Liberty International Insurance Ltd
利 寶 國 際 保 險 有 限 公 司
13/F, Berkshire House
25 Westlands Road, Quarry Bay, Hong Kong
Tel: (852) 2892 3888 Fax: (852) 2572 8071
www.libertyinsurance.com.hk

For claims not related to cancer, please contact **life.medical@libertymutual.com.hk**

CRITICAL ILLNESS CLAIM FORM 危疾賠償申請表

Part 1 (to be completed by insured / claimant) 第一部份 (由受保人或申請人填寫)

Policy No. 保單號碼:	☐ New Claim 首次索償 ☐ Further Claim 再次索償 ☐ Review 重批 / 覆核
Name of Insured 受保人姓名:	
I.D. Card / Passport No. 身份證 / 護照號碼:	Sex 性別: Male / Female
Correspondence Address & Contact Phone No. 聯絡地址及電話號碼: _____ _____ Tel: _____	

Nature of claim and related details 賠償性質及有關資料:

1. Name the critical illness you are claiming for 申請賠償的危疾名稱	1.
2. Date of first consultation 首次求診日期	2. MM 月 ____ DD 日 ____ YY 年 _____
3. Describe the symptoms from date of onset 詳述病發日起所患之一切病徵	3.
4. The name, address and contact phone no. of the doctor you first consulted for this illness 首次就此病而求診之醫生姓名，地址及聯絡電話	4.
5. How long have you been having these symptoms from the date of your first consultation? 閣下在首次求診日起，以上的病徵已存在多久？	5.
6. The name, address and contact phone no. of your regular doctor 閣下慣常求診之醫生姓名，地址及聯絡電話	6.

Record of medical consultation / hospitalization 過往之求診及住院記錄:

7. Please give below the details of any doctor(s) who have been consulted in connection with this illness.
請提供曾診治此病的其他醫生或專科醫生資料。

	Name 姓名	Address 地址	Date 求診日期 (MM/DD/YYYY)
A.			
B.			
C.			

8. Please give below the details of any hospitalization in connection with this illness.
請提供曾診治此病的其他醫生或專科醫生資料。

	Name of Hospital 醫院名稱	Date of Admission 入院日期 (MM/DD/YYYY)	Date of Discharge 出院日期 (MM/DD/YYYY)
A.			
B.			
C.			

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General 其他資料:

9. Have any of your blood relatives suffered from a similar or related illness? If "yes", please state
直系親屬中有否曾患有相同或有關之危疾？如 "有"，請填寫下欄。

	Relationship of Relative 親屬關係	Nature of Illness 危疾類別	Date Illness Diagnosed 診斷日期 (MM/DD/YYYY)
A.			
B.			
C.			

10. Are there any other illnesses/ complaints treated for or suffered by you prior to this critical illness you are claiming for? If so, please give full details.
閣下在患有是次申請賠償之疾病前是否患有其他疾病? 如 "有"，請把有關資料詳細填報。

A. _____
B. _____
C. _____

11. Are you insured for similar benefits with any other Company? If "yes", please state.
閣下是否在其它公司投保類似危疾保障? 如 "有"，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 No. 保單號碼
A.			
B.			
C.			

I hereby declare and agree that
(1) the answers and statements made in this Application and in any other documents forming part of this Application (collectively, this Application) are complete and true (and will be complete and true at the time of payment of the initial premium) and will be the basis of my contract that may arise;
(2) all material facts, being facts which might influence the assessment of this Application, have been disclosed in this Applications, it is being understood that failure to make such disclosure renders the contract voidable;
(3) the Company will not incur any liability pursuant to this Application unless the Company has approved the issue of a policy and then only if the initial premium therefore had been paid in full;
(4) no person (including any agents or brokers) has the authority to make or modify the Company's policies or waive any of the Company's rights or requirements,

