4012000401

意外賠償申請表
ACCIDENT CLAIM FORM

CSM-CLA03

第一部份 PART I

為使此賠償能儘速辦理，此申請表必須由受保人/保單持有人填寫，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。
In order to help us to process your claim promptly, this form must be completed by Insured / Claimant (all fields have to be completed) and returned to the Company within 20 days after accident together with all original documents.

受保人資料 Insured's Particulars

本表格需由受保人填寫，如受保人為十八歲以下，應由受保人之家長或合法監護人填寫此申請表。
To be completed by Insured. If the insured is under age 18, this form should be completed by the insured's parent/ legal guardian.

保單號碼 Policy No. :	受保人姓名 Name of Insured :	年歲及性別 Age and Sex	身份證/ 護照號碼 I.D. Card/ Passport No.

索償保障類別(請劃上✓ 號) Claimed Benefit(s) (please tick)

☐ 意外醫療費用 Accidental medical expenses reimbursement
☐ 意外住院津貼 Accidental hospital income
☐ 意外受傷休假 Accidental weekly income
☐ 意外永久傷殘 Accidental permanent disability

通訊地址 Mailing Address :

聯絡電話 Contact Phone No. :

☐首次索償 New Claim ☐再度索償 Further Claim

意外詳情 Accident Particulars

1. 意外發生日期、時間
Date and Time of the accident.

At _____ on _____
於 上午/下午 AM/PM 在 年/月/日 YYYY/MM/DD

2. 意外發生地點
Place of accident occurred.

3. 意外發生之起因及經過詳情
How did the accident occur? Please describe in details:

4. (a) 受傷的身體部位
_____
Part(s) of body injured.

(b) 傷勢類別 _____
Type of injury

5. 有否報警 ☐沒有No
Did you report to the police?
☐有Yes ，警署Police Station ： _____
檔案編號Case no. ： _____
**請附警察報告/ 口供紙 Please attach Police report/ statement

6. 閣下是否就此意外向其他保險公司索償？如有， 請提供保險公司名稱及保單編號Are you making a claim against other insurance company for the same accident? If yes, please provide name of the insurance company and policy number
☐有Yes ☐沒有No
保險公司名稱 Name of Insurance Company ：
保單編號 Policy number：

受僱資料 Employment Particulars

7. 現時職業詳情 Present occupation details
職位Job title：
實際職務Exact duties：

8. 僱主資料Employer details
公司名稱Company name ：
電話Telephone：
地址Address：

9. 閣下有否向僱主申請病假
Did you file your sick leave application to employer?
☐有Yes ☐沒有No
Leave from 由_____ (年/月/日 YYYY/MM/DD)
to 至_____ (年/月/日 YYYY/MM/DD)

復職日期 Resumed duty on _____
年/月/日 YYYY/MM/DD

10. 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
_____ (年/月/日YYYY/MM/DD)

Did you apply employee compensation for this accident?
閣下有否就此意外申請勞工保險賠償？
☐有Yes ☐沒有No

請提供勞工保險賠償申請表、 有關意外報告及評估報告
Please attached employee compensation claim form, relevant accident report and assessment report

治療詳情 Treatment Particulars

11. 請列出所有因此次意外受傷而就診之醫院或醫生詳情 Details of all hospitals confined or physicians consulted for the injury.

就診/住院日期 (年/月/日) Date of Consultation/ Confinement (YYYY/MM/DD)	醫生/醫院名稱 Physician/ Hospital	聯絡電話 Contact Tel. No.	住院編號/ 病人編號 Hospital No/ Patient No.

