

營業員姓名 Agent Name		營業員號碼 Agent Code		聯絡電話 Contact Tel. No.	
索償類別 Coverage claiming for	<input type="checkbox"/> 綜合意外保障 AI	<input type="checkbox"/> 意外死傷保障 ADD	<input type="checkbox"/> 其他 Others		
附上文件 Documents attached	<input type="checkbox"/> 病假證明書 Sick Leave Certificate	<input type="checkbox"/> 醫院帳單正本 Original Hospital Bills	<input type="checkbox"/> 出院報告 Discharge Summary	<input type="checkbox"/> 其他 Others	
填表須知 Instructions	<p>1. 發出此申請書並不表示本公司已接納是次索償申請。在此索償過程中，索償人無需支付任何性質之手續費予本公司之僱員或營業員。 The issue of this form is in no way an admission of liability. No fee, commission or charge of whatever nature is required to pay to the employees or agents of the company with respect to this claim.</p> <p>2. 請回答申請書第一部份所有問題。申請書第二部份必須由主診醫生填寫並由索償人支付有關費用。 Please answer ALL the questions in Part I of this claim form. Part II of this claim form MUST be completed and signed by the attending physician. The completion of this part is at claimant's own expenses.</p> <p>3. 請附上有關報告或文件，例如病假紙、醫療報告、物理治療報告、詳細列明每項費用之醫院帳單正本、醫院發出的出院報告並列明實際病因等以方便審核。 Please attach other reports or relevant documents, such as sick leave certificate, medical report, physiotherapy report, original hospital bills with breakdown details, discharge summary issued by hospital containing the exact diagnosis, etc. to enable us to assess the claim.</p> <p>4. 請確保索償人在此申請書的簽署必須和投保書簽署一致。 Please make sure the signature of claimant on this claim form is in consistent with that appearing on the policy application form.</p>				

第一部份 - 索償人聲明(由索償人/被保人填寫)

PART I - CLAIMANT'S STATEMENT (to be completed by Claimant/Insured)

New Claim 首次索償 Further Claim 再度索償 Review/Appeal 重批/覆核

保單號碼 Policy No.		被保人姓名 Name of Insured	英文 in English	中文 in Chinese
身份證號碼 ID Card No.		出生日期 Date of Birth	年 / 月 / 日 YY / MM / DD	年齡 Age
聯絡地址 Mailing address		性別 Sex	<input type="checkbox"/> 男 Male	<input type="checkbox"/> 女 Female
		聯絡電話 Contact Tel. No.		

就業詳情 Employment Details

1. 僱主名稱及地址 Name and Address of employer		聯絡電話 Contact Tel. No.	
如僱主與投保時不同，請說明何時轉工 If the employer is different from the one stated in the application, please state when it was changed		年 / 月 / 日 YY / MM / DD	
現時職業及職務(倘有兼職請列明) Present occupation & job duties (if more than one, state all)			

意外詳情 Accident Details

2. a. 意外發生日期、時間和地點 Date, Time and Place of accident	日期 Date	年 / 月 / 日 YY / MM / DD	時間 Time	<input type="checkbox"/> 上午 a.m.	<input type="checkbox"/> 下午 p.m.	地點 Place
b. 意外發生經過? How did the accident happen? (請附上新聞剪報, 如有) (attach newspaper clippings, if any)						
c. 受傷部位? Which part(s) of body injured?						
d. 受傷程度? What is the extent of the injury?						
e. 是否有報警? Had reported to police?	<input type="checkbox"/> 是, 報案警署名稱 Yes, Police station	檔案編號(請附上副本, 如有) Police reference number (submit photocopy if any)	<input type="checkbox"/> 否 No			

診治詳情 Consultation Details

3. 就此意外求診之醫生資料 Details of consultation for the injury	求診日期(年/月/日) Consultation Date (YY/MM/DD)	原因/病因 Reason/Diagnosis	醫生姓名及地址(請附上病歷咭, 如有) Name and Address of doctor (please attach patient card copy if available)
a. 首次求診的醫生 Doctor first consulted			
b. 建議入院的醫生 Doctor referred to hospital			
c. 過往就同類或有關類似病症曾求診的醫生 Doctors consulted in the past for same or similar or related condition			

住院詳情 Hospitalization Details

4. 就此意外入住的醫院資料 Details of hospital confinement for the injury	入院日期(年/月/日) Date of Admission (YY/MM/DD)	出院日期(年/月/日) Date of Discharge (YY/MM/DD)	原因/病因 Reason/Diagnosis	醫院名稱及地址(請附上病歷咭, 如有) Name and Address of hospital (please attach patient card copy if available)
5. 有否於住院期間離院? Have you taken any home leave during confinement?		<input type="checkbox"/> 是, 時間及原因 Yes, Duration & Reason		<input type="checkbox"/> 否 No

受傷情況 Extent of Injury

6. a. 請詳述現時受傷情況 Please describe the current condition of the injury				
b. 閣下何時開始不能工作? When did you become unable to engage in employment or business?			年 / 月 / 日 YY / MM / DD	
c. 請詳述由受傷至今, 不能工作之時期 Please state period of absence from work since the injury		受傷日期(年/月/日) Date of Injury (YY/MM/DD)	原因/病因 Reason	不能工作之時期 Period absent from work
d. 閣下是否已恢復工作或預料恢復工作? Did you return or expect to return to work?		<input type="checkbox"/> 是 Yes	年 / 月 / 日 YY / MM / DD	<input type="checkbox"/> 否 原因 No Reason

