MassMutual FINANCIAL GROUP℠

GROUP DENTAL CLAIM FORM
團體牙醫保健賠償申請表

To avoid return of claim due to incomplete information, please answer all questions. 為免因資料不全而被退回索償申請，請回答所有問題

TO BE COMPLETED BY INSURED MEMBER 此部份由受保成員填寫

* If the Insured Member is a child under 18 years of age, this form is to be filled in and signed by the Employee concerned.
若受保成員是僱員子女而少於十八歲，此表格須由僱員代為填寫及簽署。

NAME OF EMPLOYER 僱主名稱		NAME OF EMPLOYEE 僱員姓名
POLICY NUMBER 保單號碼	NAME OF PATIENT 病者姓名	HK I.D./CERT NO. 身份證/證書號碼
RESIDENTIAL ADDRESS 地址		

TO BE COMPLETED BY ATTENDING DENTIST 此部份由應診牙醫填寫

PLEASE ANSWER AS COMPLETELY AS POSSIBLE

If prosthesis, is this initial placement? If yes, please give brief description and dates

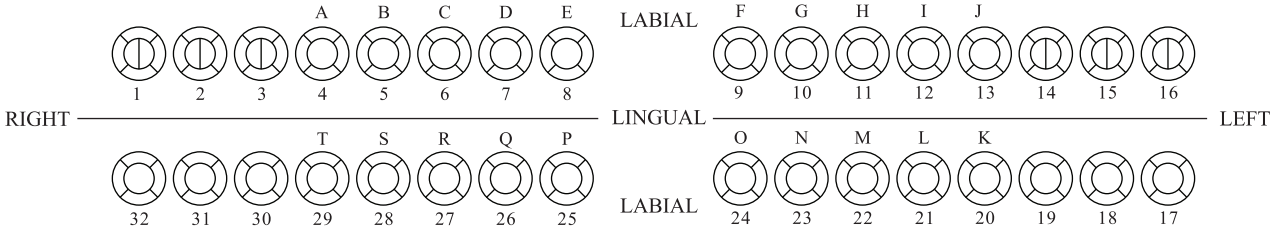
Is treatment for orthodontics?	Is treatment a result of accident?

Please fill in the particulars for oral treatment (including X-rays, prophylaxis, material used, etc):

Tooth No.	Particulars	Charges
1.		
2.		
3.		
4.		

Please mark teeth treated or area of oral treatment on following chart.

☐ PERMANENT TEETH ☐ DECIDUOUS TEETH



I hereby certify that the services listed above have been performed on the above-named patient on the date indicated.

Dentist's Name : _____ Dentist's Signature & Stamp : _____ Date : _____

Declaration and Authorization 聲明及授權

I declare that I am the insured member of the above mentioned policy and all the information supplied by me on this form is complete and true to the best of my knowledge and belief. I also declare that I have read and understood the Personal Information Collection Statement stated below. I authorize any medical attendant, hospital, clinic, insurance company or other organization, institution or person, who has any records or knowledge of me or my health to divulge to MassMutual Asia Ltd. ("MMA") any information required for the purpose of evaluating the claims application. A photocopy of this authorization shall be as valid as the original. I also confirm that the claims information regarding myself may be released to my Employer or related parties from MMA. 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 my Employer for the purpose of conducting due diligence under the relevant laws and regulations.

現聲明本人乃上述保單之受保成員，就本人所知及所信以上所填報之資料均正確無訛。本人亦聲明已閱讀及明白下列個人資料收集聲明。 本人茲授權持有本人健康或任何資料之註冊西醫、醫院、診所、保險公司、機構、協會或人仕，可以將有關資料提供予美國萬通保險亞洲有限公司("美國萬通")，作為賠償申請之參考。此授權書之副本與正本有同等效力。本人亦同意美國萬通可向本人之僱主或相關人士提供有關本人之索償資料。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美國萬通要求之證明文件。本人亦授權美國萬通向本人之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 or its Consultants (whether or not the information was supplied by you in this application or otherwise) is collected to enable the Insurer 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 Insurer; (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 Insurer; and may be used, held, transferred or disclosed to (1) any related individual or company associated with the Insurer 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. You and all Relevant Persons have the right under the Personal Data (Privacy) Ordinance or the Law Relating to the Protection of Personal Data to have access to, and to correct any of your personal data held by the Insurer. Request whereof shall be made in writing and addressed to the Manager of the Employee Benefit, and delivered to the Insurer's head office at 27/F, MassMutual Tower, 33 Lockhart Road, Wanchai, Hong Kong; or Macau office at Avenide Prais Grande No. 517, Edificio Comercial Nam Tung 16-E2, Macau.

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Signature of Patient (18 years of age or over)
病者簽署（如超過十八歲）

Signature of Employee
僱員簽署

Date : (MM / DD / YY)
日期 （月 / 日 / 年）

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