Taipei American School

Application Form for Student Insurance Claim

Please fill out the following information and provide photocopies of required documents listed in section IV:

I、Student Information

(1) Chinese name：

(2) English name：

(3) Passport number：

II、Legal Representative Information

(1) Chinese name：

(2) English name：

(3) Passport number：

(4) Taiwanese National ID Number：
(No required if you don't have one)

III、Remittance Information

(1) Account name：

(2) Bank name / Branch name：

(3) Account number：

(4) ID number used for opening the account：
(Taiwanese national ID number, passport number, or alien resident permit number)

IV、Provide "photocopies" of the following documents【of both the student and legal representative】

(1) Passport

(2) Resident permit or Taiwanese Identity Card

(2) Household Certificate (戶口名簿) (No required if you don't have one)

(3) Bank book cover (of the receiving account)

Policy Holder：Taipei American School

Note：(1) Please fill out page 1 ~ 3.
(2) Please attach a copy of your Alien Resident Certificate and bank book when you apply for a claim.

南山人壽

Claim Application

Scan the QR-code immediately, install Nanshan Mobile Smart Network

Policy No. ☐**Policy of Chaoyang Life**	(Fill in a valid policy no. as the representative for this claim) P1884	＊**Relationship with principal insured/ employee**	√Principal ☐Spouse ☐Child ☐Parent(s) (In the event of the group insurance, travel insurance, family insurance policy, please be sure to fill in the policy number and select the aforesaid box(es) conferencing the relationship herein)	**Group Policy**	Name of Applicant: TAS (Student)

This application is made for applying the claims items under this application for all insurance policies to Nanshan Life Insurance. If the aforesaid policy(ies) involves (a) group insurance(s), the field on the right for the group insurance shall be filled.
☐**Principe Disagree This claim application also includes the claim under the group insurance.** (* If this box is checked, the field on the right for the group insurance shall not be filled. ＊If this box is not checked, this claim application does not include the claim under the group insurance.)

＊ **Name of the insured**	＊ **National Identification Number**	＊ **Birth Date**	＊ **Contact Telephone Number**	＊ **Name of Employee/ Member**
		Year Month Day		

Contact Address：□□□-□□ County/City Township/District Village Road/Street
Section Land Alley Number Floor

Collection Method

☐**Remit the payment to the beneficiary's account** ☐**Same account as the last claim**
☐**Remit the payment to the account of the legal guardian(limited to beneficiaries of medical insurance payment under the age of 18, and when the Company remits such payment to the account of the legal cc, it is deemed that the beneficiary has recognized such payment is made to him/her)**
☐Insurance Fund Trust (please provide the information of insurance fund trust)

＊**Account Name:** In the event of multiple beneficiaries, please provide a copy

☐Post Office

＊☐ Bank/Cooperatives/ Agriculture Associations Bank Cooperatives Agriculture and Fishery Associations Branch Branch Representative Office

Correspondent Banking Services Bank Identifier Code---BIC □□□ - □□□□ (Bank Code) (Branch Code)

＊**Account No.** Fill the number from left to right. Please leave it blank and do not fill in 0 if there is any empty space. If failing to fill in or being inaccuracy of the account information, the payment will be made by a non-assignable and non-negotiable check payable to the beneficiary.

☐Foreign currency accounts (only for the Foreign Currency-Denominated Policy)(If the aforesaid account is a foreign currency account, please provide the account name in English to facilitate the remittance of payment), name in English:

☐a non-assignable and non-negotiable check payable to the beneficiary (If the payment amount exceeds NT$200,000, the check a parallel line is added)

Notice

Please serve the payment notice for the claim in one of the following methods, and if multiple methods are selected, the method with the smallest number will be performed. If the service method of text message or E-mail is failed or is not selected, the mail will be delivered to the contact address

＊1.☐**Notification made by the text message of mobile phone (including acceptance text message) to review the information on the Nanshan Mobile Smart Network App:** ☐**Same as the aforesaid contact telephone number** ☐**The mobile number, in addition:**
2.☐E-MAIL： @
3.☐main in "paper form" to the "contact address" filled in this application form

Incident Type

☐Illness (not fill in)
＊√Accident

Claim Items

＊In respondence with the amendment to the Insurance Act, the term of handicapped is adjusted to the term of disable, and the rights and interests of the insured are not affected by the adjustment to such term.
1.☐Medical ☐Clinic ☐Occupational Accidents
2.☐Critical Illness ☐Diagnosed with Cancer at first time ☐Living Needs Benefits
3.☐Major Burns ☐Long-term Cares ☐Waiver of Premium
4.☐Death ☐Total/Partial Disability
5.☐Proof of Difference Payment ☐Other

