MassMutual FINANCIAL GROUP℠

GROUP INSURANCE CRITICAL ILLNESS & TOTAL DISABILITY BENEFIT CLAIM FORM
團體保險嚴重疾病及傷殘保障索償申請表

Policy Number 保單編號	Name of Employer 僱主名稱
Name of Insured 受保人姓名	HK ID/Passport No. 身份証 / 護照編號
Residential Address 住址	

The issue of this form is in no way an admission of liability. No fee, commission or charge of whatever nature is required be paid to the employees or agents of the company with respect to this claim. Both Part I and Part II have to be completed.
發出此申請書並不表示本公司已接納是次索償申請。在此索償過程中，索償人無需支付任何性質之手續費予本公司之僱員或營業員。敬請填妥第一及第二部份。

PART I : CLAIMANT'S STATEMENT 第一部分 : 索償人聲明

Questions 問	**Answers** 答
1. What was the cause of this claim? Accident or Illness? (Please give full detail in appropriate box at the right column.) 是次索償原因為何？因意外受傷抑或由疾病導致？〔請詳述於右面適當空格內〕	
2. If claiming for an accident, complete the following questions: 若住院由意外導致，請填妥以下資料	
a. When did the accident happen ? 是次意外發生日期及時間	a.
b. How did it happen ? 是次意外發生之經過	b.
c. Which part(s) of the body was/were injured ? 受傷部位	c.
d. Which police station had the case been reported to and what was the police reference number ? 報案警署名稱及檔案編號	d.
3. If claiming for an illness, complete the following questions: 若住院由疾病導致，請填妥以下資料	
a. What were the symptoms presented ? 病徵為何	a.
b. How long had the symptoms been appeared ? 該病徵已持續多久	b.
c. Give the name(s) of the attending doctor that the Insured first consulted for this illness. 最初診治此症之醫生	c. Date 日期 Name and Address 姓名及地址
4. When did you become completely unable to attend to any business or occupation ? 閣下何時開始完全不能工作？	
5. Have you been wholly confined to bed since the disability, at home or in hospital ? Please name the activity(ies) you can perform. 從當日起，閣下是否需要完全躺臥在床上、在家中抑或在醫院內？請列出閣下可執行之工作或活動。	
6. Give the name(s) of all attending doctors who have treated the Insured for similar or related illness. 曾求診之所有醫生資料	Name & Address 姓名及地址 / First Consultation Date 求診日期 / Cause 原因 / Follow up Card No. 覆診卡編號
7. If you have been treated in hospital or similar institutions, please give details. 如閣下需入院接受治療，請詳述	Name of Hospital 醫院名稱 / Admitted on 入院日期 / Discharged on 出院日期 / Diagnosis 病因 / Ward/Ref. No. 檔案編號
8. Have you ever suffered from the same or similar or related condition? Please give detail of each episode of attack. 閣下以往曾否患有同類形或有關病徵？請詳述每次發病情況	Date 病初起日期 / Exact Cause of Loss 病因 / Period absent from work 不能工作之時期 / Doctor attended 主診醫生姓名及地址
9. Has your mother, father or any brother or sister suffered from diabetes, heart disease, stroke or cancer? Please give date and full particulars. 閣下之父母、兄弟或姊妹中，有否患有糖尿病、中風或癌症？如有，請詳述患病日期及詳情	

