

# Accident Claim Form 意外理賠申請書



Policy Number 保單號碼	000090001234	Name of Policyowner 保單持有人姓名	陳大文
Email Address of Policyowner 保單持有人之電郵地址 <small>*For claim status follow up and communication use 用作跟進理賠進度及聯絡</small>	chan@test.com	Name of Life Assured 受保人姓名	陳大文
Name of Financial Consultant 理財顧問姓名	王小文	Financial Consultant Contact No. 理財顧問聯絡電話號碼	6123 4567
Financial Consultant Code 理財顧問編號	00001	Division Code & Branch Office 分區編號及分行地點	D001

### Important Note 重要提示：

1. Please complete in BLOCK LETTERS. 請以正楷填寫。
2. Please submit claim application within **90 days** from date of accident. 理賠申請需於意外發生後**90天**內遞交。
3. Please do not sign on blank or incomplete form. 請勿在空白表格或尚未填妥的表格上簽署。
4. Any changes or amendments in this form must be countersigned by the Claimant in full signature. 索償人必須在此表格內任何更改或修改的地方簽署作實。
5. Prudential shall have the right to reject this form if you fail to fulfill Prudential's requirement. 若閣下未能符合保誠的有關規定，保誠有權拒絕此表格。
6. Receipt of this form by your Financial Consultants or your Broker does not constitute receipt by Prudential. 閣下的理財顧問或經紀收到此表格並不代表保誠亦已收到。
7. **If necessary, please complete and submit the "Request for Certified True Copy of Medical Receipt(s)" form to request for return of the certified true copy ("CTC") of the medical receipt(s) which are submitted together with this form. 如需要退回隨附之醫療費用收據之核實副本，請填妥及交回「醫療費用收據核實副本申請書」。**

### Part I – Claimant's Certificate (to be completed by Life Assured / Policyowner / Claimant) 第一部分 — 索償人報告 (由受保人/保單持有人/索償人填寫)

A. Claim Details 理賠資料			
Benefit(s) to claims 理賠類別	<input checked="" type="checkbox"/> Medical Expenses Benefit 醫療費用保障 <input type="checkbox"/> Temporary Disablement Benefit 暫時性傷殘保障 <input type="checkbox"/> Dismemberment Benefit 斷肢保障 <input type="checkbox"/> Total Permanent Disability Benefit 完全永久傷殘保障 <input type="checkbox"/> Double indemnity Benefit 雙倍賠償	Type of Claims 理賠種類	<input checked="" type="checkbox"/> New Claim 首次理賠 <input type="checkbox"/> Further Claim 再度理賠 <input type="checkbox"/> Pending Claim 待決理賠
Did / Will you apply for compensation from other insurer(s) / Social Welfare Department / Labour Department or other organization(s) for the same event? 閣下有否就此事曾/將會向其他保險公司/社會福利署/勞工處或其他機構申請理賠? <input checked="" type="checkbox"/> No 沒有 <input type="checkbox"/> Yes, please provide below information 有，請提供下列所需的資料			
Insurance Company / Organization 保險公司 / 機構	Policy Number 保單號碼	Benefit(s) to claim 理賠類別	Result / Status 結果 / 狀況



B. Life Assured Details 受保人資料			
Identity Document Number 身份證明文件號碼	Z 1234XXX		
Residential Address 居住地址	香港 快樂花園 第一座 十一樓A室		
Name of Employer 僱主(公司)名稱	ABC物流有限公司		
Address of Employer 僱主(公司)地址	香港 正街100號		
Present Occupation 現職	司機	Present Job Duties 職責	駕駛
Please provide the Last Occupation Change Date 請提供最後轉職日期	<input checked="" type="checkbox"/> No 沒有 <input type="checkbox"/> Yes, change occupation since _____ / _____ / _____ 已轉職 Day日      Month月      Year年		
Did you report sick leave to your present employer? (For self-employed or owner, please state the period the insured is unable to work due to the injury) 有否向現僱主申請病假? (如閣下是自僱人士, 請填寫是次受傷令閣下不能工作的期間)	<input type="checkbox"/> No 沒有 <input checked="" type="checkbox"/> Yes, please provide information on the right 有, 請提供右方所需資料	Sick leave from 病假自	_____ / _____ / _____ To _____ / _____ / _____ Day日      Month月      Year年      Day日      Month月      Year年
		(Expected) Date returned (returning) to work (預計)復職日期	_____ / _____ / _____ Day日      Month月      Year年