＊Occupational Accidents Whether the insurance payment payable of applicant to the beneficiary has been made before the application is filled ?
☐Yes (please provide the occupational accident compensation advance certificate and the consent of the transfer of debt and related supporting documents.) ☐No

The description of Accident (Apply the accident claim please fill these fields)

☐Same as the previous accident

＊☐The incident time of new accident:
Year Month Day
AM/PM Hour Minutes

Report Date: Handling Unit: Case in Charge: Tel:

＊Please describe in detail about the location, reason, circumstances, occupation and work content when the incident was occurred (Please provide the relevant information if there is any document, such as policy report(s) or police certification(s))
Fill in for Accidental Reimbursement Claim (description of the accident)

Notification from the Insurance Enterprise in Compliance with the Personal Data Protection Act

In accordance with Article 8 subsection 1, Article 9 subsection 1 and Article 6 subsection 2 of Personal Data Protection Act (hereinafter referred to as the "Act"), Nanshan Life Insurance Co., Ltd. (hereinafter referred to as the "Company") informs you of the following matters, please read carefully:
1. Purposes of Collection: (1) 001 life insurance (2) 069 policy, policy-like or other legal-related matters (3) 090 consumer and customer management and services (4) 181 other operations in line with the items of business registration or business specified in the Article of Incorporation. 2. Categories of Personal Data to Be Collected: Name, address, telephone number, personal ID number, date of birth, occupation, email, financial institution account and medical record, medical treatment, health examination, and personal information related to the verification of the accident, etc. (including the personal data provided not directly from to the Company before this claims application of this policy is filled, such as information provided when applying for enrollment or change of contract terms.), please refer to this application form and required documents. 3. Source of Personal Data to Be Collected: (1) Applicant. (2) You, your legal representatives/guardian, or assistant. (3) A third person entrusted by the Company to conduct its each various businesses. 4. Time period, object, territory, recipients, and methods of which the personal data is used: (1) Time period: The retention period required in performing the Company's business and in accordance with applicable laws and regulations. (2) Object: The Company, applicant organization, Life Insurance Association of the Republic of China, Non-Life Insurance Association of the Republic of China, Institute of Financial Law and Crime Prevention, Financial Ombudsman Institution, or other institutions handling consumer disputes, organization to which the Company outsource its business, and companies that have reinsurance business with this Company, competent investigation or financial authorities. (3) Territory: The regions where the above objects are located. (4) Method: The methods of uses in compliance with applicable laws and regulations. 5. In accordance with the provisions of Article 3 of the Personal Data Protection Act, you are entitled exercise the following rights in terms of your personal data in possession of the Company: (1) You are entitled to request the Company to: 1. make an inquiry of, review, and request a copy of your personal data; 2. supplement or correct your personal data; 3. demand the cessation of the collection, processing or use of, and erase your personal data; (2) The method to exercise the rights: In writing. 6. Effect to your rights and interests if you refuse to provide your personal data: If you do not provide relevant personal data, the Company may postpone or be unable to perform necessary review and procedures, resulting in delay or failure in payments or services to you.

Consent for Personal Data Collection, Processing and Use in Terms of Medical Records, Medical Treatment and Health Examinations, etc.

I (the insured) agree that the Company may collect, process and use the personal data related to my medical records, medical, and health examinations.

I agree that the Company may verify the turthfulness of the autopsy certificate (or death certificate) attached to this claim application by comparing with those on the death notification system of the relevant agencies.

*☐In the event of application for death/total disability benefits, due to the loss of the insurance policy, I hereby acknowledge that the insurance policy is abolished, and is not required to be reissued. (If you agree the aforesaid matters, please check the box; if you don't check the box, you are deemed to disagree)

Signature and seal of the Applicant/Insurance broker/agent

No Stamp

I agree to the aforesaid matters and appoint a "delivery agent/insurance agent or insurance broker" (i.e., the assignee) to handle the claim application on my behalf, and agree that the Company will provide the relevant documents/information related to the claim application to me through the assignee on the right-hand side.

Please do be sure to sign in person

*Signature of Beneficiary /Assignee: (Claimant)-employee/spouse/child

Beneficiary (as a legal person) ☐can ☐cannot issue bearer shares
(If the "no" is checked, the next question shall not be filled)
Beneficiary (as a legal person)☐can ☐cannot issue bearer shares
If the beneficiary is not a citizen of the Republic of China, please indicate the nationality.

