CHUBB

Agent's/Intermediary's name 保險代理 / 中介人姓名 _____

Agent's/Intermediary's contact phone no. 保險代理 / 中介人聯絡電話 _____

Agent's/Intermediary's code 保險代理 / 中介人代號 _____

Agency 組別 ___ – ___

Cashless Hospitalization Pre-authorization Form
出院免找數預先批核申請書

- Please complete this form by the Policyowner/Insured (Part I) and by the attending physician/specialist (Part II) then send via Fax no. (852) 3914-8923 or Email to: Chubb.preauth@virtuscare.com at least 5 working days prior to admission to hospital.
  請由保單持有人 / 受保人(第一部份)及註冊醫生(第二部份)填寫此表格，並於入院前最少五個工作天，傳真至(852)3914-8923或電郵到：Chubb.preauth@virtuscare.com。
- Please note:
  (1) Pre-authorization service is not applicable to treatment received at a day-case centre of Hospitals or out-patient department.
  (2) Pre-authorization decision does not represent the final claim settlement decision and amount; the final claim decision will depend on all the information that **Chubb Life Insurance Company Ltd.** (Incorporated in Bermuda with Limited Liability) ("the Company") finally received.
  (3) For cases where Cashless Hospitalization has been arranged successfully, when the Insured is discharged from Hospital, the Hospital will send the invoice to us. If there is any shortfall, a Shortfall Notice will be sent to the Policyowner and agent/intermediary.
  (4) Virtus Medical Group Limited & Aspire Lifestyles (HK) Limited are service providers appointed to provide Cashless Hospitalization pre-authorization services for the Company. Please contact Cashless Hospitalization Hotline (852) 8103-3833 for any enquiry.
  (5) Pre-authorization approval will be valid for 30 days from date of approval.

  請注意:
  (1) 預先批核服務並不適用於醫院日間手術及門診個案。
  (2) 預先批核之結果並不代表最終的賠償決定及金額；最終賠償決定將取決於**安達人壽保險有限公司**(百慕達註冊)(「本公司」)最終收到的所有資料。
  (3) 已成功安排出院免找數的個案，當受保人出院後，醫院會將賬單交予本公司。如有任何差額，差額通知書將會寄予保單持有人及保險代理/中介人。
  (4) 尚至醫療集團和奧思禮(香港)有限公司被委任為處理出院免找數預先批核個案之服務供應商。如有關出院免找數之查詢，請致電服務熱線 (852) 8103-3833。
  (5) 預先批核之結果有效期為30天(由批核日起計)。

Part I (To Be Completed by Policyowner/Insured) 第一部份(由保單持有人 / 受保人填寫)

A. Insured's Particulars 受保人資料			
1. Policy no. 保單編號			
2. Name of Insured 受保人姓名		3. Sex/Age 性別/年齡	
4. Identity document no. 身份證明文件號碼		5. Date of birth 出生日期	/ / DD日 MM月 YYYY年
6. Tel. no. 電話號碼		7. Email address 電郵地址	
8. Residential Address 居住地址			
9. Name of Employer 僱主(公司)名稱			
10. Address of Employer 僱主(公司)地址			
11. Present Occupation 現職			

12. Has the lnsured resided for 183 days or above within 12 months preceding the time of medical treatment/service in the USA?
受保人是否於美國接受治療/醫療服務前之十二個月內已於該地居住達一百八十三日或以上？ ☐ Yes 是 ☐ No 否

13. Will the Insured apply for compensation from other insurance company(ies)/organization(s) for the same event?
受保人會否就是次事件向其他保險公司/機構申請賠償？ ☐ Yes 是 ☐ No 否

If "Yes", please provide below information. 若「有」，請提供以下資料。

a) Insurance Company/Organization 保險公司/機構	b) Policy number 保單號碼	c) Benefit to claim 保障類別	d) Benefit amount 保障金額

14. ☐ **Request return of Certified True Copy of Medical Receipt(s) 要求退回醫療費用收據之核實副本**

B. If Hospitalization/Surgery was caused by ILLNESS, details as below 如因疾病住院或進行手術，詳情如下

1. Sign and symptoms 徵狀	
2. For this episode, since when have these symptoms first appeared? 就是次病況而言，何時出現首次徵狀？	_____ / _____ / _____ Day日 Month月 Year年

