4012000801

時代女性保障賠償申請表
TIME LADY INSURANCE CLAIM FORM

CSM-CLA04

第一部份 PART I

爲使此賠償能盡速辦理，此申請表必須由被保人/保單持有人直接填寫。
In order to process your claim promptly, this form must be completed by Insured/Policyholder directly.

受保人資料 Insured's Particulars

保單號碼 Policy No. :	受保人姓名 Name of Insured :	年歲及性別 Age and Sex	身份證/ 護照號碼 I.D. Card / Passport No.

初生嬰兒姓名 Name of infant	出生日期 Date of Birth	性別 Sex	出生證明書號碼 Birth Certificate No.

通訊地址 Mailing Address :	聯絡電話 Contact Phone No.

索償保障類別(請在適當之方格內劃上 ✔ 號) Nature of Claimed Benefit(s) (please tick the appropriate box)

☐ 新生嬰兒獎賞 New Born Baby Bonus ☐第一名嬰兒 1st Born Baby ☐第二名嬰兒 2nd Born Baby	☐ 嬰胎保障 Fetus & Infant Protection
☐ 乳房及女性生殖系統之原位癌 Carcinoma in-situ of Breast and Female Genital System	☐ 系統性紅斑狼瘡性腎炎 Systemic Lupus Erythematosus with Lupus Nephritis
☐ 懷孕期併發症 Complications of Pregnancy ☐ 宮外孕 Ectopic Pregnancy ☐ 葡萄胎 Hydatidiform Mole ☐ 血管內瀰漫性凝血 Disseminated Intravasular Coagulation ☐ 產後嚴重抑鬱 Postpartum Psychosis	☐ 嬰兒先天性異常 Congenital Anomalies ☐ 唐氏綜合症 Down's Syndrome ☐ 腦脊膜突出 Spina Bifida ☐ 法洛氏四重症 Tetralogy of Fallot ☐ 食道閉鎖及食道氣管漏 Oesophageal Atresia & Oesophago Tracheal Fistula ☐ 腦積水 Hydrocephalus

建議參考事項Suggested Checklist

※ 時代女性保障賠償申請表只適用於婦女疾病保障及新生嬰兒獎賞
TIME LADY INSURANCE CLAIM FORM is applicable for lady's benefit and New Born Baby Bonus ONLY
※ 如申請其他有關之賠償類別，如壽險身故、豁免保費、危疾保障及其他， 閣下必須填寫個別有關之賠償申請表格交予本公司
For other claims, please complete the relevant Claim Forms for claims related to Death, Waiver of Premium, Dread Diseases and all other supplements.
※ 如申請新生嬰兒獎賞或嬰兒先天性異常，請同時遞交新生嬰兒之出生證明書副本
For application of New Born Baby Bonus or claims for Congenital Anomaly Benefits, a copy of the new born baby's Birth Certificate is required.
※ 閣下應提供有關之病歷卡、各項化驗檢查及診斷結果報告等參考資料予本公司
References such as the Patient's Card, diagnostic or laboratory reports should be submitted.

治療詳情 Treatment Details

1. 首次出現病徵的日期 (有關系統性紅斑狼瘡或原位癌) Date when symptoms first appeared (For Systemic Lupus Erythematosus with Lupus Nephritis & Carcinoma in-situ)	1. _____/_____/_____ (年YYYY 月MM 日 DD)
2. 請描述有關病徵。 Please give details of symptoms.	2.

3. 病人就上述疾病 / 情況而求診的醫院 / 醫生 / 診所 / 醫療機構 The Hospital / Doctor/Clinic / Institution that has attended to the above condition

就診/住院日期 (年/月/日) Date of Consultation/ Confinement (YYYY/MM/DD)	醫生/醫院名稱 Physician/ Hospital	聯絡電話 Contact Tel. No.	住院編號/ 病人編號 Hospital No/ Patient No.

其他資料 Other Details

4. 閣下的 直系親屬中曾否患有相同或類似的疾病？ 如有，請列出與該親屬的關係，並需列明有關該疾病的名稱及首次被診斷患有該疾病的確診日期。Have any of your immediate family members suffered from a similar or related illness？ If yes, please state relationship to the relative, name of illness and the date when the illness was first diagnosed.

