

Request For Certified True Copy Of Medical Receipt(s) 醫療費用收據核實副本申請書



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| Policy Number 保單號碼 | | | |
| Name of Policyowner 保單持有人姓名 | | Name of Life Assured 受保人姓名 | |
| Name of Financial Consultant 理財顧問姓名 | | Financial Consultant Contact No. 理財顧問聯絡電話號碼 | |
| Financial Consultant Code 理財顧問編號 | | Division Code & Branch Office 分區編號及分行地點 | |

I, the Policyowner / Life Assured / Claimant of the captioned policy, request Prudential Hong Kong Limited ("Prudential") to return the certified true copy(ies) of medical receipt(s) submitted together with this form as the following method:

本人為上述保單持有人/受保人/索償人，謹此要求保誠保險有限公司（「保誠」）以下列方式退回隨附之醫療費用收據之核實副本：

| Mailing Information 郵遞資料 | Delivery Option 遞交方式 |
|-----------------------------|--|
| Name of Recipient 收件人名稱 | Please darken one of the boxes below. If delivery option is not specified, document(s) will be delivered via Financial Consultant. 請塗黑以下其中一項適當的選項。如沒有註明遞交方式，文件將由理財顧問轉遞。 <input type="radio"/> Via Financial Consultant 由理財顧問轉遞 <input type="radio"/> Via Ordinary Post* 以平郵方式退回* (Only applicable to Hong Kong Address 只適用於香港地址) * Please provide name and correspondence address of recipient on the left, otherwise the request may be rejected by Prudential. Correspondence address on the left will be used for dispatch purpose, please make sure it is clear and accurate. * 請於左方填寫收件人姓名及聯絡地址，否則保誠有權拒絕此申請。左方之聯絡地址將會用作郵件派遞，請確保其清晰準確。 |
| Correspondence Address 聯絡地址 | |
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Important Note 重要提示

- This request form is only for requesting Certified True Copy of Medical Receipt(s). 此申請書只適用於申請醫療費用收據核實副本。
- This request form MUST be properly completed and submitted together with the original medical receipt(s). Otherwise, Prudential would not be able to comply with your request. 此申請書必須填妥並連同醫療費用收據一併遞交。否則，保誠將不會處理有關申請。
- Original medical receipt will not be returned in any circumstance. 醫療收據正本於任何情況下均不會退回。
- Please submit separate request form for each claim application. 請就每宗理賠申請，遞交個別「醫療費用收據核實副本」申請表格。
- Please complete this form in BLOCK LETTERS. 請以正楷填寫此申請書。
- Prudential reserves the right to accept or reject this "Request for Certified True Copy Of Medical Receipt(s)." 保誠保留權利接受或拒絕此「醫療費用收據核實副本申請書」。

| Signature 簽署 | | |
|--|---|---|
| _____ Day日 Month月 Year年 | _____ Signature of Policyowner / Claimant 保單持有人/索償人簽署 | _____ Name & Identity Document Number of Policyowner / Claimant 保單持有人/索償人姓名及身分證明文件號碼 |
| _____ Day日 Month月 Year年 | _____ Signature of Life Assured 受保人簽署 | _____ Name & Identity Document Number of Life Assured 受保人姓名及身分證明文件號碼 |
| It must be consistent with that in our record 保單持有人的簽署必須與本公司的記錄相符 | | |