C. Accident Details 意外詳情			
Date of Accident 意外發生之日期	03 / 01 / 2019 Day日      Month月      Year年	Time of Accident 意外發生之時間	<input checked="" type="checkbox"/> AM 上午 / 08 : 00 <input type="checkbox"/> PM 下午      Time 時間
Location of Accident 意外發生之地點	家中		
Details of Accident (Please describe activities engaged if applicable) 意外詳情(如適用, 請形容當時進行之活動)	在家中煮食切菜時切傷右手手指		
Describe part(s) of body injured and extent of injury 請說明受傷部位及傷勢	右手手指		
Did you report to the police? 您有否報警?	<input checked="" type="checkbox"/> No 沒有 <input type="checkbox"/> Yes, please provide information on the right 有, 請提供右方所需資料	Police Station 警署地點	
		Case Ref. Number 檔案編號	
Remarks: Please attach a photocopy of the Police Report / Traffic Accident Report / Police Statement / Alcohol Test Report. 註: 請附上警察報告/交通意外報告/口供紙/酒精測試報告影印本。			

D. Consultation Details 診治詳情		
Please list out all physicians or hospitals confined for the accident. 請列出所有因是次意外而就診之醫生或醫院資料。		
Consultation Date (Day/Month/Year) 就診日期(日/月/年)	Name of Physician / Hospital 醫生/醫院名稱	Contact Phone No. 聯絡電話
03/01/2019	聖德肋撒醫院	2200 3434
Remarks: Please attach a copy of referral letter by your registered Physician for the claims of Chiropractor/Physiotherapy/Occupational therapy, Diagnostic X-ray, Laboratory Tests, Home Nursing Service and written recommendation by your registered Physician/ Physiotherapist /Occupational therapist for purchasing/renting or medical appliances. 註: 如申請脊醫治療/物理治療/職業治療、X光診斷檢查、化驗、家中護理服務之理賠, 請附上主診醫生的轉介信副本; 如申請購買/租用醫療器具費用之理賠, 請附上主診醫生/物理治療師/職業治療師的書面建議副本。		



E. Settlement Option 理賠支付方式															
By Direct Credit 直接轉賬存款 (Only applicable to Temporary Disablement Benefit and Medical Expenses Benefit claims 只適用於暫時性傷殘保障及醫療費用保障之理賠) (If claim payment is HKD100,000 or above, please choose settlement option by cheque 如理賠金額多於十萬港元或以上，請使用支票理賠方式)	<input checked="" type="checkbox"/> to Premium Deposit Account of the policies being claimed 至理賠保單的保費儲蓄戶口 (Only applicable to inforce policy with premium payment 只適用於生效並需繳付保費之保單)														
	<input type="checkbox"/> to last claim payout account 至上一次理賠的轉賬戶口														
	<input type="checkbox"/> to a HKD bank account opened in Hong Kong held by the Policyowner (Applicable to claim payment below HKD 100,000) 至保單持有人於香港開立的港元戶口(適用於理賠金額十萬港元以下) (Please provide account proof (i.e. copy of bank statement or bankbook bearing the name of account holder and account number) 請提供賬戶證明(即是印有賬戶持有人姓名及銀行賬號之銀行月結單或銀行存摺副本)														
Bank No. 銀行編號			Branch No 分行編號			Account No v 銀行賬戶號碼									
0	0	2	1	2	3	1	2	3	4	5	6	7	8	9	0
By Cheque 支票 2 working days once claim approved 理賠申請成功批核後兩個工作天	<input type="checkbox"/> Deliver through Financial Consultant 由理財顧問轉遞														
	<input type="checkbox"/> By Ordinary Mail to the Policyowner's correspondence address in the Company's record 以平郵方式郵寄至保單持有人於本公司記錄上的通訊地址														
Remark 註： 1. Please select only one of the settlement options for each claim submission. If unspecified or without clear instruction, claims cheque in HKD will be delivered via Financial Consultant. 請就每宗理賠申請選擇一種理賠支付方式。如未有註明或清晰指示，理賠之港元支票將交由理財顧問轉遞。 2. Policy currency will be paid for direct credit to Premium Deposit Account. All other settlements will be made in HKD and the HKD equivalent is based on the currency exchange rate determined by Prudential on the basis of the Company's internal exchange rate. 經直接轉賬至保費儲蓄戶口的理賠金額將以保單貨幣支付。所有其他理賠方法則將以港元支付，而其港元等值將會以保誠公司內部釐定之匯率折算。 3. For direct credit to bank account, the <u>maximum claims payment limit is HKD100,000</u> . Cheque will be issued for claims payment exceeding HK\$100,000. 經直接轉賬存款至銀行戶口的理賠金額上限為十萬港元。如理賠金額超過十萬港元，則以支票形式支付。 4. Claims payout will be made by cheque and delivered via Financial Consultant in case of failure to direct credit to designated bank account or to Premium Deposit Account. 如理賠金額未能成功轉至指定之銀行戶口或保費儲蓄戶口，相關理賠金額將以支票形式支付及交由理財顧問轉遞。 5. If the bank account provided in this form for claim settlement is non-HKD bank account (e.g. USD account of integrated bank account), the insurance benefit in Hong Kong dollar will be paid to your designated bank account which may then be converted by your bank from Hong Kong dollar to the currency of your bank account based on the exchange rate as determined by the bank. Prudential takes no responsibility for the exchange rate imposed by your bank. 如在本表格指定作理賠金額直接轉賬存款之戶口為非港元戶口(如綜合戶口內的美金戶口)，以港元支付之保險理賠金額將入賬於閣下指定之戶口，貴銀行可能隨即根據其釐定之匯率折算為戶口之貨幣。保誠不會就貴銀行釐定的匯率折算負上任何責任。 6. Prudential reserves the right for final decision of the claims settlement option. 保誠對理賠支付方式擁有最終的決定權。															