3. Other than this episode, have you had any similar/related past history? ☐ No 沒有 ☐ Yes, please provide below information
除了此次病況，閣下以往有否類似或相關的病歷？ 有，請提供下列所需資料

a) Consultation Date (DD/MM/YYYY) 就診日期（日/月/年）	b) Name of Physician/Hospital 醫生姓名/醫院名稱	c) Diagnosis 診斷結果	d) Progress of Recovery 康復進度及日期

4. Please provide details of usual Physician(s)/Hospital(s). Please provide the information in reverse chronological order.
請提供慣常求診之醫生或醫院資料。請由最近期起按時序寫醫生/醫院資料。

a) Since (Month/Year) 自從（月/年）	b) Name of Physician/Hospital 醫生姓名/醫院名稱	c) Contact Phone No. 聯絡電話號碼

C. If Hospitalization/Day Surgery was caused by ACCIDENT, details as below 如因意外住院或進行手術，詳情如下

1. Date of Accident & time 意外發生之日期及時間	_____ / _____ / _____ _____ hh: _____ mm (am/pm) Day日 Month月 Year年 時 分（早上/下午）	2. Location of Accident 意外發生之地點	
3. Details of Accident (Please describe activities engaged and how the body part(s) was injured) 意外詳情 （請形容當時進行之活動及如何受傷）			
4. Describe part(s) of body injured and nature of injury 請說明受傷部位及性質			
5. Did you report to the police? 閣下有否報警？	☐ No 沒有 ☐ Yes, please provide information on the right 有，請提供右面所需的資料	a) Police Station 警署地點	
		b) Case Ref. Number 檔案編號	

Remarks: Please attach a photocopy of the Police Report/Traffic Accident Report/Police Statement/Alcohol Test Report. (if applicable)
註：請附上警察報告/交通意外報告/口供紙/酒精測試報告影印本。（如適用）

D. Planned Hospitalization/Surgery details 計劃住院或手術之詳情

1. Information of the Physician first consulted for this illness 首次就診之醫生資料

a) Consultation Date (DD/MM/YYYY) 就診日期（日/月/年）	b) Name of Physician/Medical Provider 醫生姓名/醫療機構名稱	c) Contact Phone No. 聯絡電話

2. Information of the Physician who referred to hospital 建議入院之醫生資料

a) Referral Date (DD/MM/YYYY) 轉介日期（月/年）	b) Name of Referral Physician 轉介醫生姓名	c) Contact Phone No. 聯絡電話

3. Details of confinement/consultation 住院/就診詳情

a) Planned Hospitalization Period 計劃住院日期	b) Name of Hospital 醫院名稱	
From 由 ____ Day日 / ____ Month月 / ____ Year年 To 至 ____ Day日 / ____ Month月 / ____ Year年	c) Name of Physician 醫生姓名	

E. Credit Card Payment Authorization 信用咭付款授權書

1. Policy Number 保單編號	2. Full Name of Insured: 受保人姓名	3. *Full Name of Policyowner: 保單持有人姓名

Please note that a shortfall may occur if final costs of treatment exceed your plan coverage or the medical expenses are not eligible for reimbursement. This form authorizes **Chubb Life Insurance Company Ltd.** (Incorporated in Bermuda with Limited Liability) to collect any shortfall from the credit card account detailed below. The credit cardholder must be the Policyowner or the Insured of this Policy. The Shortfall Notice with an itemized list of charges will be sent to you (and agent/intermediary) 21 days prior to the collection.

I accept and authorize and direct **Chubb Life Insurance Company Ltd.** (Incorporated in Bermuda with Limited Liability) to debit the shortfall due from my credit card account.

I confirm that my signature on this application form is the same as that for the operation of my Credit Card Account to be debited for the transfer.

This authorization shall have effect until the claim assessment is fully completed.

