CLAIM FORM - TOTAL AND PERMANENT DISABILITY BENEFIT
完全及永久傷殘保障賠償申請書

☐ New claim 首次索償	☐ Pending claim 待決索償 ☐ Further claim 再度索償 ☐ Review/appeal 重批/覆核 Please supply claim no. for reference 請提供賠償編號以作參考

Part I (to be completed by Claimant/Insured) 甲部（由索償人/受保人填寫）

A. Insured's Particulars 受保人資料

Policy no. 保單編號	Insured's name 受保人姓名	HKID card/passport no. 香港身份證/護照號碼	Date of birth 出生日期 DD日 MM月 YYYY 年 / /	Sex 性別	Age 年齡	Tel. no. 電話號碼

B. Employment Particulars 就業詳情

1. Present Occupation 現時職業	Duties 工作範圍	Employer's name, address & tel. no. 僱主名稱、地址及電話
If more than one occupation, state all and exact nature of occupational duties 若有兼職請全部列明，並詳述職位及職責		
2. Did you file any medical leave certificates to your employer? 有否向僱主遞交病假証明書？ ☐ Yes 有 ☐ No 沒有		
3. Did you submit any claim for workmen's compensation for this accident? 有否就此意外申請勞工賠償？ ☐ Yes 有 ☐ No 沒有 Date submitted 遞交日期：(/ /) DD日 MM月 YYYY 年		

C. Other Insurance Coverage 其他保險資料

Does the Insured have any other insurance policy covering this case? 受保人會否就是次索償獲得其他保險賠償？ ☐ Yes 是 ☐ No 否
If 'Yes', please complete below particulars 若有，請詳細填寫以下資料

Name of Insurer 投保公司	Policy No. 保單號碼	Benefit Type 保障類別	Benefit Amount 保障金額

D. Disability Particulars 傷殘詳情

1. Disability due to accident 因意外導致傷殘	
1a. When (date and time) did the accident occur? 意外在何時（日期及時間）發生？	1a. (/ /) DD 日 MM 月 YYYY 年 (:) HR 時 MIN 分 ☐ AM 上午 ☐ PM 下午
1b. Where did the accident occur? 意外在何地發生？	1b.
1c. How did the accident occur? (Please describe in details) 意外如何發生？（請描述詳情）	1c.
1d. Which part of the body injured and type of injury? 受傷部位及傷勢？	1d.
1e. Any hospital confinement incurred? 有否住院？ If 'Yes' , the date of admission. 如有，請提供入院日期	1e. ☐ Yes 有 ☐ No 沒有 (/ /) DD 日 MM 月 YYYY 年

2. Disability due to illness 因病導致傷殘	
2a. Describe the symptom & abnormalities which led to Disability 請描述導致病者是次傷殘病徵及不適	2a.
2b. Details of first consultation for the illness 初診詳情	2b. Date of first consultation 初診日期 (/ /) DD 日 MM 月 YYYY 年 Doctor name 醫生姓名 _____ Address of the doctor 醫生地址 _____ Details 詳細情形 _____
2c. Since when had the symptom first appeared? 病者何時出現上述徵狀？	2c. (/ /) DD 日 MM 月 YYYY 年
2d. Have you been treated by other doctor(s) for similar or related illness in the past? 閣下有否因同類或有關疾病而求診於其他醫生？	2d. ☐ Yes, please state 如有，請詳述 ☐ No 沒有 Date of first consultation 初診日期 (/ /) DD 日 MM 月 YYYY 年 Doctor name 醫生姓名 _____ Address of the doctor 醫生地址 _____ Details 詳細情形 _____
3. When did you become totally disabled so as to prevent from doing any works? 何時開始完全傷殘並導致完全喪失工作能力	3. (/ /) DD 日 MM 月 YYYY 年
4. If still disabled, when do you expect to be able to return to full time work? 若仍然傷殘，估計何時可以回復全職工作？	4. (/ /) DD 日 MM 月 YYYY 年
5. If you have recovered, when were you able to perform part of the duties of your occupation or light work of any sort? (Please describe full job duties) 若現在已康復，何時開始可以執行你日常工作的部份職責或任何其他輕便工作？（請詳述工作性質）	5. (/ /) DD 日 MM 月 YYYY 年 Details 詳細情形 _____

