Liberty International Insurance Ltd
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Liberty International™
Member of Liberty Mutual Group

# DENTAL CLAIM FORM
# 牙 科 醫 療 賠 償 申 請 表

Please complete in block capitals and return to us.
請以正楷填寫以下資料並寄回本公司。

**How to Claim？ 如何索償？**

To help us deal with your claim, please: 爲方便本公司更快處理閣下之賠償申請, 請閣下:

1. Complete a **separate claim form for each claim & each insured person**.
   爲**每宗及每一位索償者分開**填寫賠償申請表。
2. Ensure that the dentist who treats you completes and sign the Part B of below.
   確保你的牙科醫生爲閣下完成及簽署確認第二部份的申請。
3. Send this form, together with original bills and receipts, to us within 90 days of start of treatment.
   將已填妥的申請表及收據正本於治療日起 90 天內寄回本公司。

**Section A Patient Information (to be completed by the Insured Person or His/her Legal Representative.)**
**第一部份 索償者個人資料 (請投保人或其合法代理人填寫。)**

1. Full Name 姓名: _____ 2. Date of Birth 出生日期: ____(mm 月)/____(dd 日) /____(yyyy 年) 3. Sex 性別: M / F

3. Policy No. 保單編號: _____ Certificate No. 証書編號: _____

5. Name of Employer 僱主姓名: _____

6. If the cause of treatment relates to an accident, state the date and place of the accident and give details of the circumstances:
如是次治療是因意外所導致，請提供意外發生日期、地點及當時的意外詳情。

_____

_____

7. Declaration and Authorization 聲明及授權書

I declare that the above statements and answers made by me are true and complete to the best of my knowledge.
本人聲明上述一切陳述及問題所提供之答案均爲本人所知所信事實之全部，並確實無訛。

I hereby authorize any dental surgeon, hospital or clinic by whom or where I have been observed or treated, to give full particulars about my treatment received Including my whole dental history, to Liberty International Insurance Ltd. A photostatic copy of this authorization shall have the full effect of the original authorization.
本人謹此授權任何曾受其觀察/治療的牙科醫生/醫院/診所, 提供是次觀察/治療的詳盡細節及有關過去牙科治療的紀錄給予利寶國際保險有限公司。本聲明及授權書的影印本與正本均有同等效力。

I also declare that I have not suffered from the illness/injury for which I am claiming prior the first date of my insurance cover under this policy.
本人同時聲明由本人的保障生效第一天起，之前並未曾因同一疾病/意外而導致受傷或需要因該病/意外而接受任何牙科觀察/治療

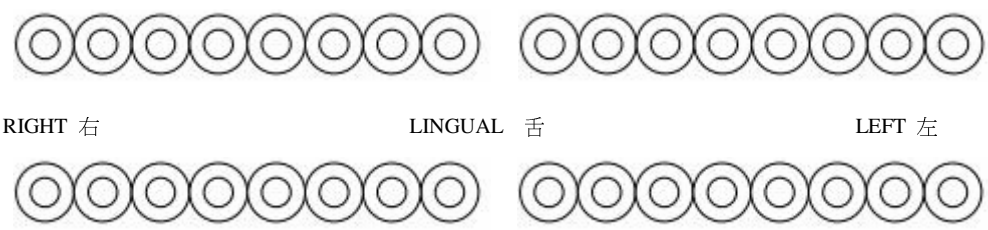
By signing below, I, for the purpose of the Personal Data (Privacy) Ordinance, consent that the personal information collected or held by Liberty International Insurance Limited (whether contained in this form or otherwise obtained) may be used by or disclosed to any individual or organization within or outside Hong Kong for the purposes of insurance or reinsurance related business including claim processing, investigation, account collection and litigation.
根據個人資料(私隱)條例，本人現簽署並同意利寶國際保險有限公司所收集或保留之任何有關資料(在此申請書所載或從其他途徑取得)，可交予本公司選定的有關人士或本港/海外機構用作處理其保險或再保險之相關業務，包括處理賠償、調查、戶口收集及訴訟。

Date 日期(mm/dd/yyyy)(月/日/年) _____ Signature of Insured Person or Legal Representative 投保人或其合法代理人簽署

**Section B To be completed by the ATTENDING DENTIST at Claimant's own expense.**
**第二部份 由主診牙科醫生填寫，費用由索償者自付。**

| Date 日期 (mm/dd/yyyy) (月/日/年) | Treatment rendered 所接受觀察或治療的詳情 | Charges 所收費用 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please mark teeth on the chart below. 請在以下圖表記下需接受觀察或治療的牙齒。



RIGHT 右 LINGUAL 舌 LEFT 左

Signature with Practice Stamp of Dentist
牙科醫生簽署及蓋章

Name of Dentist 牙科醫生姓名

Date 日期 (mm/dd/yyyy) (月/日/年)