MassMutual FINANCIAL GROUP℠

First Policy No.: 第一份保單編號：								
Second Policy No.: 第二份保單編號：								

ACCIDENT BENEFIT CLAIM FORM 意外傷亡保障索償申請書 (C01)

Name of Insured : 受保人姓名 ：	ID Card No. of Insured : 受保人身份證號碼 ：
☐ First Claim 此意外首次索償 ☐ Further Claim 延續索償	

The issue of this form is in no way constitute an admission of liability. During the claim process, no fee, commission or charge of whatever nature shall be paid to the employees or Consultants of MassMutual Asia Limited ("the Company"). All parts must be completed before we will process the claim. In the event of the claim involving any payment to be made by the Company, the Policy Owner / Insured / Assignee must provide valid documentation proofs (such as identity document and address proof) to the satisfaction of the Company for the Company to conduct due diligence pursuant to the Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance, Cap.615.

發出此申請書並不表示美國萬通保險亞洲有限公司("本公司")已承認是次賠償責任。在此索償過程中，索償人無需支付任何費用予本公司之僱員或顧問。本索償申請書所有部份必須填妥。於處理任何索償而涉及本公司需要付款予客戶的情況下，有關之保單持有人 / 受保人 / 承讓人必須提交符合本公司要求之有效証明文件(例如其身份證明及地址證明)，讓本公司能按照於「打擊洗錢及恐怖分子資金籌集(金融機構)條例」第 615 章所載進行客戶盡職審查。

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

Questions 問	Answers 答
1a. Date and time of the accident? 發生是次意外之日期及時間?	1a. _____ / _____ / _____ _____ AM/PM MM 月 DD 日 CCYY 年 Time 時間 上午/下午
1b. Where and how did it happen? 發生是次意外之地點及情況?	1b. Place of the Accident 發生意外之地點 ： Details of the Accident 意外之經過及詳情 ：
1c. Which part(s) of body is injured? 是次意外導致受保人受傷之身體部位?	1c.
1d. Had the accident been reported to police? If yes, please attach police report or provide the name of police station, the file number and vehicle number. 曾否就是次意外報警? 若有，請提供警署報告副本或警署名稱、檔案號碼及車牌號碼。	1d. ☐ No 沒有報警 ☐ Yes 有報警 Police Station : _____ File No. : _____ 報案警署名稱 檔案號碼 Vehicle number : 車牌號碼
2a. Occupation and exact duties of the Insured at the time of the accident? 於是次意外發生時受保人之職業及職責?	2a.
2b. Name and address of the company or employer of the Insured at the time of the accident? 於是次意外發生時，受保人之公司或僱主名稱及地址?	2b.
2c. When did the Insured cease working after the accident? 於是次意外發生後，受保人由何時開始停止工作?	2c. _____ / _____ / _____ ☐ Not ceased working MM 月 DD 日 CCYY 年 未曾停止工作
2d. When did the Insured resume to work after the accident? 於是次意外發生後，受保人由何時恢復工作?	2d. _____ / _____ / _____ ☐ Not yet *(Please give reason)* MM 月 DD 日 CCYY 年 尚未知道 *(請提供原因)*
2e. To what extend had the injury prevented the Insured from resuming to work if he/she is still ceasing work? 若受保人現時仍未能恢復工作，請提供未能恢復工作的原因?	2e.
3. Name and address of all doctors who the Insured had received treatments. 曾診治過受保人之所有醫生的姓名及地址。	3. Consultation Date 診治日期 Name of Doctor 醫生姓名 Address of Doctor 醫生地址
4. Did the Insured file a claim for Employee's Compensation or other compensation for the accident? 受保人有否就是次意外受傷申請僱員補償或其他索償?	4. ☐ No 沒有 ☐ Yes 有 *(Please provide copy of the claim documents 請提供索償文件副本)*
5. As a result of the accident, has the Insured applied for compensation from other insurance company / organization? If yes, please give details. 受保人有否就是次意外受傷向其他保險公司申請任何類型的賠償? 若有，請詳細說明。	5. ☐ No 沒有 ☐ Yes 有 Name of company / organization 公司名稱 Policy No. / Reference No.保單號碼/參考編號

☐ Request for Return of Original Receipts / Documents 申請退回正本收據/文件

Signed by Policy Owner 保單持有人簽署 X _____

PERSONAL INFORMATION COLLECTION STATEMENT

I/We understand and agree my/our personal information (including a record of my/our image or voice by whatever means and my/our health information) collected by or held by MassMutual Asia Limited ("the Company") may be used for the purposes of: (1) approving, evaluating or processing my/our insurance application/policy service request; (2) administering, maintaining or reinsuring my/our policies; (3) adjudicating my/our claims, or conducting any investigation or analysis of my/our claims; or (4) data matching. I/We understand and agree that failure to provide any information requested by the Company may result in the Company not being able to process my/our insurance application/policy service request.