To apply for a foreign currency insurance policy, please fill in the name in Chinese and English

*The Signature of Legal Representatives/ Guardian/Assistant: If children is under 18yr. old

If the beneficiary is a minor or a person who has become subject to the order of the commencement of guardianship, has become subject to the order of commencement of assistance, please fill this field.
If the legal representatives/guardian is not the applicant, please also provide a certificate of relationship.(ex. photocopy of Household Certificate, etc.)

*Date of Application:

Year Month Day

Delivery Channels	Reception Unit Reception Column
☐Agent/Agent Code:	
☐Insurance Broker and Agent Bank Code: Branch Name: Branch Code: Registration Card number:	
Contact telephone number:	Other Delivery Channels
Signature of Delivering Person/ Assignee	☐Person in question ☐Relatives ☐By Mail

MercerMarsh Benefits

Please send the documents to Mercer Broking Ltd. Claim Department
Address： 4F, No. 2, Sec. 3, MinQuan East Road, Taipei, Taiwan 104477
Claim Advisory Hotline：+886-2-7753-5398
E-mail：ClaimAdvisor4U@MercerMarshBenefits.com

以下同意書為理賠申請必要文件，**每次申請皆須簽署**，若未提供將通知補件後始可進行理賠作業，感謝您的配合。

Below Agreement is a required document that **must be signed for each and every claim submission**. Thank you.

美世保險經紀人股份有限公司 Mercer Broking Limited

病歷、醫療及健康檢查等個人資料蒐集、處理及利用同意書

Agreement of Collection, Processing, and Use of Personal Information Relating to Medical History, Records and Health Checks

本公司依據個人資料保護法及保險法第 177 條之 1 暨其授權辦法等規定，關於病歷、醫療及健康檢查等個人資料所為蒐集、處理及利用，除本公司「蒐集、處理及利用個人資料告知書」所列告知事項外，就　台端個人病歷、醫療及健康檢查等資料之蒐集、處理及利用，將於保險業務之客戶服務、招攬、核保、理賠、申訴及爭議處理、公司辦理內部控制及稽核之業務及符合相關法令規範等之目的及範圍內使用。若無法取得　台端之蒐集、處理及利用前述資料同意，本公司將可能無法提供　台端相關保險業務之申請及辦理。

In accordance with Personal Data Protection Act and Article 177-1 of Insurance Act and its authorized stipulations for collection, processing and use of personal information relating to medical history, records and health checks, in addition to the matters listed in “Notification of Collection, Processing and Use of Personal Information,” information relating to your personal medical history, records and health checks will be collected, processed and used for customer service, solicitation, underwriting, claims, complaints and dispute settlement of brokerage business, internal control and audit of Mercer Broking Limited (hereinafter referred to as “Mercer”) and other purposes in compliance with laws and regulations. If Mercer is unable to obtain your agreement to collect, process and use of the above mentioned information, Mercer may not be able to provide the service for related insurance application and processing.

立同意書人(即被保險人)，本人已瞭解上述說明，並同意　貴公司就本人透過　貴公司辦理投保、契約變更或申請理賠時所檢附之病歷、醫療及健康檢查等個人資料於特定目的之必要範圍內，為蒐集、處理或利用。並於符合相關法令規範範圍內將上開資料轉送與　貴公司有業務往來之產、壽險公司辦理投保、契約變更或理賠作業。立同意書人併此聲明，此同意書係出於本人意願下所為之意思表示。

I, the legislative consent (as known as the Insured), fully understand the above explanation and agree Mercer, for necessary extend of specific purposes, to collect, process or use of my personal information relating to medical history, records and health check enclosed for insurance application, change of insurance policy or claim submission. Mercer may transfer the above information to related insurance companies for insurance application, change of insurance policy or claim submission in compliance with laws and regulations. I acknowledge that I have read this Agreement and that I have entered into this Agreement voluntarily.

