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忠意人壽（香港）有限公司
忠意保險有限公司香港分行

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Internal Use Only 只供內部使用
Claim No. 理賠編號

Waiver of Premium Claim Form – Part I
傷殘豁免保費賠償申請表 – 第一部份

Policy Number
保單號碼

Private & Confidential 私人及機密

☐ New Claim 新索償 ☐ Further Claim 再度索償

Important Notes 重要提示

Please ensure the following to avoid unnecessary delay in the claim process:
1. This Part I is fully completed and signed by the Insured / Policyholder
2. Documents required to be submitted with this form:
   - ☐ Waiver of Premium Claim Form – Part II to be completed by the Insured's attending physician
   - ☐ Proof of Identity of the Insured and Policyholder (if not provided before)
   - ☐ Sick Leave Certificate and Patient Card Copy
   - ☐ Laboratory Reports

We may require additional information from you or third parties in order to assess your claim.

請確保下列各項，以免延誤索償進度：
1. 由受保人 / 保單持有人詳細填妥及簽署此申請表第一部份
2. 連同此表格一併要遞交的文件：
   - ☐ 由受保人主診醫生填寫的傷殘豁免保費賠償申請表 – 第二部份
   - ☐ 受保人及保單持有人的身份證明文件（若過往並未遞交）
   - ☐ 病假證明書及覆診卡
   - ☐ 檢驗測試報告

我們就審核是次賠償申請，或需向你或其他人士索取額外資料。

Section A – Details of the Insured and Current Claim 甲部 – 受保人及是次索償詳情

1. Name of the Insured 受保人姓名		2. HKID Card / Passport No. 香港身份證 / 護照號碼	
3. Mailing Address 通訊地址	* *Your policy record will NOT be automatically updated with this address* *此地址不會自動更新於你的保單記錄上*	4. Contact Phone No. 聯絡電話號碼	

5. Employment details 就業詳情

Occupations & nature of duties before disability
傷殘前的職位及職務 _____

Employer's name & address
僱主名稱及地址 _____

Date of absence from work (dd/mm/yyyy)
因是次傷殘而停止工作日期 _____ / _____ / _____ (日/月/年)

(Expected) Date of return to work (dd/mm/yyyy)
（預計）復職日期 _____ / _____ / _____ (日/月/年)

6. If the disability due to accident, please describe the accident in details.
若因意外導致傷殘，請詳述意外詳情。

Date of accident (dd/mm/yyyy) Place
意外日期 _____ / _____ / _____ (日/月/年) 地點 _____

Accident details, part of body injured & nature of injury
意外詳情、受傷部份及傷勢 _____

7. If the disability due to illness, please describe the illness in details.
若因疾病導致傷殘，請詳述疾病詳情。

Date symptoms first appeared (dd/mm/yyyy)
病徵首次出現日期 _____ / _____ / _____ (日/月/年)

Symptoms details
病徵詳情 _____

First consultation date (dd/mm/yyyy)
首次求診日期 _____ / _____ / _____ (日/月/年)

Name and address of the hospital/physician
醫院 / 醫生名稱及地址 _____

8. The hospital / physician first consulted for current disability.
初診此傷殘的醫院 / 醫生資料。

First consultation date (dd/mm/yyyy)
首次求診日期 _____ / _____ / _____ (日/月/年)

Name and address of the hospital/physician
醫院 / 醫生名稱及地址 _____

9. Other hospitals / physicians consulted for current disability. 曾應診現時傷殘的其他醫院 / 醫生資料。	Name of hospital / physician and address 醫生 / 醫院名稱及地址 _____ _____ Consultation date 求診日期 _____ _____
10. Have any immediate family members suffered from a similar illness? 直系親屬是否曾患有相同或類似的疾病?	☐ Yes 是 If yes, please provide details below. 若是，請於下方提供詳情 ☐ No 否 Date of diagnosis 確診日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年) Relationship with the Insured 該親屬與受保人關係 _____ Nature of illness 疾病的性質 _____
11. Apart from what have mentioned above, all other hospitals / physicians that the Insured has consulted in the past five years. 除上述已提及外，過去五年受保人曾求診的其他醫院 / 醫生資料。	Name of hospital / physician and address 醫生 / 醫院名稱及地址 _____ _____ Consultation date 求診日期 _____ _____ Illness / Diagnosis 病因 / 確診 _____ _____
12. Is there any claim submitted to other insurance companies for this disability? 此傷殘是否有向其他保險公司遞交索償申請？	☐ Yes 是 If yes, please provide details below. 若是，請於下方提供詳情 ☐ No 否 Name of insurance company 保險公司名稱 _____ _____ Policy number 保單號碼 _____ _____ Sum Insured 保額 _____ _____ Claim status 賠償進度 _____ _____

Section B – Settlement Options 乙部 – 賠償選擇

1. Payment Option (if applicable) 賠款選擇 (如適用)	Cheque 支票 : ☐ Policy Currency 保單貨幣 ☐ HKD 港幣 Other 其他 : ☐ Telegraphic Transfer 電匯 (Foreign Account only 只供海外帳戶) Note 請注意 1. The HKD equivalent will be based on the currency exchange rate provided by Generali Life (Hong Kong) Limited / Assicuraioni Generali S.p.A. Hong Kong Branch (whenever applicable) at the time of cheque issuance and it can be changed from time to time. 相等之港幣將以忠意人壽（香港）有限公司忠意保險有限公司香港分行（如適用）於簽發支票時所釐定之貨幣兌換率計算，而有關之貨幣兌換率將不時轉變。 2. If not specified, claim cheque will be made in HKD. 如沒有選擇，賠款支票將以港幣發出。 3. If require for Telegraphic Transfer, please provide the bank proof with SWIFT code; bank and account holder details. The charge of Telegraphic Transfer will be at client own cost 如選擇電匯方式，需提供有關銀行證明包括銀行代碼; 銀行及戶口持有人詳細資料。電匯費用會由客戶支付。
2. Cheque Delivery Option 支票遞送選擇	☐ By Mail (to the mailing address stated in this claim form) 郵寄（至本賠償申請表上填寫的郵寄地址） ☐ Through insurance intermediary 透過中介人遞送

