

Claim Statement (New Born Baby Bonus) 新生嬰兒利是申請表

Please fully complete the below information (請填寫下列各項)

Agent Name 營業員姓名 _____ Agent No. 營業員編號 _____
District 所屬區域 _____ Agent Tel. No. 電話號碼 _____

1. Policy Particulars (保單資料)

Policy Number(s) _____ Name of Life Insured * _____ Life Insured's HKID Card / Passport No. _____
保單編號： _____ 受保人姓名： _____ 受保人香港身份證 / 護照號碼： _____
Address of Life Insured _____ Telephone No. _____
受保人住址： _____ 聯絡電話號碼： _____
* Please complete full name as shown on HKID Card/identification document (請以身份証上的名字為準)

2. Payment Particulars (賠償資料)

I/We request that subject to proof of title, the claim payment be converted into
吾/吾等要求將有關賠款之貨幣轉為 HK\$ 港元 US\$ 美元 Sterling 英鎊 Please tick one Box (請於其中一空格內加上'✓'號)

3. Required Documents (所需文件)

1. Original * or copy of the new born baby's Birth Certificate (新生嬰兒出世紙正本*或副本)
 2. Original * or copy of the Immunization Record (in which showing the immunization was done after 30 days from the date of new born baby's birth) (免疫注射記錄正本*或副本 - 必需顯示新生嬰兒出世30天後已有接受注射之記錄)
- * The documents must be certified true copy by our Life Claims Dept. or by any authorized persons to be accepted by our Company.
須經本公司理賠部(人壽業務)或本公司接納授權人作核實副本。

4. Declaration and Authorization (聲明及授權)

1. I/We, the above Life Insured or claimant(s) hereby request payment of the total benefits in accordance with the Policy and I/We warrant that I am/We are legally and beneficially entitled to such sum.
 2. I/We, the above Life Insured or claimant(s) do hereby authorize any hospitals, physicians, medical practitioners, insurance companies or organizations that have any records or knowledge of the above Life Insured to disclose to Our Company, or its authorised representatives any and all the information with respect to his/her health, medical history, disease, hospitalization, advice, treatment, investigatory result, employment records or any other policies details and claim records, etc.
 3. I/We also agree our Company to utilize the copy of myself/ourselves or my/our relative's identification for the above claim purpose. A photostatic copy of this authorization shall be considered as effective and valid as the original.
 4. I/We declare and agree that the personal information collected or held by our Company, whether contained in this application form or otherwise obtained, may be used by our Company or disclosed to any individual or organization within or outside Hong Kong for the following purposes:
(1) to assess and process this application, (2) to provide insurance and customers services, (3) to conduct insurance claims or analysis.
 5. I/We shall have the right of access to and to request correction of any personal information concerning themselves held by our Company. A request for such access may be made to the Personal Data Privacy Officer of our Company at 24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong.
1. 本人/吾等為上述受保人/索償人現就上述保單作出賠償申請, 及聲明本人/吾等有合法資格受益於此保單之所有賠款。
 2. 本人/吾等在此授權任何醫院醫療專業人士、內外科醫生、保險公司或機構及凡持有受保人資料之人士,可向本公司保險集團"本公司"或其授權代表披露有關受保人資料包括,健康狀況、過往之病歷、病狀、入院記錄、診治建議、治療方法、調查結果、在職記錄或其他保單資料及賠償記錄等。
 3. 本人/吾等亦同意本公司使用本人或我們家屬之身份證明文件副本以作上述查詢用途, 此授權書之影印本亦屬有效。
 4. 本人/吾等在此聲明及同意一切由本公司從這投保表格或其他方式所收集或持有的個人資料, 均可供本公司使用或向在香港境內或境外之任何人仕或機構披露作以下用途: 1) 評核此項申請, 2) 提供保險及客戶服務, 3) 處理保險的索償或有關之分析。
 5. 本人/吾等有權查閱及要求更改由本公司所持有有關他們的任何個人資料。任何關於個人資料查閱或更改之要求,可向本公司之個人資料私隱主任提出, 地址為香港港島東華蘭路18號港島東中心24-27樓。

Date 日期: _____ Signature of Life Insured 受保人簽署: _____