I/We understand and agree my/our personal information collected by or held by the Company may be transferred or disclosed by the Company to any of the following persons (whether within or outside Hong Kong) for the purposes as specified above or to governmental/regulatory bodies (whether within or outside Hong Kong) for them to carry out their governmental/regulatory functions: (1) MassMutual group companies and their associated/affiliated companies; (2) financial institutions, insurance companies, intermediaries and reinsurers; (3) claims investigation companies or any companies/persons necessary for claims assessment/investigation; (4) industry associations/federations and their members; (5) governmental/regulatory bodies and law enforcement agencies; and (6) service providers and selected persons which are under a duty of confidentiality to the Company.

I/We understand that I/we have the right to access to, and to correct, any of my/our personal information held by the Company by writing to our Personal Data Protection Officer. (Address : 27/F, MassMutual Tower, 33 Lockhart Road, Wanchai, Hong Kong or Avenida Praia Grande No. 517, Edificio Comercial Nam Tung 16-E2, Macau). The Company may charge a reasonable fee for the processing of such request.

DECLARATION

I/We, the undersigned, hereby declare that all information deposed hereinabove, whether they are written by me/us or not, is true and complete to the best of my/our knowledge and belief and I/we have not withheld any material information connected with this claim. I/We also have read and understood the Personal Information Collection Statement stated above. I/We provide the information herein on a voluntary basis. However, I/we understand that failure to provide information as per the Company request may result in the Company being unable to process with this claim. This claim form and all other documents submitted to the Company for this claim shall be the property of the Company, and will be non-returnable under all circumstances.

If there is any subsequent change to the information provided, I/we undertake to notify the Company as soon as possible.

I/ We hereby agree and authorize the Company, according to the Insurance (Levy) Regulation, to deduct (1) corresponding levy on unpaid premium (if any); and (2) outstanding levy of the policy(ies) (if any) from the claim payment of the policy(ies) payable to me/ us. The levy will be remitted to the Insurance Authority by the Company. (Applicable to policy issued in Hong Kong)

AUTHORIZATION

I/We hereby on behalf of myself/ourselves irrevocably authorize (1) any individual or organization (including but not limited to my/our employer, registered medical practitioner, hospital, clinic, insurance company, bank, police, governmental department, public or private institution) that has any record, statement, information of mine/us (whether medical or otherwise) to release, disclose or transfer all the information to the Company or its representatives for the purposes of assessing and processing any insurance claim. (2) The Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and/or tests to evaluate my/our health status in related to this claim. I/We hereby acknowledge that (1) this authorization shall be binding on my/our successors and assignees and remain valid and subsisting notwithstanding my/our death or incapacity for whatever reasons; (2) A photocopy of this authorization shall be as valid as its original. I/We hereby grant my/our consent to the Company to collect, use and transfer the above health information in accordance with the Personal Information Collection Statement.

個人資料收集聲明

本人/我們明白及同意美國萬通保險亞洲有限公司(“貴公司”)所收集或持有本人/我們的個人資料(包括任何形式的肖像、聲音及與健康有關的資料)可能會被用於下列目的：(1) 批核、評審及處理本人/我們之投保計劃申請/保單服務要求；(2) 就本人/我們之保單提供行政、持續或再保險的服務；(3) 評核本人/我們索償，或就本人/我們之索償進行調查或分析；或(4) 資料核對。本人/我們明白及同意必須提供貴公司所需的個人資料，否則，貴公司將不能處理本人/我們之投保申請或就本人/我們之保單提供服務。