F. Documents Submission Checklist 所需文件檢核表 (Original documents will NOT be returned 正本恕不退還)				
Document Type 文件類別	Medical Expenses Benefit 醫療費用保障	Temporary Disablement Benefit 暫時性傷殘保障	Dismemberment Benefit 斷肢保障	Total Permanent Disability Benefit 完全永久傷殘保障
Claim Form Part I and Part II 理賠申請書第一及第二部分	◆	◆	◆	◆
Claim Form Part III 理賠申請書第三部分	#	◆ For non-self-employed life assured claiming temporary disability benefit over 10 days 如非自僱受保人並需 索償超過10日暫時性 傷殘保障賠償	#	#
Copy of Identification Document of Life Assured & Policyowner 受保人及保單持有人之身份證明文件副本	◆	◆	◆	◆
Copy of Laboratory / X-Ray/ CT scan / MRI / Pathological Report(s), if applicable 化驗 / X-光/ 電腦掃描/磁力共振/病理檢驗報告 副本，如適用	◆	◆	◆	◆
Copy of Admission Note, Discharge Summary, Discharge Certificate, Daily Medical Record & Temperature Sheet of hospital in Mainland China 中國內地醫院之病案首頁、入院紀錄、出院 總結、每日醫囑單及體溫表副本	◆	◆	◆	◆
Copy of Sick Leave Certificate with clear diagnosis 列明診斷證明之病假證明書副本	◆	◆	◆	◆
Copy of Discharge Summary / Discharge Slip 出院總結/出院紙副本	◆	◆	#	#
<b>Original</b> Medical Receipt(s) and Statement(s) of Charges 醫療收據及收費單（費用明細表） <b>正本</b>	◆	#	#	#
Copy of Chiropractic / Physiotherapy / Occupational Therapy Report(s), if applicable 脊醫治療/物理治療/職業治療報告副本，如適用	#	#	#	#
Copy of Referral letter Registered Doctor / Hospital, applicable to Chiropractic, Physiotherapy, occupational therapy and home nursing service 註冊醫生/醫院轉介信副本，適用於脊醫治療、 物理治療、職業治療或家中護理服務	◆	#	○	○
Copy of written recommendation by Registered Doctor / Physiotherapist / Occupational Therapist, applicable to charges in purchasing/renting of medical appliances 註冊醫生/物理治療師/職業治療師之書面建議 副本，適用於購買或租用醫療器具費用	#	○	○	○
Others, if applicable (for example: copy of Settlement Advice from another insurance provider, Copy of Labor Assessment Certificate, copy of police report, copy of police statement, copy of income proof) 其他，如適用（如其他保險機構之理賠通知書 副本；勞工判傷紙副本；警察報告副本； 口供紙副本，入息證明副本）	#	#	#	#
Copy of account proof 賬戶證明副本	◆ For direct credit to Hong Kong HKD a/c only 如選擇直接轉賬至 香港港元戶口	◆ For direct credit to Hong Kong HKD a/c only 如選擇直接轉賬至 香港港元戶口	○	○

◆ Required Documents 基本文件 # Additional Documents 附加文件 ○ Not applicable 不適用



## G. Personal Information Collection Statement 收集個人資料聲明

### Personal Information Collection Statement ("PICS")

Prudential Hong Kong Limited (referred to as "Company", "our", "we", or "us") take the privacy and protection of your personal information seriously. We collect personal information from you that is necessary for us to either provide you with the product or service you have requested or to comply with statutory or contractual requirements. We may collect personal information including, but not limited to, full name, address, contact details, contact details history, date of birth, gender, nationality, family members, beneficiaries, identity card copy and details, travel document information, health/medical records, credit information, product history, claims history, financial and medical information ("Personal Information") to provide you with the insurance or financial products or services. We may also collect Personal Information about you from third parties such as other insurance companies, agents, credit reference/reporting agencies, vendors, financial institutions, fraud prevention agencies, government agencies, medical personnel, courts or public record.

