中國人壽 CHINA LIFE 海外

關愛一生及康健保醫療保險計劃 - 可賠償金額估算申請表
ICARE MEDICAL INSURANCE PLAN / HEALTH GUARD HOSPITAL CARE BENEFIT PLAN - APPLICATION FORM FOR CLAIMABLE AMOUNT ESTIMATE

保單持有人姓名 Name of Policyholder	受保人姓名 Name of Insured	保單號碼 Policy No.

受保人身份證/ 護照號碼 I.D. / Passport No. of Insured

保險中介人資料 INSURANCE INTERMEDIARY INFORMATION

保險中介人姓名 Name of Insurance Intermediary

保險中介人編號 Insurance Intermediary Code

聯絡電話 Contact No.

重要須知 IMPORTANT NOTE

- 請以正楷填寫本申請表。任何資料如有更改，受保人及保單持有人/索償人/主診醫生必須在更改的位置簽署作實。Please complete this form in BLOCK LETTERS. All amendments should be countersigned by the Insured & Policyholder / Claimant/Attending Physician in full signature.
- 本申請表中所用之「本公司」或「貴公司」之表述指中國人壽保險(海外)股份有限公司。The expressions "the Company" or "our Company" used in this form refers to China Life Insurance (Overseas) Company Limited.
- 請受保人/保單持有人/索償人填妥此表格第一部份，及主診醫生填妥第二部份，並於入院/手術前**最少 7 個工作天**遞交至理賠管理部。Please complete Part 1 on the following form by the Insured / Policyholder / Claimant and Part 2 by the Attending Physician and send to Claims Department **at least 7 working days** prior to admission to hospital/surgery.
- 請注意該可賠償金額估算結果僅供參考，並不構成本公司最終賠償責任。賠償將根據所有其後遞交的必要理賠證明文件，並按保單條款及細則和保單年度內的保障限額作決定。最終的賠償金額及自付費用會根據醫院或診所發出的正式收據中所列明的實際帳目和分項收費計算。Please note that the claimable amount estimate is just for reference and will not constitute our final liability. Claim decision will depend on the submission of all supporting documents as required for claim assessment in accordance with the policy terms and conditions and benefit entitlement in the Policy Year. The final claimable amounts and out-of-pocket expenses will be subject to the actual bill amounts and breakdowns as stated in the official receipts issued by hospital or clinic.
- 可賠償金額估算的結果，會因接受醫療服務的地域或較高病房級別作出調整和限制。該估算只根據受保人保單之保障限額計算。任何未批核理賠個案或任何不保事項均未有計算在估算內。The claimable amount estimate is subject to benefit reduction or limitation in relation to the regions where the eligible medical services are incurred or the choice of higher ward class. The claimable amount estimate is based on the benefit limit of the Insured's policy. Any pending claim yet to be approved or any exclusion will not be taken into account for this estimation.
- 如受保人為十八歲或以上，受保人及保單持有人必須親自填寫及簽署本申請表，如受保人為十八歲以下，本申請表應由保單持有人及受保人之合法監護人填寫及簽署。如受保人/保單持有人因傷殘不能書寫，其直系親屬可代為填寫本申請表及簽字，並提供關係證明及醫生證明。If the insured is at or above the age of 18, the Insured and Policyholder must complete and sign this form by his or her good self. If the insured is under the age of 18, this form should be completed and signed by the Policyholder and the insured's legal guardian. In the event that the Insured/ Policyholder is physically incapacitated and prevented from signing, this form may be completed and signed by an immediate family member with relevant relationship proof and physician's statement provided.
- 受保人/保單持有人/索償人之簽署必須與本公司之紀錄相同。The signature of the Insured / Policyholder / Claimant must be the same as the Company's record.
- 閣下的保險中介人收到本申請表並不代表本公司已收到。Receipt of this form by your Insurance Intermediary does not constitute receipt by the Company.
- 如有任何查詢，請與 閣下的保險中介人聯絡或致電本公司客戶服務熱線 (852) 3999 5519 查詢。If you have any queries, please feel free to contact your insurance intermediary or our Customer Service Hotline at (852) 3999 5519 for details.
- 本公司有權隨時更新此申請表，並拒絕未符合本公司要求的申請表。請登入本公司網站 www.chinalife.com.hk 瀏覽及下載最新版本。The Company has the right to update this form from time to time and reject the form if the Company's requirements are not fulfilled. Please visit our website www.chinalife.com.hk to view and download the latest version of the form.
- 如中英文版本有任何抵觸或不符之處，一概以中文本為準。If there is any discrepancy or inconsistency between the English version and the Chinese version of this form, the Chinese version shall prevail.

保單號碼 Policy No.										

第一部分 – 聲明 (由受保人/保單持有人/索償人填寫)
PART I - DECLARATION (To be completed by the Insured / Policyholder / Claimant)

A. 保單持有人資料 (必須填寫) PARTICULAR OF POLICYHOLDER (COMPULSORY)

1 手提電話 Mobile No. *

* 以上所提供的手提電話只作可賠償金額估算申請之用，如資料與本公司現有記錄不符，一概以公司記錄為準。The above mobile phone no. and email address provided will only be used for Claimable Amount Estimate Application. If there is any discrepancy between the above information and Company's record, the Company's record shall prevail.