本人/我們明白及同意貴公司可能為達到上述目的或讓政府/監管機構(不論在香港或海外)執行其職務而向以下任何一方(不論在香港或海外)轉移或透露由貴公司收集或持有屬於本人/我們的個人資料：(1) MassMutual 集團成員公司及其關聯或相關公司；(2) 金融機構、保險公司、中介人或再保險公司；(3) 賠償調查公司及所需有關評核索償之公司及/或人士; (4) 行業組織/聯會及其成員；(5) 政府部門或監管機構和執法機構；及 (6) 與貴公司有保密協議的服務提供者及其他人士。

本人/我們明白本人/我們有權查閱和更改任何由貴公司持有屬於本人/我們的個人資料。如有需要，本人/我們可與貴公司的資料保護主任提出有關要求、並以書面方式呈交(地址：香港灣仔駱克道 33 號美國萬通大廈 27 樓或澳門南灣大馬路 517 號南通商業大廈 16 樓 E2 室)。處理上述要求時，貴公司可能會收取合理費用。

聲明

本人/我們，即下方簽署者，謹此聲明上述披露之一切資料，不論是否由本人/我們手寫，就本人/我們等所深知及確信均屬完整並真確無訛。本人/我們就此索償申請並無隱瞞任何重要資料。本人/我們等亦已閱讀及明白上述的個人資料收集聲明。本人/我們在此提供的資料均屬自願。若未能依據貴公司要求提供資料，本人/我們明白會導致貴公司不能處理此索償。此索償申請書及一切其他文件在遞交給貴公司後便會成為貴公司的財產。在任何情況下均不會獲得退回。

若本人/我們所提供的資料有任何更改時，本人/我們確保盡快通知貴公司有關的更改。

本人/我們謹此同意及授權貴公司按《保險業(徵費)規例》從支付予本人/我們之賠償金額中扣除保單 (1) 未繳保費的相關徵費(如適用)；及 (2) 尚欠的徵費(如適用)，並由貴公司把徵費轉付至保險業監管局。(只適用於香港簽發之保單)

授權書

本人/我們現授權(1) 任何擁有本人/我們等任何記錄、供詞、資料(不論是否醫學資料)之人士或機構(包括但不限於本人/我們的僱主、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此索償對本人/我們等進行有需要之醫療評估及測試，以審核本人/我們的健康狀況。本人/我們現確認 (1) 此授權書對本人/我們之繼承人及受讓人具有約束力，即使本人/我們死亡或無行為能力(不論任何原因)，此授權書仍然生效及具效力; (2) 本授權書之副本與正本具有同等效力。本人/我們謹此授權貴公司可按「個人資料收集聲明」的規定收集、使用及轉移上述有關本人/我們健康方面的資料。

Signature of Consultant 顧問簽署	Signature of Policy Owner 保單持有人簽署	Signature of Insured 受保人簽署 (only if age is over 18 若年齡超過 18 歲)
Name and Code of Consultant 顧問姓名及編號	Name of Policy Owner 保單持有人姓名	Name of Insured 受保人姓名
Date 日期	Policy Owner's ID No. 保單持有人身份證號碼	Insured's ID No. 受保人身份證號碼

To be completed by Consultant 由顧問填寫	
a) After the injury of the Insured, did you visit him/her? If yes, please describe the condition of the Insured's injury. 受保人受傷後，閣下曾否拜訪受保人? 若有，請提供會面時受保人的健康狀況及傷勢。	
b) Did the Insured resume to work when the claim form was completed? If yes, please give the date of resumption of work? 受保人於填報申請書時是否已康復並回復正常工作? 若是，請列明回復工作日期。	

CONSULTANT'S DECLARATION : I declare that the above statements and answers given are true and complete to the best of my knowledge.
顧問聲明 : 本人謹此聲明上述一切陳述及所有答案，就本人所知所信均為事實之全部，並確實無訛。

Signature of Consultant 顧問簽署	Date 日期

PART II : ATTENDING PHYSICIAN'S STATMENT 第二部份 ： 醫生報告

病者姓名 :
Patient's Name : _____ 年齡:
Age : _____ 身份證號碼.:
ID Card No. : _____

NOTE 注意 : No claim will be admitted unless the report below is duly completed by the medical attendant of the Patient. MassMutual Asia Limited will not be responsible for any fee for the completion of this report. 本報告必須由病者之主診醫生填寫。美國萬通保險亞洲有限公司不會負責填寫此報告之費用。