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10. Have both parents died? Please state age and cause of death. 閣下之父母是否已身故？如是，請列明死亡日期及死因。	Date of Death 死亡日期 Cause of Death 死因 Father 父 Mother 母
11a. Do you smoke **?** 閣下是否吸煙人仕？	a.
b. Have you ever smoked (whether you still smoke or not) 倘閣下是**或**曾為吸煙人仕，請問	b.
i. When did you start smoking? 閣下何時開始吸煙？	i.
ii. What type and how many do / did you smoke (e.g. cigarettes, cigars, etc.) per day? 種類及每天吸煙量	ii.
iii. If you have ceased smoking, when did you last smoke? 若閣下已停止吸煙，請問何時停止吸煙？	iii.
12. Have you ever been or are you at present insured by some other insurance company/ies? Please tell us in detail. 閣下曾否於其他保險公司投保？如有，請提供保險公司名稱及保單編號？	
13a. What is your occupation (including any part-time employment) and duty involved prior to disablement / accident? 閣下於停止工作/意外以前之職業〔包括兼職之工作〕為何？	a.
b. In relation to your current loss, are you entitled to receive any form of benefit granted by your employer? Please give detail. 就是次損失，閣下會否獲得僱主發出之團體保險賠償？請詳述	b.
c. Please give name and address of your employer. If you were self-employed, please tell us your company's name and usual place of business. 閣下現時僱主名稱及地址為何？如屬自僱，閣下公司名稱及慣常工作地點為何？	c.
14. When did you return to work and in what profession? To what extent had the loss been prevented you from returning to work if you are still ceasing work. 閣下恢復工作之日期及職業為何？如閣下仍未能恢復工作，請詳述閣下未能工作之原因	

DECLARATION 聲明

I, the undersigned, hereby declare and agree on behalf of myself and all Relevant Persons that all information deposed hereinabove, whether it is written by me or not, is true and complete to the best of my/our knowledge and belief and I have not withheld any material information connected with this claim. I have also read and understood the Personal Information Collection Statement stated below and provide the information herein on a voluntary basis. However, I understand that failure to provide information as per MassMutual Asia Ltd ("MMA")'s request may result in MMA being unable to process this claim. This claim form and all other documents submitted to MMA for this claim shall be the property of MMA, and will be non-returnable under all circumstances. 本人，即下方簽署者，現謹此代表本人/所有有關人士同意聲明上述披露之一切資料，不論是否由本人手寫，就本人所深知及確信均屬完整並真確無訛。本人就本申請並無隱瞞任何重要資料。本人亦已閱讀及明白下述的個人資料收集聲明。本人在此提供的資料均屬自願。本人明白若本人未能依據美國萬通亞洲有限公司(「美國萬通」)要求提供資料，可導致美國萬通不能處理本索償。本申請表及一切其他文件在遞交給美國萬通後便會成為美國萬通的財產。在任何情況下均不會獲得退回。

AUTHORIZATION 授權

I hereby authorize on behalf of myself/the insured and all Covered Person(s) (1) any individual or organization (including but not limited to any employer, registered medical practitioner, hospital, clinic, insurance company, bank, police, governmental department, private or public institution) that has any record, statement, information of mine/the insured or any of the Covered Person(s) (whether medical or otherwise) to release, disclose or transfer all the information to MMA or its representatives for the purposes of assessing and processing any insurance claim. (2) MMA or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and/or tests to evaluate my/the insured's or any Covered Person(s)'s health status in related to this claim. I hereby acknowledge that (1) this authorization shall be binding on my successors and assignees and remain valid and subsisting notwithstanding my death or incapacity for whatever reasons; (2) A photostat copy of this authorization shall be as valid as its original. I also declare that there is no change to my record provided by the Employer upon my enrollment, and if there are any changes to my record, I shall forthwith provide documentary proofs of such changes satisfactory to MMA, and I authorize MMA to obtain from and verify my personal information with the Employer for the purpose of conducting due diligence under the relevant laws and regulations. 本人現授權代表本人/所有受保人(1) 任何擁有本人/吾等任何記錄、供詞、資料(不論是否醫學資料)之人士或機構(包括但不限於任何僱主、註冊醫生、醫院、診所、保險公司、銀行、警察、政府部門、公共或私營機構)向貴公司或其代表發放、披露或轉交任何與評核及處理保險索償申請有關的資料。(2) 貴公司或任何由貴公司指定的醫務人員或化驗所可就本申請對本人/所有受保人進行有需要之醫療評估及測試，以審核本人/所有受保人的健康狀況。本人現確認 (1) 此授權書對本人之繼承人及受讓人具有約束力，即使本人死亡或無行為能力(不論任何原因)，此授權書仍然生效及具效力; (2) 本授權之副本與正本具有同等效力。本人亦聲明由僱主於登記時所提供有關本人的資料並沒有任何更改，如有關的資料有任何更改，本人會立刻向美國萬通提供與更改有關的及符合其要求之證明文件。本人亦授權美國萬通向僱主索取及核實本人的個人資料，作為於有關法例及規例下進行盡職審查之用。