#### 1. Purpose of Collection

We may use your Personal Information for the following purposes: (a) to process your application; (b) to administer and process insurance policies, insurance claims and medical, security and underwriting checks; (c) to process payment instructions; (d) to verify your eligibility for insurance, financial or wealth management products and services; (e) to design and provide you with insurance, financial and related products and services; (f) to communicate with you; (g) to comply with any regulatory or other legal requirements or other internal business requirements (whether imposed on us or any third parties in section 2 below); (h) to investigate and settle claims and detect and prevent fraud (whether or not relating to the policy issued in respect of this application); (i) to carry out checks using agencies including credit reference agencies, tracing companies or publicly available information; (j) to provide customer services; (k) to perform automated decision-making or profiling; (l) to perform a policy review or needs analysis; (m) to conduct research and statistical analysis (including use of new technologies); and (n) any other purpose directly relating to any of the above purposes. With your consent, we may also use your personal data to send you marketing communications, as described below.

Some of the purposes above are necessary to allow us to perform our contractual obligations to you and to enable us to comply with applicable laws and regulation. We may also use and share your Personal Information for the purposes described above to improve our products and services. Your Personal Information will be stored either for as long as you (or your joint policyholder) are our customer, or longer if required by law or as is otherwise necessary.

#### 2. Classes of Transferees

We may disclose your Personal Information to the group of companies including the Company and those of other entities whose ultimate parent company is Prudential plc ("companies within the Prudential Group") and to our financial/health business partners. We may also disclose your Personal Information to third parties (within or outside Hong Kong) for the purposes outlined at Section 1 above, including but without limitation, to the following third parties: (a) insurance agents; (b) insurance brokers; (c) re-insurance companies; (d) claims investigation companies; (e) organisations that consolidate claims and underwriting information for the insurance industry, fraud prevention organisations, other insurance companies (whether directly or through fraud prevention organisations or other persons named in this paragraph) and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information; (f) third party service providers who provide administrative, telecommunications, computer, payment, printing, redemption or other services to us to enable us to operate our business (including without limitation insurers, lawyers, bankers, accountants, professional advisors, financial institutions and trustees); (g) industry associations and federations; (h) medical bill review companies; (i) your joint policy or investment holder; (j) researchers; (k) credit reference agencies; (l) debt collection agencies; (m) partnering financial institutions and partnerships; and (n) regulators and government agencies, law enforcement agencies and the courts. We may also disclose your Personal Information in connection with a transaction with another company which affects the control, governance, structure and/or management of all or a substantial part of our business, or if required to satisfy applicable legal or regulatory requirements. With your consent, we may also disclose your personal data to third parties to allow them to send you marketing communications, as described below.

#### 3. Consequence of failing to provide Personal Information

Unless otherwise specified by us, it is mandatory for you to provide the Personal Information requested by us. If you do not provide such Personal Information, we may not be able to provide you the product or service that you've requested.

#### 4. Access and Correction Rights

Under the Personal Data (Privacy) Ordinance (the "Ordinance"), you have the right to request access to and correction of any Personal Information that you provide to us. If you want to exercise your rights, or if you require any other information, you can advise our Data Protection Officer at [service@prudential.com.hk](mailto:service@prudential.com.hk) or using the details on "Contact Us" section of the Company website or our Privacy Notice.

If you move/moved to a European Union ("EU") jurisdiction, we may be required to provide you with further information, and you may have additional rights, under the EU General Data Protection Regulation. This information and these rights are set out in the Privacy Notice on our Company website.

We update our Privacy Notice from time to time. We encourage you to familiarise yourself with the Privacy Notice on our Company website. By completing and progressing with this form, you confirm that you have read and understood this PICS. The Privacy Notice is available on our Company website at <https://www.prudential.com.hk/scws/pages/en/privacy-policy/index.html>.