E. Treatment Particulars 治療詳情

Details of hospital confined or physicians consulted for this injury or illness 詳列出此次受傷或疾病而就診之醫生/醫院詳情

Name of physician(s) &/or hospital(s) 醫生/醫院名稱	Address(es) 地址	Date of consultation(s) &/or period of confinement 就診/住院日期

F. Agent's Statement 保險代理聲明

I / We have verified the original HKID card / passport / residential address proof of the Policyowner and confirmed the identity details in the HKID card/passport to be matched with the identity of the Policyowner in this claim form. I / We will provide the required information and copies of the relevant documents to Chubb Life Insurance Company Ltd. without delay.
本人/吾等已核對保單持有人之香港身份證/護照/居住地址證明之正本，並確認香港身份證/護照之身份資料與此賠償申請書上保單持有人之資料一致。本人/吾等將會儘快遞交有關文件之副本予安達人壽保險有限公司。

Agent's name 保險代理姓名：_____ Agent's chop 保險代理蓋章：_____

Agent's signature 保險代理簽署：_____ Sign date 簽署日期：_____

G. Declaration 聲明

Personal Information Collection Statement

This Statement is made by Chubb Life Insurance Company Ltd (and references to Chubb Life Insurance Company Ltd, we, us or our will be references to the same) in accordance with the Personal Data (Privacy) Ordinance of the Hong Kong Special Administrative Region (the "Ordinance"). The Statement is intended to notify you why personal data is collected, how it will be used and to whom data access requests are to be addressed.

We may collect information from you to be able to supply insurance products to you, to carry on our life insurance business and use your personal data for the purpose of ensuring that content from the websites you use are presented in the most effective manner for you and for your computer; enabling us to communicate with you and to verify your identity; identifying policies of insurance issued for which you may be eligible and to provide you with quotes; processing any application for policies of insurance issued by us that you make and carry out variations, cancellations, endorsements or renewals of insurance products as the case may be; assisting in the issuance and administration of policies of insurance issued by us that you take out; administering and processing policy processing and payment instructions; assisting in processing claims handling, and compiling statistics to allow us to improve our products and services for you; carrying out our obligations arising from any contracts entered into between you and us; allowing you to participate in interactive features of our service, when you choose to do so; notifying you about changes to our service; helping prevent and detect fraud or loss; assisting with: (i) law enforcement bodies for law enforcement purposes; (ii) police for investigation purposes; or (iii) other government or regulatory bodies for meeting requirements imposed by law or agreed to with any government or regulatory bodies; promoting and direct marketing the insurance products and services of Chubb Life Insurance Company Ltd and the companies within the group of which Chubb Life Hong Kong is a subsidiary ("Chubb Life Group Companies");promoting and direct marketing the insurance products and services of authorised insurance companies by Direct Asia Agency Services (Hong Kong) Limited ("DAAS");promoting and direct marketing the insurance products and services by authorised insurance companies that are subsidiaries of Direct Asia Insurance (Holdings) Pte Ltd ("Direct Asia Group of Companies"); applying registration of activities organized and/or sponsored by Chubb Life Insurance Company Ltd; and other purposes notified at the time of collection, (together the "Purposes"). If you do not want us to use your personal data for any of the Purposes please contact us at the contact details below.

