



PERSONAL ACCIDENT CLAIM FORM 人身意外保險賠償申請表

Please complete this form in full and return together with all supporting documents to: **Blue Cross (Asia-Pacific) Insurance Limited.**

請填妥此申請表，連同有關文件盡速交回「藍十字（亞太）保險有限公司」。

Claimant's Particulars 申請賠償者資料

Name of Insured 投保人姓名		Policy No. 保單號碼	Claim No. (Office Use) 賠償號碼 (本公司填寫)
Name of the Claimant 申請賠償者姓名			
Sex 性別	Age 年齡	I.D. Card No. 身分證號碼	
Residential address 住址			
Name of Employer 僱主名稱		Address of Employer 僱主地址	
Telephone No. (Office) 電話號碼 (公司)		(Home) (住宅)	
Present Occupation (if more than one, state all) 現時職業 (如多於一項，請詳細列明)			
Main nature of occupational duties at time of accident 發生意外時的主要職業及職責			

Circumstances of Injury 受傷情形

Place of Accident 發生意外地點	Date 日期	Time 時間	
Nature of Accident (state in details, how it happen) 意外原因 (詳列細節，怎樣發生)			
Name(s) of Doctor (s) who treated you for the injury 受傷時，替你診治的醫生姓名	Address(es) of Doctor (s) 醫生地址		
Date Consulted 醫治日期			
Details of hospitalization 住院詳情 (please attach discharge note 請附收據)			
Name of Hospital 醫院名稱	Period of Hospitalization 住院日期		
Date on which you last worked prior to disability 不能工作前之最後工作日期			
Date on which you returned to work 恢復工作之日期			
Date on which you expect to return to work if you have not already done so? 如現時仍不能工作，估計可於何日恢復工作?			
If after you return to work you were not immediately able to perform all your duties, please indicate: 如已恢復工作，但工作能力未能完全恢復，請列明：			
Are you insured with any other insurance company for accident benefits? If so, please give full particulars. 你是否於其他保險公司購有意外保險？如有，請列明：		<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否

Details of claim and the amount you wish to claim under the Policy

請列明您欲依據此保險單索償的項目

Total Amount Claimed:

索償總數

HK\$

Notes 注意

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. All original itemized bills must be submitted together with this form in order to avoid delay.
呈上填妥之表格及附上醫療單據正本。

Authorization / Declaration 聲明及授權

I hereby authorize any hospital, physician, or other person and/or authority who has attended or examined me, to furnish to Blue Cross (Asia-Pacific) Insurance Limited or its authorized representative, any and all information with respect to my illness or injury, medical history, consultation, prescription or treatment, and copies of statement, all hospital or medical records. A photostat copy of this authorization shall be considered as effective and valid as original.

本人授權醫院、醫生、警方及有關人士向藍十字（亞太）保險有限公司提供所有有關本人之疾病、意外受傷、健康背景、醫療記錄及事件口供。此授權書之副本具有正本之同等效力。

I / We hereby declare to the best of my / our knowledge and belief that the above statements and particulars to be true and correct and I / we have no other insurance policy indemnifying me / us in respect of this accident. I / We hereby further agree that if I / we have made or shall make any false statement or concealment, the Policy shall be void and all rights to recovery thereunder shall be forfeited.

本人/我等在此聲明以上一切資料均屬真實，及在此次意外中，本人/我等並無得到其他保險賠償。

本人/我等亦同意，如以上或將來提供之資料有虛假成分或有隱瞞，此保險單將被作廢，而一切索償權利亦將喪失。

Personal Information Collection Statement 收集個人資料聲明

I / We understand and agree that any personal information collected or held by the Company may be used, stored, disclosed and transferred (within or outside of Hong Kong) to such individuals / organizations associated with the Company or any selected third party for the purposes of processing this application and providing subsequent services for this, and promotion of financial products or services by the Company and its affiliated companies, and communicating with me/us for such purpose. I / We have the right to obtain the Privacy Policy Statement, access to and to request correction of any personal information held by the Company. Such request could be made to Company's Corporate Data Protection Officer at 22/F, Cosco Tower, 183 Queen's Road Central, Hong Kong.

