團體人壽保險賠償申請表
GROUP LIFE INSURNACE CLAIM FORM

CS-CLA17

僱主名稱
Name of Employer_____

保單號碼
Policy No. _____

僱員姓名
Name of employee _____

身份證/護照編號
I.D. Card/Passport No. _____

保額 Amount of Claim 港幣 HK$ _____

☐ 人壽保險 Life Insurance _____

☐ 意外保險 Accidental Insurance _____

身故日期及地點
Date and Place of Death_____

身故原因
Cause of Death_____

僱員職業及職位 _____
Employee's Occupation/Position at time of Death

身故時之月薪(港幣)_____
Monthly Salary at Death(HK$)

受僱日期 _____
Date of Employment

最後全職工作日期 _____
Last day of active full time work

如因意外引致身故，請詳述意外發生經過。If Death is due to accident, please give details.

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_____

死者何時發現患上最後的病症 _____
When did the Deceased first complain or give indications of last illness?

受益人 _____ 關係 _____ 身份證/護照編號 _____
Beneficiary Relationship I.D. Card/Passport No.

受益人地址
Beneficiary's Address _____

_____ _____
僱主簽署及公司印章 受益人簽署
Authorized Signature of Employer and Co. Stamp Signature of Beneficiary
日期 Date : 日期 Date :