



## 人身意外保險報告書 PERSONAL ACCIDENT INSURANCE CLAIM FORM

請填妥此索償表格上之所有資料。倘若表格不敷應用，請另加紙張填寫。  
Please complete this claim form in full. If space provided for your answers is insufficient, please continue on a separate sheet.

此表格並不代表本公司會承認任何責任  
The issue of this claim form is not an admission of liability on the part of the Company

保單 / 保險證書編號 Policy/Certificate number \_\_\_\_\_ 索償編號 Claim number \_\_\_\_\_

(本欄由保險公司填寫 For office use only)

### I 投保人資料 Insured details

投保人姓名及身份証號碼 Name & I.D. no. of the Insured \_\_\_\_\_

出生日期 / 性別 Date of birth / Sex \_\_\_\_\_ / \_\_\_\_\_ 男M 女F

通訊地址 Correspondence address \_\_\_\_\_

電話號碼 Telephone no. \_\_\_\_\_ 公司 / 住宅 Office / Residence \_\_\_\_\_ / \_\_\_\_\_

職業 Occupation \_\_\_\_\_

僱主稱號，地址及行業 Name, address and business of employer \_\_\_\_\_

### II 賠償資料 Claim Information

1) 請陳述意外發生日期 Please state : Date \_\_\_\_\_ 1) \_\_\_\_\_ a.m. / p.m.  
時間 Time \_\_\_\_\_  
地點 Place of accident \_\_\_\_\_

2) 敘述意外發生情況 Describe exactly how accident happened and what you were doing at the time? 2) \_\_\_\_\_

3) 請述受傷性質 Describe the nature and extent of the injuries you sustained thereby 3) \_\_\_\_\_

4) 目擊意外者之姓名 Name of Witness of accident (if any) 4) \_\_\_\_\_

電話號碼 Telephone no. \_\_\_\_\_

地址 Address \_\_\_\_\_

5) a) 敘明出事後為閣下診治醫生之姓名及地址

Give name and address of the Doctor attending you for these injuries

5) a) \_\_\_\_\_  
\_\_\_\_\_

b) 他是否慣常為閣下診治之醫生？

Is he your usual Medical Attendant?

b) 是  否

Yes No

c) 閣下曾否諮詢其他醫生？

Has any other Doctor been consulted?

c) 是  否

Yes No

d) 是否仍須接受治療？

Any further treatment(s) required?

d) 是  否

Yes No

6) a) 受傷後，有沒有需要停止工作？

Have you ceased work after the accident?

6) a) 是  否

Yes No

b) 若然，何時停止工作？

If yes, when?

b) \_\_\_\_\_

c) 何時恢復工作？

Date on which you returned to work?

c) \_\_\_\_\_

7) 倘尚未完全康復，閣下預料何時恢復工作？

Date on which you expect to return to work if you have not already done so

7) \_\_\_\_\_

8) 如已恢復工作但工作能力未能完全恢復，請列明

If after you return to work you were not immediately able to perform all your duties, indicate

a) 恢復工作之日期

Date of your return to work

8) a) \_\_\_\_\_

b) 未能即時履行之職責

Details of duties you were not immediately able to perform

b) \_\_\_\_\_

c) 估計最遲可以肩負全責

Date on which you were finally able to perform all your duties

c) \_\_\_\_\_

9) 閣下是否還有向其他保險公司索償？

Are you insured with any other insurance company for accident benefits?

9) 是  否

Yes No

若然，請敘述詳情

If so, please give particulars

#### 聲明及授權書

本人/我們聲明此表格內填報的資料，就本人/我們所知所信全部正確無訛，並無任何保留。本人/我們同意如為處理有關本索償事宜，安盛保險有限公司可使用所收集及持有關於我/我們/受保人的個人資料(包括在此索償表格內或其他地方之資料)或將該等資料給予有關之人士或機構(包括在香港境內或境外之再保公司、賠償調查公司、保險業協會/聯會及其他提供保險業有關服務之公司等)。