其他資料 Other Information

7. a. 有否向僱主遞交病假證明書? Did you file a sick leave certificate to your employer?		<input type="checkbox"/> 是, 從 Yes, From	年 / 月 / 日 YY / MM / DD	至 to	年 / 月 / 日 YY / MM / DD	<input type="checkbox"/> 否 No
b. 有否就此意外申請勞工賠償? Did you file a claim for Employee's Compensation?		<input type="checkbox"/> 是, 申請日期 Yes, Date of Submission	年 / 月 / 日 YY / MM / DD			<input type="checkbox"/> 否 No
8. 閣下曾否因同一事故申索/接受其他機構包括保險公司、政府及僱主之傷殘保障賠償?(如是, 請提供以下資料) Are you claiming/receiving similar benefit for the same event with any other organizations including insurance company, the government, and employer compensation? (If yes, please provide the following information)						
保險公司/機構 Insurance Company/Organization		保障類別/保單號碼/團體保險編號 Benefit Type / Policy No. / Group Member No.		申索/接受之傷殘保障賠償 Benefits Amount Claimed/Received		結果/狀況 Result/Status

本人謹此明白及同意:

(1) 所有在本申請書的一切陳述及答案, 不論是否本人親手所寫, 就本人所知所信, 均為事實無訛; (2) 香港人壽保險有限公司(以下簡稱「貴公司」) 所收集或持有本人或其他人在本申請書提及之人士的個人資料, 可儲存、使用、透露、發放及轉交予 (不論在本港或海外) 任何與貴公司有關之人士/機構或任何貴公司認為有需要之人等, 以用作處理本申請或其他保險或財務產品/服務之申請, 及提供所有關於該等申請之繼續服務、處理理賠或其有關分析、統計或精算研究用途、直接銷售及資料核對、與本人或貴公司認為有關之機構/人士溝通; (4) 本人有權查閱及要求更正貴公司持有任何由本人提供有關於本人或其他人在本投保書提及及人之個人資料。有關的要求可以書面向貴公司資料保護主任提出。

本人謹此授權:

(1) 任何僱主、醫生、醫院、診所、保險公司、政府部門、其他機構或人士, 凡曾已或將會知悉或持有本人之個人資料 (不論是醫療或其他資料), 均可向貴公司或其代表透露、發放或轉交該等資料, 以作為處理本申請; (2) 貴公司或任何其他其指定之醫護人員或化驗所, 可就本申請, 替本人進行所需之醫療評估及測試以審核本人之健康狀況。即使本人死亡或喪失能力, 此授權書仍具效力, 而本人之繼承人及承讓入亦會受此授權書約束。本授權書之影印本與正本均有同等效力。

I hereby understand and agree that:

(1) All statements and answers in this application whether or not written by my own hand are complete and true to the best of my knowledge and belief; (2) Any personal information relating to me or other persons named herein collected or held by HONG KONG LIFE INSURANCE LIMITED ("the Company") may be stored, used, disclosed, released and transferred (whether within or outside Hong Kong) by the Company to any individuals/organizations associated with the Company or any selected party as the Company may consider necessary for the purpose of processing this application or any other application for insurance or financial related product/service and providing all on-going services related to such application, claim processing or any analysis of it, statistical or actuarial research, direct marketing and data matching, and communication with me or any relevant organization/person as the Company may consider necessary; (4) I have the right to obtain access to and to request correction of any personal information provided by me and held by the Company concerning me or other persons named herein. Such request can be made in writing and addressed to the Data Protection Officer of the Company.

I further hereby authorize:

(1) any employer, doctor, hospital, clinic, insurance company, government office or any organization or person who has or may hereafter have any record, knowledge or information of me (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to this application; (2) the Company or any of its appointed medical/paramedical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of me in relation to this application. This authorization shall bind the successors and assignees of me and remain valid notwithstanding death or incapacity. A photocopy of this authorization shall be valid as the original.

日期 (年/月/日) Date (YY/MM/DD)	索償人/被保人身份證號碼 ID Card No. of Insured Claimant	索償人/被保人姓名 Name of Insured/Claimant	索償人/被保人簽署 Signature of Claimant/Insured
日期 (年/月/日) Date (YY/MM/DD)	代理人/見證人身份證號碼 ID Card No. of Agent/Witness	代理人/見證人姓名 Name of Agent/Witness	代理人/見證人簽署 Signature of Agent/Witness

公司專用 FOR OFFICE USE ONLY	Claim No.	Date Received	Captured By	Signature Verified by	Checked By	Approved By	Remarks

PART II - ATTENDING PHYSICIAN'S STATEMENT (to be completed by attending physician at claimant's expense)

1. Name of Patient		Age / Sex		ID Card No.	
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2. a. Date of first consultation for the patient's injury	YYYY	/	MM	/	DD	Date of accident	YYYY	/	MM	/	DD
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b. Was there evidence of an external and visible bruise or wound at first visit? Yes No

c. Which part of the body injured?

d. Describe the cause, character and the extent of injury

e. As a result of the injury, has the patient been treated for any of the following? If yes, please give details. Yes No

Treatment	Date (YY/MM/DD)	Details of Treatment (type, frequency, result, etc.)
1. Hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Hospital : Date of Admission (YY/MM/DD) : Date of Discharge (YY/MM/DD) :
2. Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. X-rays <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Special diagnostic procedures <input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Suturing <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Physiotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Dressing <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Others		

f. Did the patient consult any other physicians or admit in hospital for the same injury? If yes, please give details. Yes No

Consultation Date/ Period of Confinement (YY/MM/DD)	Diagnosis/Treatment	Name and Address of other physicians/hospitals