☐否 No ☐有 Yes Please Specify 請註明

5. 閣下是否有吸煙之習慣？ 如有，請列明數量、類別及持續吸煙已多久
Do you smoke？ If yes, state quantity, type and duration of smoking.

☐否 No ☐有Yes 類別 Type _____ 每天數量 Daily Quantity _____

持續吸煙已多久 Duration of smoking _____

6. 閣下有否在其他保險公司作類似的投保？如有，請列出該保險公司的名稱、投保金額、保單號碼。
Are you insured for similar benefits with any other Insurance Company？ Please state the name of Insurance Company, policy no. and sum insured.

☐否 No ☐有Yes 保險公司名稱Name of Insurance Company _____

投保金額 Sum insured _____ 保單號碼 Policy No. _____

聲明及授權 Declaration and Authorization

授　權

本人謹此授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、或其他機構、組織或人士、凡知道或持有任何有關本人/受保人之紀錄者，均可將該等資料提供、發放及轉交給中國人壽保險(海外)股份有限公司(以下簡稱「貴公司」)； (2) 貴公司或任何其指定之醫生或化驗所，可就此賠償申請替本人/受保人進行所需之醫療評估及測試，作爲審核本人/受保人之健康狀況。此授權對本人/受保人之繼承人及授讓人具有約束力；即使本人/受保人死亡或無行爲能力時，此授權書仍具效力。此授權書的影印本與正本均有同等效力。

AUTHORIZATION

I HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of me/the insured to disclose, release and transfer such information to China Life Insurance (Overseas) Company Limited (hereinafter called “the Company”); (2) the Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ the insured in relation to this claim. This authorization shall bind the successors and assignees of me/the insured and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

聲　明

本人謹此聲明及同意(1)上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所信，均爲事實之全部並確實無訛； 本人明白倘有任何未知是否屬於重要事項的資料均須透露；(2)本人對任何人所作出之任何聲明，如沒有在此申請書上填寫或印出，貴 公司不須受其約束。若相關人士不能提供任何此賠償申請表所需的資料，貴 公司可能因此不能審核及處理此賠償申請。

DECLARATION

I HEREBY DECLARE and AGREE that (1) all the foregoing statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true; I also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. (2) The Company is not bound by any statement which I may have made to any person if not written or printed here. If any relevant persons fail to provide any information requested in this claim form, it may result in the Company’s inability to process and deal with this claim.

_____	_____	_____	_____
受保人/保單持有人簽署 Signature of Insured/Policyholder	受保人/保單持有人姓名 Name of Insured/Policyholder	身份證/護照號碼 I.D. Card / Passport No.	日期(年/月/日) Date (YYYY/MM/DD)

備　註: 此聲明及授權書必須由受保人簽署，若受保人爲小童，則可由其家長/合法監護人簽署。

. Remarks: This declaration and authorization must be signed by the insured. If the insured is a minor, the insured’s parent/legal guardian can sign on his/her behalf.

如受保人因傷殘不能書寫，其家屬或代理人可代爲填寫此申請書及簽字。.

In the event of the Insured is physically incapacitated and prevent from signing, PART I may be signed by a close relative or other representative authorized by the Insured.

若簽署者非受保人，請填寫此欄 Please complete if the signature is not given by the Insured.

受保人姓名 (正楷書寫) _____ 與受保人/保單持有人關係_____

Name of insured (in block letter) Relationship with Insured/ Policyholder .

收集個人資料聲明 Personal Information Collection Statement

本人確認已閱讀及明白中國人壽(海外)股份有限公司的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於 www.chinalife.com.hk 下載或向中人壽(海外)股份有限公司索取。

I confirm that I have read and understood the personal information collection statement of China Life Insurance (Overseas) Company Limited. For the latest version of the personal information collection statement, it can be downloaded from www.chinalife.com.hk or is made available upon request.

_____	_____
受保人/保單持有人簽署 Signature of Insured/Policyholder	日期 (年/月/日) Date (YYYY/MM/DD)

保險中介人專用 For Insurance Intermediary use only

本人認爲上述之答案全屬正確無訛。I believe that the answers given above are true and to the best of my knowledge.