本人/我們明白並同意貴公司可使用及保存所收集或持有本人/我們之個人資料，並可將此等資料使用、儲存、透露及轉達（於本地或以外）予任何與貴公司有關之人士/機構或被選定之第三者，用以處理及審核此項申請及提供有關之服務，介紹貴公司及其聯營公司之財務產品或服務，及與本人/我們聯絡。本人/我們有權致函香港皇后大道中183號22樓向貴公司之個人資料保護主任索取「私隱政策聲明」，查詢及要求更正貴公司所持有之個人資料。

Date
日期Signature of Claimant
申請賠償者簽署

Notes 注意

Employer's Confirmation of Sick Leave and Certificate of Medical Attendant have to be filled in only if you are claiming for Permanent Total or Temporary Total Disablement Benefit.

如非申請永久或暫時完全喪失工作能力賠償，毋須填寫僱主認可休假證明書及醫生證明書。

Employer's Confirmation of Sick Leave 僱主認可休假證明書

To be completed by claimant's employer

由申請賠償者的僱主填寫

This is to certify that the claimant _____ who is our employee serving the position currently as _____
_____ had suffered an injury of _____ occurred on _____
and as a result of the said injury he/she did not attend to work for a total of _____ days during the period from _____ to _____

We further confirm that his/her basic salary at the time of accident was HK\$ _____

(excluding bonus, commission, overtime and other allowance)

茲證明 _____ (申請賠償者姓名)，為本公司 _____ (職位)

因發生於 _____ 之意外而致 _____ 受傷

由 _____ 至 _____ 休假供 _____ 天。

本人/公司證明該申請賠償者，每月的基本薪金（不包括花紅、佣金、超時補薪及其他津貼）為港幣 _____ 元。

Date
日期

Signed by Employer
僱主簽署

Company Chop
公司蓋章

Date
日期

Signature of Claimant (Signed to confirm the above statements are true and correct)
申請賠償者簽署（證明以上資料真實無誤）

A. State your Basic Salary: (excluding bonus, commission, overtime and other allowances)
請列明你的基本薪金（不包括花紅、佣金、超時補薪及其他津貼）

HK\$

Or B. If you are self-employed: State gross income for previous 12 months: (after deduction of all operating expenses of your business)

或 如果你是自僱者：請列明最近12個月的總收入（扣除所有營業支出後計）

HK\$

Certificate of Medical Attendant 醫生證明書

No claim can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expenses of the insured.
 醫生證明書必須由政府註冊及批准執業之醫師證明簽字否則無效。此項費用由保戶負責。

Patient's Name	Age	Identity Card No.	Date of Accident
1. Describe and locate cause, character and extent of injury			
2. Is there any external and visible evidence of injury at the 1st consultation			
3. Present condition of the injury			
4. Treatment administrated (as number of stitches, dressing, etc.)			
Date	Time (am/pm)	Treatment	
5. Names and Addresses of other Physicians who treated the insured for the same injury			
Names	Addresses	Approximate Dates	
6. Where did you see him after the accident?			
7. Did injury require (if yes, please give details)			
(a) hospitalization?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date admitted Date discharged
(b) X-rays?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
(c) Special diagnostic procedures?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Please specify:
(d) Surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Please specify:
8. (a) Was healing complicated? <input type="checkbox"/> No <input type="checkbox"/> Yes			
(b) If so, state what special treatment was given?			
9. Bearing in mind the patient's occupation, do you feel that the injuries would have prevented him/her from working? <input type="checkbox"/> No <input type="checkbox"/> Yes			
10. If answer to the above is "Yes" and an absence from work of more than three days was necessary, please describe in detail the reasons why you feel the patient could not return to work earlier.			
11. Given details of any circumstances, such as intoxication, physical defects or <u>medical history</u> which may have contributed to the accident and/or lengthen the period of disability.			
12. Give date of first and last consultation or treatment.			
First Date	Last Date		
13. In your opinion how long was he/she disabled from performing any kind of duty pertaining to his/her occupation.			
Total disablement	days from	to	
14. In your opinion how long was he/she disable from performing one or more important daily duties performing to his/her occupation ?			
Partial disablement	days from	to	
I hereby certify that I have examined and treated the patient for the above injuries and that the facts as given above present my opinion of his/her condition.			
Signed	Name of Physician & Chop	Date	
Qualification	Address	Tel. No.	
For identity purpose, the Claimant must sign his name <u>in the presence of the Physician.</u>		Signature of Claimant 申請賠償者姓名及簽署	