Dread Disease Claim Form - Cancer
危疾保障索償表格 - 癌症

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 ____________ 保單編號 Policy No.____________

受保人香港身份證號碼 HK Identity Card No. of Insured ____________ 年齡 Age ________ 性別 Sex 男 女 M / F 出生日期 Date of Birth ____________

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 listedcorrespondence address.
☐ 是，請用上述通訊地址 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 l8 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 or 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証號碼 HK identity Card No. of Insured Policyholder ____________

Attending Physician Statement - Cancer

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

Name of Patient: ______________________________ Age: ______________

H.K.I.D.No. of Patient: ______________________________ Sex: ______________

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. What is the origin of the tumor?

   ____

5. What was the site or organ involved?

   ____

6. Was the cancer completely localized? Please expound.

   ____

   ____

7. Was there any lymph node involvement and to what extent of the lymph node involvement?

   ____

   ____

8. Was there any invasion of adjacent tissue? Please expound.

   ____

   ____

9. Were there distant metastases? If so, to what extent of the metastases?

   ____

   ____

10. What is the staging of the above-mentioned cancer?

    ____

11. What is the prognosis? According to your professional opinion, does the cancer pose any life threatening signs or does it result in any permanent/irreversible loss of function.

____

____

About the medical history

12. Was the patient referred to you by another doctor for further management? If so, please state name and clinical address of referral doctor

☐ No ☐ Yes, the name & clinical address of referral doctor is ______________________________

13. When did the first consultation take place for the related signs and symptoms?

__________________ (DD/MM/YY)

14. What sign(s) and symptom(s) was/were being aware of at the onset of the cancer?

____

____

15. According to the patient, for how long had such symptoms(s) persisted before the first consultation mentioned in Q.13?

____

16. Please list in below all medical consultations, hospital confinement, surgical procedure and course of medical therapy relating to the said cancer and / or its related symptom(s).

Date/Period	Medical Treatment Type	Details

17. Please indicate if the said cancer is associated with

( ) Under the influence of drug or alcohol

( ) AIDS

18. 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