5012000101

團體意外賠償申請表
GROUP ACCIDENT CLAIM FORM

CSM-CLA23

第一部份 PART I

受保人資料 Insured's Particulars

保單號碼 Policy No. :	僱主名稱 (保單持有人) Name of Employer (Policyholder)		
僱員/受保人姓名 Name of Employee/Insured :	年齡及性別 Age and Sex	出生日期Date of Birth (年 月 日)	身份證/僱員編號 I.D.Card / Staff no.
索償保障類別(請劃上✓ 號) Claimed Benefit(s) (please tick) ☐ 意外永久傷殘 Accidental permanent disability ☐ 其他 Other		僱員/受保人國藉Nationality of Employee	
現時住址 Current Residential Address :			
永久住址(如與現時住址不同) Permanent Address (if differ to current residential 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 YY/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 YY/MM/DD)

to 至________________ (年/月/日 YY/MM/DD)

復職日期 Resumed duty on ________________________
年/月/日 YY/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YY/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 (YY/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，作爲審核本人/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/受保人死亡或無行爲能力時，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，均爲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塡寫或印出，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.

僱員簽署 Signature of Employee	僱員姓名 Name of Employee	身份證號碼 I.D. Card	日期(年/月/日) Date (YY/MM/DD)

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.hk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.hk or is made available upon request.

僱員簽署 Signature of Employee	日期 (年/月/日) Date (YYYY/MM/DD)

建議索償文件/參考事項 Suggested Checklist

1. ☐ 已由應診醫生填寫賠償申請表第二部份 Claim Form Part II Completed by the Attending Physician
2. ☐ 正本收據，總額 MOP__________________ Original receipts. Total amount MOP_______________
3. ☐ 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 ________)
4. ☐ 出院證明書/西醫轉介信 (如適用) Discharge note/ Referral letter by physician, if any.
5. ☐ X光/電腦掃描/ 磁力共震報告(如適用) X-ray / CT Scan / MRI report , if any.
6. ☐ 勞保判傷報告 (如適用) Employee compensation assessment report, if any.
7. ☐ 警察報告/口供紙 (如適用) Police report/ statement, if any.
8. ☐ 僱主發出之病假證明信(如適用) Employer confirmation letter for sick leave period, if any.
9. ☐ 退回正本文件申請表格Request for Return of Original Documents

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 YY/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 YY/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 YY/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YY/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?
(b) 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 (YY/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 如上述任何一項爲"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 ______________________ ______________________
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爲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爲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 (YY/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 (YY/MM/DD) Signature of Insured