聲明及授權 Declaration and Authorization

授　權

本人謹此授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、或其他機構、組織或人士、凡知道或持有任何有關本人/受保人之紀錄者，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生或化驗所，可就此賠償申請替本人/受保人進行所需之醫療評估及測試，作為審核本人/受保人之健康狀況。此授權對本人/受保人之繼承人及授讓人具有約束力；即使本人/受保人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。

AUTHORIZATION

I HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of me/the insured to disclose, release and transfer such information to China Life Insurance (Overseas) Company Limited (hereinafter called "the Company"); (2) the Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ the insured in relation to this claim. This authorization shall bind the successors and assignees of me/the insured and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

聲　明

本人謹此聲明及同意(1)上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所信，均為事實之全部並確實無訛； 本人明白倘有任何未知是否屬於重要事項的資料均須透露；(2)本人對任何人所作出之任何聲明，如沒有在此申請書上填寫或印出，貴 公司不須受其約束。 若相關人士不能提供任何此賠償申請表所需的資料，貴 公司可能因此不能審核及處理此賠償申請。

DECLARATION

I HEREBY DECLARE and AGREE that (1) all the foregoing statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true; I 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 may have made to any person if not written or printed here. 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.

_____	_____	_____	_____
受保人/保單持有人簽署 Signature of Insured/Policyholder	受保人/保單持有人姓名 Name of Insured/Policyholder	身份證/護照號碼 I.D. Card / Passport No.	日期(年/月/日) Date (YYYY/MM/DD)

備　註: 此聲明及授權書必須由受保人簽署，若受保人為小童，則可由其家長/合法監護人簽署。

Remarks: This declaration and authorization must be signed by the insured. If the insured is a minor, the insured's parent/legal guardian can sign on his/her behalf.

如受保人因傷殘不能書寫，其家屬或代理人可代為填寫此申請書及簽字。.

In the event of the Insured is physically incapacitated and prevent from signing, PART I may be signed by a close relative or other representative authorized by the Insured.

若簽署者非受保人，請填寫此欄 Please complete if the signature is not given by the Insured.

受保人姓名 (正楷書寫) _____ 與受保人/保單持有人關係_____

Name of insured (in block letter) Relationship with Insured/ Policyholder.

收集個人資料聲明 Personal Information Collection Statement

本人確認已閱讀及明白中國人壽(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 www.chinalife.com.mo 下載或向中人壽(海外)股份有限公司索取。

I confirm that I have read and understood the personal information collection statement of China Life Insurance (Overseas) Company Limited. For the latest version of the personal information collection statement, it can be downloaded from www.chinalife.com.mo or is made available upon request.

_____	_____
受保人/保單持有人簽署 Signature of Insured/Policyholder	日期 (年/月/日) Date (YYYY/MM/DD)

建議索償文件/參考事項 Suggested Checklist

1. ☐保單合同正本Original Policy
2. ☐賠償申請表第二部份Claim Form Part II
3. ☐正本收據，總額 MOP/HK$_____ Original receipts. Total amount MOP/HK$_____
4. ☐載有明確診斷之病假證明書 (病假共_____天) Original sick leave certificate with diagnosis (Total no. of days _____)
5. ☐出院證明書/西醫轉介信 (如適用) Discharge note/ Referral letter by physician, if any.
6. ☐X光/電腦掃描/ 磁力共震報告(如適用) X-ray / CT Scan / MRI report , if any.
7. ☐勞保判傷報告 (如適用) Employee compensation assessment report, if any.
8. ☐警察報告/口供紙 (如適用) Police report/ statement, if any.
9. ☐僱主發出之病假證明信(如適用) Employer confirmation letter for sick leave period, if any..

保險中介人專用 For Insurance Intermediary use only

本人認為上述之答案全屬正確無訛。I believe that the answers given above are true and to the best of my knowledge.

_____	_____	_____	_____
保險中介人簽署 Signature of Insurance Intermediary	保險中介人姓名 (正楷填寫) Name of Insurance Intermediary (in block letter)	保險中介人代碼(如適用者) Insurance Intermediary Code (if any)	日期 (年/月/日) Date (YYYY/MM/DD)

應診醫生報告書 ATTENDING PHYSICIAN STATEMENT

第二部份 PART II

由主診醫生填寫，所有費用由索償人自行承擔

To be completed by the attending physician at the claimant's own expenses.

