



意外賠償申請書 INDIVIDUAL ACCIDENT CLAIM FORM

PART I 第一部份

In order to help us process your claim promptly, this form must be completed by Insured / Claimant, and please returned to the Company within 20 days from the end of waiting period with original sick leave certificate.

為使此賠償能盡速辦理，此申請表必須由被保險人/申請人填寫，並需於意外日期起二十天內連同有關之病假證明書正本呈交本保險公司。

Insured's Particulars 被保險人資料

Policy No. : 保單編號	Name of Insured : 被保險人姓名	Age/Sex 年歲/性別	I. D. Number 身份證編號
Claimed Benefit(s) (please tick) 索償保障類別(請劃上:"✓" 號) <input type="checkbox"/> 甲種意外保險 <input type="checkbox"/> 附加意外傷害誤工補償保險 <input type="checkbox"/> 甲種意外(加保暴動)保險 <input type="checkbox"/> 綜合意外保險		Case Type 賠償個案類別: <input type="checkbox"/> New Claim 首次索償 <input type="checkbox"/> Further Claim 再度索償 <input type="checkbox"/> Pending Claim 待決賠償 <input type="checkbox"/> Review / Appeal 重審 / 覆核	
Mailing Address : 通訊地址		Contact Phone No. 日間聯絡電話:	

Accident Particulars 意外詳情

1. When and where did the accident occur ? 意外日期、時間及地點	1. At _____ on _____ 於 _____ AM/PM (上午/下午) on _____ YY/MM/DD (年/月/日) Place _____ 地點
2. How did it occur ? Please describe in detail. 意外發生之起因及經過詳情	2.
3. (a) Which part of body was injured ? 受傷的身體部位 (b) Type of injury ? 傷勢類別	3. (a) (b)
4. (a) How long have you been/be away from work after disability ? 受傷後停止工作的日期 (b) Date on which you returned to work ? 何時恢復工作	4. (a) From _____ to _____ 由 _____ YY/MM/DD (年/月/日) to _____ YY/MM/DD (年/月/日) (b) On _____ 在 _____ YY/MM/DD (年/月/日)
5. Date on which you expect to return to work if you have not already done so ? 倘尚未完全康復，閣下預料何時恢復工作	5.
6. Are you making a claim under any insurance policy for the same accident ? If yes, please state : name of the insurance company and policy number 閣下是否因同一次意外向其他保險公司索償 ? 如是，請詳述該保險公司名稱及保單編號	6. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Please specify : 請註明

Employment Particulars 受僱資料

7. Present occupation & exact nature of occupation duties (if more than one, state all) 現時職業及確實職務 (倘有兼職，請列明)	7.
8. Name, address and telephone no. of business or employer 公司或僱主名稱、地址及電話	8.
9. Did you file a medical leave certificate to your employer ? 閣下曾否向僱主遞交病假證明書	9. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
10. Did you submit a claim for workmen's compensation for this accident ? 閣下有否就此意外向勞工處申請僱員補償	10. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否

Treatment Particulars 治療詳情

11. Details of hospitals confined or physicians consulted for the injury (Please attach discharge note)

請列出因此次意外受傷而就診之醫院或醫生詳情 (請呈交出院證明書)

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(s) 就診/住院日期
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Declaration and Authorization 聲明及授權

DECLARATION

I/WE HEREBY DECLARE AND AGREE on behalf of myself/the Insured and all Covered Person(s) and other Persons referred to in this claim form ("Relevant Persons") 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/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 if not written or printed here. (3) Any personal data of the Relevant Persons collected or held by the Company (whether contained herein or otherwise obtained), may be used in connection with matching for whatever purpose (whether or not with a view to taking any adverse action against the Relevant Persons) with such other personal data and/or may be held, used, stored, disclosed, released and transferred (whether within or outside Hong Kong) to such persons as the Company may consider necessary including without limitation any of its affiliated companies, or any other company carrying on insurance or reinsurance related business or any intermediary or claims investigator or other service provider providing services relevant to insurance business or professional advisor or any association or government authority or federation of insurance companies that exists or is formed from time to time or any individual/organization associated with the Company or any selected party as the Company may consider necessary whether local or overseas for the purpose of (i) any insurance or financial related product or service or any addition, alteration, variation, cancellation, renewal or reinstatement of them (ii) any scope of insurance coverage, claim processing and analysis of it (iii) process and deal with this claim and/or underwrite and evaluate any other existing policies and/or application for insurance (iv) provide all services related to this claim and underwrite and evaluate any other existing policies and/or application for insurance and promote, improve and further promotion of services by the Company and its affiliated companies (v) direct marketing and data matching (vi) communicate with the Relevant Persons for any other purpose and/or comply with the laws of any applicable jurisdiction.