Section C – PEP Self-declaration 丙部 - 政治人物自我聲明 *(Compulsory to complete 必須填寫)*

Are you or any relevant parties[#1] of this policy a politically exposed person ("PEP[#2]"), PEP family member or PEP close associate?
閣下或本保單相關各方人士[#1]是否政治人物「PEP[#2]」、其家庭成員或與政治人物有關係密切的人？

☐ No 否 ☐ Yes 是, please provide 請提供

a. Name of this "PEP" : _____ Position :_____
政治人物的姓名 職位

b. Name of the relevant party(ies) of this policy : _____
本保單相關人士的姓名

c. Relationship with this "PEP" : _____
與此政治人物的關係

[#1] *Relevant parties include but not limited to the policyholder, insured, beneficiary(ies), person acting on behalf of the policyholder, beneficial owner(s) etc.*
相關各方人士包括但不限於保單持有人、受保人、受益人、代表保單持有人行事的人、實益擁有人等。

[#2] A politically exposed person (PEP) is an individual who is or has been entrusted with a prominent public function in Hong Kong / a place outside Hong Kong/ by an international organization
政治人物被界定為在香港 / 香港以外地方 / 國際組織擔任或曾擔任重要公職的個人。

Section D – Declaration and Authorization 丁部－聲明及授權

1. I / We confirm that I / we have accessed, read and understood the Personal Information Collection Statement (the "**Statement**") of Generali Life (Hong Kong) Limited / Assicurazioni Generali S.p.A. Hong Kong Branch (whichever applicable) ("**Generali**"), which is available on **Generali** 's website: https://www.generali.com.hk/EN_US/personal_information. I / We agree that **Generali** may collect, use, store, disclose, transfer and otherwise process my / our personal data in accordance with the terms of the Statement. I / We further confirm that I / we have obtained the express consent of the life insureds and any other relevant individuals (where applicable) for providing their personal data to **Generali** for the purposes stated in the **Statement** and for allowing **Generali** to collect, use, store, disclose, transfer and otherwise process such personal data in accordance with the terms of the **Statement**.
本人 / 我們確認已經查閱並且明白由忠意人壽(香港)有限公司 / 忠意保險有限公司 香港分行（如適用）（下稱「**忠意**」）的收集個人資料聲明（「**該聲明**」），**該聲明**可於**忠意**網站查閱：https://www.generali.com.hk/ZH_HK/personal_information; 本人 / 我們同意**忠意**可依照該聲明的條款收集、使用、儲存、披露、轉移及以其他方式處理本人 / 我們的個人資料。本人 / 我們進一步確認，本人 / 我 們已獲得受保人和任何其他有關人士（如適用）的明示同意，可以按照**該聲明**所述的用途將他們的個人資料提供給**忠意**，並允許**忠意**可依照該聲明的條款收集、使用、儲存、披露、轉移及以其他方式處理該等個人資料。

2. I/We declare and agree on behalf of myself/the Insured and other person referred to this form that all 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.
本人/我們謹此代表本人/受保人及其他在此申請表提及之人士聲明及同意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，均為事實全部並確實無訛。

3. I/We hereby authorize on behalf of myself/the Insured (i) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of me/the Insured to disclose such information to Generali or its representatives any and all information with respect to the my/the Insured's health, medical history, hospitalization, advice, treatment, disease, investigatory result, employment record, accident report or statement (including but not limited to completing claim form – part II of Generali); (ii) Generali or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/the Insured in relation to this claim. This authorization shall bind my/our successors and assignees and remains valid notwithstanding death or incapacity. A photocopy of this declaration and authorization shall be considered as effective and valid as the original.
本人/我們謹此代表本人/受保人同意及授權(i)任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構或其他機構、組織或人士，凡知道或持有任何有關本人/受保人健康、病歷、住院、治療、疾病、調查結果、受僱記錄、意外報告或其他資料之紀錄者，均可將該等資料（包括但不限於填寫忠意的賠償申請表格－第二部份）提供給忠意或其指定的代表人士；(ii) 忠意或任何其指定之醫生或化驗所，可就此賠償申請替本人/受保人進行所需之醫療評估及測試，作為審核本人/受保人之健康狀況。此授權對本人/我們之繼承人及承讓人具有約束力；即使死亡或無行為能力時，此授權仍具效力。本授權及同意書的影印本與正本均有同等效力。

4. I/We declare and agree that I/we have the full authority from and consent of the Insured to make the above authorizations.
本人/我們聲明及同意已獲受保人授權及同意本人/我們作出上述授權。

Signature of the Insured (Aged 18 or above) 受保人簽署 (十八歲或以上)	Name in block letters and ID / Passport No. of Insured 受保人姓名(正楷書寫) 及身份證 / 護照號碼	Sign Date (dd / mm / yyyy) 簽署日期 (日 / 月 / 年)
Signature of the Policyholder 保單持有人簽署	Name in block letters and ID / Passport No. of Policyholder 保單持有人姓名(正楷書寫) 及身份證 / 護照號碼	Sign Date (dd / mm / yyyy) 簽署日期 (日 / 月 / 年)