繳交保費通知及向本人收取保費及欠款；(v) 任何與保險有關的產品或服務的任何更改、變更、取消或續期；(vi) 就以上用途聯絡本人；(vii) 中銀集團保險行使任何代位權；(viii) 其它與上述用途有直接關係的附帶用途；及(ix) 遵循適用法律，條列及業內守則及指引。

中銀集團保險亦可因應上述用途將本人及/或受保人的個人資料移轉予下列各方：
(a) 就上述用途，向中銀集團保險提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問（包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商）；
(b) 處理索賠個案的理賠師、理賠調查員及醫療顧問； (c) 追討欠款的收數公司或索償代理；(d) 保險資料服務公司及信貸資料服務公司；(e) 再保公司及再保經紀；(f) 本人的保險經紀（若有）；(g) 中銀集團保險的法律及專業業務顧問；(h)中銀集團保險的關連公司(以《公司條例》內的定義爲準)；(i) 現存或不時成立的任何保險公司協會或聯會或類同組織(「聯會」)及其會員，以達到任何上述或有關目的，或以便「聯會」執行其監管職能，或其他基於保險業或任何「聯會」會員的利益而不時在合理要求下賦予「聯會」的職能；(j) 透過「聯會」移轉予任何「聯會」的會員，以達到任何上述或有關目的；(k) 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；(l) 保險索償投訴局及同類的保險業機構；及(m) 法例要求或許可的政府機關。
本人在此授權中銀集團保險可向「聯會」從保險業內收集的資料中查閱及/或核對本人及/或受保人的任何資料。
此外，經本人同意，中銀集團保險可能會以其它方式使用及披露本人及/或受保人的個人資料。
本人有權查閱及要求更正由中銀集團保險持有有關本人及/或受保人的個人資料。如有需要，可向中銀集團保險法律與合規部提出 (電話：2867 0888，傳真：3906 9939)。

Signature (Insured /Parent or legal guardian if insured aged under 18)
受保人簽署(十八歲以下請由父母或合法監護人代簽)

Date (DD/MM/YY) 日期

Name 姓名

Contact No. (If Applicable) 聯絡電話 (如適用)

Document submission with Application 遞交索償申請所需文件

In order to speed up your claim application, please attach the following documents together with this application form and kindly tick against the documents submitted with this form. 爲能儘速辦理閣下之索償申請，請將此表格連同以下文件遞交，並於提交的文件欄內畫上 "√" 。

☐	Claim Form Part II completed by attending Doctor for your claimed critical illness 閣下索償有關危疾的主診醫生填寫之索償申請表第二部份
☐	Original medical expenses receipt(s) 正本醫療收據
☐	Original hospital receipt(s) 正本住院收據
☐	Hospital discharge summary 出院總結
☐	Laboratory / X-ray / CT scan / MRI report 化驗報告 / X光/ 電腦掃瞄/ / 磁力共震報告
☐	Pathology report 病理檢驗報告
☐	Patient Card Copy of Consulted Dotor 醫生覆診卡副本