PERSONAL INFORMATION COLLECTION STATEMENT個人資料收集聲明

The information you provide to MassMutual Asia Limited ("the Company") or its Consultants (whether or not the information was supplied by you in this application or otherwise) is collected to enable the Company to carry on its insurance business and may be used for the purposes of : - (1) evaluating and processing policy service requests, administering and reinsuring your insurance coverage with the Company (2) adjudicating any insurance or related claims, or conducting any investigation or analysis of such claims; (3) promoting and providing any insurance or financial related product or service or any addition, alternation, variation, cancellation, renewal or reinstatement of such product or service; (4) exercising any right of subrogation; (5) calculating premiums or benefits; (6) data matching and direct marketing; (7) communicating with any person or organization relating to this and other insurance claims; (8) any other purpose relating to the settlement of your insurance coverage with the Company; and may be used, held, transferred or disclosed to (1) any related individual or company associated with the Company or any other company carrying on insurance or reinsurance related business or any intermediary or a claims or investigation or other service provider providing services relevant to insurance business or professional advisers for any of the above or related purposes; (2) any association, governmental authority of federation of insurance companies ("Authority") that exists or is formed from time to time for any of the above or related purposes or to enable the Authority to carry out its regulatory functions or such functions that may be assigned to the Authority from time to time and are reasonably required in the interest of the insurance industry or any members of the Authority; and (3) any selected party as we may consider necessary whether within or outside Hong Kong or Macau. You, the insured and all Covered Person(s) and other Persons referred to in this claim form ("Relevant Persons") have the right under the Personal Data (Privacy) Ordinance or Law Relating to the Protection of Personal Data or Law Relating to the Protection of Personal Data (as the case may be) to have access to, and to correct any of your personal data held by the Company. Request whereof shall be made in writing and addressed to the Manager of the Employee Benefit, and delivered to the Company's head office at 27/F, MassMutual Tower, 33 Lockhart Road, Wanchai, Hong Kong or to the Macau office at Avenide Praia Grande No. 517, Edificio Comercial Nam Tung 16-E2, Macau (as the case may be). 閣下提供的資料(不論是藉閣下於本申請中或透過其他途徑所提供)，為美國萬通保險亞洲有限公司(「本公司」)或其顧問提供保險業務所需，並可能使用於下列目的: (1) 評審及處理保單服務要求，就閣下於本公司之保險保障提供行政及再保險服務; (2) 評核任何保險或相關索償，或就該等索償進行任何調查或分析; (3) 推銷及提供任何與保險或財務有關的產品或服務，或就該等產品或服務所作的任何增加、更改、變更、取消、續期或復效; (4) 行使任何代位權; (5) 計算保費或得益; (6) 資料核對及直接銷售; (7) 聯絡與此或其他保險索償有關的人士或機構; (8) 任何關於賠償閣下於本公司的保險保障的其他用途;及可能被使用、保存、轉移或披露予(1) 任何與本公司有聯系的有關個人或公司，或任何其他從事與保險或再保險業務有關的公司，或與任何保險業務有關的中介人或索償或調查或其他服務提供者，或專業顧問以達到任何上述或有關目的; (2) 任何團體、政府機構或現存或不時成立的任何保險公司協會或同類組織(「該等機構」)以達到任何上述或有關目的，或以便該等機構執行其監管職能，或其他基於保險業或任何該等機構會員的利益而不時在合理要求下賦予該等機構的職能；及 (3) 任何本公司認為有需要之有關人等(不論在香港或澳門以外)。根據個人資料(私穩)條例或個人資料保護法，閣下、任何合資格的僱員、其家屬及其他在本申請書內所指人士(「有關人士」)有權查閱和更正本公司持有閣下或有關人士的個人資料。閣下或有關人士可以書面方式呈交本公司位於香港灣仔駱克道33號美國萬通大廈27樓的總公司或澳門南灣大馬路517號南通商業大廈16樓E2座的澳門分公司，向僱員福利部經理提出有關要求。