### 收集個人資料聲明 (「收集個人資料聲明」)

保誠保險有限公司 (簡稱「本公司」或「我們」) 認真對待閣下個人資料的私隱及保護。為使我們可以向閣下提供閣下要求的產品或服務, 或為遵守法定及合約要求, 我們會向閣下收集必要的個人資料。為向閣下提供保險或金融產品或服務, 我們可能會向閣下收集個人資料, 包括但不限於全名、地址、聯絡資料、出生日期、性別、國籍、家庭成員、受益人、身分證副本及資料、旅遊證件資料、健康/醫療紀錄、信貸資料、過往產品紀錄、過往索償紀錄、財務及醫療資料 (「個人資料」)。我們亦可能會從第三方, 如其他保險公司、代理、信貸資料服務/報告機構、供應商、金融機構、防欺詐機構、政府機構、醫務人員、法院或公開紀錄, 收集關於閣下的個人資料。

#### 1. 收集資料之目的

我們可能會使用閣下的個人資料作下列目的: (a) 處理閣下的申請; (b) 管理和處理保單、保險索償、醫療、抵押和承保檢查; (c) 處理付款指示; (d) 核實閣下申請保險、金融或財富管理產品及服務的資格; (e) 設計及為閣下提供保險、金融及相關的產品和服務; (f) 與閣下進行通訊; (g) 遵守任何監管或其他法律規定或其他內部業務規定 (不論是向我們或下述第 2 部分所列的任何第三方實施); (h) 就索償進行調查及和解, 以及偵查及防止欺詐 (不論是否有關就本申請發給的保單); (i) 使用代理機構 (包括信貸資料服務機構)、追蹤公司或公開可得資料以執行核實; (j) 提供客戶服務; (k) 執行自動決策或資料剖析; (l) 進行保單審查或需求分析; (m) 進行研究和統計分析 (包括使用新科技); 及 (n) 與上述任何目的直接相關的任何其他目的。經閣下同意, 我們亦可能會按照以下說明使用閣下的個人資料以向閣下發出促銷通訊。

為履行對閣下的合約責任及至使我們能夠遵守適用法律及法規, 上述部分目的屬必要的。我們亦可能會為上述所列的目的使用及分享閣下的個人資料以改善我們的產品及服務。只要閣下 (或閣下的聯名保單持有人) 仍為我們的客戶, 我們將一直保存閣下的個人資料, 或如法律有所規定或因其他原因而為必要, 我們則將其保存更長時間。

#### 2. 被資料轉交者的類別

我們可能會向該公司集團, 包括本公司以及其他母公司為英國保誠集團的實體 (「保誠集團內的公司」), 及我們的金融/健康業務夥伴, 透露閣下的個人資料。為達到上述第一部分所列明之目的, 我們亦可能會向第三方 (在香港境內或境外) 透露閣下的個人資料, 包括但不限於以下各方: (a) 保險經紀; (b) 保險經紀; (c) 再保險公司; (d) 索償調查公司; (e) 為保險業整合索償及承保資料的組織、防欺詐組織、其他保險公司 (不論直接或透過防欺詐組織或本段指名的其他人士), 及保險業用作分析及核實現有資料與及後提供的資料而使用的數據庫或登記冊 (及其營運商); (f) 提供行政、電訊、電腦、付款、印刷、贖回或其他服務以令我們的業務可以運作的第三方服務供應商 (包括但不限於保險公司、律師、銀行家、會計師、專業顧問、金融機構及受託人); (g) 行業協會及聯會; (h) 醫療賬單審查公司; (i) 閣下的聯名保單或投資持有人; (j) 研究人員; (k) 信貸資料服務機構; (l) 收賬代理; (m) 夥伴金融機構及合作夥伴; 及 (n) 監管機構及政府機構、執法機構及法院。在有關影響到我們全部或重大部分業務的控制權、治理、結構及/或管理的與另一公司的交易時, 或在必須符合適用的法律或監管要求下, 我們亦可能會透露閣下的個人資料。經閣下同意, 我們亦會向第三方透露閣下的個人資料以讓該等第三方向閣下發出促銷通訊 (如下文所述)。

#### 3. 未能提供個人資料的影響

除非我們另有規定, 否則閣下必須提供我們要求的個人資料。若閣下未提供有關個人資料, 我們可能無法為閣下提供所要求的產品或服務。

#### 4. 查閱和更正的權利

根據《個人資料(私隱)條例》(「條例」), 閣下有權要求查閱及更正任何閣下提供給我們的個人資料。閣下如欲行使閣下的權利, 或如閣下需要任何其他資料, 請發送電郵至 [service@prudential.com.hk](mailto:service@prudential.com.hk) 或使用本公司網站或我們的私隱通知中「聯絡我們」部分所列的資料與我們的資料保護主任聯絡。

如閣下搬遷/已搬遷至歐洲聯盟 (「歐盟」) 司法管轄區, 我們可能需要向閣下提供進一步資料, 且閣下可能在歐盟《通用數據保障條例》下享有額外權利。此類資料及此等權利均載於本公司網站上的私隱通知中。

我們會不時更新我們的私隱通知, 並建議閣下瀏覽本公司網站以了解該私隱通知。閣下填妥並繼續提交本表格, 即表示閣下確認已閱讀並理解本收集個人資料聲明。該私隱通知可在本公司網站 <https://www.prudential.com.hk/scws/pages/tc/privacy-policy/index.html> 上查閱。



**G. Personal Information Collection Statement (Continued) 收集個人資料聲明 (續)**

**Opting-out of Marketing Communications or Materials 拒絕接收促銷信息或資料**

We intend to send you marketing communications but we can only do so with your consent. If you consent, we may use your contact details and information about the products you have purchased (including the sales channel from which such products were purchased).