It may, in certain circumstances, be obligatory for you to provide to us certain categories of personal data (which shall be specified at the time of collection). If you do not provide any personal data marked as obligatory, we may not be able to process your case and/or provide you with insurance products and services you have applied for. Personal data held by us will be kept confidential but we may, for the Purposes, transfer your personal data to DAAS and any authorised insurance company in respect of which DAAS is or becomes an registered insurance agent; Chubb Life Group Companies; Direct Asia Group of Companies; reinsurers; loss adjusters; claims investigations companies; industry associations/federations; appointed service providers providing payment, data processing, website hosting, administration and other services in connection with operations and provision of policy administration and insurance services; credit reference agencies; debt collection agencies; law enforcement bodies; government or judicial or competent regulatory bodies or any person to whom we are under a legal and/or regulatory obligation to make disclosure; and other parties as notified to you at the time of collection, in each case both within and outside of Hong Kong. Where we transfer your personal data outside of Hong Kong we will ensure that the recipient of your personal data has in place policies, procedures, suitably secure servers and other measures at least equivalent to our own. Transfer of your personal data will only be made for the Purposes.

For our policy on using your personal data for direct marketing purposes, we may use your name, contact details (including email address and postal address) and policy details ("Relevant Personal Data") for the purposes of direct marketing insurance products and services of ours, Chubb Life Group Companies, any authorised insurance company in respect of which DAAS is or becomes a registered insurance agent and Direct Asia Group of Companies by providing you with promotional materials by email or by post. We may transfer your Relevant Personal Data to Chubb Life Group Companies or, DAAS and Direct Asia Group of Companies in Hong Kong (in respect of which we may receive money or other property in return from DAAS and Direct Asia Group of Companies for providing your Relevant Personal Data) for the purpose of providing you with promotional communications and materials in relation to our and/or their insurance products and services.

However, we cannot use your Relevant Personal Data and cannot transfer the same to DAAS, Direct Asia Group of Companies and Chubb Life Group Companies for the sake of direct marketing without your prescribed consent at the time of collection. You may also exercise your right to withdraw your consent to the use and/or the provision of your Relevant Personal Data by us to a third party for direct marketing purposes, and if you choose to exercise such right, we shall ensure that the use of Relevant Personal Data for direct marketing purposes ceases. If you do not object to the use of your Relevant Personal Data for direct marketing insurance products and services by us, DAAS and Direct Asia Group of Companies in Hong Kong please indicate where specified below at the time of collection. You have the right in accordance with the Ordinance to request access to and correction of information about you held by us. Your right of access can be exercised in accordance with the Ordinance. If you wish to access or correct your personal data held by us, please contact The Data Protection Officer of Life Administration, Chubb Life Insurance Company Ltd., 33/F, Windsor House, 311 Gloucester Road, Causeway Bay, Hong Kong. Any request for access to and correction of information will be dealt with promptly and we will use our best endeavors to handle such requests before the expiry of 40 days maximum. A reasonable charge of HK$50 may be imposed for processing of an access request, however no charge will be imposed for a correction request. Any questions, comments and requests regarding this Privacy Information Collection Statement and our Privacy Policy should be emailed to Enquiries.HKLife@chubb.com.

All information you provide to us is stored on secure servers. Any payment transactions and all pages that require personal information will be encrypted using SSL (secure socket layer) technology. Chubb Life Insurance Company Ltd will also take all reasonable steps to ensure that the personal data you provide to us is properly stored. Your personal data will only be kept for as long as necessary to achieve the purpose for which it was collected and to comply with any legal and regulatory requirements. If your personal data is no longer required for any purpose, reasonable steps shall be taken to securely delete or destroy your personal data.

私隱政策及個人資料收集聲明

安達人壽保險有限公司（「安達人壽」、「我們」或「我們的」）根據香港特別行政區個人資料(私隱)條例(第486章)(「私隱條例」）制定本私隱政策，旨在通知您收集個人資料目的、使用及要求查閱個人資料的方法。

