人身意外險索償表格

PERSONAL ACCIDENT INSURANCE CLAIM FORM

保單資料
Insurance Policy Details

保戶名稱
Name of Insured _____ 保單號碼 Policy No. _____

身份證號碼 Identity Card No._____ 性別 Sex____ 出生日期 Date of Birth DD___MM_____YY____ 職業 Occupation_____ 聯絡電話 Contact Tel No. _____

地址
Address_____ 電郵 E-mail _____

索償人 / 被保人 資料 (如非保戶)
Particulars of Claimant / Insured Person (if not the Insured)

索償人 / 被保人 姓名
Name of Claimant / Insured Person_____ 與保戶關係 Relationship with the Insured_____ 聯絡電話 Contact Tel No._____

身份證號碼 Identity Card No._____ 性低 Sex_____ 出生日期 Date of Birth____DD____MM_____YY 職業 Occupation _____

地址
Address_____

索償資料
Particulars of Claim

(1) 意外發生的日期及時間 Date and time of accident.	日 DD 月 MM 年 YY 時間 Time: 上午 am 下午 pm
(2) 意外發生的地點 Place of accident.	
(3) a. 該意外的詳情 Description of accident	
b.如有報警,列明報案的警署及報案編號 If the accident has been reported to the police, please state which police station and police report number.	
(4) 傷勢及其部位 Nature and region of injury.	
(5) 暫時完全喪失工作能力的期間 Period of Temporary Total Disablement from engaging in or attending to usual employment or occupation.	由 From 日 DD 月 MM 年 YY 至 To 日 DD 月 MM 年 YY
(6) a. 意外是否在受僱期間因工作引致 Was this accident occurred in the course of and/or arising out of your employment? b. 如是,列明承保僱員補償險的保險公司的名稱及保單編號 If yes, state the name of insurance company of Employees Compensation Insurance and the respective policy No.	a. 否 No 是 Yes b. _____
(7) a. 被保人是否就是次意外向其他保險公司索償 Is the Insured Person entitled to claim under any other insurance policies in respect of this accident? b. 如是,列明保險公司的名稱,保單編號及索償保障項目 If yes, state the name of insurance company(s), respective policies Nos and details of benefits.	a. 否 No 是 Yes b. _____
(8) a. 被保人以往是否有類似的受傷情況 Has the Insured Person ever sustained similar injury? b.如是,列明詳情及何時發生 If yes, please give detail and date.	a. 否 No 是 Yes b. 否 No 是 Yes

聲明 **DECLARATION**

本人 / 吾等聲明，本人 / 吾等已填報一切必要的資料，絕對正確，並無隱瞞或保留。本人 / 吾等明白本人 / 吾等提供的資料為泰山保險顧問有限公司提供保險業務所需，並可能使用於下列目的：i) 任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期；ii) 任何索償，或該等索償的調查或分析；iii) 行使任何代位權；及可能移轉予任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的。

I / We declare that the Statements and particulars given in this application are true and that I / We have not withheld any material information. The information provided by me / ourselves to Taishan Insurance Brokers Ltd. is collected to enable Taishan Insurance Brokers Ltd. to carry on insurance business and may be used for the purpose of: i) any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or service; ii) any claim or investigation or analysis of such claim; and iii) exercising any right of subrogation; and may be transferred to any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes.

支付經紀佣金 **PAYMENT OF BROKER COMMISSION**

泰山保險顧問有限公司 (「該公司」) 藉向保險公司收取的佣金，作為其所提供服務的酬金。 閣下同意進行是項保險交易，即構成閣下同意該公司收 取佣金。

Taishan Insurance Brokers Limited is remunerated for its services by the receipt of commission paid by insurers. Your agreement to proceed with this insurance transaction shall constitute your consent to the receipt of commission by the Company.

本人 / 投保人亦明白泰山保險顧問有限公司必須取得本人 / 投保人以上的同意，才可以處理本人 / 投保人之保險申請。

I / Proposed insured further understand that the above agreement is necessary for Taishan Insurance Brokers Limited to proceed with the application.

索償人 / 被保人 簽署 Signature of Claimant / Insured Person 日期 Date:	保戶簽署 (如屬公司請蓋章) Signature of Insured (with company chop if applicable) 日期 Date:

文件 REQUIREDDOCUMENTS

1. 病假證明書正本
   Original sick leave certificate(s)
2. 醫療清單副本及收據正本
   Copies of statement of account and original receipt(s)
3. 如有報案,請提供所有警方口供紙副本
   Copies of all police statements, if any
4. 關暫時完全喪失工作能力的索償,需提供意外前 12 個月的入息証明文件副本
   Copy of documentary proof of income over the 12 months preceding to the accident for claim under Temporary Total Disablement from engaging in or attending to usual employment or occupation

This statement should be fully completed and signed by Attending Physician. Any expense for completing this statement must be paid by the Insured.
本表格必須由主診醫生填侑和簽署,所需費用由保戶自行支付。

ATTENDING PHYSICIAN'S STATEMENT
主診醫生証明書

Name of Patient:	Identity Card No.:	Date of birth (DD/MM/YY):	Date of Accident (DD/MM/YY) :

(1) a. What is the exact diagnosis? b. Is there any external and visible evidence of injury at your first consultation? c. State part of body injured d. Describe the cause and extent of injury	a. _____ b. ☐ No ☐ Yes c. _____ d.
(2) Present condition of injury:	
(3) a. Is there any treatment administered? b. If yes, please give details (such as suturing, physiotherapy, type of dressing, etc.)	a. ☐ No ☐ Yes b. Date Time Treatment
(4) a. Did any other physicians treat the patient for the same injury? b. If yes, please give:	a ☐ No ☐ Yes ☐ Unknown b. Name Address Date of Treatment
(5) Did injury require the followings: (If yes, please give details) a. hospitalization b. x-ray? c. special diagnostic procedures? d. surgery?	a. ☐ No ☐ Yes _____ b. ☐ No ☐ Yes _____ c. ☐ No ☐ Yes _____ d. ☐ No ☐ Yes _____
(6) a. Did any permanent disablement expected as a result of his/her injury? b. If yes, please state the proportionate disability in percentage	a. ☐ No ☐ Yes b. _____
(7) Did injury cause Temporary Total Disablement from engaging in or attending to usual employment or occupation?	☐ No ☐ Yes From _____ To _____
(8) Was such injury induced from or effected by any of the following which may contribute to the accident and/or lengthen the period of disability? (If yes, please give details) a. physical defects / congenital anomaly b. unfavourable past medical history c. degenerative d. alcohol or drugs	a. ☐ No ☐ Yes _____ b. ☐ No ☐ Yes _____ c. ☐ No ☐ Yes _____ d. ☐ No ☐ Yes _____
(9) Bearing in mind the Patient's occupation , do you feel that the injuries would have prevented him/her from working? a. at your first consultation. b. at your last consultation.	a. ☐ No ☐ Yes From To _____ b. ☐ No ☐ Yes From _____ To _____
(10) If an absence from work of more than two weeks was necessary, please describe in detail the reasons why you feel the Patient could not return to work earlier.	

I hereby certify that I have personally examined & treated the Patient for the above injury and that the facts as given above present my opinion of his /her condition.

Address : _____

Signature :

Telephone No.:

Name of Physician :
(with stamp)

Date : _____

Qualification : _____