# Critical Illness Claim Form
# 危疾索償表格

Please complete and return this form with the supporting documents (see "Claims Document Checklist" on page 2) to FWD Life Assurance Company (Hong Kong) Limited / FWD Life (Hong Kong) Limited (wherever applicable) ("FWD Assurance") at P.O. Box 69465, Kwun Tong Post Office, Kowloon, 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」)，寄回香港九龍觀塘郵政局郵政信箱69465號富衛人壽保險（香港）有限公司 / 富衛人壽（香港）有限公司(如適用)(「富衛壽險」)。

| Insurance Intermediary' s Information 保險中介人資料 | |
|---|---|
| Name of Insurance Intermediary 保險中介人姓名 | |
| Insurance Intermediary Code in FWD Assurance (if applicable) 富衛壽險保險中介人編號 (如適用) | |
| Contact Phone No. 聯絡電話 | |

## 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. 保單號碼 | Name of Insured 受保人姓名 | ID card no. 身份證號碼 | Age 年歲<br>Sex 性別 | Mobile no. 手提電話號碼 |
|---|---|---|---|---|
| Correspondence address 通訊地址 | | | | ☐ New claim 首次索償<br>☐ Further claim 再度索償<br>☐ Reply document 回覆文件<br>☐ Review / Appeal 重審 / 覆核 |
| Present occupation 現職 | Name & address of employer 僱主名稱及地址 | | | |

## B. DETAILS OF MEDICAL CONSULTATION / HOSPITALIZATION 求診 / 住院詳情

1. Critical illness claimed 索償之危疾名稱

2. 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 Critical illness 首次就診此危疾之醫生 / 醫院資料 | | |
| (b) Other doctor / hospital seen for this Critical illness 其他曾診治此危疾之醫生 / 醫院資料 | | |
| (c) Usual doctor / hospital for general illnesses 慣常求診一般疾病的醫生 / 醫院資料 | | |
| | | |

3. Are there any other illness treated for or suffered other than this Critical illness claimed 除患有是次索償之危疾外，有否患有其他疾病

☐ No 沒有 ☐ Yes 有，please provide 請提供 _____ Illness 病患 _____ Date of diagnosis (MM/DD/YY) 診斷日期 (月 / 日 / 年) _____ Name & address of doctor / hospital 醫生 / 醫院名稱及地址

## C. CRITICAL ILLNESS DUE TO ILLNESS 危疾 (因病患)

1. Describe the symptoms 詳述病徵

2. When did the symptoms first appear 上述徵狀何時首次出現

MM/DD/YY 月 / 日 / 年

3. Has the Insured previously suffered from, been tested / treated for the above / related condition 以往曾否患上上述 / 有關病患並作檢驗 / 治療

☐ No 沒有

☐ Yes 有，please provide 請提供

Illness 病患 _____ Date of diagnosis (MM/DD/YY) 診斷日期 (月 / 日 / 年)

Name & address of doctor / hospital 醫生 / 醫院名稱及地址

## D. CRITICAL ILLNESS DUE TO ACCIDENT 危疾 (因意外)

1. Date, time and place of accident 意外日期、時間及地點

MM/DD/YY 月 / 日 / 年 ☐ AM 上午 ☐ PM 下午 Place 地點

2. How did the accident happen 意外發生經過

3. Part of body injured and injury severity 受傷部位及傷勢

4. Was the accident reported to the police 有否就是次意外報警

☐ No 沒有

☐ Yes 有，please provide name of the 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

## E. OTHER INFORMATION 其他資料

1. Has any of Insured' s blood relatives suffered from, been tested / treated for a similar or related illness 直系親屬中，有否曾患類同或有關之危疾，並曾作出檢驗 / 治療

☐ No 沒有 ☐ Yes 有，please provide 請提供 _____ Relationship of relative 親屬關係 _____ Illnes 病患 _____ Date of diagnosis (MM/DD/YY) 診斷日期 (月 / 日 / 年) _____ Name & address of doctor / hospital 醫生 / 醫院名稱及地址

2. Are you making any other insurance claim regarding this critical illness 有否向其他保險公司就是次危疾提出索償

☐ No 沒有 ☐ Yes 有，please provide 請提供 _____ name of the insurance company(ies) 保險公司名稱 _____ policy number(s) 保單號碼

Note: Please delete, cross out or put "NA" for question (if applicable) 請刪除或於問題註明「不適用」(如適用)



**FWD Life Assurance Company (Hong Kong) Limited 富衛人壽保險(香港)有限公司**
**FWD Life (Hong Kong) Limited 富衛人壽(香港)有限公司**
18/F., Devon House, Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong,香港鰂魚涌英皇道979號太古坊德宏大廈18樓

