HSBC Life
滙豐保險

MACUDIS

PICS 2021May

Total & Permanent Disability/Disability/Accidental Dismemberment Claim Form
完全及永久喪失工作能力／喪失工作能力／意外傷殘賠償申請書

Policy No. 保單號碼: ______________ Date 日期: ______________

CLAIMS DOCUMENT CHECKLIST 索償文件清單

- ☐ Part I is fully completed & signed by the Policyholder/Insured 索償表第一部分經由保單持有人／受保人填寫並簽署
- ☐ Part II is fully completed & signed by the Attending Physician with chop (this report required to be applied by the claimant at his/her own cost) 索償表第二部份經由主診醫生填寫，簽署並蓋印(此報告需由申請人負責及自費索取)
- ☐ Copy of Sick Leave Certificate with diagnosis and/or Consultation Proof 列有診斷證明之病假證明書及／或治療詳情副本
- ☐ Copy of Physiotherapy/Occupational Therapy Report(s) (if applicable 物理治療／職業治療報告副本(如適用)
- ☐ Copy of Laboratory, Ultrasonogram, X-Ray, CT Scan, MRI and Diagnostic Written Report(s) (if applicable) 化驗、超聲波、X-光、電腦掃描、磁力共震及診斷之書面報告副本(如適用)
- ☐ Copy of Police Report (if applicable) 警察事故報告副本(如適用)
- ☐ Copy of Policyholder & Insured's Identity Card 保單持有人及受保人之身份證明文件副本
- ☐ Copy of Bank Account Proof (applicable for Policyholder's sole or joint name bank account other than Policyholder's premium deduction account) 銀行戶口證明文件副本(適用於保單持有人之個人或聯名非保費轉賬戶口)

Notes 注意：

1. A claim must be made as soon as possible after the insured becoming aware that he/ she is suffering from disability whilst this Policy is in force. 索償人需於受保人已獲悉或被診斷傷殘時盡快在保單有效期內提出索償。
2. Please ensure completion of the above procedures to avoid unnecessary delay in claim process. 請確保完成以上各項，以免延緩索償進程。
3. We will inform you as soon as possible if we require additional information from you or we consider that your claim has to be assessed from third parties (such as doctor, hospital, etc.). As the time required for obtaining the information is variable, the processing time of your claim will likely be lengthened. 若我們有需要就審核是次賠償申請而向您或其他人士(如醫生、醫院等)索取額外資料，我們會盡快通知您。因索取有關資料需時，賠償申請的審核時間會較長。

Part I: To be completed by the Insured/Claimant/Policyholder 第一部分：受保人／索償人／保單持有人填寫

A. Details of Life Insured* 受保人資料*

1. Name of Insured 受保人姓名	2. I.D. Card/Passport No. 身份證／護照號碼	3. Age 年齡
4. Correspondence Address 通訊地址		
5. Telephone No. 聯絡電話 (Please provide telephone no. with its country/region. 請提供聯絡電話及其所屬國家／地區。) ☐ Macau SAR 澳門特別行政區(853) ☐ Mainland China 中國內地(86) ☐ Other Country/Region 其他國家／地區 ______	Telephone no. 聯絡電話 ______	

B. Details of Qualifications and Employment 學歷及就業資料

6. Position 職位	7. Employer / Business Industry 僱主／公司行業	8. Job Activities 工作範圍	9. ☐ Indoor 戶內 ☐ Outdoor 戶外 ☐ Indoor & Outdoor 戶內及戶外
10. Employer's Name, Address & Telephone No. 僱主名稱、地址及電話號碼			
11. Did you provide a sick leave certificate to your employer? 曾否向僱主遞交病假證明書 ☐ Yes 有 ☐ No 沒有			
12. Date you last worked 最後工作日期(DD 日／MM 月／YYYY 年)		13. Date you returned to work 何時恢復工作(DD 日／MM 月／YYYY 年) (If not, then give expected date of return)(如否，祈望何時可恢復工作)	
14. Your academic qualification, qualified knowledge and training. 您之學歷、認可知識及訓練。			

Please ✓ the appropriate box. 請在適當的方格內加上✓號。

* If a claim is made on the Payor's disability, please complete this form with respect to the disabled Payor instead of Insured. 若此為付款人喪失工作能力之賠償申請書，請以付款人資料回答。

