

# CLAIM FORM

## 賠償表格

東京海上火災保險(香港)有限公司

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TOKIO MARINE

MILLEA GROUP

## GROUP HEALTH AND ACCIDENT INSURANCE

### 僱員醫療及意外保險

TO BE COMPLETED BY THE EMPLOYEE / PATIENT

由僱員/ 病人填寫

Date 日期:

|                        |                  |
|------------------------|------------------|
| Name of Insured 投保人名稱: | Policy No. 保單編號: |
|------------------------|------------------|

|                        |                  |
|------------------------|------------------|
| Name of Employee 僱員姓名: | Staff No. 僱員編號:  |
| Name of Patient 病人姓名:  | Relationship 關係: |

#### Details of Sickness / Accident 疾病 / 意外受傷情況

|  |
|--|
| Nature of Sickness / Accident in detail 詳述疾病 / 意外受傷經過: |
|--|

|   |
|---|
| Date of Sickness / Accident first appeared 疾病 / 意外受傷首次發生日期: |
|---|

|                         |                                   |
|-------------------------|-----------------------------------|
| Place of Accident 意外地點: | Which part of body injured? 受傷部位: |
|-------------------------|-----------------------------------|

|   |  |
|---|--|
| Have you had any prior treatment for this Sickness / Accident?<br>閣下是否曾經同一病況 / 意外受傷而接受治療? | <input type="checkbox"/> No. 沒有                |
|   | <input type="checkbox"/> Yes, Date 有, 日期 _____ |

#### Witness of Accident 意外証人

|          |               |             |
|----------|---------------|-------------|
| Name 姓名: | Telephone 電話: | Address 地址: |
|----------|---------------|-------------|

|                                     |                                    |
|-------------------------------------|------------------------------------|
| <hr/> SIGNATURE OF INSURED<br>投保人簽署 | <hr/> SIGNATURE OF PATIENT<br>病人簽署 |
|-------------------------------------|------------------------------------|

## AUTHORIZATION

### 同意書

HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED OR EXAMINED ME, TO FURNISH TO THE COMPANY, OR TO AUTHORIZED REPRESENTATIVE, ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION PRESCRIPTIONS OR TREATMENT, AND COPIES OF ALL HOSPITAL OR MEDICAL RECORDS. A PHOTO STATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

\_\_\_\_\_  
SIGNATURE OF INSURED  
投保人簽署

\_\_\_\_\_  
SIGNATURE OF PATIENT  
病人簽署

## ATTENDING PHYSICIAN'S REPORT

Name of Patient

Date of Sickness/Accident

Nature of Sickness/Accident

Is Condition due to Pregnancy?     Yes     No

Is Condition due to Congenital?     Yes     No

Is Condition due to Hereditary?     Yes     No

Is Condition due to Myopia?     Yes     No

When did Patients symptoms first appear?

Date of Contraction as per your estimation

Nature of Medical or Surgical Treatment Required

### Itemize Amount paid to Doctor

Consultation

Medicine

Surgical Operation

X-Ray Examinations

Laboratory Tests

Professional Nursing

Surgical Dressings

Anaesthetics

Operating Room Charge

Extraction

Fillings

Root Canal Treatment

Periodontal Treatment

The others

**TOTAL**

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF ATTENDING PHYSICIAN