我們可能需要收集您的個人資料，以為您提供保險產品、處理保險業務及使用您的個人資料作以下用途：確保您及您的電腦能以最有效方式瀏覽本網站內容，確保我們能與您聯絡，並驗證您的身份；識別您符合資格的保險計劃並提供報價；為您處理投保申請，並在需要時處理您的保單變更、取消、附加批註或續保；協助我們簽發及管理您的保單；協助我們管理及處理保單申請及執行付款指令；協助我們處理索償，結集統計數據，以改善我們的產品和服務；履行我們與您之間的合約義務；在您自願的情況下，讓您使用我們所提供的服務的互動功能；通知您服務的變更；協助我們防止及偵察欺詐或損失；協助：（一）執法機構執法；（二）警方調查；或（三）其他政府或監管機構所提出符合法律或雙方同意的要求；推廣及直銷安達人壽保險有限公司及與其隸屬同一集團附屬公司之其他公司（「安達集團公司」）的保險產品及服務；由Direct Asia Agency Services (Hong Kong) Limited（「DAAS」）推廣及直銷獲授權保險公司的保險產品及服務；由Direct Asia Insurance (Holdings) Pte Ltd轄下附屬並獲授權的保險公司(「DirectAsia集團」)推廣及直銷保險產品及服務；處理參與由安達人壽保險有限公司主辦和/或贊助的活動申請；及其他在收集個人資料時列明之目的（上述各項統稱為「收集目的」）。如您不同意上述任何一項的收集目的，請按以下聯絡方法與我們聯繫。

在某些情況下，您必須提供某些個人資料（須在收集個人資料時列明）。否則我們可能無法處理您的申請，和/或無法為您提供所要求的保險產品及服務。所有收集得來的個人資料將予以保密，但我們可能會按收集目的，把您的個人資料轉讓至：DAAS及任何已經或將會接受DAAS作為其註冊保險代理的授權保險公司、安達集團公司、DirectAsia集團、再保險公司、損失核算人、理賠調查公司、指定的服務供應商，包括提供付款、數據處理、網站託管、行政服務及其他與業務營運、保單行政及保險服務有關的管理及服務供應商，信貸參考機構、追收債務機構、執法團體、政府、司法或監管機構、或任何具有法律及/或監管責任而須予以披露的人士、和/或其他在收集個人資料時列明的轉讓人士，不論屬本地或海外，假如我們需要把您的個人資料轉讓至香港境外地區，我們會確保受讓者須擁有相當於我們的政策、程序、合適的安全伺服器及其他措施，而轉讓必須符合收集目的。

有關使用您的個人資料作直銷用途的政策，我們可能會使用您的姓名、聯繫資料（包括電郵地址及郵遞地址）及保單資料（「相關個人資料」）作直接促銷保險相關產品/服務，讓我們、安達集團公司、任何已經或將會接受DAAS作為其註冊保險代理的授權保險公司及DirectAsia集團以電郵或郵寄的方式提供與保險產品和服務相關的宣傳資料。我們可能會把您的相關個人資料轉讓至安達集團公司或DAAS及DirectAsia集團香港附屬公司（我們可能會就提供您的相關個人資料而獲取DAAS及DirectAsia集團金錢上或其他形式上的回報），並向您提供有關我們和/或他們的保險產品和服務的宣傳資料。

然而我們在未獲得您同意之前，將不能使用您的相關個人資料，並不能將其轉讓至DAAS、DirectAsia集團及安達集團公司作直銷用途。您亦可以行使權利，撤回先前同意我們使用和/或向第三方提供您的相關個人資料作直銷用途的決定。假如您選擇行使該權利，我們會確保停止使用您的相關個人資料作直銷用途。假如您不反對安達集團公司、DAAS及DirectAsia集團香港附屬公司使用您的相關個人資料作直銷保險相關產品/服務的用途，請在收集個人資料時的特設部分列明您的選擇。

按照「私隱條例」規定，您有權查閱及更正我們所持有有關您的個人資料，若您要行使有關權利，請按照以下方式聯繫我們：壽險行政部資料保護主任 - 安達人壽保險有限公司，香港銅鑼灣告士打道311號皇室大廈33樓。 我們會盡快處理您提出的查閱及更正個人資料要求，並盡力在提出申請後最多40天內處理有關申請。我們可能就處理查閱資料的要求收取港幣50元行政費用，但不會就更正個人資料要求收取費用。如果您對我們的私隱政策及個人資料收集聲明有任何疑問、意見及要求，請電郵至Enquiries.HKLife@chubb.com。