本人吾等在此明白及同意
(1) 此申請表及任何其他組成此申請表之文件(布此併稱為「此申請表」)中所作之答案及陳述均為完全及屬實(並於繳付首次/供款/保費時及屬完全及屬實)並將成為任何由此產生的合約之依據；
(2) 所有重要事實，此及指可影響評估此申請之事實均已於此申請表中披露，若任何重要事實未能披露則可使合約無效；
(3) 除非貴公司已核准簽發保單而該保單之首次保費亦全數繳付，否則貴公司不會根據此申請表承擔任何責任；
(4) 任何人士(包括顧問)無權更改貴公司之保單或豁免任何貴公司之權利或規定。

I hereby authorize
(a) any doctor, hospital, clinic, insurance company, government office, organization or persons who has any records, knowledge or information about me (whether medical or otherwise) to disclose, release or transfer to Liberty International Insurance Ltd. ("the Company") or its representative such records, knowledge or information pertinent to this Application for insurance, reinsurance and any claims arising therefrom; and
(b) the Company or any of its appointed medical/paramedical examiners or laboratories to perform necessary medical assessments and tests to evaluate the health status of me in relation to this Application for insurance, reinstatement and any claim arising therefrom. This authorization shall bind my successors and assignee and remains valid notwithstanding death or incapacity.
A photostatic copy of this authorization shall be valid as the original.

本人吾等現正授權
(a) 任何擁有任何本人/吾等之紀錄、詳情或資料(醫療或其他資料)之醫生、醫院、診所、保險公司、政府部門，機構或人士就有關此投保申請、復保申請及由此所引起之任何索償向利寶國際保險有限公司(「貴公司」)或其代表披露、透露或轉移此等紀錄，詳情或資料；及
(b) 貴公司或貴公司指定之醫生/醫護人員或化驗所進行必要之健康評估及檢驗。以評估與此投保申請、復保申請及由此所引起之任何索償有關之本人吾等的健康情況。此授權書對本人/吾等之繼承人及受讓人有約束力，並於本人/吾等身故得或喪失能力後仍然有效。
此授權書的正本及影印本同屬有效。

_____	_____
Signature of Witness 見證人簽署	Signature of Insured/Claimant 受保人/申請人簽署
Name 姓名:	Name 姓名:
I.D. Card/Passport No. 身份證/護照號碼:	I.D. Card/Passport No. 身份證/護照號碼:
Date 日期:	Date 日期:

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Claim Document Checklist

Please attach the following documents together with this application form and kindly tick against the documents submitted with this form. 請將此表格連同以下文件遞交，並於提 交的文件欄內畫上 "√"號。

- ☐ Histopathological Report 病理檢驗報告
- ☐ Confidential Medical Certificate for your claimed critical illness or performed surgery 您所索償的危疾或有關手術的危疾保障賠償醫生報告
- ☐ Laboratory, Ultrasonogram, X-Ray and/or MRI Report(s) 化驗、超聲波、X-光、電腦掃描及磁力共震報告
- ☐ Hospital Discharge Summary / Sick Leave Certificate with Diagnosis 出院總結/列有診斷証明之病假証明書
- ☐ Patient Card Copy of Consulted Doctor(s) 醫生覆診卡副本

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Part 2 (to be completed by Attending Physician at Insured's cost)
第二部份 (受保人自費由主診醫生填寫)

Policy No. 保單號碼:	Sex 性別: Male / Female
Name of Insured 受保人姓名:	
I.D. Card / Passport No. 身份證 / 護照號碼:	Age 年歲:
Date of Birth 出生日期:	

