

# Dread Disease Claim Form - Myocardial Infarction

## 危疾保障索償表格 - 心肌梗塞



CIGNA Worldwide Life Insurance Company Limited  
CIGNA Worldwide General Insurance Company Limited

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第一部份 - 此部份由受保人填寫  
Part I - To be completed by the insured

個人資料 Personal Particulars		Ref: _____ (for office use)	
保單持有人姓名 Name of Policyholder	英文 Eng _____	中文 Chin _____	
受保人姓名 Name of Insured	英文 Eng _____	中文 Chin _____	
受保人香港身份證號碼 HK Identity Card No. of Insured	年齡 Age _____	性別 Sex _____	
	男 M	女 F	
	出生日期 Date of Birth _____	保單編號 Policy No. _____	
日間聯絡電話 / 傳呼機號碼 Daytime Contact Telephone No. / Pager _____	通訊地址 Correspondence Address _____		
	電郵地址 E-mail Address _____		
若上述通訊地址亦同時用作日後保單通訊之用，請在下列方格“√”。若否，上述通訊地址只作是次索償通訊之用途。 If policy and all future correspondence use the listed correspondence address, please "tick" the below box. Otherwise, all claims correspondences, including claim payment, are mailed to the listed correspondence address.			
<input type="checkbox"/> 是，請用上列通訊地址 Yes, please use the listed correspondence address			
現任僱主名稱 Name of Current Employer _____	受僱職位 Position Held _____		
現任僱主地址 Address of Current Employer _____	公司電話 Tel No. _____		
病情闡述 Details of Disability			
1. 所患疾病種類。如病況乃因意外創傷，請述意外發生日期、時間、地點及起因。 Type of disability you are suffering from. If the disability is caused by an injury, please specify date, time, place and details of the accident.			
_____			
_____			
2. 請述主要病徵並約在何時開始發現上述徵兆： Signs and symptoms you are suffering from and please give an approximate commencement date when such symptoms are being aware of:			
_____			
_____			
3. 請順序列述台端因此病而求診的所有醫生或醫療機構。 Please state all medical doctors consulted for the disability in chronological order.			
醫生姓名 Name of Physician	醫院 / 診所名稱及地址 Name and Address of Hospital/Clinic	求診 / 住院日期 Date of Consultation / Confinement	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
其他 Others			
台端有否投保於其他保險公司？如有，請註明： Do you have other insurance coverage? If so, please specify:			
承保公司名稱 Name of Insurer	保單編號 Policy Number	保障類別 / 投保額 Type of Cover / Sum Insured or Benefits Level	保單生效日期 Policy Effective Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
聲明及授權書 Declaration & Authorization			
(請由受保人簽署，如受保人未滿18歲，請由保單持有人簽署 To be signed by insured. If insured is below 18 years old, please sign by Policyholder)			
本人謹此聲明上述一切陳述，不論是否本人親手所寫，均屬正確無訛，並為吾所知所信之全部，本人同意(1)任何蓄意欺騙或隱瞞將構成法律責任並導致保單失效(2)任何持有有關於本人或上述受保人記錄或資料之醫生、醫院、藥劑師、保險公司、警署、僱主、或其他機構發放有本人或上述投保人之病歷、病情預後、治療、醫假、或在職、離職詳情、或在其他保障下可獲之保障額、索償金等資料予信諾環球保險公司或其代表及授權公司(或其代表)、而在香港私隱權條例容許之情況下，本人並同意將個人資料給予其他在港或以外之機構。而此授權書之副本亦如正本一樣具同等效力。			
I hereby declare all the statements to all questions above, whether or not written by my own hand are to the best of my knowledge and belief complete and true. I agree that any concealment or misstatement as regards to amount or otherwise, in connection with this claim may result in prosecution and the policy shall become void.			
I hereby to authorize any physician, hospital, pharmacy, insurance company, police station, employer, or other organization, who has records or knowledge of myself or the insured, to release all information regarding medical history - prognosis treatment (including drug and alcohol abuse information), sick leave history, employment history, reason of employment termination, earnings or benefit payable under other insurance coverage to CIGNA Worldwide Life Insurance Company Limited and CIGNA Worldwide General Insurance Company Limited or its representative and permit said company (or its representative). In accordance with the provisions of the Personal Data (Privacy) Ordinance of Hong Kong by signing below, I consent that the personal information collected or held by the Company, whether contained in this application & otherwise obtained, is provided and may be disclosed to individuals or organizations within or outside Hong Kong. A photostatic copy of this Declaration & Authorization shall be as valid as the original.			
受保人 / 保單持有人簽署 (如受保人未滿 18 歲) Signature of Insured / Policyholder (if insured is below 18 years old)	_____	簽署日期 Date Signed _____	
受保人 / 保單持有人姓名 (請以正楷書寫) Name of Insured / Policyholder (in block)	_____	受保人 / 保單持有人香港身份證號碼 HK identity Card No. of Insured Policyholder _____	

# Attending Physician Statement - Myocardial Infarction

(To be completed by a registered physician at insured's expense)

Name of Patient: \_\_\_\_\_

Age: \_\_\_\_\_

H.K.I.D.No. of Patient: \_\_\_\_\_

Sex: \_\_\_\_\_

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We are given to know that the above named (hereafter called the patient) has been under your care. To properly evaluate the condition of the patient, please kindly furnish us the following information:

## About the medical condition.

1. Please state the EXACT diagnosis.  
\_\_\_\_\_
2. When was it made?  
\_\_\_\_\_ (DD/MM/YY)
3. By whom was it made? Please give full name of doctor.  
\_\_\_\_\_
4. Please describe is there any abnormal findings for the first electrocardiogram done after the onset of the disorder.  
\_\_\_\_\_  
\_\_\_\_\_
5. Is the current episode the first attack of its kind? If "No", please answer Q.6  
( ) Yes. I) The first date of the attack is on \_\_\_\_\_ (DD/MM/YY)  
II) The duration of the first attack is \_\_\_\_\_ (Min/Sec)  
III) Can the pain be relieved by rest or by medication?  
( ) Yes, the pain can be relieved by rest or medication  
( ) No, the pain cannot be relieved by rest or medication
6. According to the patient/your knowledge (please circle one)  
I) The first date of the attack of its kind was on \_\_\_\_\_ (DD/MM/YY)  
II) The duration of the first attack was \_\_\_\_\_ (Min/Sec)  
III) Could the pain be relieved by rest or medication?  
( ) Yes, the pain can be relieved by rest or medication  
( ) No, the pain cannot be relieved by rest or medication  
IV) Patient has visited \_\_\_\_\_ (Dr. Name) at \_\_\_\_\_ (clinic address) On \_\_\_\_\_ (DD/MM/YY)



14. Please indicate if the said disorder is associated with

- ( ) Under the influence of drug or alcohol
- ( ) Congenital Nature

**15. Please attach copy of pathological/laboratory reports relating to the said disorder.**

\_\_\_\_\_  
Signature of Physician with chop

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Name in Block

\_\_\_\_\_  
Qualification

\_\_\_\_\_  
Clinical Address and phone number of Physician

\_\_\_\_\_  
Hospital Stamp

