亞 洲 保 險
ASIA INSURANCE

TOTAL AND PERMANENT DISABILITY CLAIM FORM 完全及永久喪失工作能力賠償申請書

PART I (TO BE COMPLETED BY INSURED / CLAIMANT) 第一部份 (由受保人或申請人填寫)

Name of insured 受保人姓名	Policyholde 保單持有人名稱
Present occupation/position 職業	Policy No. 保單編號
Date and place of birth 出生日期及地點	I.D Card/ Passport No. 身分証/護照號碼
Age 年歲	Sex 性別
This is a: □ New claim 首次索償 □ Review 重批/覆核	Contact phone no. 聯絡電話
Correspondence address 聯絡地址	

Employment particulars: 就業詳情

1. Occupation and exact nature of occupational duties before disability 現職職位及職責	1.
2. Name and address of business or employer 公司或僱主名稱及地址	2.
3. Did you file a sick leave certificate with your employer? 曾否向僱主遞交病假証明書	3.
4. Date you last worked 最後工作日期 (DD/MM/YYYY)	4.
5. Date you returned to work, (if no, then give expected date of return) 何時恢復工作 (如否，祈望何時可恢復工作)	5.

Please complete if disability was due to illness: 因病而導喪失工作能力適用

6. Indicate the illness and give a brief description of symptoms 指出所患疾病及描述其病徵	6.
7. How long had he/she been having these symptoms prior to the first consultation? 受保人在首次就診前該等病徵已存在多久	7.
8. Give details of consultation. 治療詳情 i) The doctor first consulted for this illness. 首次就診醫生資料 ii) The doctor who referred the insured to hospital. 建議入院的醫生資料	8. Date 求診日期 Name(s) & Address(s) of Doctor(s)/ Hospital(s)醫生/醫院名稱及地址 i) ii)
9. Have you had this or similar trouble before? 在以前是否有同樣疾病或損傷	No 否 ☐ Yes 是 ☐ If so, when? (Date) / Name of doctor 如是，何時(日期) /醫生資料 …………………………………… …………………………………… ……………………………………

10. Details of Physician(s) consulted or Hospital(s) admitted for current disability.
曾就診此病之醫生或醫院詳情。

Name 姓名	Address 地址	Date (DD/MM/YYYY) 求診日期
a.		
b		
c.		

11. Are you insured for similar benefits with any other Company? If "yes", please state.
閣下是否受保於其他保險公司？如 "是"， 請填寫下欄。

Name of Insurer 投保公司名稱	Type/ Amount of Benefit 投保類別/金額	Policy numbe 保單號碼
a		
b		
c		

DECLARATION AND AUTHORIZATION 聲明及授權

I/WE UNDERSTAND AND AGREE THAT:
(1) THE FURNISHING OF THIS FORM OR ANY SUPPLEMENTARY FORMS BY ASIA INSURANCE COMPANY LIMITED SHALL NOT CONSTITUTE OR BE CONSIDERED AN ADMISSION BY IT THAT THERE WAS ANY INSURANCE IN FORCE ON THE TOTAL AND PERMANENT DISABILITY IN QUESTION NOR A WAIVER OF ANY OF ITS RIGHTS OR DEFENSES;

(2) THE ANSWERS TO ALL THE ABOVE QUESTIONS ARE COMPLETE, TURE AND ACCURATE AND ARE GIVEN TO THE BEST OF MY KNOWLEDGE AND BELIEF;

I/WE AUTHORIZED ANY PHYSICIAN, HOSPITAL, CLINIC OR ANY ORGANIZATION OR PERSON THAT HAS ANY RECORDS OR KNOWLEDGE OF THE ILLNESS, INJURY OR MEDICAL HISTORY OF THE INSURED, TO GIVE ASIA INSURANCE SUCH INFORMATION. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

本人了解及同意:

(一) 貴公司發出本表格或任何其他補充表格，並不表示貴公司承認上述完全及永久喪失工作能力保險有效，亦不表示貴公司放棄任何權利或答辯；

(二) 上述所有問題的答案均是完整，真實及準確，並且是盡本人所知及所信而作答的；

本人授權任何醫生，醫院，診所或機構或任何人士，凡對上述受保人之疾病，受傷或病歷有資料或紀錄者可將此類資料或紀錄供給亞洲保險有限公司，本授權書之影印副本同屬有效。

_____

SIGNATURE OF INSURED/CLAIMANT

受保人/索償人簽署

NAME 姓名:

I.D CARD/PASSPORT NO.身份証號碼:

DATE日期: (DD/MM/YYYY)

FOR USE OF ASIA INSURANCE 亞洲保險專用

亞 洲 保 險
ASIA INSURANCE

ASIA INSURANCE COMPANY LIMITED – PERSONAL INFORMATION COLLECTION STATEMENT ("PICS")

1. Your personal information and particulars may be required by Asia Insurance Company Limited (the "Company") in connection with our services and products. Failure to provide the necessary information and particulars may result in the Company being unable to provide or continue to provide these services and products to you.

2. The Company may also generate and compile additional personal data using the information and particulars provided by you. All personal data collected, generated and compiled by the Company about you from time to time is collectively referred to in this PICS as "Your Personal Data".

3. "Your Personal Data" will also include personal data relating to your beneficiaries, dependents, authorised representatives and other individuals in relation to which you have provided information. If you provide personal data on behalf of any person you confirm that you are either their parent or guardian or you confirm that you have obtained that person's consent to provide that personal data for use by the Company for the purposes set out in this PICS.

4. As detailed in this PICS, Your Personal Data may also be processed by the Company's subsidiaries, holding companies, associated or affiliated companies and companies controlled by or under common control with the Company (collectively, "the Group").

5. The Company may use the personal data the Company collect about you for the following purposes:
   (a) processing and assessing of applications or requests for any insurance products and daily operation of the related services;
   (b) administering your insurance policy and providing services in relation to your insurance policy;
   (c) investigating, analyzing, processing and paying claims made under your insurance policy;
   (d) exercising any right under the insurance policy including right of subrogation, if applicable;
   (e) detecting and preventing fraud (whether or not relating to the policy issued in respect of this application);
   (f) developing insurance and other financial services and products;
   (g) developing and maintaining credit and risk related models;
   (h) carrying out and/or verifying any eligibility, credit, physical, medical, security, underwriting and/or identity checks in connection with our services and products;
   (i) for statistical or actuarial research undertaken by the Company or any member of the Group;
   (j) complying with the requirements under any law and regulation, industry codes, guidelines, requests from regulators, industry bodies, government agencies and court order;
   (k) contacting you for any of the above purposes;
   (l) other ancillary purposes which are directly related to the above purposes.

6. Your Personal Data may be transferred or disclosed to the following parties in Hong Kong or overseas for the purposes set out in the above paragraph:
   (a) any insurance adjusters, agents and brokers, employers, healthcare professionals, hospitals, advisors, contractors or third party service providers who provide administrative, telecommunications, computer, payment, debt collection, security, data processing or storage or related services or any other company carrying on insurance or reinsurance related business, or an intermediary, or a claim or investigation or other service provider providing services relevant to insurance business, for any of the above or related purposes;
   (b) organisations that consolidate claims and underwriting information for the insurance industry;
   (c) fraud prevention organisations;
   (d) other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information;
   (e) any association, federation or similar organization of insurance companies ("Federation") 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;
   (f) any members of the Federation by the Federation for any of the above or related purposes;
   (g) regulators;
   (h) lawyers;
   (i) accountants, financial advisors, auditors;
   (j) other members of the Group;
   (k) any assignee, transferee, participant or sub-participant of all or any substantial part of the Company's business;

   The Company undertakes to keep the information confidential and solely for the purposes set out in the above paragraph.

7. If you do not agree to the use of your personal data for above purposes, it would not be possible for the Company to process your policy and/or claim application and render the services.

8. You have the right to ascertain the Company policies and practices in relation to personal data, obtain access to and to request correction of any personal information concerning yourself held by the Company and the Company has the right to charge you a reasonable fee for processing your data access request. Requests for such access or correction can be made in writing to the Personal Data Protection Officer, Asia Insurance Company Limited, 8/F, 118 Connaught Road West, Sheung Wan, Hong Kong SAR.

9. In case of any discrepancies between the English and Chinese versions of this PICS, the English version shall apply and prevail.