Critical Illness – Cancer 危疾 – 癌
General Information

1. Are you the Insured's usual medical physician? 2. 閣下是否受保人慣常求診醫生？ ☐ Yes 是 ☐ No 否 If "yes", when did the Insured first consult you? 如"是"，請問受保人首次向閣下求診之日期? (/ /) MM/DD/YYYY 月/日/年	Details of "Yes" answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities). 如答"是"，請提供診斷結果、日期、病徵持續時期及主診醫生姓名、醫療機構名稱及地址等資料。
3. When were you first consulted for this illness? 受保人首次就有關疾病向閣下求診之日期。 (/ /) MM/DD/YYYY 月/日/年 What were the symptoms? 受保人之病徵。 _____ _____ How long had the symptoms been present? 該病徵約存在了多久? _____ _____	
4. Has the Insured previously suffered from this illness or any related conditions? 受保人是否有同類之病史? ☐ Yes 是 ☐ No 否 If "yes", please give dates of consultations and the resulting diagnosis. 如"有"，請提供求診日期及診斷詳細結果。 _____	
5. On which date was the diagnosis made? 有關疾病之診斷是何時首次確認? (/ /) MM/DD/YYYY 月/日/年 On which date was the Insured first made aware of it? 受保人何時首次知悉有關疾病之診斷? (/ /) MM/DD/YYYY 月/日/年	
6. Is there anything in the Insured's family history which would have increased the risk of this illness? 受保人之家族病史是否增加受保人患上此病之機會? ☐ Yes 是 ☐ No 否	
7. Is the Insured a smoker? 受保人是否吸煙人仕? □ Yes 是 □ No 否 If "Yes", what is his/her smoking habit? 若為吸煙人仕，他/她的吸煙習慣為何? Daily smoking amount 每日吸煙數量: _____ For how many years? 吸食年數 _____	

Other/Additional Information 其他/附加資料

Please provide names, addresses and dates of doctors and hospitals which the Insured was referred and/or admitted to. 請提供受保人曾經就診之所有醫生姓名或醫院名稱及地址

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Details of the Insured's Illness 受保人病況之詳情

Please provide full and exact details of the diagnosis, the site involved and the precise histology of the tumour. 請提供受保人之所有及確定的診斷詳情，包括該腫瘤之確定的位置及細胞組織分析。	Details of "Yes" answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities). 如答"是"，請提供診斷結果、日期、病徵持續時期及主診醫生姓名、醫療機構名稱及地址等資料。
1. What is the TNM staging of the tumor? 該癌症屬於哪一階段? _____ (a) ☐ carcinoma-in-situ 原位癌 (b) ☐ pre-malignant tumour (c) ☐ completely localized 完全局限性 (d) ☐ resection margin / node involvement 涉及切除邊緣/淋巴結組織 (e) ☐ distant metastasis (secondary site 繼發位置: _____)	
2. What is the nature of treatment? 受保人接受哪一種治療? ☐ Surgical 外科手術 ☐ Radiotherapy 放射性治療 ☐ Chemotherapy 化學治療 ☐ Palliative 姑息治療 ☐ Hormonal treatment 荷爾蒙療法 ☐ Others: please specify 其他, 請註明: _____ Please provide details of procedure(s): 請提供治療之詳情: _____	
3. Investigations 檢驗: i. Was a biopsy of the tumour performed? 有否進行細胞組織分析? ☐ Yes 是 ☐ No 否 Date of biopsy 細胞組織分析日期 (/ /) MM/DD/YYYY 月/日/年 Biopsy performed by 進行細胞組織分析之醫生/醫院 _____ Reason for not examining if no biopsy was done? 若未有進行分析, 原因為何? _____ ii Please enclose copies of all reports including biopsy records, cytology reports, X-rays, CT scans, other imaging studies, laboratory evidence, surgical report, etc, and any relevant hospital reports that are available. 請提供所有診斷報告, 如活體檢視紀錄, 細胞分析報告, X 光檢查, 電腦掃描, 超聲波, 驗血, 心電圖, 及其他化驗報告等, 或任何有關的醫院告。	
4. Please state if the Insured has suffered/been treated for any other illness(es)/complaints other than this Critical Illness. 除此危疾外, 請列明受保人曾患的其他疾病或徵狀。	
5. Is there any further information, which in your opinion will assist us in assessing this claim? 請提供其他有助審核本索償個案之資料。	

_____ _____
Name of doctor and qualification 醫生姓名及醫學資格 Signature and official chop 簽署及蓋印

_____ _____
Address and telephone number 地址及聯絡電話 Date 日期