If the 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.

I/WE declare and agree that I/we have the full authority from and consent of the Relevant Persons to make the above declarations and agreements.

The Relevant Persons have the right under the Personal Data (Privacy) Ordinance to request access to and correct any of the personal data held by the Company concerning the Relevant Persons. Any request may be made in writing and addressed to the head of the Claims Department of China Life Insurance Co., Ltd. (Macau Branch) at Avenida dr. Rodrigo Rodrigues, No. 338 15 Andar, Edificio do Grupo de Seguros da China Macau. I/we further understand that a reasonable fee may be charged for such request.

聲明

本人/吾等謹此代表本人/被保險人、所有被保險人及其他在此賠償申請表提及之人士("相關人士") 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/吾等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/吾等對任何人所作之任何聲明, 如沒有在此申請書上填寫或印出, 貴公司不須受其約束; (3) 貴公司可以在任何情況下 (不論是可否打算對相關人士採取不利行動) 核對貴公司所收集或持有之任何相關人士的個人資料 (不論是是否此賠償申請表所載或其他途徑所取得) 及/或可以持有、使用、儲存、透露、發放及轉移 (不論在本澳或海外) 任何 貴公司所收集或持有之任何相關人士的個人資料 (不論是是否此賠償申請表所載或其他途徑所取得) 給 貴公司認為有需要之人士, 不受限制地包括 貴公司之任何關聯公司, 進行保險或再保險業務之公司, 中間人, 賠償調查員, 其他提供有關保險業務服務者, 專業顧問, 各團體, 政府機關, 保險業協會 (現有或將來成立), 與 貴公司有聯繫之個人或團體, 或任何 貴公司認為有需要之有關人等 (不論本地或外地) 作以下用途: (i) 有關保險或財務之產品或服務, 或該等產品或服務之增加、更改、轉變、取消、更新或復效; (ii) 任何保障範圍, 賠償申請, 或有關分析; (iii) 審核及處理賠償申請書及/或審核及評估任何其他保單及/或投保申請; (iv) 提供所有關於此賠償申請及/或審核及評估任何其他保單或投保申請之服務及推廣、改善及進一步推廣關於貴公司及其關聯公司所提供之服務; (v) 直接銷售、資料核對; (vi) 用於與相關人士作任何其他目的之溝通及/或遵守任何適用之司法區域之法律。

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。

本人/吾等聲明及同意已獲得相關人士授權及同意本人/吾等作出上述聲明及協議。

所有相關人士有權依據個人資料(私隱)條例要求查閱及更正任何 貴公司持有關於相關人士之個人資料, 他們可以以書面向中國人壽保險股份有限公司(澳門分公司)理賠部主管提出要求(地址:澳門羅理基博士大馬路338號中保集團大廈15樓)。本人/吾等同時明白 貴公司可就有關要求酌量收費。

AUTHORIZATION

I/WE HEREBY AUTHORIZE on behalf of myself/the Insured and all Covered Person(s) (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 or any of the Covered Person(s) and who has attended or may hereafter attend myself/the Insured and any of the Covered Person(s) to disclose, release and transfer such information to China Life Insurance Company Ltd.; (2) China Life Insurance Company Ltd. 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 or any Covered Person(s) 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 photostatic copy of this authorization shall be as valid as the original.

I/WE declare and agree that I/we have the full authority from and consent of the Insured and all Covered Persons to make the above authorizations.

授權

本人/吾等謹此代表本人/被保險人及所有被保險人授權 (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/被保險人或任何一位被保險人之紀錄者, 及/或會診驗或可能將會診驗本人/被保險人及任何一位被保險人者, 均可將該等資料提供、發放及轉交給中國人壽保險股份有限公司(澳門分公司); (2) 中國人壽保險股份有限公司(澳門分公司)或任何其他其指定之醫生或化驗所, 可就此賠償申請書本人/被保險人及任何被保險人進行所需之醫療評估及測試, 作為審核本人/被保險人及任何被保險人之健康狀況。此授權對本人/被保險人之繼承人及授權人有約束力; 即使本人/被保險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。

本人/吾等聲明及同意已獲得被保險人及所有被保險人授權及同意本人/吾等作出上述授權。

Dated at 簽署於	on 在	YY/MM/DD 年/月/日	Signature of Agent/Witness 營業員/見證人簽署	Signature of Insured 被保險人簽署	Signature of Owner/Claimant (if other than insured) 保單要保人/申請人簽署 (如非被保險人)
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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.