C. Reason of Disability 喪失工作能力的原因

☐ 15. Disability was due to accident 因意外而導致喪失工作能力：

(a) Date and time of accident 意外日期及時間(DD 日／MM 月／YYYY 年 and am上午／pm 下午)

(b) Where and how did it happen? 意外地點及經過？

(c) Part of body injured and type of injury 受傷部位及傷勢

(d) Was the accident reported to the police? 曾否向警方申報是次意外？ ☐ Yes 是 ☐ No 否

If yes, please provide details. 如有，請提供有關資料。

Report number and the name of the Police station 報案號碼及警署名稱

(e) Was the accident reported to your employer? 曾否向僱主申報是次意外？ ☐ Yes 是 ☐ No 否

If yes, please provide details. 如有，請提供有關資料。

☐ 16. Disability was due to illness 因疾病而導致喪失工作能力：

(a) Describe the illness and give a brief description of the symptoms 所患病症及其病徵

(b) How long had you been having these symptoms prior to visiting physician? 受保人在首次就診前該等病徵已存在多久？

(c) Details of consultation 診治詳情

(i) The first physician consulted for illness 首次就診的醫生資料：

Name of Physician/Hospital & Address 醫生／醫院名稱及地址

Consultation Date 求診日期(DD 日／MM 月／YYYY 年)

(ii) The physician who referred the insured to hospital 建議入院的醫生資料：

Name of Physician/Hospital & Address 醫生／醫院名稱及地址

Admission Date 求診日期(DD 日／MM 月／YYYY 年)

(iii) Please give details of all physician(s) consulted or hospital(s) to which Insured was admitted during this illness 曾診治此病的其他醫生資料：

Physician/Hospital 醫生／醫院		Admission No. 求診或住院號碼	Admission Date 求診或住院日期
Name 姓名	Address 地址		

(iv) Name, address and details of your family physician/usual physician 家庭醫生／慣常就診的醫生資料、名稱及地址：

Physician/Hospital 醫生／醫院		Admission No. 求診或住院號碼	Admission Date 求診或住院日期
Name 姓名	Address 地址		

17. Do you smoke cigarettes or take alcoholic drink(s)? 您是否有吸煙及飲酒習慣？ ☐ Yes 是 ☐ No 否

If yes, state quantity, type and duration. 如有，請列明數量、類別及持續多久。

18. Are you currently insured with any other insurance company as a result of this illness or accident?
有關此次疾病或意外，您是否有申請其他保障賠償？ ☐ Yes 是 ☐ No 否

Name of Insurance Company 保險公司名稱	Protection Amount 保障額	Type of Benefit 保障類別	Policy No. 保單號碼

MAC016

D. Payment Instruction 付款指示

1. By cheque (in MOP) 以支票支付(以澳門幣)

☐ Mail to the Policyholder's correspondence address 寄往保單持有人之通訊地址

☐ Pass the cheque to me through your staff 交予貴行職員轉交本人 ：

Staff Name 職員姓名：____________________ Staff Number 職員號碼：____________________

Branch name 分行名稱：____________________ Branch code 分行編號：____________________

2. By bank transfer 以轉賬支付

☐ By Bank Account (in MOP) 經銀行戶口(以澳門幣)

☐ By Bank Account (in policy currency) 經銀行戶口(以保單貨幣)

☐ Transfer to the policyholder's premium deduction account (not applicable if the bank account is held by someone other than the policyholder's sole or joint name) 轉賬至保單持有人之保費轉帳戶口(不適用於非保單持有人之個人或聯名銀行戶口)

☐ Transfer to the Policyholder's sole or joint name bank account below 轉賬至以下保單持有人之個人或聯名銀行戶口

|_|_|_| – |_|_|_| – |_|_|_|_|_|_|_|_|_|

Account Holder Name 戶口持有人姓名 ____

Notes 註：
Please also submit adequate proof showing the full name and the bank account number of Policyholder's sole or joint name bank account (such as copy of bank book, ATM card, bank statement, etc.) to the company. If we do not receive the copy of the required document(s), the payment will be made by cheque payable to the Policyholder and mailed to the Policyholder's correspondence address. 請同時提交印保單持有人之個人或聯名戶口全名及銀行戶口號碼之充足證明(如銀行存摺或自動櫃員機卡或月結單副本等)。若您沒有提供上述所需文件，款項將以支票形式寄予保單持有人之通訊地址。

