危疾保險索償表
CRITICAL ILLNESS CLAIM FORM

STARR INSURANCE COMPANIES

如果表格空間不足或沒有適用之欄位，請以附件補充資料。If the space is not enough or no applicable field available, please supplement information by attachment.

保單持有人及受保人資料 POLICYHOLDER AND INSURED PERSON INFORMATION

保單號碼 Policy number	保單持有人姓名 Name of Policyholder	
受保人姓名 Name of Insured Person	索償人姓名 (如不是受保人) Name of claimant (if not Insured Person)	與受保人關係 Relationship to Insured Person
索償人身分證號碼 Claimant HKID number	聯絡電話 Contact phone number	電郵地址 E-mail address
通訊地址 Correspondence address		

索償類別及金額 TYPES OF CLAIMS AND AMOUNT

☐ 危疾保障 Critical Illness　☐ 癌症外科手術治療 Cancer Surgical Treatment　☐ 飲食或營養療法 Dietary or Nutrition Therapy

索償金額 Claim Amount: _____

索償詳情 CLAIM DETAILS

如索償是由**意外**導致，請詳述如下:- If the claim is due to **accident**, please specify the below:-

意外發生日期，時間及地點 Date, time and place of accident	
意外發生的詳情 Circumstances of accident	
傷勢及受傷部位 Nature of injury and affected part of body	最後診斷之病症 Final diagnosis

曾否報警？ Did you report the accident to the police ?

☐ 有 (請附上警方報告) Yes (Please provide Police Report)　☐ 否 No

如索償是由**疾病**導致，請詳述如下:- If the claim is due to **sickness**, please specify the below:-

首次出現病徵日期 Date of symptom first appeared	首次求診日期 Date of first consultation	危疾名稱 Critical illness
DD 日　MM 月　YYYY 年	DD 日　MM 月　YYYY 年	

請簡述疾病開始之病徵 Brief description of the symptoms from the date of onset

閣下過往曾否患上此類或相關疾病或因該疾病而需要接受治療？如是，請詳述。Have you ever suffered from or received treatment for similar or related sickness? If yes, please give full details.

直系親屬中曾否患有相同或有關之危疾？開始之病徵 Have any of your blood relative(s) suffered from similar or related sickness? If yes, please give details.

☐ 是 Yes (請詳述如下 Please specify below)　☐ 否 No

親屬關係 Relationship of Relative	危疾類別 Nature of Illness	診斷日期 Diagnosed Date

診治及住院詳情 **DETAILS OF MEDICAL CONSULTATION / HOSPITALIZATION**

請提供就此病或傷求診詳情 Details of any doctor(s) who have been consulted in connection with this or related illness / injury

求診日期 Consultation Date(s)	醫生姓名 Doctor's Name(s)	地址 Address(es)

請提供就此病或傷而需住院之詳情 Details of any hospitalization in connection with this or related illness / injury

醫院名稱 Name of Hospital	入院日期 Date of Admission	出院日期 Date of Discharge

請提供閣下慣常求診之醫生姓名，地址及聯絡電話 Details of the name, address and contact no. of the Insured's regular doctor

其他保險或賠償 **OTHER INSURANCE OR COMPENSATION**

閣下是否在其他公司投保於類似保障？ Are you insured for similar benefits with any other company? ☐ 否 No ☐ 是 Yes (請詳述如下 Please specify below)

保險公司之名稱 Name of Insurer	保單號碼 Policy number	保障項目 Benefit	保額 Sum insured

收款方式 **SETTLEMENT METHOD**

請選擇以下其中一項收款方式
Please select one of the following settlement method

☐ 銀行轉帳 Bank Transfer
登記銀行名稱 Name of the Bank _____

銀行號碼 Bank Code _____

銀行户口號碼 Account No. _____

銀行户口持有人名稱 Full Name of Account Holder _____

☐ 港幣支票 Hong Kong Dollar Cheque
郵寄往受保人/符合條件的索償者的通訊地址。
Mail to the Insured Person/eligible claimant's correspondence address