所有您提供給我們的資料將儲存於安全的伺服器內，所有涉及付款交易及收集個人資料的網頁亦會使用 SSL（secure socket layer）加密。安達人壽保險有限公司將採取切實可行的步驟，以確保我們所持有的個人資料穩妥地儲存。我們只會於法例及監管規定的期間保留您的個人資料。假如我們不再需要您的個人資料作任何用途，我們會採取合理步驟，安全地刪除或銷毀您的個人資料。

H. Authorization 授權

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. "the Company" or Direct Asia Agency Services (Hong Kong) Limited "DAAS" or its representative such information pertinent to this 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 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（如不同）的任何紀錄、知識或資料，可將該等資料向貴公司或 Direct Asia Agency Services (Hong Kong) Limited（「DAAS」）或貴公司代表透露、發放或移交，用以作為該份索償申請的參考；(ii) 貴公司或DAAS或貴公司委任的醫療/輔助醫療檢查員或檢驗所，就有關索償的申請，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。

Name of witness 見証人姓名	**Signature must be consistent with that in your policy record.** 閣下簽名模式，應與保單記錄之簽名相同，以作核對。			
Signature of witness 見証人簽署	Signature of insured 受保人簽署	Date 日期	Signature of policyowner (if other than insured) 保單持有人簽署（如並非受保人）	Date 日期
	Full name of insured 受保人姓名		Full name of policyowner* 保單持有人姓名*	
	HKID card/passport no. of insured 受保人香港身份証/護照號碼		HKID card/passport/BR no. of policyowner* 保單持有人香港身份証/護照/商業登記號碼*	
	Date of birth of insured 受保人出生日期		Date of birth of policyowner* 保單持有人出生日期*	
Date 日期	Nationality of insured 受保人國籍		Nationality of policyowner* 保單持有人國籍*	

* 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 Office of the Commissioner of Insurance as amended from time to time, Direct Asia Agency Services (Hong Kong) Limited is required to collect the identity information for the above items with asterisk (*) and verify the identity of the Policyowner. Direct Asia Agency Services (Hong Kong) Limited, 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」，Direct Asia Agency Services (Hong Kong) Limited 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。Direct Asia Agency Services (Hong Kong) Limited 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。

Total and Permanent Disability Benefit Claim
Attending Physician's Statement (to be completed by Registered Medical Practitioner at the claimant's own expense)

Policy no. _____

A. GENERAL INFORMATION

Patient's name	HK ID card/passport no.	Date of birth	Sex	Age

Are you the patient's usual doctor? ☐ Yes ☐ No Since when (/ /) DD MM YYYY

B. HISTORY & DIAGNOSIS

1. The date when symptoms first appeared or accident happened (/ /) DD MM YYYY
2. Symptoms and complaints presented by the patient
3. If the condition was due to accident, please provide the cause of this accident
4. The date of first consultation (/ /) DD MM YYYY
5. Clinical and physical findings
6. The date when the diagnosis was first given (/ /) DD MM YYYY
7. If surgery perfomed, please describe fully the date and nature of surgery (/ /) DD MM YYYY
8. The final diagnosis of the condition and its complications
9. The date the patient was first absent from work due to this condition
10. Has the patient ever had same or similar condition? If so, please state when and give details.
    ☐ No ☐ Yes (/ /) DD MM YYYY Diagnosis: _____
11. Details of consultations and treatment rendered by you / hospital

Date / period (DD MM YYYY)	Treatment details	Investigation / procedure

12. Name and address of other doctors / hospitals attended for treatment of this condition

Date of treatment (DD MM YYYY)	Physician / hospital attended	Address

C. CURRENT HEALTH CONDITIONS

1. Progress of recovery

   ☐ Recovered ☐ Improving ☐ Static ☐ Retrogressed

   Remarks:

2. Current state of mobility, give name of hospital and the period of confinement, if any.

   ☐ Ambulatory ☐ Home confined ☐ Bed confined ☐ Hospital confined

   Remarks:

3. Please describe the current physical improvement of the patient.

4. Can the patient perform Daily Living Activities without the use of mechanical equipment, special device or other aids and adaptations?