For your attention 請注意：

1. If the benefit payments are settled in currencies other than the policy currency(ies), the benefit payments would be subject to change according to the prevailing exchange rate of policy currency(ies) to payment currency(ies) to be determined by the Company from time to time. The fluctuation in exchange rates may have impact on the amount of payments. By choosing the payment currency(ies) other than local currency, you are subject to exchange rate risks. Exchange rate fluctuates from time to time. You may suffer a loss of your benefit values as a result of the exchange rate fluctuations. 如利益支付款項的貨幣不是保單貨幣，該款項可能會受本公司不時釐定當時保單貨幣對支付貨幣的匯率而改變。匯率之波動會對利益支付款項構成影響。選擇非本地貨幣結算支付款項，您須承受匯率風險。匯率會不時波動，您可能因匯率之波動而損失部分的利益價值。
2. If the receiving bank account is a non-HSBC bank account, bank charges may incur which will be deducted from the amount payable by the said receiving bank and/or HSBC, if applicable. If you provide a bank account in currency different from the payment currency, the amount payable is subject to exchange rates difference. The Company will not be liable for any charges or loss due to payment settled via non-HSBC bank, currency exchange or rejection of transaction by the receiving bank as a result of incorrect bank account details. 如收款戶口非滙豐銀行之戶口，該銀行及／或滙豐銀行可於款項中收取服務費用，如適用。如您提供與利益支付款項的貨幣不同貨幣的戶口，請留意匯率的兑換差價。本公司將不會承擔任何因不同銀行或貨幣而導致被收取之費用或損失或因銀行戶口資料不乎而被拒絕轉賬之責任。
3. Unless otherwise specified, claim payment will be made according to the current payment instruction (if any) registered with the Company. 如無明確指示，賠償會按本公司的現有記錄轉賬(如有)。

E. Personal Information Collection Statement 收集個人資料聲明

1 HOW WE COLLECT AND STORE YOUR DATA

We collect your data

- when you interact with us, apply for and use our products and services
- visit our websites (please see the "Privacy and Security" section of www.hsbc.com.mo and refer to "Use of cookies policy" for details of how we use cookies)
- from other people and companies, including other HSBC group companies

We may store your data locally or overseas, including in the cloud. We apply our global data standards and policies wherever your data is stored.

We're responsible for keeping your data safe in compliance with the Macau Special Administrative Region ('**Macau**') Macau law.

2 WHAT WE USE YOUR DATA FOR

We use your data

- to send you direct marketing if you've consented to it
- to consider applications for, offer, provide and manage products and services

  For example: (i) insurance, annuities, pensions and health and wellness products and services; (ii) educational materials; (iii) products and services relating to campaigns and promotions which you have signed up to
- to design and improve our products, services and marketing
- to help us and other HSBC group companies comply with laws, regulations and requirements, including our internal policies, in or outside Macau
- to detect, investigate and prevent financial crimes
- for the other purposes set out in section B

3 WHO WE SHARE YOUR DATA WITH

We share your data with

- other HSBC group companies
- third parties who help us to provide services to you or who act for us
- third parties who you consent to us sharing your data with
- local or overseas law enforcement agencies, industry bodies, regulators or authorities
- the other third parties set out in section C

We may share your data locally or overseas.

You can access your data

You can request access to the data we store about you. We may charge a fee for this.

You can also ask us to

- correct or update your data
- explain our data policies and practices

You control your marketing preferences

You control whether you receive marketing from us.

You can change this at any time by contacting us.

You can contact us

The Data Protection Officer HSBC Life (International) Limited, Macau Branch, 1/F Edf. Comercial Si Toi, 619 Avenida da Praia Grande, Macau

A
Collect and store

We may collect

- biometric, medical and health/ lifestyle data such as your heart rate, BMI and steps count
- your geographic data and location data based on your mobile or other electronic device
- data from people who act for you or who you deal with through our services
- data from public sources, aggregators and other sources available to us
- data from policyholders or members of our insurance policies of which you benefit from or are insured by

If you don't give us data then we may be unable to provide products or services.

We may also generate data about you

- by combining information that we and other HSBC group companies have collected about you
- based on the analysis of your interactions with us and information which we have collected about you
- through the use of cookies and similar technology when you access our website or apps.