Signature of Witness 見證人簽署　　Signature of Insured 受保人簽署

Agency Location and Code 區域及編號　　Insurance Consultant 保險顧問　　Date 日期

PART II must be completed by the Insured's attending doctor. 第二部份必須由診治受保人之註冊西醫填寫

MassMutual Asia Ltd. 美國萬通保險亞洲有限公司

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PART II ATTENDING PHYSICIAN STATEMENT (CI/TPD)

Patient Name : _____ Age : _____ HKID Card No. : _____

NOTE : **No claim will be admitted unless the form below is duly completed by a registered medical practitioner. MassMutual Asia will not be responsible for any fee for the completion of this report.**

Questions	Answers
1. How long have you known the patient? If you know this patient prior to the consultation of the claimed illness/disorder, how did you know this patient?	
2. Was the patient being referred to you from another doctor? If yes, please give us his/her name and address.	☐ No ☐ Yes
3a. When did you first attend the patient?	3a
3b. What were the complaints and symptoms presented? How severe was the condition? How frequent was the attack?	3b.
3ci. How long has the patient experienced such symptoms prior to first consultation?	3ci.
3cii. How long do you think the symptoms has lasted prior to first consultation to you? Did you inform the patient of your opinion? If yes, when?	3cii.
4. Has any laboratory test such as cytological, X-Ray, pathological or serological studies been performed? Please give details and provide us with a set of the results to us if available.	Date performed Detail of Procedure Result / Readings
5. Please list down the date and details of each visit of the patient to your clinic/hospital in the order of dates	Date Complaints Diagnosis Treatment / Physiotherapy (Length of Course)

Please Turn Over

6a. Has the patient previously suffered from same or similar disorders?	6a.
6b. If yes, please give the date and details of each disorder	Date of occurrence / Exact Nature / Cause of Attack / Test /Treatment Received / Duration of Disability / Doctor Attended
6c. If not, do you consider that the disability is in any way associated with a pre-existing disease or disorder? If available, please provide the date and details of when the patient was aware of such pre-existing disease or disorder.	6c.
7a. What was your final diagnosis? Please also give the date of diagnosis.	7a.
7b. When was the onset date before the patient first consulted you (as mentioned in Q3)?	7b.
8a. When did the patient first become unable to engage in employment or business?	8a.
8b. Will you expect that the patient would have been prevented from engaging in any occupation, employment or business and remains in the same condition which continuously requires medical care and attention? Please give reason?	8b.
8c. For how long would the patient remain in the above condition? Please let us know the rehabilitation plan for the patient.	8c.
9a. When did you last see the patient?	9a.
9b. What was the condition of the patient?	9b.
10. Did you have any other information to supplement the above? Please give us in details.	
11. Please give the name and address of other doctors who have treated the patient:	

I hereby certify that I have personally attended the above named claimant and that all the information supplied by me on this form is true and correct to the best of my knowledge and brief.

Signature : _____ Date : _____

Name of Medical Attendant : _____ M.D. Qualification(s) : _____

Stamp of Hospital/ Medical Center : _____

Doctor : This report is a matter of importance to the Insured, please complete and return it without delay. Thank you very much.