B. 收集個人資料聲明 PERSONAL INFORMATION COLLECTION STATEMENT

本人/我們確認已閱讀及明白「中國人壽保險（海外）股份有限公司」的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於 https://www.chinalife.com.hk/zh-hk/privacy-policy/personal-information-collection-statement-clio 下載或向中國人壽保險（海外）股份有限公司索取。I/We confirm that I/we have read and understood the Personal Information Collection Statement ("PICS") of China Life Insurance (Overseas) Company Limited. For the latest version of the PICS, it can be downloaded from https://www.chinalife.com.hk/zh-hk/privacy-policy/personal-information-collection-statement-clio or is made available upon request.

☐ 否 No　如閣下不欲本公司就是次可賠償金額估算的申請通知閣下的保險中介人。請在"否"加上剔號。If you do not wish the Company to inform your insurance intermediary about this claimable amount estimate application, please tick "No".

☐ 否 No　本人／我們不同意根據以上收集個人資料聲明（參閱 "為直接促銷目的而使用個人資料" 部份）為直接促銷之目的而使用和提供本人／我們的個人資料，亦不希望接收任何推廣及直接促銷材料。請在"否"加上剔號。I / We do not agree with the use and provision of my / our personal data for direct marketing purposes as set out above in the Personal Information Collection Statement (see "Use of personal data in direct marketing") and do not wish to receive any promotional and direct marketing materials. Please tick "No".

C. 聲明及授權 DECLARATION AND AUTHORIZATION

授權 Authorization

本人/我們，受保人/保單持有人/索償人，代表本人/我們及尚未成年之受保人(如有)謹此授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、政府部門，或其他機構、組織或人士，凡知道或具有任何有關本人/我們/尚未成年之受保人之醫療病歷、紀錄或資料者，均可將該等資料提供、發放及轉交給中國人壽保險（海外）股份有限公司（以下簡稱「貴公司」）； (2) 貴公司或任何其指定之醫療/輔助醫療檢查員或化驗所，可就本索償申請替本人/我們/尚未成年之受保人進行所需之醫療評估及測試，作為審核本人/我們/尚未成年之受保人之健康狀況。此授權對本人/我們之繼承人及授讓人具有約束力。此授權書的影印本與正本均有同等效力。I /We, the Insured/Policyholder/Claimant, represent me/ us/ the under aged Insured (if any) HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, government department, or other organization, institution or person, that is aware of or has any medical history, records or information of me/us/the under aged Insured to disclose, release and transfer such information to China Life Insurance (Overseas) Co. Ltd ("the Company"); (2) the Company or any of its appointed medical / para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ ourselves/ the under aged Insured in relation to this claim. This authorization shall bind the successors and assignees of me/us. A photocopy of this authorization shall be as valid as the original.

聲明 Declaration

本人/我們，受保人/保單持有人/索償人，謹此聲明及同意(1)上述一切陳述及問題的所有答案，不論是否本人/我們親手所寫，就本人/我們所知所信，均為事實之全部並確實無訛； 本人/我們明白倘未知任何一項是否重要，本人/我們均須將其事實在本申請表上說明；(2)本人/我們對任何人所作出之任何聲明，除在本申請表上填寫或印出及經 貴公司發表和批准外，貴公司不須受其約束。若相關人士不能提供任何本申請表所需的資料，貴公司可能因此不能審核及處理本索償申請；(3)本人/吾等明白並同意貴公司有權撤回或要求本人/吾等退回因提供不正確資料而導致的錯誤賠償; (4)本人/吾等同意賠償任何損失，索償及與國籍、居住及/或稅務狀況有關資料之虛報、誤導或不完整所導致的行動。I/ We, the Insured/Policyholder/Claimant HEREBY DECLARE and AGREE that (1) all the foregoing statements and answers to all questions whether or not written by my/our own hand are to the best of my/our knowledge and belief complete and true; I/We also understand that in the event of doubt as to whether a fact is material, it should be disclosed here; (2) The Company is not bound by any statement which I/ we may have made to any person unless it is written or printed here and is presented and approved by the Company. If any relevant persons fail to provide any information requested in this claim form, it may result in the Company's inability to process and deal with this claim; (3) I/We understand and agree that the Company has the right to reverse/claw back any incorrect payment caused by incorrect information provided by me/us; (4) I/We agree to indemnify the Company against any loss, claim and action in connection with any false, misleading or incomplete information of my/our nationality, residence and/or tax status.

D. 簽署(請勿在空白表格上簽署) SIGNATURE (Please DO NOT sign on BLANK form)

	受保人 Insured			保單持有人 / 索償人* Policyholder / Claimant*			見證人 Witness		
簽署 Signature									
姓名 Name									
身份證/護照號碼 I.D. Card / Passport No.									
日期 Date	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day
*索償人與受保人/保單持有人關係 *Relationship with Insured/Policyholder									