B
Use

We use your data to

- handle and take care of claims
- help us to comply with requirements or requests that we or the HSBC group have or receive such as legal or regulatory in or outside Macau. Sometimes we may have to comply and other times we may choose to voluntarily comply
- conduct identity, medical or credit checks
- create and maintain the credit and risk related models of the HSBC group (such as underwriting models, health and wellness models and models/algorithms for data analytics and artificial intelligence)
- manage our business, including exercising our legal rights
- determine, pay or collect money owed to you or to us
- provide personalised advertising to you on third party websites (this may involve us aggregating your data with data of others)
- other uses relating to the above or to which you have consented

If you provide data about others

If you provide data to us about another person, you should tell that person how we will collect, use and share their data as explained here. This is because we assume that they have given us, through you, the necessary consent for us to collect, use and share their data as explained.

C
Share

We share your data with

- local or overseas bodies or authorities such as legal, regulatory, law enforcement, government and tax and any partnerships between law enforcement and the financial sector
- any person who is a party to a transaction (or a potential transaction) buying interest or assuming risk in an insurance policy, such as reinsurers
- payment recipients, beneficiaries or any person who act for our customer or you, or anyone whose data is provided for receiving benefits under an insurance policy or otherwise
- hospitals, clinics, medical practitioners, laboratories, technicians, loss adjustors, risk intelligence providers, legal advisers or private investigators who act for us
- any third party who we may transfer our business, policies or assets to so it can evaluate our business and use your data after any transfer
- partners and providers of reward, co-branding or loyalty programmes, charities or non-profit organisations
- social media advertising partners (who can check if you have or use our products and services and send our adverts to you and advertise to people who have a similar profile to you)

We may share your anonymised data with other parties not listed above. If we do this you won't be identifiable from this data.

D
Direct Marketing

This is when we use your data to send you details about financial, insurance, pensions, annuities or related products, services and offers (such as health and wellness) and promotional campaigns provided or hosted by us or our co-branding, rewards or loyalty programme partners, charities or other third party financial institutions and service providers.

We may use data such as your demographics, the products and services that you're interested in, transaction behaviour, portfolio information, location data, social media data, analytics, health and wellness data and information from third parties when we market to you.

We don't give your data to others for them to market their products and services to you. If we ever wanted to do this, we'd get your separate consent.

This document will apply for as long as we store your data. If we use your data for a new purpose, we'll get your consent.

By signing below, I/we acknowledge and expressly agree that HSBC may collect, process, use and disclose all personal data (including any sensitive data) about me/us that HSBC currently or subsequently hold for the purposes as set out in this form. I/we also acknowledge and expressly agree that the personal data (including any sensitive data) about me/us may be shared to third parties as set out in this form, as well as be transferred to outside of Macau.

1

我們如何收集及儲存您的資料

我們收集您資料的途徑包括

- 您與我們互動，向我們申請及使用我們的產品和服務
- 您瀏覽我們網站(有關我們如何使用「cookies」的詳情，請參閱我們網站www.hsbc.com.mo進入「私隱與保安」閱覽「Use of cookies 政策」)
- 其他人士及公司(包括其他滙豐集團旗下公司)

我們可能將您的資料儲存於本地或海外，包括雲端。無論您的資料儲存於何處，均受我們的環球資料標準及政策約束。

我們有責任根據澳門特別行政區(「**澳門**」)法律保護您的資料安全。

2

我們如何使用您的資料

我們將您的資料用於

- 經您同意後向您發送直接促銷資料
- 考慮申請、為您推薦、提供及管理產品與服務

  例如：(i)保險、年金、退休金、健康與保健產品及服務；(ii)教育材料；(iii)關於您已報名參與之活動及推廣的產品與服務
- 設計及改進我們的產品、服務及市場推廣活動
- 幫助我們及其他滙豐集團旗下公司遵守澳門或其以外的國家或地區的法律、法規和要求，包括我們的內部政策
- 偵測、調查及預防金融罪案
- B部分所列的其他目的

3

我們與誰披露您的資料

我們與下列人士披露您的資料

- 其他滙豐集團旗下公司
- 幫助我們向您提供服務或代表我們行事的第三方
- 您同意我們與之披露您資料的第三方
- 本地或海外執法機構、行業組織、監管機構或權力機關
- C部分所列的其他第三方