備註: 此聲明及授權書必須由被保險人簽署, 若被保險人為小童, 則可由其家長/合法監護人簽署。

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.

如被保險人因傷殘不能書寫, 其家屬或代理人可代為填寫此申請書及簽字。

Please complete if the signature is not given by the Insured. 若簽署者非被保險人, 請填寫此欄

Name (in block letter) 姓名 (正楷書寫)	Relationship with Insured: 與被保險人關係
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Suggested Checklist 建議參考事項

- * Please write down the correct Insured name & policy number. 請填上正確被保險人姓名及保單編號;
- * Please complete all the questions in Part I. 此表格上所有問題都必須作答;
- * Please ensure Part II to be completed by a registered doctor. 請確保填寫表格第二部份之醫生是註冊西醫;
- * Please attach the original sick leave certificate. If need to return, please tick "YES" 請交上病假證明書正本, 如需退還, 請於 "是" 劃上 "✓" 號; YES 是
- * Please attach discharge note, if any. 請交上出院證明書; (如適用者)
- * Please attach the certificate of compensation assessment, if any. 請交上勞工處僱員補償評估證明書; (如適用者)
- * Please attach the employer's confirmation, if any. 請交上僱主病假證明書; (如適用者)
- * Please make sure the signature of the Insured / owner is consistent with that in policy application. 請確保以上之簽名與保單申請書之署模式一致。

For Agent's / Witness's Use only 營業員/見證人專用

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

Documents attached with this claim form 與申請表一起呈遞之文件

- Sick leave certificate from _____ to _____
病假證明書. 由 YY/MM/DD (年/月/日) 至 YY/MM/DD (年/月/日)
- Other(s) 其他: _____

Signature of Agent/Witness
營業員/見證人簽署

Name of Agent/Witness (in block letter)
營業員/見證人姓名 (正楷書寫)

Agent Code & Region (if any)
營業員編號及區域(如適用者)

Date (YY/MM/DD)
日期 (年/月/日)

ATTENDING PHYSICIAN'S STATEMENT 應診醫生報告書

PART II 第二部份

No claims can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expense of the Insured.

本表格必須由被保險人自費聘請合資格之執業註冊西醫填寫。否則，本保險公司將不會接受辦理該索償申請。

Full name of Patient 病人姓名	Age/Sex 年歲/性別	I. D. Number 身份證號碼
1. Date of Accident. 意外發生日期	1. At _____ on _____ 於 AM/PM 上午/下午 YY/MM/DD 年/月/日	
2. Date of first consultation for this injury. 受傷後首次接受就診日期	2. At _____ on _____ 於 AM/PM 上午/下午 YY/MM/DD 年/月/日	
3. Dates of subsequent consultations for this injury. 與此次意外有關之其他全部覆診、治療日期	3.	
4. (a) Cause of accident. 意外發生之原因 (b) State part of body injured. 身體受傷之正確部位 (c) Type and extent of injury. 受傷類別和程度 (e) Is there any evidence of a visible contusion, an accident cut or wound of the exterior of the body at your <u>1st consultation</u> ? If yes, please describe in detail. 閣下於首次會診該病人時，其身體有否外傷及可見之表面傷痕證明	4. (a) (b) (c) (e) <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 please describe 請描述 _____ _____ _____	
5. Present condition of injury. 現時受傷情況	5.	
6. (a) Is there any treatment administered? 有否接受任何治療 (b) If yes, please give details (such as suturing, physiotherapy, type of dressing, etc.) 如是者，請詳述詳情 (如縫針、物理治療、洗傷口包紮類型等)	6. (a) <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 (b) <u>Date</u> 日期 <u>Treatment</u> 治療	
7. (a) Any other physicians who treated Insured for the same injury? 被保險人於是次同一意外受傷裏，有否接受其他醫生治療 (b) If yes, please give 如是，請註明 <u>Name(s)</u> 姓名 <u>Telephone No. & Address(es)</u> 電話及地址 <u>Approximate Date(s)</u> 會診日期	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 <input type="checkbox"/> Unknown 不知道	
8. Is hospitalization required? If yes, please state 是否需要住院治療？如是，請述詳情 (a) which hospital? 哪一間醫院 (b) Date of admission to hospital 入院日期 (c) Date of discharge from hospital 出院日期	8. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 (a) _____ (b) On 在 _____ (YY/MM/DD 年/月/日) (c) On 在 _____ (YY/MM/DD 年/月/日)	

