MassMutual
FINANCIAL GROUP℠

GROUP INSURANCE DEATH CLAIM STATEMENT
團 體 人 壽 保 險 死 亡 索 償 申 請 表

Policy Owner/Employer 保單持有人/僱主名稱	: ____________________	Policy No. 保單編號	: ____________
Name of Life Insured (Deceased) 受保人（死者）姓名	: ____________________	Identity Card No. 身分証號碼	: ____________
Loan No. (If applicable) 貸款編號（如適用）	: ____________________		

Furnishing this form is not to be construed or considered as a waiver of any of the company's rights regarding liability under the policy, or the identity of persons entitled to benefits payable, or of any other rights, or defenses available to the company. Every question must be fully and distinctly answered, and further information may be required if necessary. 遞交此表格不表示本公司已接納是次索償申請或已放棄保單上賦與本公司之任何權利。 下列問題必須詳細答覆，如有需要時，本公司可要求其它詳情。

Questions 問	Answers 答
1a. Date of Birth of Deceased (MM/DD/YY) : 死者出生日期 （月/日/年）	a.
b. Place of Birth : 出生地點	b.
2a. Date of Death : 死亡日期	a.
b. Place of Death : 死亡地點	b.
c. Cause of Death : 死亡原因	c.
d. Duration of Illness : 患病時期	d.
e. When was the health of Deceased first impaired? 死者健康何時出現問題	e.
f. Give name of the attending doctor who last treated the Deceased. 最後診治死者之醫生姓名	f.
3a. Occupation of Deceased at Date of Death : 死者生前職業	a.
b. Date of Employment : 受僱日期	b.
c. What was the date Deceased last at full time work? 死者最後全職工作日期	c.
4a. Has case been reported to police ? If YES, what is the police reference number and reported station. 報案警署名稱及檔案編號	a. ☐ No 無 ☐ Yes 有
5a. Was a death inquest or post-mortem examination held on the body ? If YES, (Please attach Report) 何時、何處舉行死因審查或屍體解剖	a. ☐ No 無 ☐ Yes 有

DECLARATION聲明

I, the undersigned, hereby declare and agree on behalf of myself and all Relevant Persons that all information deposed hereinabove, whether they are written by me or not, is true and complete to the best of my/our knowledge and belief and I have not withheld any material information connected with this claim. I have also read and understood the Personal Information Collection Statement stated above and provide the information herein on a voluntary basis. However, I understand that failure to provide information as per your Company's request may result in your Company being unable to process this claim. This claim form and all other documents submitted to your Company for this claim shall be the property of your Company, and will be non-returnable under all circumstances. 本人，即下方簽署者，現謹此代表本人/所有有關人士同意聲明上述披露之一切資料，不論是否由本人手寫，就本人所深知及確信均屬完整並真確無訛。本人就本申請書內並無隱瞞任何重要資料。本人亦已閱讀及明白上述的個人資料收集聲明。本人在此提供的資料均屬自願。若未能依據貴公司要求提供資料，本人明白會導致貴公司不能處理本申請。本申請書及一切其他文件在遞交給貴公司後便會成爲貴公司的財產。在任何情況下均不會獲得退回。

AUTHORIZATION授權書

I hereby authorize on behalf of myself/the insured and all Covered Person(s) (1) any individual or organization (including but not limited to any employer, registered medical practitioner, hospital, clinic, insurance company, bank, police, governmental department, private or public institution) that has any record, statement, information of mine/the insured or any of the Covered Person(s) (whether medical or otherwise) to release, disclose or transfer all the information to your Company or its representatives for the purposes of assessing and processing any insurance claim. (2) your Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and/or tests to evaluate my/the insured's or any Covered Person(s)'s health status in related to this claim. I hereby acknowledge that (1) this authorization shall be binding on my successors and assignees and remain valid and subsisting notwithstanding my death or incapacity for whatever reasons; (2) A photostat copy of this authorization shall be as valid as its original. 本人現授權代表本人/所有受保人(1) 任何擁有本人/吾等任何記錄、供詞、資料(不論是否醫學資料)之人士或機構(包括但不限於任何僱主、註冊醫生、醫院、診所、保險公司、銀行、警察、政府部門、公共或私營機構)向貴公司或其代表發放、披露或轉交任何與評核及處理保險索償申請有關的資料。(2) 貴公司或任何由貴公司指定的醫務人員或化驗所可就本申請對本人/所有受保人進行有需要之醫療評估及測試，以審核本人/所有受保人的健康狀況。本人現確認 (1) 此授權書對本人之繼承人及受讓人具有約束力，即使本人死亡或無行爲能力(不論任何原因)，此授權書仍然生效及具效力; (2) 本授權書之副本與正本具有同等效力。

