請掃二條碼登入客戶專頁，隨時提交索償申請及查閱進度。
https://cs.chinalife.com.hk

中國人壽 CHINA LIFE | 海外

意外賠償申請表 ACCIDENT CLAIM FORM

保單持有人姓名 Name of Policyholder	受保人姓名 Name of Insured	保單編號 Policy No.

受保人身份證/ 護照號碼 I.D. / Passport of Insured

保險中介資料 INSURANCE INTERMEDIARY INFORMATION

保險中介名稱 Name of Insurance Intermediary

保險中介編號 Insurance Intermediary Code

聯絡電話 Contact No.

重要須知 IMPORTANT NOTE

- 請以正楷填寫本申請表。任何資料如有更改，受保人/保單持有人/索償人必須在更改的位置簽署作實。Please complete this form in BLOCK LETTERS. All amendments should be endorsed by the Insured / Policyholder / Claimant in full signature.
- 本申請表中所用之「本公司」或「貴公司」之表述指中國人壽保險(海外)股份有限公司。The expressions "the Company" or "our Company" used in this form refers to China Life Insurance (Overseas) Company Limited.
- 本申請表第一部分必須由受保人/保單持有人/索償人填寫，並需於意外日期起二十天內連同有關之文件正本呈交本公司。Part I of this form must be completed by Insured/Policyholder/Claimant and returned to the Company within 20 days from date of accident together with all original documents.
- 如受保人為十八歲或以上，受保人及保單持有人必須親自填寫及簽署本申請表，如受保人為十八歲以下，本申請表應由保單持有人及受保人之家長或合法監護人填寫及簽署。如受保人/保單持有人因傷殘不能書寫，其直系親屬可代為填寫本申請表及簽字，並提供關係證明及醫生證明。If the insured is at or above age 18, the Insured and policyholder must complete and sign this form by his or her good self. If the insured is under age 18, this form should be completed and signed by policyholder and the insured's parent/ legal guardian. In the event that the Insured/ policyholder is physically incapacitated and prevented from signing, this form may be completed and signed by an immediate family member with relevant relationship proof and physician's statement provided.
- 若受保人/保單持有人/索償人以圖章蓋印簽署，必須由一位見證人予以見證。見證人之個人資料只會用於處理本索償申請及核實和確認本申請表簽署人的身份之用。If the Insured/Policyholder/Claimant uses a signature stamp, it must be witnessed by a witness. The personal particulars of the witness will only be used for the purpose of processing this claim and verifying and confirming the identity of the signatory of this form.
- 受保人/保單持有人/索償人之簽署必須與本公司之紀錄相同。The signature of the Insured / Policyholder / Claimant must be the same as the Company's record.
- 保險中介人或銀行營業員收到本申請表並不代表本公司已收到。Receipt of this form by your Insurance Intermediary or bank officer does not constitute receipt by the Company.
- 如有任何查詢，請與 閣下的保險中介人聯絡或致電本公司客戶服務熱線(853) 2859 5519 查詢。填妥的表格及所需文件請寄往澳門新口岸宋玉生廣場 263 號中土大廈 22 樓 A、B、K-P 座。If you have any queries, please feel free to contact your insurance intermediary or our Customer Service Hotline at (853) 2859 5519 for details. Completed form(s) and required document(s) should be sent to China Life Insurance (Overseas) Co. Ltd., Alameda Dr. Carlos D' Assumpção No. 263, 22 Andar A, B, K-P, Edif. China Civil Plaza, Macau.
- 本公司有權隨時更新此申請表，並接受或拒絕未符合本公司要求的申請表。請登入本公司網站 www.chinalife.com.mo 瀏覽及下載最新版本。The Company has the right to update this form from time to time and to accept or to reject the form if the Company's requirements are not fulfilled. Please visit our website www.chinalife.com.mo to view and download the latest version of the form.
- 如中英文版本有任何抵觸或不符之處，概以中文本為準。If there is any discrepancy or inconsistency between the English version and the Chinese version of this form, the Chinese version shall prevail.