此致

美世保險經紀人股份有限公司

To Mercer Broking Limited

立同意書人（即被保險人）簽名：_____ **法定代理人簽名：**_____

(被保險人(事故人)請務必簽名) **(若被保險人(事故人)未滿十八歲，法定代理人請務必簽名)**

Legislative Consent (the Insured) Signature **Legal Representative Signature**

中華民國 Date： _____**年 Year** _____**月 Month** _____**日 Day**

【2023.01 版】

★ Applying for Insurance Benefits – Required Documents & Notes

1. Documents to be provided when applying for various insurance benefits:

Application Item / Required Documents	Decease			Disability		Long-term care benefits/ life assistance for total disability	Living Benefits	Critical Illness			Waiver of Premium						Medical Treatment				Missing/ missing by accidents	Occupational Accidents		
												Applicant												
	Decease by general disease	Decease by cancer	Decease by accidents	Total disability	Partial disability/ major burns			Critical illness/diagnosed with cancer for the first time	Living needs benefits	Living subsidy benefits for cancer patients	Insured	Decease by disease	Decease by accidents	Tier 1 to 6 disability (enrolled after October 1, 2006) Tier 1 to 3 disability	Critical illness	Major burns	Medical treatments for injuries\hospitalization/cancer	Trauma suture surgery/ outpatient care	Emergency medical transportation benefits	Allowance for bone fracture (PBB/DHI)		Death benefits	Disability benefits	Payment for illness and injury (wage compensation for being not able to work during medical treatment)
Claim Application	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Death Certificate	✓	✓										✓									✓	✓		
Autopsy Certificate			✓										✓											
Household Certificate Transcript with household register that deceased's name is crossed off of the insured	✓	✓	✓																		✓			
The identity certificate of the beneficiary	✓	✓	✓	✓		✓	✓	✓				✓	✓	✓	✓	✓					✓	✓	✓	
Certificate of Diagnosis/ Certificate of Diagnosis for Disability				✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓			✓	✓
Receipt and expense schedule																	✓	✓ (Group Insurance)						
Pathology report for the tissue segment/relevant test report		✓				✓	✓	✓		✓	✓				✓									
Proof of accidental injury (e.g. X-Ray film)			✓	✓	✓								✓	✓		✓	✓			✓	✓			
Proof of emergency medical transport by ambulance																			✓					
Survival Certificate for the Insured						✓	✓			✓														
Photo-copy of the receipt of labor insurance benefit payment																						✓	✓	✓
Barthel Index or Clinical Dementia Rating Scale (CDR) or Mini-Mental State Examination (MMSE) or other professional assessment scale						✓																		

2. Notes:

1. The beneficiary shall fill every fields of this application form in detail and apply his/her signature. The beneficiary is defined as follows:
   (1) In case of medical, critical illness, or disability benefits, the beneficiary shall be the person sustaining illness or injuries.
   (2) In case of death benefits, the beneficiary shall be the beneficiary of death benefits as stated on the insurance policy. In the event that there are more than one beneficiary, each beneficiary shall sign jointly on one application form or file an application individually.
   ※ If the beneficiary is a minor under the age of 7, his/her legal guardian shall sign and sign on his/her behalf.
   ※ If the beneficiary with limited capacity reaches the age of 7 but has yet to attain the age of 20, he/she and his/her legal guardian shall both sign.
   ※ If the beneficiary has been adjudicated of the commencement of guardianship, his/her guardian shall sign and sign on his/her behalf. If the beneficiary has been adjudicated of the commencement of assistantship, both him/her and his/her assistant shall sign.
   ※ If the signer is illiterate, sustains serious hand(s) injuries or total blindness in both eyes, he/she may use finger print(s) instead of signature with two persons bearing witness.
   ※ If signer has both hands amputated, he/she may use stamp instead of signature with two persons bearing witness.
   ※ If a legal person, religious group, public welfare institution, or social welfare institution is designated as the beneficiary of death benefit, in accordance with the provisions of Article 44 of the Insurance Act, such organization may request for a copy of the insurance policy as the interested party of this policy. In addition, in accordance with the "Regulations Governing the Processing of Applications for Household Certificate Transcript and Access to Household Registration Record", the aforesaid organization may also request for the Household Registration Cancellation Transcript and death certificate documents from the Household Registration Office as the interested party (i.e. the beneficiary) of this policy. However, the Household Registration Office may reject the aforementioned application based on its sole discretion.
2. If the cause of death is stated as "under autopsy," the beneficiary shall later submit a copy of "autopsy report" or "autopsy certificate" specifying the cause of death.
3. If the insured claiming for total disability benefits is unable or clearly lack the ability to make or receive declaration of intention, or to discern its outcome due to mental disorder or defects, please provide a copy of the court ruling for commencement of guardianship or assistance.
4. If you are claiming for group reimbursement benefits for outpatient surgeries, please provide the receipt and details of charge; if you claim for group death/total disability benefits for your child or spouse, you do not need to provide a copy of insurance policy.
5. Waiver of Premiums:
   (1) If the insured encounters an incident eligible for waiving the premiums, he/she shall file the documents listed in the above table along with the application, and shall, in the event of critical illness (including cancer), also enclose the tissue segment/relevant test report.
   (2) If the applicant enrolling in "Insured of Nanshan Life Insurance with Waiver of Premium Rider," "Insured of Nanshan Life Insurance with Waiver of Premium for Purchaser Endorsement (WPP)" and "Insured of Nanshan Life Insurance Family with Waiver of Premium