聲明及授權 **DECLARATION AND AUTHORIZATION**

- 本索償表簽署人謹此聲明，就我/我們所知所信，本索償表上所填報之資料均屬實無訛。我/我們同意任何蓄意欺詐或隱瞞將會導致保單失效。我/我們並同意 Starr International Insurance (Asia) Ltd ("SIIA") 或其授權代理可保留，使用或透露 SIIA 所收集或保留之任何有關我/我們的個人資料給予 SIIA 有關人士/機構或任何被選定的機構，用作處理此索償申請及資料核對等用途，及因此等用途與我/我們聯絡。我/我們明白倘若未能提供索償表所需的資料，SIIA 將可能無法處理有關索償。我/我們同時有權向 SIIA 查閱及申請改正個人資料。有關的申請可致函 SIIA 的營運部經理，地址為香港灣仔港灣道 18 號中環廣場 19 樓 1901 室。
- 我/我們現授權 SIIA 或其代理人向醫生、醫院、診所、保險公司、政府機構或有關組織，提取我/我們與這意外或索償事件有關之病歷記錄。即使我/我們身故或喪失能力，此授權書仍然存有法律效力，而我/我們之繼承人也會受此約束，其副本與正本同屬有效。
- The undersigned hereby declares that to the best of my/our knowledge and belief, the above statement and particulars are fully and truly made. I/We agree that if any fraudulent means or devices are used in connection with obtaining any benefit under the Policy, the Policy shall be void against me/us. I/We agree that any of my/our personal information collected or held by Starr International Insurance (Asia) Ltd. ("SIIA") or its authorized representatives is provided and be held, used and disclosed by SIIA to individuals/organization associated with SIIA or any selected third party for the purpose of processing the claims herein, providing data matching and to communicate with me/us for such purposes. The undersigned understand that SIIA may be able to process the claims herein if I/we fail to provide any information requested in this Claim Form. The undersigned further understand that I/we have the right to obtain access and to request correction of my personal information held by SIIA. Such request can be made to SIIA's Operations Services Manager at Suite 1901, 19/F Central Plaza, 18 Harbour Road, Wanchai, Hong Kong.
- I/We hereby irrevocably authorize SIIA or its authorize representative to obtain my/our medical records from my/our treating physicians, hospitals, clinics, insurance companies, government agencies or other relevant organizations in relation to the accident or claim. This authorization is valid even I/we am/are deceased. My/our next of kin is also bound by this authorization. The original or copy of this authorization has the same effects.

受保人/索償人簽署 Signature of Insured Person/claimant	保單持有人簽署（請蓋公司印，適用於團體保單） Signature of Policyholder (with company chop, applicable to group policy)	日期 Date DD 日 MM 月 YYYY 年

危疾保醫療報告（需由主診醫生填寫）

CRITICAL ILLNESS MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIANS)

病人資料 Patient Information

病人姓名 Name of patient	出生日期 Date of Birth	香港身份證或護照號碼 HKID/Passport No.

意外/疾病詳情 Details of Accident/Illness

閣下是否受保人慣常求診醫生? Are you the patient's usual physician? ☐是 Yes ☐不是 No

如「是」，請提供有關詳情。If yes, please provide details:

應診期間 Period of Consultation

過往健康記錄 Past Health History

病人是否由另一位醫生轉介閣下？如是，請提供轉介醫生之姓名 Was the patient referred to you by another physician ? If yes, please advise the name of referral doctor.

最後診斷 Final Diagnosis	診斷日期 Diagnosis Date

請詳述病徵及症狀 Please describe the signs and symptoms

首次求診日期 Date of first consultation	受傷或首次出現病徵日期 Date of occurrence of injury or first symptom
DD 日 MM 月 YYYY 年	DD 日 MM 月 YYYY 年

據你所知，病人以往曾否出現同樣或類似的病況? 如是，請提供日期及詳情。To the best of your knowledge, has the patient ever had the same or similar condition(s) or symptom(s)? If yes, please state the dates and conditions/symptom.

是次情況是否由其他潛在疾病導致？如是，請提供詳情。Was the condition caused by any underlying disease? If yes, please specify.

是次情況會否引致永久傷殘或身體機能喪失? 如是，請提供詳情。Will the current condition(s) or symptom(s) result in any permanent disability or irreversible loss of function? If yes, please advise details.

如是次情況與燒傷有關，請評估燒傷程度及身體面積之百分比。If the current condition or symptom relates to burn injury, please advise (a) degree of burnt and (b) estimated % of burnt body surface.

診斷是否由下列情況導致或有關連 Is the diagnosis due to or associated with any of the following?