Questions 問	Answers 答
1a. First date of consultation of the patient's record? 首次就診日期? 1b. First date of consultation of the claimed illness/disorder? 因今次傷患向閣下首次求診日期?	1a. _____ / _____ / _____ MM 月 DD 日 CCYY 年 1b. _____ / _____ / _____ MM 月 DD 日 CCYY 年
2. When did the accident happen? 病者之意外何時發生?	2. _____ / _____ / _____ MM 月 DD 日 CCYY 年
3. Which part of the body get injured? 請列明病者受傷部位。	3.
4. Describe the cause and the extent of injury? 請提供意外之發生情況及其傷勢。	4.
5. Was there any evidence of a visible bruise or wound at patient's first visit? If yes, please provide details. 病者第一次求診時，有沒有明顯瘀痕或傷口? 若有，請提供詳情。	5. ☐ No 否 ☐ Yes 有 Details 詳情 : _____
6. What is the current condition of the injury? Please state complications, if any. 病者現時傷勢如何? 若有任何併發症，請列明。	6.
7. What type(s) of treatment have been given? (e.g. Suturing, Physiotherapy or Dressing, etc.) 病者曾接受哪一種治療? (例如縫針、物理治療和包紮等)	7. Date 日期 / Details of Treatment 治療詳情
8. As a result of the injury, has the patient taken the following test(s)? If yes, please give details. 就此次意外，病者有否接受以下之檢驗? 請詳細列明: a. X-rays X 光檢查 b. MRI / CT scan / others 磁力共振 / 電腦掃描 / 其他 c. Surgery 外科手術 d. Hospitalization 留院治理	8. No 否 / Yes 是 / Date 日期 / Result of Test(s) 檢查結果 ☐ ☐ _____ _____ ☐ ☐ _____ _____ ☐ ☐ _____ _____ ☐ ☐ 入院日期 Admitted on _____ 出院日期 Discharge on _____
9a. After the accident, please provide the period of which : 意外發生後，請提供 : The patient is unable to perform each and every duty of his/her own occupation (as stated on page 1) 病者無法從事其本身職業(頁一上註明)之所有職責之時期 : 9b. The patient is unable to perform one or more major duties of his/her own occupation 病者無法從事其本身職業一項或多項主要職責之時期 :	9a. _____ (MM/DD/CCYY) (月/日/年) to _____ (MM/DD/CCYY) (月/日/年) Reason 原因 _____ 9b. _____ (MM/DD/CCYY) (月/日/年) to _____ (MM/DD/CCYY) (月/日/年) Reason 原因 _____
10. Was there any factors which may have contributed to the accident and/or lengthen the period of disability? If yes, please give details. 是否因某種因素而促成此次意外及/或延長此次傷殘時間? 若是，請詳細列明。	10. Past injury or illness 過去傷患或疾病 ☐ No 否 ☐ Yes 是 Self-inflicted injury 自傷身體 ☐ No 否 ☐ Yes 是 Alcohol or drugs intoxication 酒精或藥物中毒 ☐ No 否 ☐ Yes 是 Degenerative changes 退化性病變 ☐ No 否 ☐ Yes 是 Congenital anomalies 先天性缺陷 ☐ No 否 ☐ Yes 是 Chronic disease 慢性疾病 ☐ No 否 ☐ Yes 是 Others : _____ 其他 : _____ ☐ No 否 ☐ Yes 是 If any of the above is "Yes", please give details. 如上述任何一項為「是」，請註明詳情。
11. When will the patient be expected to resume duty? 病者何時可恢復工作?	11.
12. Give name and address of other doctor(s) who have treated the patient for the same injury. 就此次意外，請提供其他曾醫治病者的醫生姓名及地址。	12.

I hereby certify that I have personally examined and treated the patient for the above injuries and that the facts as stated above represent my opinion of her/his condition respective to the above injuries.
本人現聲明本人已替上述病者就以上身體受傷作出檢查及治療，而上述各項所提供的資料均為本人就此病者以上身體受傷情況所提供之意見。

Signature of Medical Attendant (with chop) 主診醫生簽名及蓋章

Hospital Specialty/Unit/Department 醫院專科 / 單位 / 部門

Name of Medical Attendant/Qualification(s) 主診醫生姓名 / 專業資格

Date 日 期