我們有意向閣下發送促銷信息或資料，但僅經閣下同意我們才可以這樣做。如閣下同意，我們將可能使用閣下的聯絡資料及有關閣下已購買的產品的資料（包括購買有關產品的銷售渠道）。

I/we do not wish to receive any marketing communications from Prudential Hong Kong Limited.  
本人 / 我們不希望收到保誠保險有限公司發出的任何促銷信息。

**H. Declaration & Authorization 聲明及授權**

I / We, the Life Assured / Policyowner / Claimant, declare that the above information is true and complete to the best of my / our knowledge and belief.

I / We, the Life Assured / Policyowner / Claimant, hereby confirm my / our understanding of and agreement to the above Personal Information Collection Statement.

I / We, the Life Assured / Policyowner / Claimant, authorize on behalf of myself / ourselves and the minor Life Assured (if any) that (1) any doctors, hospitals, clinics, insurance companies, employers, organizations and persons that have any medical history or records or knowledge of me / us / the minor Life Assured, whom I / we / the minor Life Assured have attended or may hereafter attend may disclose such information to Prudential Hong Kong Limited ("the Company") for the purpose of assessing and processing the proposal for assurance and claims and providing subsequent services. To avoid any uncertainty, this authorization shall be binding on my / our successors, assignees, executors and administrators and shall remain valid notwithstanding my / our death or incapacity (including but not limited to mental incapacity). A photocopy of this authorization shall be deemed to be valid as the original; (2) the Company or any of its appointed medical examiners or laboratories may perform the necessary medical assessment and tests to underwrite and evaluate the health status of myself / ourselves / the minor Life Assured in relation to the proposal for assurance and any claims arising therefrom.

本人 / 吾等，受保人 / 保單持有人 / 索償人，特此聲明就本人 / 吾等所知所信，以上資料均為正確無訛及完整。

本人 / 吾等，受保人 / 保單持有人 / 索償人，在此確認本人 / 吾等明白並同意上述之收集個人資料聲明。

本人 / 吾等，受保人 / 保單持有人 / 索償人，代表本人 / 吾等及尚未成年之受保人（如有）茲授權（1）任何醫生、醫院、診所、保險公司、僱主、機構或人士，將已經或其後存錄的有關本人 / 吾等 / 尚未成年之受保人之醫療病歷、紀錄或其他資料披露予保誠保險有限公司（“貴公司”），作為評估及處理此投保申請及索償及提供其後服務之用。為免任何疑問，本授權書對本人 / 吾等之繼承人、受讓人、遺囑執行人及遺產管理人均具有約束力。即使本人 / 吾等死亡或無行為能力（包括但不限於精神上無行為能力），本授權書仍具約束力。本授權書之副本將視為與正本具同樣效力；（2）貴公司或任何由貴公司指定之醫生、醫務人員或化驗所，可就此投保申請或任何有關索償申請替本人 / 吾等進行所需之醫療評估及測試，以審核本人 / 吾等之健康狀況。

If Life Assured is on or above the age of 18, the form should be signed by him/her. If Life Assured is below the age of 18, the Policyowner should sign on his/her behalf. If Life Assured and Policyowner are not able to sign on the form, the Claimant should sign on their behalf.

如受保人年滿 18 歲，則由受保人簽署。受保人未滿 18 歲，則由保單持有人簽署。如受保人及保單持有人未能簽署，則由索償人簽署。

10 / 01 / 2019

Day日 / Month月 / Year年

*Chan TM*

Signature of Policyowner / Claimant  
保單持有人/索償人簽名

陳大文

Name of Policyowner / Claimant  
保單持有人/索償人姓名

Z 1234XXX

Identity Document Number of Policyowner / Claimant  
保單持有人/索償人身份證明文件號碼

10 / 01 / 2019

Day日 / Month月 / Year年

*Chan TM*

Signature of Life Assured  
受保人簽名

陳大文

Name of Life Assured  
受保人姓名

Z 1234XXX

Identity Document Number of Life Assured  
受保人身份證明文件號碼

**Please DO NOT sign on BLANK form. 請勿在空白表格上簽署。**



**Part II – Medical Certification (to be completed by the Attending Physician, duly qualified and registered, at the claimant's expense)**  
**第二部分 — 醫療報告 (由索償人自費聘請主診註冊醫生填寫)**
**Patient Details 病人資料**