第一部份 – 索償資料(由受保人/保單持有人/索償人填寫)
PART I – PARTICULARS OF CLAIM(To be completed by Insured/Policyholder/Claimant)

A. 受保人資料 PARTICULARS OF INSURED

1 受保人年齡及性別 Age and Sex of Insured_____ 聯絡電話 Contact Phone No. _____

B. 一般資料 GENERAL INFORMATION

1 索償保障類別 Benefit(s) to claim

☐ 意外醫療費用 Accidental medical expenses reimbursement
☐ 意外住院入息 Accidental hospital income
☐ 意外受傷休假 Accidental weekly income
☐ 意外喪失肢體 Accidental dismemberment

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B. 一般資料(續)GENERAL INFORMATION(Continued)

2 索償申請類別 Type of claims

☐ 首次索償 New Claim ☐ 再度索償 Further Claim ☐ 待決賠案 Pending Claim ☐ 重批/覆核 Review / Appeal

3 閣下有否因同一事故曾/將會向其他保險公司索償？如是，請提供該保險公司名稱及保單號碼。 Did/Will you make a claim against any other insurance company for the same incident? If yes, please indicate the name of insurance company and policy no.. ☐ 是 Yes ☐ 否 No

保險公司名稱 Name of Insurance Company

保單號碼 Policy No.

4 是否申請退回收據的核實副本 Request return of certified true copy receipt(s) ☐ 是 Yes ☐ 否 No

C. 意外詳情 ACCIDENT PARTICULARS

1 意外發生日期及時間 Date and time of the accident

年 Year 月 Month 日 Day 時 Hour 分 Minute 上午/下午 AM/PM

2 意外發生地點及經過 Location and details of the accident

3 請詳述意外受傷部位及傷勢類別 Please describe the part(s) of body injured and the type of injury

4 閣下有否報警？如有，請提供以下資料 Did you report to the police? If yes, please provide the following information

☐ 是 Yes ☐ 否 No

警署地點 Police Station

檔案編號 Case Reference No.

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。
Remarks: Please attach a photocopy of the Police Report / Traffic Accident Report / Police Statement / Alcohol Test Report.

5 閣下有否就次意外向社會福利署/勞工處申請理賠？Did you apply for compensation from Social Welfare Department / Labour Department for the same accident?

☐ 沒有 No ☐ 有，請提供判傷紙/傷殘津貼證明 Yes，please provide Social Welfare Allowance / Labour Assessment Certificate

D. 治療詳情 TREATMENT DETAILS

1 因此次意外受傷就診之醫生或醫院(名稱、地址及診治日期)Details of hospitals confined or physicians consulted for the injury(Name, address and consultation date)

年 Year 月 Month 日 Day 醫生/醫院名稱 Name of physician/hospital

醫生/醫院地址 Address of physician/hospital

2 受保人有否於住院期間請假外出？如有，請列明外出及返回之日期及時間。Has the Insured taken any home leave during the hospital confinement? If yes, please state the starting and ending date and time. ☐ 有 Yes ☐ 沒有 No

	年 Year	月 Month	日 Day	時 Hour	分 Minute	上午/下午 AM/PM
外出日期及時間 Starting date and time						
返回日期及時間 Starting date and time						

3 若就診之註冊醫生/醫療服務提供者與受保人/保單持有人/索償人/保險中介人有任何關係，請列明之。Is there any relationship between the Registered Medical Practitioner / Medical Services Provider and the Insured /Policyholder /Claimant / Insurance Intermediary? If so, please state the relationship.

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E. 受僱資料 EMPLOYMENT PARTICULARS

1 公司/僱主名稱 Company/Employer Name _____ 電話號碼 Telephone No. _____

地址 Address _____

2 現職職位及職責(若多於一種職業,請列明所有職位及職責)Position and duties of present occupation (if more than one, please state all).

_____

_____

3 閣下有否向僱主申請病假 Did you file your sick leave application to employer?	年 Year	月 Month	日 Day
☐ 沒有 No ☐ 有 Yes 由 From			
至 To			
復職日期 Resumed duty on			
4 如仍在休假中，請提供預計復職日期。If you are still on sick leave, please provide the expected date to resume duty.			