本人/我們並授權持有任何關於本人/我們/受保人的健康或醫療記錄或資料之人士或機構，向安盛保險有限公司或其代理人，提供與本索償事宜或與保險公司的追償權有關之記錄或資料。即使我/我們/受保人死亡或在法律上失去能力，對我/我們/受保人的繼承人及受託人而言，本授權將繼續生效。本授權書之影印本將與正本具有同等效力。

#### DECLARATION AND AUTHORIZATION

I/We hereby declare that to the best of my/our knowledge and belief the above statement and particulars contained herein are in all respects true and complete and are made without reservation of any kind. I/We agree that any of my/our/the Insured's personal information collected or held by AXA General Insurance Hong Kong Limited (whether contained in this claim form or otherwise obtained) is provided and may be held, used and disclosed by the Company to individuals/organization associated with the Company or any selected third party (within or outside Hong Kong, including reinsurance and claim investigation companies and industry associations/federations and other service provider providing services relevant to insurance business) for the purpose of processing this claim.

I/We further authorize any organization, institute or individual that has any records or knowledge of my/our/the Insured's health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to AXA General Insurance Hong Kong Limited on its authorized representatives such information which is/are relevant to the settling of this claim and/or the Insurer's rights of recovery. This authorization shall bind my/our/the Insured's successors and assigns and remain valid notwithstanding my/our/the Insured's death or incapacity in so far as legally possible. A photostat of this authorization shall be considered as effective and valid as the original.

日期  
Date \_\_\_\_\_

投保人簽署  
Insured's signature \_\_\_\_\_

## Certificate Of Medical Attendant

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.

|  |                             |  |
|--|-----------------------------|--|
| Patient's name   | Identity Card no.           | Age  |
| 1) Date of accident  | 1)                          |  |
| 2) Cause of injury   | 2)                          |  |
| 3) Part of the body injured  | 3)                          |  |
| 4) Nature and extent of the injuries (Describe complications, if any)                      | 4)                          |  |
| 5) Is the condition due to pregnancy?  | 5)                          |  |
| 6) Date on which the patient first consulted you for this condition                        | 6)                          |  |
| 7) State whether there is evidence of a visible bruise or wound at <u>1st consultation</u> | 7)                          |  |
| 8) Treatment given (e.g. suturing, physiotherapy, type of dressing etc.)                   | 8)                          |  |
| Date   | _____                       |  |
| Time   | _____                       |  |
| Treatment  | _____                       |  |
| 9) Did injury require (If yes, please give details)  | 9)                          |  |
| a) Hospitalization?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> Date admitted _____ |
| b) X-rays?   | <input type="checkbox"/>    | <input type="checkbox"/> Date discharged _____   |
| c) Special diagnostic procedures?  | <input type="checkbox"/>    | <input type="checkbox"/> _____                   |
| d) Surgery?  | <input type="checkbox"/>    | <input type="checkbox"/> _____                   |

|   |   |
|---|---|
| <p>10) Bearing in mind the patients's occupation as stated overleaf, do you feel that the injuries would have prevented him/her from performing his/her duties?<br/>If yes, please give details</p> | <p>10)<br/>No <input type="checkbox"/> Yes <input type="checkbox"/> a) Total and absolutely disabled (unable to work)<br/>from _____ to _____<br/>b) Partially disabled<br/>from _____ to _____</p> |
| <p>11) Give details of any circumstances, such as physical impairments, medical history or intoxication which may have contributed to the accident and/or lengthen the period of disability</p>     | <p>11)<br/>_____</p>  |
| <p>12) Names and addresses of other doctors who have treated Insured for the same injury</p> <p>Name _____</p> <p>Address _____</p><br><br><br><br><br><br><br><br><br><br><p>Date _____</p>        | <p>12)<br/>_____<br/>_____<br/>_____<br/>_____<br/>_____<br/>_____<br/>_____</p>  |

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

|                     |                         |
|---------------------|-------------------------|
| Signed _____        | Name of Physician _____ |
| Date _____          | Address _____           |
| Tel. no. _____      | _____                   |
| Qualification _____ | _____                   |
| _____               | _____                   |

For identity purpose, the Claimant must sign below in the presence of the Physician

|            |                |
|------------|----------------|
| Date _____ | Claimant _____ |
|------------|----------------|