## 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 "FWD Assurance".)**
**(請完成及提交以下之基本所需文件，以便「富衛壽險」盡快審核閣下的索償個案。)**

| Basic Document Required 基本所需文件 | Claimed Benefit 索償保障 |
|---|---|
| | Critical Illness Benefit 危疾保障 |
| Fully completed Critical Illness Claim Form Part I 已填妥的危疾索償表格第一部份 | ✓ |
| Fully completed Critical Illness Claim Form Part II 已填妥的危疾索償表格第二部份 | ✓ |
| Policyowner' s ID copy 保單持有人身份証副本 | ✓ |
| Pathology report & laboratory report 病理及化驗報告 | ✓ |
| Police report / Police statement 警察報告 / 口供紙 | ❍ |

**Remarks:** ✓ **Basic documents** 基本文件 ❍ **Supplementary documents** 補充文件

**Note: (i) Supplementary documents / information may be further required from you or other related parties for claims assessment.**
**(ii) "FWD Assurance" reserves the right to request for original documents if "FWD Assurance" deemed necessary.**

**注意：(i)「富衛壽險」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，「富衛壽險」保留權利要求閣下提交文件正本。**

## REQUEST FOR RETURN OF DOCUMENTS 退回文件

If you want to get back the following submitted documents , please tick the corresponding box(es) below:
如閣下欲取回下列已呈交之文件，請於有關文件欄內劃上"✓"號：

☐ Certified true copy of receipts 醫療費用收據核實副本

## DECLARATION AND AUTHORIZATION 聲明及授權

I/We declare that I/we have read and fully understand the implications of the contents of this Application, and that the information given in this Application is true and complete to the best of my/our knowledge. I / We agree that if I/We fail to provide any information requested in this Application, it may result in the inability of FWD Assurance to accept the application.

I/We (acting on behalf of the Insured, wherever applicable) 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/us (or the Insured, wherever applicable) to disclose, release or transfer to FWD Assurance or its representative(s) such information pertinent to this application. This authorization shall bind my/our successors and assignees and remain valid notwithstanding my/our (or the Insured, wherever applicable) death or incapacity in so far as legally feasible. This authorization shall be valid until my/our further instructions. A photocopy of this authorization shall be as valid as original.

I/We have read, understand and accept this PICS. I/We consent to the transfer of my personal data outside Hong Kong and I/We understand my/our personal data may not be protected to the same or similar level in Hong Kong.

本人/吾等在此聲明本人/吾等已閱讀及完全明白本申請所載內容及含意，就本申請所提供的資料均屬本人/吾等所知的事實及全部。本人/吾等同意若本人/吾等不能提供本申請所需的任何資料，可致使富衛壽險不能接受本申請。
本人/吾等(代表受保人，如適用)在此授權(並不可撤回)任何凡持有本人/吾等(或受保人,如適用)任何記錄、資訊或資料(不論醫療或其他性質)的僱主、醫生、醫院、診所、保險公司、政府部門或其他機構或人士，向富衛壽險或其代表透露、發放或轉移該等資料作本申請之用。本授權對本人/吾等繼承人及承讓人具約束力，不管本人/吾等(或受保人，如適用 ) 死亡或喪失行為能力，在法律容許下依然生效，直至本人/吾等進一步指示。本授權書的影印本具有與正本同等的效力。

本人/吾等已細閱及本人/吾等明白及接受本收集個人資料聲明。本人/吾等同意把本人的個人資料轉移至香港境外，並本人/吾等明白本人/吾等的個人資料未必可以獲得與在香港相同或類似程度的保障。

| | |
|---|---|
| Signature of Policyowner 保單持有人簽署 | # Signature of Insured 受保人簽署 |
| Name & ID card no. of Policyowner 保單持有人姓名及身份證號碼 | # Name & ID card no. of Insured 受保人姓名及身份證號碼 |
| Email address of Policyowner 保單持有人電郵地址 | Date (MM/DD/YY) 日期 ( 月 / 日 / 年 ) |
| # Mobile No. of Policyowner 保單持有人手提電話號碼 | Relationship between Insured and Policyowner 受保人與保單持有人之關係 |
| Date (MM/DD/YY) 日期 ( 月 / 日 / 年 ) | # Not required if the Insured is the Policyowner<br># 如受保人同為保單持有人，此欄無須簽署或填寫 |

## ENQUIRIES 查詢

**For enquiries, please call our Service Hotline on 2199 1000 during office hours, from Monday to Friday, 9:00am to 6:00pm 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，上午九時至下午六時，及星期六上午九時至下午一時 ( 公眾假期除外 ) ，致電服務熱線 2199 1000。**