F. 領款方式(請選擇一種理賠支付方式) PAYMENT METHOD (Please select only one of the settlement options)

1 自動入賬申請 Direct Credit Application

☐ 已登記的「付款銀行賬戶」Registered Payment Bank Account

此服務只適用於本公司指定的澳門開立銀行賬戶，並於本公司已完成及成功辦理登記的指定銀行賬戶。The service is only applicable to a bank account set up in Macau designated bank by the company and the bank account which registration is completed successfully in the company.

☐ 指定銀行帳戶 Designated bank Account

請提供賬戶證明文件，如印有賬戶持有人姓名/名稱及賬戶號碼的銀行卡/月結單/存摺。Please provide bank account document(s), such as bank card/monthly statement/ passbook with account holder name and account no.

至保單持有人/索償人於本公司指定的澳門開立銀行賬戶 To a bank account set up in Macau designated bank by the company held by the Policyholder/Claimant.

銀行名稱 Name of Bank	銀行編號 Bank No.	分行編號 Branch No.	銀行賬戶號碼 Account No.

賬戶持有人姓名(中文) (必須為保單持有人/索償人) Name of bank account holder (Chinese) (Policyholder/Claimant Only)	賬戶持有人姓名(英文) (必須為保單持有人/索償人) Name of bank account holder (English) (Policyholder/Claimant Only)

本人/我們現申請以上理賠匯款方式領取金額，並同意銀行於匯款中扣除相關手續費 (如有)
I/We agree to apply the captioned Claims Remittance Service and bank charge would be deducted from the payment amount. (If applicable)

實際到賬時間會因應個別銀行而有差異，申請前請先向有關銀行查詢。The actual time to receive the payment may vary among banks. Please enquire to the bank before application.

倘未有足夠資料顯示銀行賬戶持有人為保單持有人/索償人或因故未能成功自動入賬，有關款項將以劃線支票形式發出。If there is insufficient information to identify the ownership of bank account belongs to Policyholder/Claimant or direct credit is failed for any reason, the payment will be issued by cheque.

2 本地銀行劃線支票 MACAU LOCAL CROSSED CHEQUE

賠款貨幣選擇 Preferred Settlement Currency

☐ 保單貨幣 Policy Currency ☐ 港元 (按中國人壽保險(海外)股份有限公司每月之固定兌換率計算) Hong Kong Dollar (at monthly fixed rate of China Life Insurance (Overseas) Company)

☐ 親自到客戶服務中心提取 Collect Cheque at Customer Service Centre in person
(請保單持有人/索償人帶同身份證明文件親臨本公司的澳門客戶服務中心收取支票。) (The Policyholder/Claimant should collect the cheque at our Macau Customer Service Centre by presenting the identity document.)

☐ 授權第三者(代領人)領取 Pick up cheque in person by authorized person

代領人姓名 Name of authorized person	代領人聯絡電話 Contact no. of authorized person	代領人身份證明文件號碼 I.D. no. of authorized person

☐ 郵寄至保單登記的通訊地址 Mail to correspondence address registered in our Company
☐ 經保險中介轉遞 Deliver via Insurance Intermediary
☐ 經銀行營業員轉送 (請指定銀行分行及經辦人員) Deliver by bank officer (Please state the branch and bank officer)

銀行分行 Branch _____ 經辦人員 Bank Officer _____

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F. 領款方式(請選擇一種理賠支付方式) (續) PAYMENT METHOD (Please select only one of the settlement options) (Continued)

3 其他領款方式 OTHER PAYMENT METHODS

☐ 抵付保費 (僅適用於同一保單持有人名下生效之保單，請指定保單號碼。) Offset the premium (only applicable to inforce policy under same Policyholder, please specify the policy no..)

