Manulife
INDIVIDUAL INSURANCE
宏利個人保險

CLAIM FORM FOR ACCIDENT
索償表格（意外）

Advisor's Name 保險顧問姓名	Advisor Code 保險顧問編號

1. a) Policy No(s) 保單編號： b) Benefits to claim 保障計劃： AI ☐ AB ☐ (Please select as appropriate 請選擇適當項目)	2. a) Name 姓名： b) Age 年齡： c) I.D. Card No. 身分證號碼：
3. Residential Address 住宅地址	4. a) Business Tel. No. 辦公電話號碼 b) Residential Tel. No. 住宅電話號碼
5. Present Occupation (state all) 現時職業（請列出所有從事的職業）	6. Exact Nature of Occupational Duties 實際工作性質
7. Name and Address of Business or Employer 僱主姓名／公司名稱及地址	8. Your Average Monthly Income 每月平均收入
9. Date and Time of Accident 意外發生日期及時間	10. Did you file a medical leave certificate to your employer? 有否向僱主呈交病假證明？
11. Nature of Accident 意外性質 a) Where did it take place 意外發生地點 b) How did it happen 意外發生經過	12. Describe the injuries in details 詳述受傷情況 a) Part(s) of body injured 身體受傷部位 b) Type(s) of injury (e.g. fracture, cut, bruise etc.) 受傷類型（例如骨折、割傷、挫傷等）
13. Date on which you last worked prior to disability 傷殘前工作日期	14. Date you have returned to work or expect to return to work 重返工作或預計可重返工作之日期

15. Details of Hospitals confined or Physicians consulted for the injury (Please attach discharge note)
受傷後留院治療或由醫生診治詳請（請附交出院通知）

Name of Physician(s) and/or Hospital(s) 醫生姓名及／或醫院名稱	Address(es) 地址	Date of Consultation(s) and/or Period of Confinement(s) 診治及／或留院日期

I hereby declare that the answers in the above statement are full and true to the best of my knowledge and I make application for the benefits available under the policy as a result of this accident. I authorize any physician, hospital, insurance company or organization that has any records or knowledge of me or my health to give to Manulife (International) Limited any such information. A photostatic copy of this authorization shall be as valid as the original.
本人聲明本表格內之資料已是本人所知之全部並為真實無訛。本人因是次意外而申請索取保單內列明之賠償。本人現授權任何醫生、醫院、保險公司或其他持有本人個人資料或健康狀況記錄之組織提供有關資料與宏利人壽保險（國際）有限公司。此授權書之複製本將與正本同樣有效。

Date (DD/MM/YYYY) 日期（日／月／年）

X
Signature of Claimant (if Aged 18 or Above) * 索償人簽署（如十八歲或以上）*

* For claimant aged below 18, signature of the policyowner should be provided for the claim. 十八歲以下索償人之索償申請必須由保單持有人簽署。

X
Signature of Policyowner 保單持有人簽署

Note: All personal data collected under this form is collected for the purpose of processing the claim under the relevant insurance policy. It is compulsory for the claimant(s) to complete the form to claim for the relevant benefit(s) available under the policy. Appropriate correction and access to the personal data under this form is allowed with the approval of Manulife (International) Limited. Request may be made by writing to the Home Office (at the Customer Relations Department, Manulife (International) Limited, 31/F., Manulife Tower, 169 Electric Road, North Point, Hong Kong). The personal data of this form may be transferred to any related companies or any service providers for adjudicating the claim and may be transferred to any insurance regulatory bodies to enable them to carry out their regulatory functions. 註：本表格所收集之任何個人資料乃用以處理有關保單之賠償申請，索償人必須完成本表格以索取保單所列明之賠償。索償人於宏利人壽保險（國際）有限公司同意下可提出修改及取得本表格之個人資料，有關要求可向宏利之客戶服務部提出（地址：香港北角電氣道169號宏利保險中心31樓宏利人壽保險（國際）有限公司）。本表格之個人資料可轉移予任何相關公司、其他服務供應商作處理賠償申請用途、並供保險業監管機構執行監管職權。