請注意若最終的治療費用超過閣下的保障額，或有關費用不屬於保障範圍內，此授權書將授權**安達人壽保險有限公司**（百慕達註冊）在下列信用咭賬戶收取差額費用。信用咭持有人必須為此保單之受保人或保單持有人。賠償明細及差額通知書將於收取差額費用21天前郵寄予保單持有人及保險代理/中介人。

本人同意及授權**安達人壽保險有限公司**（百慕達註冊）從以下信用咭戶口扣除到期之差額費用。

本人證明在此表格上之簽名式樣與本人之信用咭戶口式樣一致。

本授權書將繼續生效直至索償程序完結為止。

Name of party to be credited 收款之一方	Bank No. 銀行編號	Branch No. 分行編號	A/C No. to be Credited 收款賬戶編號
CHUBB LIFE INSURANCE COMPANY LTD. 安達人壽保險有限公司	0 0 3	4 4 7	0 0 5 3 3 7 9 9

Please complete all details shown below 請填寫下列各項

4. Name of Cardholder 信用咭持有人姓名	5. ID/Passport Number 證件編號

6. Card Number 信用咭編號	Card Expiry Date 信用咭有效期至
| | | | | | | | | | | | | | | |	____ / MM月份 / YY年份

7. SIGNATURE OF ACCOUNT HOLDER 戶口持有人簽名

X

Date:日期 DD日/MM月/YYYY年

F. Declaration 聲明

PERSONAL INFORMATION COLLECTION STATEMENT AND CONSENT I/WE UNDERSTAND AND CONSENT THAT, by signing this Cashless Hospitalization Pre-authorization Form, any personal data collected or held by **Chubb Life Insurance Company Ltd.** (Incorporated in Bermuda with Limited Liability) (the "Company") is provided and may be used, processed, stored, disclosed, transferred by the Company to the companies within the group of which the Company is a subsidiary (the "Group Companies"), its authorized agents, reinsurers, claims investigators, loss adjudicators, medical advisors, recovery agents, insurance industry associations and federations, credit reference bureaus, government or judicial or regulatory bodies or any person to whom the Company is under legal and/or regulatory obligation to make disclosure, and the Company's appointed third party agents, contractors and advisors, in each case whether within or outside of Hong Kong to; (i) process and evaluate the pre-authorization application/claims and any future insurance application I/we may make; (ii) provide all services related to this pre-authorization application/claim, administer and process policy, medical and underwriting checks, payment instructions, premiums collection, data matching, and communicate with me/us for such purposes; (iii) enable the industry associations, the federations, the government or regulatory bodies to carry out the functions and requirements that may be assigned to them from time to time and are reasonably required in their interest and that of the insurance industry; and (iv) provide payment, data processing, administration, communications, computer, security and other services (including medical services, emergency assistance services, mailing and IT services) in connection with the operation of the Company and the provision of services to me/us. Moreover, the Company is hereby authorized to obtain access to and/or to verify any of my/our data with the information collected by the insurance industry associations, the federations, the government and regulatory bodies and medical personnel or organizations. I/We am/are obliged to supply the information required from me/us under claim form which is a condition precedent for me/us to apply the pre-authorization application/claim. Failure to supply the required information may result in the Company being unable to process the pre-authorization application/claim. I/We understand that I/we have the right to obtain access to and to request correction of any personal data held by the Company or be given reasons for any refusal of access or correction. I/We also understand that a reasonable fee may be charged by the Company for processing of any access. Any questions regarding personal data, access to or correction of personal data should be made in writing and forwarded to The Data Protection Officer of Chubb Life Insurance Company Ltd. at 33/F, Chubb Tower, Windsor House, 311 Gloucester Road, Causeway Bay, Hong Kong. **個人資料收集聲明及授權** 就簽署此賠償出院免找數預先批核申請書，本人／吾等明白及同意**安達人壽保險有限公司**（百慕達註冊）（「貴公司」）可以使用、處理、儲存、透露、轉移任何貴公司所收集或持有任何本人／吾等的個人資料與貴公司隸屬同一集團附屬公司之其他公司（「集團公司」）、其獲授權的代理人、再保險公司、理賠調查員、處理索賠個案的理賠師、醫療顧問、索償代理、保險行業協會及聯會、信貸資料服務公司、政府或司法或監管機構或對貴公司具有法律及／或監管責任而須予以披露的任何人士，及貴公司指定的第三方代理、承包商及顧問，不論屬本地或海外，以 (i) 處理及審批預先批核申請/索償及本人／吾等將來提交之保險申請；(ii) 提供所有關於此預先批核申請/賠償之服務，管理及處理保單、醫療和核保檢查、付款指示、保費收取、資料核對，及因此等用途與本人／吾等聯絡；(iii) 令保險行業協會及聯會、政府或監管機構執行其經不時修定及為合理要求以維護其及保險行業利益的功能及規定；及 (iv) 提供因貴公司營運及給予本人／吾等服務之相關付款、數據處理、行政、通訊、電腦、保安及其它服務（包括醫療服務、緊急救援服務、郵寄服務及資料科技服務）。此外，貴公司獲授權向保險行業協會及聯會、政府及監管機構、及醫務人員或機構取閱及／或核實任何該等機構向本人／吾等收集之資料。本人／吾等有責任提供此申請書上之所需資料，以作為預先批核申請/賠償之先決條件。如未能提供所需的資料，可能會導致貴公司無法處理本預先批核申請/賠償。本人／吾等明白本人／吾等有權取閱及要求更正任何貴公司持有之有關本人／吾等的任何個人資料，或被給予拒絕查閱或更正的理由。本人／吾等亦明白貴公司可能會收取任何查閱資料的要求之合理費用。如欲查詢有關個人資料事宜，查閱或更正個人資料必須以書面形式向貴公司的資料保護主任提出，並送交至香港銅鑼灣告士打道三一一號皇室大廈安達人壽大樓三十三樓。