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4 其他方式 Other Methods

☐ 其他(請列明) Others (Please specify) _____

G. 索償所需文件清單 CLAIM DOCUMENT CHECKLIST

- ✓基本文件 Basic Documents；●附加文件 Additional Documents；×不適用 Not Applicable

索償所需文件 (文件的核實副本可於本公司的客戶服務中心辦理) Claim Document (Documents can be certified at our Company's Customer Service Centre)		意外醫療費用 Accidental medical expenses reimbursement	意外受傷休假 Accidental weekly income	意外住院津貼 Accidental hospital income	意外喪失肢體 Accidental dismemberment
☐	由閣下填妥並簽署之本申請表第一部分 Part I of this form completed and signed by your good self	✓	✓	✓	✓
☐	由主診醫生填寫並且簽署及蓋印之本申請表第二部分 Part II of this form completed and signed by attending physician with chop	✓	✓	✓	✓
☐	載有明確診斷之出院紙/病假紙/醫生證明書(適用於香港醫院管理局轄下醫院之治療) Discharge slip/sick leave certificate/medical certificate with clear exact diagnosis (applicable to treatment received in hospitals of the Hospital Authority of Hong Kong)	✓	✓	✓	✓
☐	出院小結(適用於中國境內之治療) Discharge summary (applicable to treatment received in Mainland China)	✓	✓	✓	✓
☐	醫療收據正本及其帳單明細表 Original medical receipt and statement of account	✓	● 只需副本 Copy required only	✓ 只需副本 Copy required only	● 只需副本 Copy required only
☐	受保人身份證明文件之核實副本 The certified true copy of identity document of the Insured.	✓	✓	✓	✓
☐	投保人之身分證文件之核實副本 (受保人非投保人) The certified true copy of identity document of Policyholder (Insured is not Policyholder).	✓	✓	✓	✓
☐	其他保險公司或機構賠付之清單明細 Settlement advice from other insurer/ party	●	●	×	●
☐	診斷測試報告 (如：病理報告、驗血報告、正電子掃描/電腦掃描/磁力共振報告、心電圖報告、超聲波報告、X光報告等)Diagnosis report and laboratory test report (such as pathological report, blood test report, PET Scan/CT Scan/MRI report, ECG report, ultrasound report and X-ray report etc.)	●	●	●	●
☐	勞工判傷紙/僱主發出之病假證明 Labour Assessment Certificate / Employer confirmation letter for sick leave record	●	✓	●	✓
☐	警署報告及/或交通意外報 Police report and/or traffic accident report	●	●	●	●
☐	物理治療/職業治療報告 Physiotherapy / occupational therapy report	●	●	●	●
☐	報章剪報 Newspaper clipping	●	●	●	●
☐	註冊醫生/ 醫院發出的轉介信副本 Copy of referral letter issued by registered medical practitioner / Hospital	●	●	●	●

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H. 個人資料收集聲明 PERSONAL INFORMATION COLLECTION STATEMENT

本人/我們確認已閱讀及明白「中國人壽保險（海外）股份有限公司」的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於 https://www.chinalife.com.mo/zh-hant/personal-information-collection-statement 下載或向中國人壽保險（海外）股份有限公司索取。

I/We confirm that I/we have read and understood the Personal Information Collection Statement ("PICS") of China Life Insurance (Overseas) Company Limited. For the latest version of the PICS, it can be downloaded from https://www.chinalife.com.mo/zh-hant/personal-information-collection-statement or is made available upon request.

I. 電子票據索償聲明 DECLARATION FOR ELECTRONIC RECEIPT

☐ 本人/我們，受保人/保單持有人/索償人謹此確認是次遞交之電子票據為唯一收據，相關診所醫院並沒有就是次求診收據曾經或重覆發出書面正本收據。I/We, the Insured/Policyholder/Claimant, confirm that the electronic receipt(s) submitted for this claim application is/ are the sole receipt(s). The clinic / hospital of this visit has not ever or repeatedly issued the original paper receipt(s) for the same visit. 本人/我們，受保人/保單持有人/索償人亦聲明及保證除貴公司外，就該住院或有關求診將獲賠付部份，並沒有向其他保險公司或機構進行重覆索償。I/We, the Insured/Policyholder/Claimant, declared and guarantee that apart from our company, I/we have not filed/ will not file the duplicate claims against other insurance companies or institutions concerning the amount to be claimed in your company for the said electronic receipt(s). 本人/我們，受保人/保單持有人/索償人承諾如上述聲明不正確，本人願意退還貴公司就該住院或有關求診之全部賠償，並承擔有關之一切法律責任。I/We, the Insured/Policyholder/Claimant, undertake that if the above statement is incorrect, I/we are willing to refund the full claim payment for the said receipt(s) to our company and bear all related legal liabilities.