PERSONAL INFORMATION COLLECTION STATEMENT個人資料收集聲明

The information you provide to MassMutual Asia Limited ("the Company") or its Consultants (whether or not the information was supplied by you in this application or otherwise) is collected to enable the Company to carry on its insurance business and may be used for the purposes of : - (1) evaluating and processing policy service requests, administering and reinsuring your insurance coverage with the Company (2) adjudicating any insurance or related claims, or conducting any investigation or analysis of such claims; (3) promoting and providing any insurance or financial related product or service or any addition, alternation, variation, cancellation, renewal or reinstatement of such product or service; (4) exercising any right of subrogation; (5) calculating premiums or benefits; (6) data matching and direct marketing; (7) communicating with any person or organization relating to this and other insurance claims; (8) any other purpose relating to the settlement of your insurance coverage with the Company; and may be used, held, transferred or disclosed to (1) any related individual or company associated with the Company or any other company carrying on insurance or reinsurance related business or any intermediary or a claims or investigation or other service provider providing services relevant to insurance business or professional advisers for any of the above or related purposes; (2) any association, governmental authority of federation of insurance companies ("Authority") that exists or is formed from time to time for any of the above or related purposes or to enable the Authority to carry out its regulatory functions or such functions that may be assigned to the Authority from time to time and are reasonably required in the interest of the insurance industry or any members of the Authority; and (3) any selected party as we may consider necessary whether within or outside Hong Kong or Macau. You, the insured and all Covered Person(s) and other Persons referred to in this claim form ("Relevant Persons") have the right under the Personal Data (Privacy) Ordinance or Law Relating to the Protection of Personal Data or Law Relating to the Protection of Personal Data (as the case may be) to have access to, and to correct

MassMutual Asia Ltd. 美國萬通保險亞洲有限公司
Hong Kong Head Office-4/F, MassMutual Tower, 38 Gloucester Road, Wanchai, Hong Kong 香港總公司-香港灣仔告士打道 38 號美國萬通大廈 4 樓 Tel 電話: (852) 2919 9111 Fax 傳真 : (852) 2919 9233
Macau Branch Office-Avenida Praia Grande No. 517, Edificio Comercial Nam Tung 16-E2, Macau 澳門分公司-澳門南灣大馬路517號南通商業大廈16樓E2座 Tel 電話: (853) 2832 2622 Fax 傳真 : (853) 2832 2042

any of your personal data held by the Company. Request whereof shall be made in writing and addressed to the Manager of the Employee Benefit, and delivered to the Company's head office at 4/F, MassMutual Tower, 38 Gloucester Road, Wanchai,

Hong Kong or to the Macau office at Avenide Praia Grande No. 517, Edificio Comercial Nam Tung 16-E2, Macau (as the case may be). 閣下提供的資料(不論是藉閣下於本申請中或透過其他途徑所提供)，爲美國萬通保險亞洲有限公司(“本公司”)或其顧問提供保險業務所需，並可能使用於下列目的: (1) 評審及處理保單服務要求，就閣下於本公司之保險保障提供行政及再保險服務; (2) 評核任何保險或相關索償，或就該等索償進行任何調查或分析; (3) 推銷及提供任何與保險或財務有關的產品或服務，或就該等產品或服務所作的任何增加、更改、變更、取消、續期或復效; (4) 行使任何代位權; (5) 計算保費或得益; (6) 資料核對及直接銷售; (7) 聯絡與此或其他保險索償有關的人士或機構; (8) 任何關於賠償閣下於本公司的保險保障的其他用途;及可能被使用、保存、轉移或披露予 (1) 任何與本公司有聯系的有關個人或公司，或任何其他從事與保險或再保險業務有關的公司，或與任何保險業務有關的中介人或索償或調查或其他服務提供者，或專業顧問以達到任何上述或有關目的; (2) 任何團體、政府機構或現存或不時成立的任何保險公司協會或同類組織(“該等機構”)以達到任何上述或有關目的，或以便該等機構執行其監管職能，或其他基於保險業或任何該等機構會員的利益而不時在合理要求下賦予該等機構的職能; 及 (3) 任何本公司認爲有需要之有關人等(不論在香港或澳門以外)。根據個人資料(私穩)條例或個人資料保護法，閣下、任何合資格的僱員、其家屬及其他在本申請書內所指人士(“有關人士”)有權查閱和更正本公司持有閣下或有關人士的個人資料。閣下或有關人士可以書面方式呈交本公司位於香港灣仔告士打道38號美國萬通大廈4樓的總公司或澳門南灣大馬路517號南通商業大廈16樓E2座的澳門分公司，向僱員福利部經理提出有關要求。

Signature of Claimant 索償人簽署

Relationship with the above-named Life Insured 與上述受保人關係

Name of Claimant in BLOCK LETTER 索償人姓名（ 請以正楷書寫）

Identity Card No. (if applicable) 身分証號碼（如適用）

Address 地址

Contact Telephone No. 聯絡電話號碼

Authorized Signatory of Policy Owner 保單持有人授權簽署

Name and Position of authorized signatory 授權人姓名及職位

Date of Statement Prepared 填報日期

CLAIM INSTRUCTION 索 償 須 知

1. Return this statement and the original death certificate (to be returned after inspection) to Employee Benefits Department.

2. Where more than one Beneficiary/Administrator/Executor are claiming, please fill & sign on separate forms.

3. Where Estate is the Beneficiary, the Executor or Administrator must sign this form and submit a current certificate of appointment.

4. Where the Beneficiary is a minor or incompetent, the guardian of the Estate must sign this form and submit a current certificate of appointment.

5. Where the Beneficiary passed away, a certified copy of the Beneficiary's death certificate must be submitted.

6. Where the Beneficiary is a corporation, this form must be completed and duly signed by an authorized person of the corporation.