G. Authorization 授權書

I hereby irrevocably authorize or authorize on behalf of the Insured (if different); (i) any employer, doctor, hospital, clinic, insurance company, government office or any organizations or persons who have any records, knowledge or information (whether medical or otherwise) of me or the Insured (if different) to disclose, release or transfer to **Chubb Life Insurance Company Ltd.** (Incorporated in Bermuda with Limited Liability) "the Company"or its representative such information pertinent to this pre-authorization application/claim; (ii) the Company or any of its appointed medical/para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate my or the Insured (if different) health status in relation to this pre-authorization application/claim. This authorization shall bind my and the Insured's successors and assignees and remain valid notwithstanding my or the Insured's death or incapacity in so far as legally possible. A photocopy of this Authorization shall be valid as the original. 本人或受保人授權（如有不同）；(i) 任何僱主、醫生、醫院、診所、保險公司、政府部門，或其他機構及人士，如具有本人／受保人（如有不同）的任何紀錄、知識或資料，可將該等資料向**安達人壽保險有限公司**（百慕達註冊）（「貴公司」）或貴公司代表透露、發放或移交，用以作為此該份預先批核申請/賠償的參考； (ii) 貴公司或貴公司委任的醫療／輔助醫療檢查員或檢驗所，就有關預先批核申請/賠償，進行醫療評估或測驗，以檢定本人／受保人（如有不同）的健康狀況。該授權書對本人／受保人的繼承人及承讓人均有約束力，即使在本人／受保人（如有不同）死亡或喪失行為能力後仍然有效。該授權書的影印本具有與正本同等的效力。

I/We agree to the Company may deduct any outstanding levy from the policy payment amount (If applicable). 本人/吾等同意貴公司或會從保單的給付金額中扣除任何逾期的保費徵費（如適用）。

Day 日 / Month 月 / Year 年	Signature of Policyowner 保單持有人簽名	Name of Policyowner 保單持有人姓名
		Identity Document Number of Policyowner 保單持有人身份證明文件號碼
Day 日 / Month 月 / Year 年	Signature of Insured 受保人簽名	Name of Insured 受保人姓名
		Identity Document Number of Insured 受保人身份證明文件號碼

Please DO NOT sign on BLANK form 請勿在空白表格上簽署

* In compliance with the Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance and the Guideline on Anti-Money Laundering and Counter-Terrorist Financing which is issued by the Insurance Authority as amended from time to time, **Chubb Life Insurance Company Ltd.** (Incorporated in Bermuda with Limited Liability) is required to collect the identity information for the above items with asterisk (*) and verify the identity of the Policyowner. Your agent/intermediary, therefore, is needed to verify the original identification documents and collect the copies of the relevant and other documents as deemed necessary of the Policyowner.