J. 聲明及授權 DECLARATION AND AUTHORIZATION

授權 Authorization

本人/我們，受保人/保單持有人/索償人，代表本人/我們及尚未成年之受保人(如有)謹此授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、政府部門，或其他機構、組織或人士，凡知道或具有任何有關本人/我們/尚未成年之受保人之紀錄、認識或資料者，均可將該等資料提供、發放及轉交給中國人壽保險（海外）股份有限公司（以下簡稱「貴公司」）； (2) 貴公司或任何其指定之醫療/輔助醫療檢查員或化驗所，可就本索償申請替本人/我們/尚未成年之受保人進行所需之醫療評估及測試，作為審核本人/我們/尚未成年之受保人之健康狀況。此授權對本人/我們之繼承人及授讓人具有約束力；即使本人/我們死亡或無行為能力時，此授權書仍具效力。此授權書的影印本與正本均有同等效力。I/We, the Insured/Policyholder/Claimant, represent me/ us/ the Insured under 18 years old (if any) HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, government department, or other organization, institution or person, that is aware of or has any records, knowledge or information of me/us/the insured under 18 years old to disclose, release and transfer such information to the Company; (2) the Company or any of its appointed medical / para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ ourselves/ the insured under 18 years old in relation to this claim. This authorization shall bind the successors and assignees of me/us and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

聲明 Declaration

本人/我們，受保人/保單持有人/索償人，謹此聲明及同意(1)上述一切陳述及問題的所有答案，不論是否本人/我們親手所寫，就本人/我們所知所信，均為事實之全部並確實無訛； 本人/我們明白倘未知任何一項是否重要，本人/我們均須將其事實在本申請表上說明；(2)本人/我們對任何人所作出之任何聲明，除在本申請表上填寫或印出及經 貴公司發表和批准外，貴公司不須受其約束。若相關人士不能提供任何本申請表所需的資料，貴公司可能因此不能審核及處理本索償申請。I/We, the Insured/Policyholder/Claimant HEREBY DECLARE and AGREE that (1) all the foregoing statements and answers to all questions whether or not written by my/our own hand are to the best of my/our knowledge and belief complete and true; I/We also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. (2) The Company is not bound by any statement which I/we may have made to any person unless it is written or printed here and is presented and approved by the Company. If any relevant persons fail to provide any information requested in this claim form, it may result in the Company's inability to process and deal with this claim.

K. 簽署(請勿在空白表格上簽署) SIGNATURE (Please DO NOT sign on BLANK form)

	受保人(年齡 18 歲或以上) Insured(whose age is 18 or above)			保單持有人 / 索償人* Policyholder / Claimant*			見證人 Witness		
簽署 Signature									
姓名 Name									
身份證/護照號碼 I.D. Card / Passport No.									
日期 Date	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day
*索償人與受保人/保單持有人關係 *Relationship with Insured/Policyholder									

保單編號 Policy No.										

第二部份–主診醫生報告書(由主診醫生填寫，所有費用由受保人/保單持有人/索償人自行承擔)
PART II – ATTENDING PHYSICIAN'S STATEMENT (To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)

A. 病人資料 PARTICULARS OF PATIENT

病人姓名 Name of patient		病人年齡/性別 Age/sex of patient	/	病人身份證/護照號碼 I.D / Passport No. of patient	

B. 診治資料 CONSULTATION DETAILS

1 意外發生日期 Date of Accident — 年 Year | 月 Month | 日 Day | 時 Hour | 分 Minute | 上午/下午 AM/PM

2(a) 如有住院，請提供住院時段 Period of hospital confinement if hospitalized — 年 Year | 月 Month | 日 Day | 時 Hour | 分 Minute | 上午/下午 AM/PM

2(b) 醫院名稱 Name of hospital

3 受傷後首次接受就診日期 Date of first consultation for this injury — 年 Year | 月 Month | 日 Day ☐ 上午 AM ☐ 下午 PM

4(a) 意外發生經過 Circumstances of accident

4(b) 身體受傷之部位 Part of body injured

4(c) 受傷類別和程度 Type and extent of injury

4(d) 閣下於首次會診該病人時，其身體有否可見之表面傷痕？如有，請描述。Is there any visible contusion, cut or wound on the exterior body part at your first consultation? If yes, please describe in details. ☐ 是 Yes ☐ 否 No

☐ 是 Yes

5 最後會診日期 Date of last consultation 年 Year | 月 Month | 日 Day

病人之康復情況 Status of recovery

6 請提供所有治療詳情(例如留院、手術、物理治療、X 光、特別診斷程序檢查) Please provide all treatments details (such as hospitalization, surgery, physiotherapy, X-ray, special diagnostic procedures and investigation etc.)