10. The Company reserves the right, at any time effective upon notice to you, to add to, change, update or modify this PICS.

Version: 05.09.2019

亞 洲 保 險
ASIA INSURANCE

亞洲保險有限公司 - 收集個人資料聲明

1. 亞洲保險有限公司（「本公司」）可能會要求閣下就本公司提供的服務及產品提供個人資料及詳情。如未能提供所需資料及詳情，可能會導致本公司無法向閣下提供或繼續提供有關服務及產品。

2. 本公司亦可以利用閣下提供的資料及詳情製作及匯編額外的個人資料。本公司不時收集、製作及匯編的所有個人資料，以下統稱為「閣下的個人資料」。

3. 「閣下的個人資料」亦包括由閣下提供有關閣下的受益人、受養人、獲授權代表及其他人士的資料。如閣下代表他人提供個人資料，代表閣下確認閣下乃是該等人士之父母或監護人或閣下確認已取得該等人士同意提供其之個人資料予本公司作本聲明之用途。

4. 如本聲明所述，閣下的個人資料亦可能被本公司的附屬公司、控股公司、聯營或聯屬公司或本公司控制的公司或與本公司受共同控制的公司（統稱「本集團」）處理。

5. 本公司將所收集閣下的個人資料，可能用作下列的用途：
   (a) 處理及評估任何保險產品之申請或要求，及有關服務之日常運作；
   (b) 管理閣下的保單及為閣下的保單提供相關服務；
   (c) 閣下保單索償的調查、分析、處理及賠償；
   (d) 行使有關保險單賦予的任何權利包括代位權，如適用；
   (e) 偵測和防止欺詐行為（無論是否與就此申請而發出的保單有關）所需的目的；
   (f) 發展保險及其他金融服務及產品；
   (g) 發展及維持本公司信貸及風險之相關模型；
   (h) 就本公司之服務及產品作出資格、信貸、身體、醫療、擔保、 承保及／或身份核証；
   (i) 作本公司或本集團的任何成員的統計或精算研究；
   (j) 遵守及符合任何法例及條例規定的要求、行業手則、指引，監管機構、相關行業認可機構、政府機構及法庭頒令的要求；
   (k) 為上述任何用途與閣下聯絡；
   (l) 與上述用途直接有關之其他附帶的目的。

6. 閣下的個人資料可能會轉移或披露予下列各方在香港或海外單位作前段所述的用途：
   (a) 任何保險理算人、代理和經紀、僱主、醫護專業人士、醫院、顧問、諮詢人、承辦商或提供行政、電訊、電腦、付賬、債務追討、保安、數據處理或儲存或有關服務的第三者服務供應人或任何其他從事與保險或再保險業務有關的公司，或中介人，或索償或調查或其他提供與保險業務有關的服務供應人，以達到任何上述或有關的用途；
   (b) 整合保險業申索和承保資料的組織；
   (c) 防欺詐組織；
   (d) 其他保險公司（無論是直接地，或是通過防欺詐組織或本段中指名的其他人士）；警察；和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊（及其運營者）；
   (e) 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），以達到任何上述或有關的用途，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；
   (f) 或透過聯會提供予任何聯會的會員，以達到任何上述或有關的用途；
   (g) 監管機構；
   (h) 執業律師；
   (i) 會計師、財務顧問、認可核數師；
   (j) 本集團的其他成員；
   (k) 任何承讓人、受讓人、本公司業務的任何實質部分的參與人或次參與人；

   本公司承諾將資料保密並純粹用作上述的用途。

7. 如果閣下不同意本公司使用閣下的個人資料於上述用途上，本公司可能不能處理閣下之保單及/或索償申請及為閣下提供服務。

8. 閣下有權查明本公司就個人資料的政策和實務，並有權要求查閱及更正由本公司持有有關閣下的個人資料，及本公司有權就處理閣下的查閱資料要求而收取合理費用。 有關查閱或更正的要求，可致函香港上環干諾道西一百一十八號八樓亞洲保險有限公司的個人資料保護主任提出。

9. 中英文版本如有差異，將以英文版本為準。

10. 本公司保留隨時增補、更改、更新及修訂本聲明之權利，任何更改將於發出通知時起生效

版本: 05.09.2019

亞 洲 保 險
ASIA INSURANCE

Part II: Attending Physician's Report – Total & permanent Disability Claim Form

(To be completed by physician at claimant's expenses)