我們可能在本地或海外披露您的資料。

您可查閱自己的資料

您可要求查閱我們所儲存有關您的資料。我們可能就此向您收取費用。

您可要求我們

- 改正或更新您的資料
- 說明我們的資料政策及慣例

您可控制自己的市場推廣偏好

您可控制您會否從我們收取市場推廣資料。

您可隨時聯絡我們對此作出更改。

您可聯絡我們

資料保護主任

滙豐人壽保險(國際)有限公司
澳門分公司
澳門南灣大馬路619號
時代商業中心1字樓

A
收集及儲存

我們或會

- 收集生物辨識、醫療及健康／生活模式資料，例如您的心跳率、身高體重指數及步數統計
- 基於您的流動或其他電子裝置收集您的地域及位置資料
- 從代表您的人士或您透過我們服務與之往來的人士收集資料
- 從公開渠道、資料整合機構及其他我們接觸得到的渠道收集資料
- 從您受益或受保於我們的保險下的保單持有人或保單成員收集資料

若您不向我們提供資料，我們可能無法提供產品或服務。

我們亦可能透過以下途徑衍生有關您的資料

- 整合我們及其他滙豐集團旗下公司收集的有關您的資料
- 分析您與我們的互動及我們已收集得來有關您的資料
- 於您瀏覽我們網站或應用程式時使用cookies或類似技術

B
使用

我們將您的資料用於

- 處理及安排索償
- 幫助我們遵守包括澳門或其以外的地區或國家的法律或監管機構對我們或滙豐集團現有或所收到的相關監管規定或要求。這些監管規定或要求可能是我們必須遵從或選擇自願遵從的
- 進行身份審查、身體檢查或信用審查
- 設立及維持滙豐集團的信貸及風險相關準則(例如承保準則、健康及保健準則，以及用於資料分析及人工智能的準則／算法)
- 管理我們業務，包括行使我們的法律權利
- 釐定、支付或收取欠您或欠我們的款項
- 於第三方網站上為您提供個人化廣告(這可能涉及我們將您與他人的資料進行整合)
- 與上述用途相關或經您同意的其他用途

若您提供他人的資料

若您向我們提供有關其他人士的資料，您應按此所述，告知該人士我們將如何收集、使用和披露其資料。我們將假設該人士已經透過您，同意我們如上所述收集、使用和披露其資料。

C
披露

我們與下列人士披露您的資料

- 本地或海外的法律、監管、執法、政府和稅務等機構或權力機關，以及執法機構與金融業界之間的任何合作夥伴
- 交易(或潛在交易)下收購保單權益或承擔保單風險的一方，例如再承保人
- 收款人、受益人或任何為我們的客戶或您行事的人；或任何為收取保單賠償或為其他目的而資料被提供的人
- 代表或為我們提供服務的醫院、診所、醫生、化驗所、技術員、理賠員、風險情報提供機構、法律顧問或私家偵探
- 我們可能轉讓業務、保單或資產的任何第三方，以便其評估我們的業務及在轉讓後使用您的資料
- 獎賞、合作品牌或忠誠計劃的合作夥伴及供應商，以及慈善或非牟利機構
- 社交媒體廣告合作夥伴(可查看您是否擁有或使用我們的產品及服務，並向您及與您個人資料相似的人士發送我們的廣告)

我們可能與上文並未列出的其他人士披露您的匿名資料。在此情況下，有關資料將無法識別出您的身分。

D
直接促銷

指我們使用您的資料向您發送由我們或我們的合作品牌、獎賞或忠誠計劃合作夥伴、慈善機構或其他第三方金融機構及服務供應商所提供或舉辦的金融、保險、退休金、年金或相關產品、服務和優惠詳情(例如健康與保健)及推廣活動的詳細資料。

向您進行市場推廣時，我們或會使用您的資料，例如人口統計資料、您感興趣的產品及服務、交易行為、投資組合資料、位置資料、社交媒體資料、分析、健康及保健資料和來自第三方的資料。

我們不會向他人提供您的資料，以供其向您推廣產品及服務。如有此意，我們會另行徵求您的同意。

本文件於我們儲存您的資料期間適用。若我們將您的資料用於新用途，則會徵求您的同意。

本人(等)在下方簽署即知悉及明確同意滙豐可按本表格內列出的用途收集、處理、使用及披露於現時或其後持有本人(等)的全部個人資料(包括敏感資料)。本人(等)亦知悉及明確同意本人(等)的個人資料(包括敏感資料)可能按本表格所列分享予第三方，以及被轉移到澳門以外的地區。

F. Declaration and Authorisation 聲明及授權

I hereby certify that the answers and statement given above are true and complete to the best of my knowledge and that I have withheld no material fact. 本人在此聲明以上所提供的資料均屬正確無訛且並無缺漏。