<p>9. Did injury require: (If yes, please give details) 是否需要接受下列各項 (如是, 請註明詳情)</p> <p>(a) X-rays? X光檢查</p> <p>(b) Special Diagnostic procedures? 特別診斷程序</p> <p>(c) Surgery? 手術治療</p> <p>If any of the above is yes, please give details. 如上述任何一項是, 請註明詳情</p>	<p>9.</p> <p>(a) <input type="checkbox"/> Yes 是 _____ <input type="checkbox"/> No 否</p> <p>(b) <input type="checkbox"/> Yes 是 _____ <input type="checkbox"/> No 否</p> <p>(c) <input type="checkbox"/> Yes 是 _____ <input type="checkbox"/> No 否</p>
<p>10. Was such injury induced from or effected by any of the following which may contributed to the accident and/or lengthen the period of disability ? 該次受傷是否由下列一項引致而受其影響並導致發生意外及/或加長傷殘時間 ?</p> <p>(a) Physical defects / congenital anomaly 身體缺陷 / 先天異常</p> <p>(b) Unfavourable past medical history 過往不良健康狀況記錄</p> <p>(c) Degenerative changes 退行性變化</p> <p>(d) By drugs or alcohol 藥物或酒精</p> <p>If any of the above is yes, please give details. 如上述任何一項是, 請註明詳情</p>	<p>10.</p> <p>(a) <input type="checkbox"/> Yes 是 _____ <input type="checkbox"/> No 否</p> <p>(b) <input type="checkbox"/> Yes 是 _____ <input type="checkbox"/> No 否</p> <p>(c) <input type="checkbox"/> Yes 是 _____ <input type="checkbox"/> No 否</p> <p>(d) <input type="checkbox"/> Yes 是 _____ <input type="checkbox"/> No 否</p>
<p>11. (a) Was healing complicated ? 康復過程中, 有否引起其他併發症</p> <p>(b) If so, state why & any special treatment given. 如是者, 註明原因及採用之任何特別治療</p>	<p>11. (a) <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p>
<p>12. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries would have prevented him/her from working ? 根據該病人於表格上填報之職業, 你認為此次意外受傷有否影響及阻礙其職業之日常工作</p>	<p>12. at 1st consultation 於首次會診時 <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 否</p> <p>at last consultation 於末次會診時 <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 否</p> <p>Sick Leave from _____ to _____ 病假假期由 (YY/MM/DD 年/月/日) 至 (YY/MM/DD 年/月/日)</p>
<p>13. If an absence from work of more than two weeks was necessary, please describe in details the reasons why you feel the patient could not return to work earlier. 病人如需暫停工作超過兩星期, 請詳細註明原因, 並解釋為何該病人不能提早恢復工作</p>	<p>13.</p>
<p>14. Additional information which you feel will help the assessment of this claim. (Example, complication or similar condition before) 閣下有否其他額外資料提供, 以便本保險公司處理評估賠償 (如: 併發症或 相似之狀況等)</p>	<p>14.</p>
<p>I hereby certify that having personally examined and treated the above named patient for the above disability and that the facts as given above present my option of his/her condition. 謹此證明本人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被保險人之情況作出的意見。 I declare and agree to make the "Declaration" on Part I of this claim form. 本人聲明及同意此表格內第一部份 "聲明" 之一切內容。</p> <p>Signed : _____ Name of physician (with stamp) : _____ 簽署 醫生姓名 (連蓋章證明)</p> <p>Qualification / Registered No. : _____ Address : _____ 執業資歷 / 註冊編號 地址</p> <p>Date : _____ Telephone No. : _____ 日期 電話</p>	
<p>For identity purpose, the Insured must sign below in the presence of the Physician : 為確保證明, 被保險人必須在應診醫生處簽署證實</p> <p>Date : _____ Signature of Insured. : _____ 日期 被保險人簽署</p>	