第二部份: 醫療報告 – 完全及永久喪失工作能力賠償申請書

(由主診醫生填寫，費用由索償人支付)

Total and Permanent Disability

In order for a claim to be valid, the following definition must be fulfilled:

1. The insured must be permanently, totally and irreversibly disabled, thus, rendering him/ her totally incapable of being employed or engaging in any occupation whatsoever for remuneration or profit;
2. Total and irrevocable loss of sight of both eyes; or
3. Loss by complete severance of two limbs at or above the wrist or ankle; or
4. Total & irrevocable loss of sight of one eye & loss by complete severance of one limb at or above the wrist or ankle.

Name of Patient	HKID No./ Passport No.	Date of Birth (DD/MM/YYYY)	Age	Sex (M/F)

1. General

i. Are you the usual medical attendant? If "Yes", over what period do your record extend?

□ Yes □ No

_____

ii. When were you last consulted for this condition and how long had the symptoms been present at that time?

_____

iii. Date of last consultation / examination.

_____

iv. Date when first absent from work.

_____

v. Are you currently issuing Medical Certificates? If "Yes", for what period do you intend to renew them?

□ Yes □ No

_____

vi. Please give details of the patient's habits in relation to cigarette smoking and drink habit.

_____

2. Medical Details

i. What is the nature and extent of your patient's condition?

_____

ii. Please give the precise diagnosis.

_____

iii. Please describe the symptoms currently disabling your patient.

_____

iv. How long have the symptoms been present?

_____

v. Has the patient previously suffered from this condition or any related illness?

_____

vi. Is the patient suffering from any other condition? If "yes", does this have an effect on the condition above

□ Yes □ No

_____

vii. Please describe the residual disability:

□Recovered	□ Improved
□ No improvement	□ Deteriorating
□ Other, please specify	

viii. Are there any other circumstances that may have an effect on the patient's return to work?

_____

3. Nature of the treatment

i. What treatment is being rendered and what types of medication are being prescribed?

_____

ii. Please comment on the response to treatment.

_____

iii. Please give the name and address of all consultants, specialists or hospital to which your patient has been referred to or attended for this condition.

_____

iv. Is your patient still receiving hospital care? Please give details.

_____

4. Details of physical impairment

Please comment on your patient's ability to perform the following:

i. Capable of heavy manual duties (i.e. little restriction on mobility).

_____

ii. Capable of light manual duties (i.e. slight restriction on mobility).

_____

iii. Capable of sedentary duties (i.e. moderate restriction on mobility).

_____

iv. Incapable of sedentary duties (i.e. marked/ severe restriction on mobility)

_____

5. Details of mental impairment

i. Are stress, emotional or psychological conditions relevant to your patient's condition?
If "Yes", please comment.

□ Yes □ No

_____

ii. Do you anticipate that any psychological condition will permanently affect the insured's ability to resume employment? If "yes", please comment.

□ Yes □ No

_____

6. Prognosis

We should be grateful for your advice on your patient's ability to perform an occupation as follows:

	Own occupation	Other occupation (including sedentary)
i. Is your patient totally disabled from performing...		
ii. Do you anticipate an improvement in the condition so as to enable a return to ...		
iii. If "yes" when do you consider your patient will be able to resume work in ...		

7. Rehabilitation

i. Is your patient currently undergoing any form of rehabilitation? If Yes, please provide details.

□ Yes □ No

_____

ii. Please comment on any further treatment or rehabilitation which may improve your patient's condition. (e.g. retraining, physiotherapy)

_____

8. Further information

If there is any further information which, in your opinion, will assist us in assessing this claim, please give details: (we should be grateful for copies of any relevant hospital reports which are available.)

_____

9. In your opinion, does the condition suffered by your patient fulfil the definition stated?

_____

Declaration

I hereby certify that I have personally examined and treated the patient in connection with the above disability and that the facts as given above present my opinion of his / her condition.

I hereby certify that I have not withheld any information at the request of the patient.

_____ _____

Signature of physician (with stamp) Name of physician

_____ _____

Qualification Telephone no.

_____ _____

Address Date