1. Name of Patient 病人姓名			
2. Identity Document Number 身份證明文件號碼			
3. Age 年齡		4. Sex 性別	
5. Occupation and duties 職業及職責			
6. Are you the patient's usual physician? 你是否病人慣常求診的醫生?	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes, medical records traceable to 是, 醫療紀錄可追溯至 _____ / _____ / _____ Day日    Month月    Year年		

**Consultation Details for this accident 就是次意外之求診資料**

7. <b>FIRST</b> consultation date for this accident 病人首次就此意外向閣下求診之日期	_____ / _____ / _____ Day日    Month月    Year年	8. Date of Accident 意外日期	_____ / _____ / _____ Day日    Month月    Year年
9. Cause of injury			

~ Part II should be completed by the  
Attending Physician of life assured ~  
~ 由受保人之主診醫生填寫此第二部分 ~

	<input type="checkbox"/> Laceration / abrasion / wound 割傷/擦傷/傷口 <input type="checkbox"/> Others, please specify 其他, 請註明 _____	
12. Nature and degree of injury 傷勢的性質及程度		
13. Was hospitalization required? 是否需要住院?	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide below information 是, 請提供以下資料	
	Hospitalized from _____ / _____ / _____ To _____ / _____ / _____ 住院日期由 Day日    Month月    Year年    至    Day日    Month月    Year年	
	Hospital Name 醫院名稱	
14. Please state the investigations/ treatments administered (e.g. X-ray, physiotherapy, etc.) and results for this accidental injury 請列明因這次意外受傷而接受之檢查或治療項目(例如X光、物理治療等)及結果		
Date (DD/MM/YYYY) 日期(日/月/年)	Investigations / Treatments 檢查 / 治療	Result / Progress 結果 / 進度
Remarks: Please attach copies of X-ray report / physiotherapy report / operation summary, etc.. 註: 請連同X-光報告 / 物理治療報告/手術撮要等副本一併交回。		



Consultation Details for this accident (Continued) 就是次意外之求診資料 (續)			
15. Subsequent consultation date 隨後的診治日期		16. Subsequent treatment details 隨後的治療詳情	
17. Present condition of Injury / degree of recovery 現時受傷的情況 / 康復程度			
18. Describe the current range of motion of the injured area 請詳述受傷部位現時之活動程度			
19. Describe the progress of recovery 請詳述康復進度			
Recovery Progress and Impact Details 康復進度及影響資料			
20. Is recovery progress complicated by other factors? 右否甘仲田妻影響康復	<input type="checkbox"/> No 沒有	<input type="checkbox"/> Yes, please provide information on the right 有，請提供右方	Reason 原因

~ Part II should be completed by the  
 Attending Physician of life assured ~  
 ~ 由受保人之主診醫生填寫此第二部分 ~

疾病或缺陷?			
22. To the best of your knowledge, was such accident due to or aggravated by the following(s)? 根據閣下所知，意外是否因下列情況而導致或加劇?	<input type="checkbox"/> No 否	<input type="checkbox"/> Yes, please tick where it is appropriate and provide details 有，請在適當位置劃上“✓”號及提供詳情	
	<input type="checkbox"/>	Alcohol / narcotics / drug abuse 飲用酒精飲料/毒品/濫用藥物	<input type="checkbox"/>
	<input type="checkbox"/>	Hazardous sport / activity 參與危險性運動/活動	<input type="checkbox"/>
	<input type="checkbox"/>	Degenerative changes / congenital abnormalities 退化/先天性異常	<input type="checkbox"/>
	<input type="checkbox"/>	Self-inflicted injury 自我傷害	<input type="checkbox"/>
	<input type="checkbox"/>	Past injury / illness 過往的傷患/疾病	<input type="checkbox"/>
	<input type="checkbox"/>	AIDS/AIDS related complex diseases 後天免疫力缺乏症/後天免疫力缺乏症相關的綜合症	<input type="checkbox"/>
	<input type="checkbox"/>	Pregnancy/Childbirth/Complications arising from pregnancy 懷孕/分娩/懷孕引起的併發症	<input type="checkbox"/>
	<input type="checkbox"/>	Others, please specify details 其他，請詳細說明	<input type="checkbox"/>
23. Bearing in mind the declared occupation of this patient, please indicate the effect of the accident / disablement: 以病人的職業而論，請詳述此意外/傷勢對其的影響：			
a) Describe on how the injury, disablement affect the patient's daily job activity(ies) 請詳述此意外/傷勢對其日常工作的影響	Severity of disability 傷殘嚴重程度 <input type="checkbox"/> Cannot perform <u>his/her own</u> duties and occupation 不能從事其本身之工作或職業 <input type="checkbox"/> Cannot perform <u>any</u> kind of work and duties 不能從事任何工作或職業 Duration of disability 傷殘持續時間 <input type="checkbox"/> Period which patient is not able to perform some of his duties from _____ to _____ 喪失部分工作能力的時間 由 D日M月Y年 至 D日M月Y年 <input type="checkbox"/> Period which patient is not able to perform all of his duties from _____ to _____ 喪失全部工作能力的時間 由 D日M月Y年 至 D日M月Y年		
b) Please explain the reason why the patient cannot return to work earlier 請詳述病人未能提早復工之原因			