* 根據打擊洗錢及恐怖分子資金籌集（金融機構）條例及保險業監理處所發出及不時修訂之「打擊洗錢及恐怖分子資金籌集指引」，**安達人壽保險有限公司**（百慕達註冊）必須收取以上註有星號 (*) 項目之保單持有人身份資料並核實保單持有人之身份。閣下之保險代理／中介人必須核實保單持有人之正本身份證明文件，並收取有關及其他所須文件之副本。

Part II – Attending Physician's Statement (To Be Completed by Attending Physician at the Applicant's Own Expense)

第二部份－主診醫生報告（由申請人自費，由主診醫生填寫） **Policy No.** | | | | | | | | | | |

A. Patient Information 病人資料

1. Name of Patient 病人姓名		2. Identity Document Number 身份證明文件號碼	
3. Age 年齡		4. Sex 性別	
5. Are you the patient's usual physician? 閣下是否病人慣常求診之醫生？	☐ No 否 ☐ Yes, medical records since: 是，醫療紀錄開始日期： _____ / _____ / _____ Day 日 Month 月 Year 年		

B. Consultation Details 診治資料

1. Date on which the patient **FIRST** consulted you for this illness or injury 有關是次病症或受傷，病人**首次**向閣下求診的日期	_____ / _____ / _____ Day 日 Month 月 Year 年		
2. Signs and symptoms complained of at the **FIRST** consultation **首次**求診時出現的徵狀			
3. Cause of Consultation 求診原因	a) ☐ Accident 意外 Date of accident 意外日期 _____ / _____ / _____ Day 日 Month 月 Year 年 Time of Accident 意外時間 ☐ AM 上午 / ☐ PM 下午 _____ : _____ Time 時間	b) ☐ Illness 病症 How long had the patient been experiencing these sign and symptoms BEFORE the first consultation? 首次求診前其徵狀已存在多久？ _____ Day(s) 日 _____ Month(s) 月 _____ Year(s) 年 Or since 或自 _____ / _____ / _____ Day 日 Month 月 Year 年	
4. For this episode, had the patient previously seen other physician(s) for these symptoms? 就此次病症而言，病人之前有否就有關之病況向其他醫生求診？	☐ No 沒有 ☐ Yes, please provide information on the right 有，請提供右方所需資料	a) Name of Physician 醫生姓名	
		b) Address of Physician 醫生地址	
		c) Date 日期	_____ / _____ / _____ Day 日 Month 月 Year 年

C. Planned Hospitalization Or Treatment Details 計劃住院或治療詳情

1. Name of Hospital/Medical Provider 醫院/醫療機構名稱

2. ☐ Clinic 診所 ☐ Hospital OPD 醫院門診部 ☐ In-patient 住院 ☐ Day Case 日症

3. Bed Class 住院級別 ☐ Private 私家房 ☐ Semi-private 半私家房 ☐ Ward 大房 ☐ Other, please specify 其他，請註明：_____

4. Planned date of admission 計劃入院日期 _____ / _____ / _____ Day 日 Month 月 Year 年	5. Planned date of discharge 計劃出院日期 _____ / _____ / _____ Day 日 Month 月 Year 年

6. Estimated Length of Stay 預計留院日數 _____ days 日

7. Diagnosis 診斷

8. Treatment plan in detail 治療計劃之詳情
(e.g. name of diagnostic tests, prescriptions, route of administration, etc.)（例如 :診斷性檢查及化驗，處方，給藥途徑等）

9. Procedure name 手術名稱	10. Anaesthesia 麻醉 ☐ G.A. 全身麻醉 ☐ L.A. 局部麻醉	11. Planned date of surgery 計劃手術日期 _____ / _____ / _____ Day 日 Month 月 Year 年

12. If Hospitalization is arranged for scans, diagnostic testing or a procedure that is normally carried out in a day case, please explain reason of Hospital stay is necessary 如是次住院之目的為檢驗，進行診斷掃描或一般日症手術，請說明留院之原因

13. To the best of your knowledge, was the patient's injury/illness directly or indirectly due to or aggravated by the following
根據閣下所知，病人是否因以下之原因，直接或間接引致或加劇有關之受傷/病症

☐ No 否 ☐ Yes, please tick where it is appropriate and give details
是，請在適當的位置劃上剔號及提供詳情