I expressly consent any physician, hospital, clinic, insurance company or other individual organisation or government office that has any records (including but not limited to health records, but to be considered as relevant for this claim) and/or information of myself/my child (the name of my child), to disclose to HSBC Life (International) Limited or its representative any information relevant to this claim (including but not limited to sensitive data). 本人明確同意任何知道本人／本人的子女健康情況之任何記錄(包括但不限於健康記錄，但僅限於與本索賠有重要性的資料)及／或資料之醫生、醫院、診所、保險公司或其他私人、政府機構向滙豐人壽保險(國際)有限公司或其代表提供本人／本人的子女有關且對本索賠有重要性的資料(包括但不限於敏感資料)。此授權書於本人死亡或喪失能力後依然生效。本授權書之影印本亦屬有效。

By signing below, I/we expressly agree that the Company may use and disclose all personal data about me/us that the Company currently or subsequently hold for the purposes as set out in the Personal Information Collection Statement which accompanies this form. 本人(等)在下方簽署即明確同意貴公司可按本表格隨附的關於個人資料(私隱)條例的通知內列出的用途使用及披露貴公司現時或其後持有有關本人(等)的全部個人資料。

Signature of Insured 受保人簽署	Signature of Policyholder 保單持有人簽署
______________________	______________________
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

To HSBC Life (International) Limited
致：滙豐人壽保險(國際)有限公司

Date 日期: ____________________

Policy No. 保單號碼: ____________________

Part II : Attending Physician's Report — Disability/Accidental Dismemberment Claim Form (To be completed by physician at claimant's expense)
第二部分：醫療報告 — 喪失工作能力／意外傷殘賠償申請書 （由主診醫生填寫，費用由索償人支付）

1. Name of patient (Surname first)	2. Age	3. ID No. / Passport No.	4. Occupation and job duties

5. (a) Please state the cause of the disability.

   ____

   (b) Date on which you first saw the patient for this illness or injury. (DD/MM/YYYY)

   ____

   (c) Was the patient referred to you by another doctor? If so, please indicate his / her name and address.

   ____

   (d) What symptoms did the patient complain of at this first consultation?

   ____

   (e) Was the patient's presentation consistent with the symptoms and level of disability complained of?

   ____

6. If the disability was due to illness:

   (a) According to the patient, how long had he / she experienced the symptoms before the first consultation?

   ____

   (b) How long do you think the symptoms had been in existence before the first consultation?

   ____

7. Please give details of all consultations and treatments given as far as your records go back. (Alternatively, a copy of the patient's record can be provided.)

Date	Complaints & Symptoms	Diagnosis	Type of Treatment Given	Duration of Treatment

8. (a) Names and addresses of hospitals to which patient was admitted during this disability

   ____

   ____

   (b) Period of hospitalisation(s):

   From: (DD/MM/YYYY) ____________________ To: (DD/MM/YYYY) ____________________

   (c) Names and addresses of other physicians consulted during this disability.

   ____

   ____

   (d) Is further hospitalisation / surgery necessary? If so, please specify.

   ____

MAC016

9. Please indicate the results of all investigation & test (such as neurological examination, laboratory tests, X-rays and Wassermann, etc.). We would appreciate receiving copies of all such test results. If insufficient space, please attach a separate list.

____

10. Did the injury / illness result from or was the period of disability lengthened by?

	Yes	No
(a) Physical defects / congenital anomaly?	☐	☐
(b) Past medical history?	☐	☐
(c) Degenerative changes?	☐	☐
(d) Alcohol or drug abuse?	☐	☐
(e) Smoking?	☐	☐
(f) HIV/AIDS related condition?	☐	☐
(g) Prior psychiatric illness?	☐	☐

11. (a) Please give the date the patient was first absent from work.

____

(b) If the disability was interrupted, please give date(s) patient returned to work.

____

12. What is the present condition of the patient's disability?

____

13. What treatment has been prescribed?

____

14. Did the patient comply with this treatment?

____

15. Please advise what duties of the patient's pre-disablement occupation he / she is:

- Able to perform ______________________________
- Unable to perform ______________________________

16. On what date did the patient return to work? Was this on a full-time or part-time basis?

____

____

MAC016

17. To the best of your knowledge, has the patient ever been treated for the same / related conditions or for any other serious disorder? If so, please state when and the names of any other hospital(s) and / or physician(s) attended.