I believe that the answers given above are true to the best of my knowledge.
本人確信本表格內之資料為真實無訛。

Date (DD/MM/YYYY) 日期（日／月／年）

X
Signature of Insurance Advisor/Witness 保險顧問/見證人簽署

The Chinese version of this claim form is for reference only. In the event of conflicts between the Chinese and English versions, the English version shall prevail. 此索償表格之中文譯本只供參考之用，若與英文有異，一概以英文為準。

Manulife (International) Limited 宏利人壽保險（國際）有限公司 *Incorporated in Bermuda 百慕達註冊成立*
C12 (02/2004)

ATTENDING PHYSICIAN'S STATEMENT
應診醫生報告

This form must be completed by a qualified and registered physician at the insured's expense.
本表格必須由受保人自費聘請之合資格註冊醫生填寫。

1. Name of Patient (the insured) 病人（受保人）姓名	2. Age 年齡	3. I.D. Card No. 身分證號碼	4. Date of Accident 意外發生日期

5. a) Had the patient any external and visible evidence of injury at your first consultation. (e.g. bruise and swelling etc.)
病人於第一次會診時有否外傷及可見之受傷證明。（例如各類挫傷及瘀腫等情況）
☐ Yes 有 ☐ No 否

b) If yes, state the type of injury 若「有」，請註明受傷類型

c) Describe the cause and extent of injury 請註明受傷原因及受傷程度

6. Present condition of injury 現時受傷情況

7. Did injury require: (if yes, give details) 是否因受傷而需要接受下列各項治療或檢查？（若「是」，請註明詳情）

a) Hospitalization? 留院治療 ☐ No 否 ☐ Yes 是 Date admitted 入院日期 ______

b) X-rays? X光檢查 ☐ No 否 ☐ Yes 是 Date discharged 出院日期 ______

c) Surgery? 進行手術 ☐ No 否 ☐ Yes 是 Details 詳情 ______

d) Medical Treatment? 醫學治療 ☐ No 否 ☐ Yes 是 ______
(e.g. stitches, physiotherapy, type of dressing etc. 例如縫針、物理治療、包紮類型等)

e) Others? 其他 Please specify 請註明： ______

8. 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?
該受傷是否由下列任何一項引致或受其影響而導致發生意外及／或加長傷殘時間？

a) Physical defects/congenital anomaly 身體缺陷／先天異常 ☐ No 否 ☐ Yes 是

b) Unfavourable past medical history 過往不良健康狀況記錄 ☐ No 否 ☐ Yes 是

c) By drugs or alcohol 藥物或酒精 ☐ No 否 ☐ Yes 是

If any of the above is yes, give details. 如上述任何一項為「是」，請註明詳情。 ______

9. Was healing complicated? 康復過程是否複雜？ ☐ No 否 ☐ Yes 是
If yes, state the reason(s) and any special treatment(s) given.
如「是」，請註明原因及曾採用之任何特別治療。

10. Name(s) and address(es) of other physician(s) who have treated the patient for the same injury.
其他曾就是次受傷為病人診治之醫生姓名及地址。

11. Do you feel that the injury would have prevented the patient from working? (Patient's occupation is stated overleaf)
你認為是次受傷會否令病人不能工作？（病人的職業見背頁）

a) at your first consultation 第一次會診時？ ☐ No 否 ☐ Yes 是

b) at your recent consultation 最近一次會診時？ ☐ No 否 ☐ Yes 是

12. 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.
如病人需暫停工作超過兩星期，請詳細註明原因，解釋為何病人不能提早恢復工作。

13. I hereby certify that I have personally examined and treated the patient (the insured) for the above injury and that the facts as given above present my opinion of his/her condition. 謹此證明本人已親自為病人（受保人）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病人（受保人）之情況作出的意見。

Signature 簽署 X ______ Name of Physician (with stamp) 醫生姓名（連印章） ______

Date 日期 ______ Address 地址 ______

Qualification 資格 ______ Tel. No. 電話號碼 ______