招商永隆保險有限公司
CMB Wing Lung Insurance Company Limited
招商局集團成員公司
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# Personal Accident Claim Form
# 人身意外保險報告書

Please submit this Claim Form with all necessary original supporting documents within 30 days after occurrence of accident.
索償申請表連同所有相關證明文件之正本必須於意外發生後 30 天內遞交。

Note: In the event of the insured being unable to write on account of disablement, this form should be filled up and signed by his / her spouse, or some responsible person acting as attorney for the Insured for the time being.
備註：如保戶因身體傷殘而不能書寫，請其配偶或法定代表人填寫及簽署

Part I – To be completed by Insured, or policyholder if Insured is below 18 years old (Please attach receipts with this form)
第一部份 – 請由受保人填寫，如受保人未滿 18 歲，則由保單持有人填寫（請連同所須索償之收費單據一併交回）

## Personal Details 個人資料

Policy no. 保單號碼 _____ Name of policyholder 保單持有人姓名 _____
Name of Insured 保戶姓名 _____ Date of birth 出生日期 _____
Age 年齡 _____ Sex 性別 M 男 ☐ / F 女 ☐
Address 地址 _____
Occupation 職業 _____ Position held 受僱職位 _____
Tel. no. 電話號碼 _____ (Office 公司) _____ (Residence 住宅) _____
*Fax no. 傳真號碼 _____ E-mail address 電郵地址 _____
*Name of current employer
現任僱主名 _____
Address of current employer 現任僱主地址 _____ Office tel. no. 公司電話 _____
*非必須資料 Optional information

## Details of accident 意外詳情

Please state the following particulars of accident: 請述以下有關資料：
Date 日期 _____ Time 時間 _____ am 上午 / pm 下午
Place of accident 意外發生地點 _____
How did it happen? 意外經過 _____

Please describe the injuries sustained, indicating the part of the body injured and the type of injury (e.g. fracture, cut, bruise etc.)
請述受傷部位及其傷勢（如：骨折、刀傷、瘀腫等）

Was the accident reported to the police? 上述意外有否交由警方調查？ NO 沒有 ☐ YES 有 ☐
If 'YES', please state name and address of the police station to which the accident was reported, the case reference no. and provide a copy of the police statement. 如「有」，請列明所辦理之警署地點，報案編號及提交該口供紙副本。

Please list all doctor(s) or hospital(s) consulted and the date of consultation. 請列出就上述意外而求診之所有醫生或醫院名稱及求診日期。

| Name of doctor / hospital 醫生 / 醫院名稱 | Date of first consultation 初診日期 |
|---|---|
| | |
| | |
| | |

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## Others 其他資料

No. of work hours per week (if applicable) 每星期工作多少小時（如適用） _____

Percentage of clerical work and manual work (if applicable) 文職工作和體力工作所佔比例（如適用） _____

Any concurrent claim about this disability with other companies? 有否就此傷殘同時向其他保險公司提出索償？ NO 沒有 ☐ YES 有 ☐

If 'YES', please give the name of the company and the policy number. 如有，請列明其公司名稱及保單號碼

_____

Name of witness 證人姓名 _____ Address 地址 _____

Notes

1. By furnishing this form the Company makes no admission of liability.
   呈上此表格非視為本公司承認有關責任。
2. Claims will not be processed unless declaration and authorization are signed by the claimant.
   本公司只接受已簽署聲明及授權書的索償申請表。

## Declaration and Authorization 聲明及授權書

1. I/We declare that the above information is in all respect true and complete to the best of my/our knowledge and belief;
   本人／我們就此作出聲明，就本人／我們等所深知及確信，上述資料均屬真確無訛。

2. It is agreed that upon request by CMB Wing Lung Insurance Company Limited, I/we shall make a statutory declaration to re-affirm the genuineness of all information contained in this claim form; and
   若招商永隆保險有限公司提出有關要求，本人／我們將同意作出重申本索償申請表內資料均屬真確的法定聲明；及

3. I, the undersigned claimant, hereby authorize the parties concerned to disclose to CMB Wing Lung Insurance Company Limited or its representative or its authorized loss adjusters any and all information with respect to my medical history regarding illness or injuries, my claimed loss/damage under the above Section(s) and my full claim history with other insurance companies.
   本人（下述簽署的索償人）現授權有關人士向招商永隆保險有限公司或其代表或其授權的公證行提供任何一切有關本人於上述索償項目中申報本人患病、受傷和財物損失／損毀的資料記錄及本人於其他保險公司的所有索償紀錄。