年 Year	月 Month	日 Day	治療詳情 Treatment details	檢查結果/治療時期 Result/ Treatment duration

7 受保人就此次意外受傷，有否接受其他醫生治療？如有，請註明 Any other physicians who treated Insured for the same injury? If yes, please give details ☐ 是 Yes ☐ 否 No

年 Year	月 Month	日 Day	醫生姓名 Name of physician(s)	電話及地址 Telephone No. & Address(es)

保單編號 Policy No.										

B. 診治資料(續)CONSULTATION DETAILS(Continued)

8 **該次受傷是否由下列任何一項而導致加長傷殘時間？如下述任何一項為"是"，請註明詳情 Was such injury induced from or affected by any of the following which may contribute to and/or lengthen the period of disability? If any of the below is "yes", please give details.**

(a)	身體缺陷 / 先天異常 Physical defects / congenital anomaly	☐ 是 Yes		☐ 否 No
(b)	過往不良健康狀況記錄 Unfavourable past medical history	☐ 是 Yes		☐ 否 No
(c)	退化性轉變 Degenerative changes	☐ 是 Yes		☐ 否 No
(d)	藥物或酒精 By drugs or alcohol	☐ 是 Yes		☐ 否 No

9 **有沒有其他因素影響痊癒進度？如有，請註明詳情及採用之任何特別治療 Was healing complicated? If yes, please state details & any special treatment given.** ☐ 是 Yes ☐ 否 No

10 **以病人本身的工作或職業而論，請詳述此意外/ 傷勢對其的影響: Bearing in mind the declared duties/occupation of this patient, please indicate the impact of the accident / disablement:**

☐ 能夠從事任何工作或職業 Can perform any kind of work and duties

☐ 不能從事其職業本身之部分工作 Cannot perform partial duties of his/ her own occupation

☐ 不能從事其職業本身之任何工作 Cannot perform all duties of his/ her own occupation

☐ 不能從事任何類型的工作或職業 Cannot perform any kind of work and duties

請提供喪失部分工作能力的時間 **Please state period of incapable to perform some of his/her duties**

由 From _____(dd/mm/yyyy) 至 to _____(dd/mm/yyyy)

請提供喪失全部工作能力的時間 **Please state period of incapable to perform some of his/her duties**

由 From _____(dd/mm/yyyy) 至 to _____(dd/mm/yyyy)

11 **根據該病人之職業，此次受傷如何影響及阻礙其職業之日常職務 Bearing in mind patient's occupation, how would the injury prevent the patient from performing all the duties of his/her job?**

12 **若不能工作兩星期以上，請詳述閣下認為病人不能提早復工之原因。If an absence from work for more than two weeks is necessary, please describe in details why you think the patient could not return to work earlier.**

13 **如是次意外導致該病人永久傷殘，請評估傷殘對身體功能所造成永久損失的程度(以%表示) If the accident caused any permanent disability to the patient, please assess the loss of body function permanently caused by the injury, expressed in percentage.**

14 **病人在發生意外當時，是否已患上任何疾病或缺陷？Is the patient now/ Was the patient at the time of this accident suffering/suffered from any illness, disease or infirmity?**

☐ 沒有 No ☐ 有，請提供詳情 Yes，Please provide details.

C. 主診醫生資料 PARTICULARS OF ATTENDING PHYSICIAN

主診醫生姓名 Name of Attending physician		**資歷 Qualification**			
地址 Address		**聯絡電話 Contact No.**			
主診醫生簽署/ 醫院蓋章 Signature & Stamp of Attending Physician/ Hospital		**日期 Date**	年 Year	月 Month	日 Day