_____	_____	_____	_____
保險中介人簽署 Signature of Insurance Intermediary	保險中介人姓名 (正楷填寫) Name of Insurance Intermediary (in block letter)	保險中介人代碼(如適用者) Insurance Intermediary Code (if any)	日期 (年/月/日) Date (YYYY/MM/DD)

應診醫生報告書 ATTENDING PHYSICIAN STATEMENT

第二部份 PART II

由主診醫生填寫，所有費用由索償人自行承擔

To be completed by the attending physician at the claimant's own expenses.

病人姓名 Name of Patient	年齡及性別 Age and Sex	身份證/ 護照號碼 I.D.Card / Passport No.

A. 有關女性疾病及妊娠期間併發症之病史 CLINICAL HISTORY OF FEMALE DECEASES AND PREGNANCY COMPLICATIONS

1. 病人之醫療記錄可追溯至 We can trace the medical record of patient back to _____
(年/月/日 YYYY/MM/DD)

2. 首次出現病徵日期或意外發生日期 Date of the accident occurred or symptoms first appeared _____
(年/月/日 YYYY/MM/DD)

3. 病人首次有關此病症之求診日期 Date of first consultation for this condition or related illness _____
(年/月/日 YYYY/MM/DD)

4. 請詳細說明首次會診時之徵狀和病症 Please describe the symptoms and complaints at first consultation.

_____

5. 病人是否由其他醫生轉介？如是，請提供該醫生之姓名及地址。
Is the patient referred by other physician? If yes, please give the name and address of the referring doctor.

_____

6. 診斷 Diagnosis

7. 住院資料 Hospitalization Details

醫院名稱 Name of Hospital _____

入院日期 Date of Admission _____ 出院日期 Date of Discharge _____

8. 手術資料 Surgical Procedure Details

手術日期 Date of Surgical Procedure _____ (年/月/日 YYYY/MM/DD)

手術名稱 Name of the Surgical Procedure _____

手術性質 Nature of the Surgical Procedure_____

9. 出院撮要 BRIEF DISCHARGE SUMMARY
住院期間之治療、檢查及其結果、有否任何併發症及出院後之覆診或跟進計劃
(including treatments, investigation procedures, results, and/or any complications and follow up plan)

B. 有關嬰兒先天性異常 INFANT CONGENITALANOMALY

1. 是項先天性異常之確實診斷 Exact clinical diagnosis for infant congenital anomaly

_____

2. 請提供所有臨床病徵及異常狀況 Please give details of the clinical manifestations.

_____

_____

_____

3. 治療撮要 BRIEF TREATMENT SUMMARY
有關上述診斷之治療、檢查及其結果、有否任何併發症及覆診或跟進計劃
(including treatments, investigation procedures, results, and/or any complications and follow up plan)

D. 其他醫療病史 OTHER MEDICAL HISTORY

1. 請圈出病人過往有否以下病症/習慣。Does patient have any medical history or habit as indicated below? Please circle the appropriate.

哮喘 Asthma /心臟病 Cardiac problem /糖尿病 Diabetes Mellitus / 乙型肝炎 Hepatitis B / 高血壓 Hypertension /

曾接受手術 Previous operation /濫藥 Drug abuse /飲酒習慣 Drinking /吸煙習慣 Smoking /

其他疾病，請說明 Other remarkable illness, please specify _____/ 以上皆沒有 None

2. 該病人曾否因患上述疾病或其他嚴重疾病接受醫生或醫院治療？如是者，請述詳情
Had the patient been treated or hospitalized for the above illness or other major illness? If so, please give details.

日期 Dates	疾病 Disease/Disorder	治療/住院詳情 Details or treatment/hospitalization	醫生姓名/醫院名稱 Name of Physician/Hospital

3. 請提供病人飲酒/吸煙習慣詳情 Please provide details of Drinking & Smoking habit of patient.

習慣始自 Drinking/ Smoking start date since _____ (年/月/日 YYYY/MM/DD)

每日用量 Daily consumption _____ (支/包/樽/罐 piece/ pack/ bottle/ can)

_____ _____
主診醫生姓名 Name of Attending physician　　資歷 Qualification

_____ _____
地址 Address　　聯絡電話 Contact Phone No.

_____ _____
主診醫生簽署/ 醫院蓋章
Signature & Stamp of Attending Physician/ Hospital　　日期 (年/月/日)
Date (YYYY/MM/DD)