(a)	先天性異常 Congenital anomalies	☐是 Yes ☐不是 No
(b)	視力矯正 Refractive error or correction of eyesight	☐是 Yes ☐不是 No
(c)	遺傳性疾病 Heredity condition	☐是 Yes ☐不是 No
(d)	美容或整形手術 Cosmetic or plastic surgery	☐是 Yes ☐不是 No
(e)	懷孕或分娩 Pregnancy or childbirth	☐是 Yes ☐不是 No
(f)	不論在神志清醒與否下之自我損傷或自殺行為 Self-inflicted injuries or suicide while sane or insane	☐是 Yes ☐不是 No
(g)	酒精或藥物影響 Drugs or alcohol	☐是 Yes ☐不是 No
(h)	精神或心理病 Mental or nervous disorders	☐是 Yes ☐不是 No

因此病況求診、住院及手術之詳情。Details of medical consultations, hospital confinement and operation

Date / Treatment period 日期 / 治療期間	Treatment Details 治療詳情

如確診為癌症、原位癌、中風或心臟病，請填寫以下有關部分。Please complete the below respective sections if the final diagnosis is Cancer, Carcinoma-In-Situ, Stroke or Heart Attack.

Cancer 癌症 / Carcinoma-In-Situ 原位癌

1. 有關的病徵及腫瘤之原發位置 What were the symptoms? And what was the origin of the tumor?

2. 腫瘤屬於哪一階段 (即原位癌, 癌前惡性腫瘤, 完全局限性或遠距離轉移等) ? What is the TNM staging of the tumour (i.e. Carcinoma-in-situ, Pre-malignant tumour, Completely localized or Distant metastasis etc.)?

3. 病人接受那一種治療? 請提供詳情。What is the nature of treatment? Please provide the details.

4. 有否進行細胞組織分析? 如有，請提供有關詳情(即細胞組織分析日期, 進行細胞分析的地點及結果等)Was a biopsy of the tumour performed? If yes, please provide the details (i.e. biopsy date, biopsy performed by and the result etc.)

Stroke 中風

1. 是次中風有否導致永久性神經功能缺損? 請詳述。Is there any permanent neurological functional impairment? Please provide details.

2. 請詳述由哪種檢查確診有關病況及其結果。Please advise the tests was found to confirm the diagnosis and the test results.

3. 診斷是否由下列情況導致或有關連? Is the condition due to or associated with any of the following?

(a)	短暫性腦缺血 Transient Ischemic Attacks (TIA)	☐ 是 Yes	☐ 不是 No
(b)	因意外、感染、血管炎、炎症性的疾病或偏頭痛引致的腦部損傷 Brain damage due to an Accident, infection, vasculitis, inflammatory disease or migraine	☐ 是 Yes	☐ 不是 No
(c)	影響眼部的血管疾病 Disorders of the blood vessels affecting the eye	☐ 是 Yes	☐ 不是 No
(d)	前庭系統的缺血性失調 Ischemic disorders of the vestibular system; and	☐ 是 Yes	☐ 不是 No
(e)	電腦影像顯示的無症狀腦中風 Asymptomatic silent stroke found on imaging	☐ 是 Yes	☐ 不是 No

Heart Attacks 心臟病

1. 這次事件有否診斷出新出現的急性心肌梗塞? Is the current episode a new definite acute myocardial infarction? ☐是 Yes ☐不是 No
2. 受保人之病徵及有否典型的胸痛症狀病歷? What were the symptoms and any history of typical chest pain?

3. 確診前的首次心電圖有否異常發現? Any abnormal findings for the first electrocardiogram (ECG) done after the onset of the disorder?

4. 心肌酵素有否顯著升高? 如有，請提供詳情。Is there any elevation of cardiac enzymes levels? If so, please provide the details.

5. 有否因冠狀動脈出現問題令血液不足而導致部分心肌壞死? Is there any death of a portion of the heart muscle as a result of inadequate blood supply due to coronary artery disease?

醫院/診所地址 Address of hospital/clinic		
醫院/診所電話 Phone number of hospital/clinic	醫療報告日期 Date of medial report DD 日 MM 月 YYYY 年	
主診醫生姓名 Name of attending physician/specialist	主診醫生簽名及蓋章 Signature and stamp of attending physician/specialist	日期 Date DD 日 MM 月 YYYY 年

STARR
INSURANCE COMPANIES
Starr International Insurance (Asia) Limited
香港灣仔港灣道 18 號中環廣場 19 樓 1901 室 Suite 1901, 19/F, Central Plaza, 18 Harbour Road, Wanchai, Hong Kong
索償熱線 Claim Hotline: (852) 3765 5577 傳真 Fax : (852) 3765 5501 電郵 E-Mail: asia.ahclaim@starrcompanies.com