病人姓名 Name of Patient	年齡/性別 Age and Sex	身份證/ 護照號碼 I.D. Card/ Passport No.

1. 意外發生日期 Date of Accident.	1. At _____ on _____ 於 上午/下午 AM/PM 在 年/月/日 YYYY/MM/DD
2. 受傷後首次接受就診日期 Date of first consultation for this injury.	2. At _____ on _____ 於 上午/下午 AM/PM 在 年/月/日 YYYY/MM/DD
3. (a) 意外發生經過 Circumstances of accident. (b) 身體受傷之部位 Part of body injured. (c) 受傷類別和程度 Type and extent of injury. (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.	3. (a) _____ _____ (b) _____ (c) _____ (d) ☐是Yes ☐否No 請描述please describe _____ _____
4. 最後會診日期及病人之康復情況 Date of last consultation and status of recovery.	4. At _____ on _____ 於 上午/下午 AM/PM 在 年/月/日 YYYY/MM/DD 請描述please describe _____

5. 請提供所有治療詳情(例如留院、手術、藥物、物理治療、檢查等)
Please provide all treatments details (such as hospitalization, surgery, medication, physiotherapy, investigation etc.)

日期Date (年/月/日YYYY/MM/DD)	治療詳情Treatment details	劑量/ 檢查結果/ 治療時期Dosage/ Result/ Treatment duration

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

醫生姓名Name of physician(s)	電話及地址Telephone No. & Address(es)	會診日期(年/月/日)Date of treatment (YYYY/MM/DD)

7. 該次受傷是否由下列任何一項而導致加長傷殘時間 ? Was such injury induced from or affected by any of the following which may contribute to and/or lengthen the period of disability? (a) Physical defects / congenital anomaly 身體缺陷 / 先天異常 (b) Unfavourable past medical history 過往不良健康狀況記錄 (c) Degenerative changes 退化性轉變 (d) By drugs or alcohol 藥物或酒精 如上述任何一項為"是"，請註明詳情 If any of the above is "yes", please give details.	7. (a) ☐是Yes _____ ☐否No (b) ☐是Yes _____ ☐ 否No (c) ☐是Yes _____ ☐否No (d) ☐是Yes _____ ☐否No
8. (a) 康復過程中，有否引起其他併發症 Was healing complicated? (b) 如有，請註明詳情及採用之任何特別治療 If yes, please state details & any special treatment given.	8. (a) ☐有Yes ☐沒有No (b) _____ _____
9. 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 According to patient's occupation, how would the injury prevent him/her from job duties?	9. ☐不適用於非在職人仕 Not applicable for unemployed 請註明詳情Please state details _____ _____ Sick Leave from _____ to _____ 病假假期由 (YYYY/MM/DD 年/月/日) 至 (YYYY/MM/DD 年/月/日)
10. 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.	10. ☐不適用 Not applicable 請註明詳情Please state details _____ _____ _____
11. 額外資料以便本公司評估此賠償 Additional information to supplement our assessment.	11.

本人謹此證明已親自為上述該病人就上述受傷進行檢查及治療，並確認表格內之資料為本人對受保人之實際情況所作出的意見。
I hereby certify that having personally examined and treated the above named patient for the above injury and that the information given above present my opinion of his/her actual condition.
本人聲明及同意此表格內第一部份"聲明"之一切內容
I declare and agree to make the "Declaration" on Part I of this claim form.

簽署 _____ 醫生姓名 (連蓋章證明) _____
Signature Name of physician (with stamp)

資歷 _____ 地址 _____
Qualification Address

日期 (年/月/日) _____ 聯絡電話 _____
Date (YYYY/MM/DD) Contact Phone No.

受保人必須在應診醫生處簽署作實 For identity purpose, the Insured must sign below in the presence of the Physician

日期 (年/月/日) _____ 受保人簽署 _____
Date (YYYY/MM/DD) Signature of Insured