Date	Disease / Disorder	Details of Treatment(s) / Hospitalisation(s)	Name of Physician / Hospital

18. Have any medical certificates been provided to any other persons, insurance companies or other companies? If so, please provide full details.

____

19. If the patient is still disabled, is he / she

- Motivated to return to work? ______________________________
- Motivated to undertake re-training or other rehabilitative schemes? If so, please specify.

____

20. Has a treatment plan been put in place to return the patient to work? If so, please provide details.

____

Declaration

I hereby certify that I have personally examined and treated the patient in connection with the above disability and that the facts as given above present my opinion of his / her condition.

I hereby certify that I have not withheld any information at the request of the patient.

____
Name of Physician (With Stamp)

____
Name of Physician

____
Qualification

____
Telephone No.

____
Address

____
Date 日期

MAC016

To HSBC Life (International) Limited
致：滙豐人壽保險(國際)有限公司

Date 日期: ______________________

Part II : Attending Physician's Report — Total & Permanent Disability Claim Form
(To be completed by physician at claimant's expense)

Policy No. 保單號碼: ______________________

第二部分：醫療報告 — 完全及永久喪失工作能力賠償申請書
（由主診醫生填寫，費用由索償人支付）

Name of Patient	HKID No./Passport No.	Date of Birth	Age	Sex (M/F)

1. General

i. Are you the usual medical attendant? If "yes", over what period do your record extend? ☐ Yes ☐ No

ii. When were you last consulted for this condition and how long had the symptoms been present at that time?

iii. Date of last consultation/examination.

iv. Date when first absent from work.

v. Are you currently issuing Medical Certificates? If "yes", for what period do you intend to renew them? ☐ Yes ☐ No

vi. Please give details of the patient's habits in relation to cigarette smoking and drinking habit.

2. Medical Details

i. What is the nature and extent of your patient's condition?

ii. Please give the precise diagnosis.

iii. Please describe the symptoms currently disabling your patient.

iv. How long have the symptoms been present?

v. Has the patient previously suffered from this condition or any related illness?

vi. Is the patient suffering from any other condition? If "yes", does this have an effect on the condition above. ☐ Yes ☐ No

vii. Please describe the residual disability:

☐ Recovered	☐ Improved
☐ No improvement	☐ Deteriorating
☐ Other, please specify	

viii. Are there any other circumstances that may have an effect on the patient's return to work?

3. Nature of the treatment

i. What treatment is being rendered and what types of medication are being prescribed?

ii. Please comment on the response to treatment.

iii. Please give the name and address of all consultants, specialists or hospital to which your patient has been referred to or attended for this condition.

iv. Is your patient still receiving hospital care? Please give details.

4. Details of physical impairment

Please comment on your patient's ability to perform the following:

i. Capable of heavy manual duties (i.e. little restriction on mobility).

ii. Capable of light manual duties (i.e. slight restriction on mobility).

iii. Capable of sedentary duties (i.e. moderate restriction on mobility).

iv. Incapable of sedentary duties (i.e. marked/severe restriction on mobility).

5. Details of mental impairment

i. Are stress, emotional or psychological conditions relevant to your patient's condition? If "yes", please comment. ☐ Yes ☐ No

ii. Do you anticipate that any psychological condition will permanently affect the insured's ability to resume employment? If "yes", please comment. ☐ Yes ☐ No

6. Prognosis

We should be grateful for your advice on your patient's ability to perform an occupation as follows:

	Own occupation	Other occupation (including sedentary)
i. Is your patient totally disabled from performing ...		
ii. Do you anticipate an improvement in the condition so as to enable a return to ...		
iii. If "yes" when do you consider your patient will be able to resume work in ...		

7. Rehabilitation

i. Is your patient currently undergoing any form of rehabilitation? If Yes, please provide details. ☐ Yes ☐ No

ii. Please comment on any further treatment or rehabilitation which may improve your patient's condition. (e.g. retraining, physiotherapy)

8. Further information

If there is any further information which, in your opinion, will assist us in assessing this claim, please give details: (we should be grateful for copies of any relevant hospital reports which are available.)

9. In your opinion, does the condition suffered by your patient fulfil the definition stated?

Declaration

I hereby certify that I have personally examined and treated the patient in connection with the above disability and that the facts as given above present my opinion of his/her condition.

I hereby certify that I have not withheld any information at the request of the patient.

Signature of physician (with stamp)

Name of physician

Qualification

Telephone no.

Address

Date

MAC016