Recovery Progress and Impact Details (Continued) 康復進度及影響資料 (續)	
24. Please evaluate patient's ability on the following activities of daily living (for non gainfully employed or retired life assured claiming Total Permanent Disability Benefit only) 請評估病人就下列日常生活活動之能力 (只適用於非在職或退休受保人並需索償完全永久傷殘保障)	
Washing - the ability to wash in bath or shower or to wash satisfactorily by other means 洗澡 - 於浴缸洗澡或淋浴 (包括進出浴缸或淋浴室) 的能力或以其他方式滿意及合理地完成梳洗	<input type="checkbox"/> No help is required 不需要協助 <input type="checkbox"/> Some help or supervision are required 偶爾需要協助或指導 <input type="checkbox"/> Need someone to help most of the time 大部分時間都需要協助 <input type="checkbox"/> Not able to do ownself at all 完全無法自行完成
Dressing - the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances 更換/穿著衣服 - 穿上、脫下、繫緊或鬆開各種衣服或任何適當的支架、義肢或其他外科器具的能力。	<input type="checkbox"/> No help is required 不需要協助 <input type="checkbox"/> Some help or supervision are required 偶爾需要協助或指導 <input type="checkbox"/> Need someone to help most of the time 大部分時間都需要協助 <input type="checkbox"/> Not able to do ownself at all 完全無法自行完成
Feeding - the ability to feed oneself once food has been prepared and made available	<input type="checkbox"/> No help is required 不需要協助 <input type="checkbox"/> Some help or supervision are required 偶爾需要協助或指導

~ Part II should be completed by the  
 Attending Physician of life assured ~  
 ~ 由受保人之主診醫生填寫此第二部分 ~

Other Related Information 其他相關資料			
25. Did you refer the patient to another physician / hospital? 你有否轉介病人往其他醫生或醫院?	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide information on the right 有, 請提供右方所需資料	Name of the physician / hospital 醫生/醫院名稱	
		Address of the physician / hospital 醫生/醫院地址	
		Details for the referral reason 詳述轉介原因	
26. Had other physicians treated the patient for the same accident? 病人曾否就此次意外向其他醫生求診?	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide information on the right 有, 請提供右方所需資料	Consultation Date 求診日期	____ / ____ / ____ Day日    Month月    Year年
		Name of Physician 醫生姓名	
		Address of Physician 醫生地址	



Physician Details 醫生資料			
Name of Attending Physician 主診醫生姓名		Qualification 資歷	
Hospital Name (if applicable) 醫院名稱 (如適用)		Telephone No. 聯絡電話	
Address 地址			
Signature & Hospital /			

~ Part II should be completed by the  
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**Part III – Confirmation of Sick Leave (Please have Insured's Employer to complete)**  
**第三部分 — 確認病假證明 (請受保人之僱主填寫)**

**Please complete this part for below claims type 以下索償種類請填妥此部分：**

**Required 基本**

-Temporary Disablement Benefit 暫時性傷殘保障 (for non-self-employed life assured claiming temporary disability benefit over 10 days如非自僱受保人並需索償超過10日暫時性傷殘保障賠償)

**Where applicable 如適用**

- Dismemberment Benefit 斷肢保障  
- Total Permanent Disability Benefit 完全永久傷殘保障

**Employee's Information 僱員資料**

Name 姓名	
Identity Card Number 身份證明文件號碼	

~ **Part III should be completed by the**  
**Employer of life assured** ~  
~ **由受保人之僱主填寫此第三部分** ~

<b>Employer's Information 僱主資料</b>	
Signature of Employer & Title 僱主簽署及職位	
Contact Person & Contact Number 聯絡人及聯絡電話號碼	
Company Address 公司地址	
Company Chop 公司印章	
Date (D/M/Y) 日期 (日/月/年)	