Transfer (to get in bed and out of bed or chair):	☐ Yes	☐ No
Mobility:	☐ Yes	☐ No
Dressing:	☐ Yes	☐ No
Bathing & Washing:	☐ Yes	☐ No
Eating	☐ Yes	☐ No
Toileting:	☐ Yes	☐ No

Remarks:

5. Did the patient sustain the following disablement:

a. Total and irremediable blindness (total loss of sight) ☐ Yes ☐ No Which eye(s) _____

Severance of limb(s) ☐ Yes ☐ No Please specify which limb(s) and the joint involved _____

Physical and/or total functional disablement of limb(s) ☐ Yes ☐ No Please specify which limb(s) and the joint involved _____

Permanent and total loss of hearing ☐ Yes ☐ No Which ear(s) _____

b. Has the patient suffered the above disablement continuously and without interruption for 180 days as a result of the condition as stated in Part B?
☐ Yes ☐ No

6. With the health condition of the patient in mind, what would you rate the working capacity of the patient, please tick the appropriate.

☐ No limitation of functional capacity, capable of heavy work without restriction.

☐ Capable of medium manual activity.

☐ Slight limitation of functional capacity, capable of light work.

☐ Moderate limitation of functional capacity, capable of clerical / administrative activity.

☐ Severe limitation of functional capacity, incapable of minimum activity.

Remarks:

7. Please describe the mental impairment of the patient (if normal, please go the Part D)

8. With the mental status of the patient as described above, what would you rate the ability for interpersonal relations and communication of the patient, please tick the appropriate.

☐ Able to engage in all interpersonal relations and communication (without limitations)

☐ Able to engage in most interpersonal relations and communication (slight limitations)

☐ Able to engage in only limited interpersonal relations and communication (moderate limitations)

☐ Unable to engage in interpersonal relations and communication (maked limitations)

☐ Has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

D. PROGNOSIS & REHABILITATION

1. Is the patient TOTALLY DISABLED for

His / her own job	☐ No	☐ Yes	From (/ /) DD MM YYYY	To (/ /) DD MM YYYY
Any other jobs	☐ No	☐ Yes	From (/ /) DD MM YYYY	To (/ /) DD MM YYYY

2. If the patient is unable to return to his / her own occupation, what other type of occupation can he / she perform?

3. If the patient is still disabled, please give approximate date the insured should be able to return to work?

(/ /) DD MM YYYY

4. How long was or will the patient be partially disabled?

From (/ /) DD MM YYYY To (/ /) DD MM YYYY

5. What duties of the patient's job is he / she incapable of performing?

6. Do you expect a fundamental or marked change of this present condition in the future. ☐ No ☐ Yes (if 'No", go to question 7)

If yes, how long do you expect the patient will take to perform duties.

In terms of own job:

- ☐ Within 1 Mth
- ☐ 1-3 Mths
- ☐ 3-6 Mths
- ☐ 6-12 Mths
- ☐ >12 Mths
- ☐ Never

Remarks:

In terms of any other jobs:

- ☐ Within 1 Mth
- ☐ 1-3 Mths
- ☐ 3-6 Mths
- ☐ 6-12 Mths
- ☐ >12 Mths
- ☐ Never

Remarks:

7. If answer of question 6 is 'No', please explain

8. Please state any further treatment/rehabilitation

E. MISCELLANEOUS

1. Please state if the patient has suffered / been treated for any other illness(es) / complaints other than this condition.

2. Is there any further information which in your opinion will assist us in assessing this claim?

I hereby certify that I have personally examined and treated the patient for the above illness and that the facts as given above present my opinion of his / her conditions.

Name of physician (with stamp)	Qualification	Signature	Date

Address: _____

_____

Telephone number: _____

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