4. I/We believe that the facts stated in this claim form are true and correct. I/We acknowledge that the Insurers will rely upon the information supplied by me/the policyholder/the Insured, which I/we verily and honestly believe to be true and correct, in prosecuting or defending any claims or proceedings in future, and the signatory/the policyholders/Insured under this policy, if so required by the Insurers, will be asked and are bound to sign any court documents on the basis of information provided herein.
   本人／我們確認此索償申請書內之事實均為真實及正確。本人／我們確認貴保險公司會依靠本人／保單持有人／受保人所提供的資料（本人／我們誠實地相信該等資料是真實和正確），作為將來進行或辯護任何索賠及訴訟程序之用。如貴保險公司要求，本簽署人／保單持有人／受保人將會及必定同意簽署任何有關倚靠該等資料所準備之法律文件。

5. I/We confirm that I/we have read and understood the CMB Wing Lung Insurance Company Limited *Notice to Customers relating to the Personal Data (Privacy) Ordinance* attached in this Claim Form.
   本人／我們確認已閱讀並清楚明白附於本意外報告書內之招商永隆保險有限公司《關於個人資料（私隱）條例致客戶的通知》。

| | |
|---|---|
| _____ | _____ |
| Signature of Insured 受保人簽署 | Signature of claimant 索償人簽署 |
| _____ | _____ |
| HKID card no. 身份證號碼 | HKID card no. 身份證號碼 |
| _____ | _____ |
| Date 日期 | Date 日期 |

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Part Ⅱ - Attending physician statement (To be completed by the Insured's attending doctor at the Insured's cost)
第二部份 - 主診醫生報告（此欄須由受保人之主診醫生填寫，而費用須由受保人負責）

Full name of patient 病人姓名 _____ Age 年齡 _____
HKID card no. 身份證號碼 _____ Sex 性別 _____

## Details of injury 意外詳情

Date 日期 _____ Time 時間 _____ am 上午 / pm 下午

Place of accident 意外發生地點 _____
Please give the circumstances of the accident in detail. 請詳述意外是如何發生。 _____

When is the first consultation date? Any external visible signs of bodily injury revealed at the first consultation? Please give details.
請問首天診治在何時？傷者在首次求診時，受傷部位有否可見明顯之外傷？請詳述。 _____

What is the exact diagnosis? 傷勢之診斷？ _____

Investigations, treatment, therapy and surgical procedures done: 因意外而接受之檢查、治療及手術項目：

| Type of treatment given 治療項目 | Date given 日期 |
|---|---|
| | |

Has the patient previously suffered from this or similar condition or is it a recurrence of a previous injury or illness? 以往傷者有否患上類似之疾病或舊傷 / 病復發？NO 沒有 ☐ YES 有 ☐ If 'YES', please state. 如「有」，請說明 _____

Name of hospital (if hospitalized) 醫院名稱（如有住院） _____ Date of admission 入院日期 _____
Period of hospital confinement 住院期間 _____ Date of discharge 離院日期 _____
Regarding the current condition of the injured, 就傷者現時之傷勢，

Ⅰ) Was there any functional limitation revealed (i.e. range of motion, weight bearing power etc.) 有否導致任何功能上之障礙（如受傷部位之活動幅度，提重能力等等） _____
Ⅱ) According to the occupation of the patient, please indicate the period of insured disability. 據傷者之職業，請指出其傷殘之時段。

a) Inability to perform one or more duties from _____ (YY/MM/DD) to _____ (YY/MM/DD).
不能從事其一或部份之工作由 至
b) Inability to perform each and every duty from _____ (YY/MM/DD) to _____ (YY/MM/DD).
不能從事全部之工作由 至
c) In what ways & how did the injury prevent the patient from his / her work / any occupation as indicated above (a & b)? Please give details. 其傷殘是如何及怎樣阻礙傷者從事上述之工作 / 職業？請詳述。

Please indicate if the medical condition and its subsequent treatment are associated with the following: 請指出上述病況是否與以下情況有關：

| | | | |
|---|---|---|---|
| NO / YES 否 / 是 | Congenital anomalies, infertility or sterilization 先天性不正常情況、不育或絕育情況 | NO / YES 否 / 是 | Routine medical check-up 例行醫療檢查 |
| NO / YES 否 / 是 | Under the influence of drugs or alcohol 受酒精或藥物影響 | NO / YES 否 / 是 | Rest cure, rehabilitation, convalescence or extended care 休養、復康或延續護理 |
| NO / YES 否 / 是 | Self-inflicted injuries or suicidal attempt while sane or insane 不論在神志清醒與否下之自我損傷或自殺行為 | NO / YES 否 / 是 | Psychiatric problem 精神病科 |
| NO / YES 否 / 是 | Pregnancy conditions or any related complications 懷孕或由此引發之病況 | | |

Signature of physician 醫生簽署 _____ Hospital / physician stamp 醫院 / 醫生蓋印 _____
Qualification 資歷 _____ Date signed 簽署日期 _____
Clinic address of physician 駐診地址 _____

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