☐ Congenital condition/anomalies 先天性不正常情況
☐ Alcohol/narcotics/drug abuse 酗酒/濫用毒品/濫用藥物
☐ Self-inflicted injuries 自我傷害
☐ Geriatric; psychogeriatric or psychiatric condition 老年病、老年精神病或精神病情況
☐ Sexually transmitted diseases 性接觸傳染的疾病
☐ Pregnancy, miscarriage, child birth, infertility or any related complications 懷孕、流產、生產、不育或由此引發之病況
☐ Treatment of obesity 肥胖治療
☐ Experimental and/or unconventional medical technology/procedure/therapy performed on the Insured; or novel drugs/medicines/ stem cell therapy 醫療實驗治療或未經相關機構批准之新型藥物或幹細胞治療
☐ Convalescence, custodial or rest care 療養、復康護理
☐ Cosmetic or plastic surgery 美容或整形手術
☐ Corrective aids or treatment of refractive errors 視力矯正
☐ Hazardous sport/activity 參與危險性運動/活動
☐ AIDS/AIDS related compiex disease 後天免疫力缺乏症/與後天免疫力缺乏症相關的綜合症
☐ Body check/vaccination & immunization injections 身體檢查/防疫注射
☐ Developmental or behavioral problem 發育問題或行為問題
☐ Dental care/treatment 牙科護理/治療

14.

a) Did the patient have the following **PAST** medical history/habit 病人**過往**有否以下之病史/習慣
☐ No 否 ☐ Yes, please tick where it is appropriate and give details
是，請在適當的位置劃上剔號及提供詳情

☐ Asthma 哮喘
☐ Hepatitis B 乙型肝炎
☐ Previous operation 曾接受手術
☐ Smoking habit 吸煙習慣
☐ Obesity 肥胖症
☐ Cardiac problem 心臟病
☐ Hypertension 高血壓
☐ Hyperlipidaemia 高脂血症
☐ Diabetes mellitus 糖尿病
☐ Unfavorable family history 家族病史
☐ Chronic illness 長期病況
☐ Other, please specify details:
其他，請說明詳情：
_____

b) Please give the name and address of the physician/hospital by whom was the above **PAST** medical history FIRST detected 請詳述首次診斷出上述**過往**病史之醫生姓名/醫院名稱及地址	
c) Please provide FIRST diagnosis date and treatment details of the above **PAST** medical history 請提供上述**過往**病史之首次診斷日期及治療詳情	
d) Current prognosis of the above past medical history 上述病史癒後的情況	☐ Fully Recovered 完全康復 ☐ On treatment 治療中

15. To your best knowledge, has the patient ever been treated for any other serious disorders? If "yes", please state the details below
據閣下所知，病人過往是否曾接受任何嚴重病況治療？如「有」，請提供資料如下

☐ No 沒有 ☐ Yes 有

a. Disease/disorder 病況

b. Details of treatment/hospitalization 治療/住院詳情

c. Name of Doctor/Hospital 醫生姓名/醫院名稱

D. Estimated Costs 預計費用

1. Name and address of Hospital 醫院名稱及地址

2. Estimated length of stay 估計留院日數	3. ☐ Private 私家房 ☐ Semi-private 半私家房 ☐ Ward 大房 ☐ ICU 深切治療 ☐ Other, please specify 其他，請註明：_____

Item 項目	Charges 費用	Item 項目	Charges 費用
4. Daliy room charge 每日房錢		5. Anaesthetist's fee 麻醉師收費	
6. Daliy attendance Doctor fee 每日醫生巡房費		7. Specialist's fee, if any 專科醫生收費（如適用）	
8. Surgeon's fee 醫生手術費 Assistant surgeon's fee (if any) 副刀手術費（如適用）		9. Other expenses (i.e. diagnostic tests, imaging, medicines, operation theatre etc.) 其他費用 （如：診斷檢查，影像，藥物，手術室等）	
Total Estimated Hospital Cost (HKD) **預計所有住院費用總數 (港幣)**		HKD 港幣 _____	

E. Physician Details 醫生資料

Name of Attending Physician 主診醫生姓名		Qualification 資歷	
Hospital Name (if applicable) 醫院名稱（如適用）		Telephone No. 電話號碼	
Address 地址			
Are you related to the patient in any way other than the professional capacity? 除專業身份外，與病人是否有其他關係？	☐ No 否 ☐ Yes, please specify the relationship with patient 是，請註明與病人之關係 _____		
Signature & Hospital/ Physician's Chop 醫院/醫生簽署及蓋印		Date 日期	_____ / _____ / _____ Day 日 Month 月 Year 年

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