

BANK OF CHINA GROUP INSURANCE COMPANY LTD.

總公司：香港德輔道中 71 號永安集團大廈八樓 電話：2867 0888 傳真：2521 8985
HEAD OFFICE: 8/F., WING ON HOUSE, 71 DES VOEUX ROAD CENTRAL, HONG KONG.
TEL.: 2867 0888 FAX: 2521 8985

本公司專用

Office Use

賠案編號

Claim No. _____

人身意外險索償表格

PERSONAL ACCIDENT INSURANCE CLAIM FORM

保單資料 Insurance Policy Details	
保戶名稱 Name of Insured _____	保單號碼 Policy No. _____
身份證號碼 Identity Card No. _____	性別 Sex _____
出生日期 Date of Birth _____	日 月 年 DD MM YY
職業 Occupation _____	聯絡電話 Contact Tel No. _____
地址 Address _____	電郵 E-mail _____
索償人 / 被保人 資料 (如非保戶) Particulars of Claimant / Insured Person (if not the Insured)	
索償人 / 被保人 姓名 Name of Claimant / Insured Person _____	與保戶關係 Relationship with the Insured _____
聯絡電話 Contact Tel No. _____	
身份證號碼 Identity Card No. _____	性別 Sex _____
出生日期 Date of Birth _____	日 月 年 DD MM YY
職業 Occupation _____	
地址 Address _____	
索償資料 Particulars of Claim	
(1) 意外發生的日期及時間 Date and time of accident.	日 月 年 時間 DD MM YY Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm
(2) 意外發生的地點 Place of accident.	_____
(3) a. 該意外的詳情 Description of accident	a. _____ b. _____
如有報警，列明報案的警署及報案編號 If the accident has been reported to the police, please state which police station and police report number.	
(4) 傷勢及其部位 Nature and region of injury.	_____
(5) 暫時完全喪失工作能力的期間 Period of Temporary Total Disablement from engaging in or attending to usual employment or occupation.	由 日 月 年 至 日 月 年 From DD MM YY To DD MM YY
(6) a. 意外是否在受僱期間因工作引致 Was this accident occurred in the course of and/or arising out of your employment? 如是，列明承保僱員補償險的保險公司的名稱及保單編號 If yes, state the name of insurance company of Employees Compensation Insurance and the respective policy No.	a. <input type="checkbox"/> No <input type="checkbox"/> Yes b. _____
(7) a. 被保人是否就是次意外向其他保險公司索償 Is the Insured Person entitled to claim under any other insurance policies in respect of this accident? 如是，列明保險公司的名稱，保單編號及索償保障項目 If yes, state the name of insurance company(s), respective policies Nos and details of benefits.	a. <input type="checkbox"/> No <input type="checkbox"/> Yes b. _____
(8) a. 被保人以往是否有類似的受傷情況 Has the Insured Person ever sustained similar injury? 如是，列明詳情及何時發生 If yes, please give detail and date.	a. <input type="checkbox"/> No <input type="checkbox"/> Yes b. _____

聲明及授權
Declaration and Authorization

本人聲明上述資料完整及正確無訛，並無隱瞞任何重要資料。

本人明白本人提供的資料為 貴公司提供保險業務所需，並可能使用於下列目的：

- 任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期；
- 任何索償，或該等索償的調查或分析；
- 行使任何代位權；及

可能移轉予：

- 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或其他服務提供者，以達到任何上述或有關目的；
- 現存或不時成立的任何保險公司協會或聯會或同類組織（「聯會」），以達到任何上述或有關目的，或以便「聯會」執行其監管職能，或其他基於保險業或任何「聯會」會員的利益而不時在合理要求下賦予「聯會」的職能；及
- 透過「聯會」移轉予任何「聯會」的會員，以達到上述或有關目的。

此外，本人授權 貴公司可向「聯會」從保險業收集的資料中查閱及/或核對本人任何資料。本人明白本人有權查閱及要求更正由 貴公司持有有關 本人的個人資料。如有需要，本人將向 貴公司辦公室提出（電話：2867 0888，傳真：2522 1705）

I declare that the above information is complete and true to the best of my knowledge and belief and I have not withheld any material information connected with this claim.

I understand that the information I provide to Bank of China Group Insurance Co Ltd ("the Company") is collected to enable the Company to carry on insurance business and may be used for the purpose of:

- any insurance or financial related products or services or any alterations, variations, cancellation or renewal of said products or services;
- any claim or investigation or analysis of such claim;
- exercising any right of subrogation; and

may be transferred to:

- any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
- any association, federation or similar organization of insurance companies ("Federation") that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation and
- any members of the "Federation" by the "Federation" for any of the above or related purposes.

Moreover, the Company is hereby authorized to obtain access to any / or to verify any of my data with the information collected by the Federation from the insurance industry. I understand I have the right to obtain access to and to request correction of any personal information concerning myself held by the Company. Requests for such access can be made to the Administration Department of the Company. (Tel: 2867 0888 / Fax: 2522 1705)

索償人 / 被保人 簽署

Signature of Claimant / Insured Person

日期

Date:

保戶簽署 (如屬公司請蓋章)

Signature of Insured (with company chop if applicable)

日期

Date:

所需文件
REQUIRED DOCUMENTS

- | | |
|--|--|
| 1. Original sick leave certificate(s)
病假證明書正本 | 3. Copies of all police statements, if any
如有報案，請提供所有警方口供紙副本 |
| 2. Copies of statement of account and original receipt(s)
醫療清單副本及收據正本 | 4. Copy of documentary proof of income over the 12 months preceding to the accident for claim under Temporary Total Disablement from engaging in or attending to usual employment or occupation
有關暫時完全喪失工作能力的索償，需提供意外前12個月的入息證明文件副本 |

This statement should be fully completed and signed by Attending Physician. Any expense for completing this statement must be paid by the Insured.
 本表格必須由主診醫生填妥和簽署，所需費用由保戶自行支付。

ATTENDING PHYSICIAN'S STATEMENT
主診醫生證明書

Name of Patient:	Identity Card No.:	Date of birth (DD/MM/YY):	Date of Accident (DD/MM/YY) :
(1) a. What is the exact diagnosis ? b. Is there any external and visible evidence of injury at your first consultation? c. State part of body injured d. Describe the cause and extent of injury	a. _____ b. <input type="checkbox"/> No <input type="checkbox"/> Yes c. _____ d. _____		
(2) Present condition of injury:			
(3) a. Is there any treatment administered? b. If yes, please give details (such as suturing, physiotherapy, type of dressing, etc.)	a. <input type="checkbox"/> No <input type="checkbox"/> Yes b. <u>Date</u> <u>Time</u> <u>Treatment</u>		
(4) a. Did any other physicians treat the patient for the same injury? b. If yes, please give:	a. <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown b. <u>Name</u> <u>Address</u> <u>Date of Treatment</u>		
(5) Did injury require the followings: (If yes, please give details) a. hospitalization b. x-ray? c. special diagnostic procedures? d. surgery?	a. <input type="checkbox"/> No <input type="checkbox"/> Yes _____ b. <input type="checkbox"/> No <input type="checkbox"/> Yes _____ c. <input type="checkbox"/> No <input type="checkbox"/> Yes _____ d. <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
(6) a. Did any permanent disablement expected as a result of his/her injury? b. If yes, please state the proportionate disability in percentage	a. <input type="checkbox"/> No <input type="checkbox"/> Yes b. _____		
(7) Did injury cause Temporary Total Disablement from engaging in or attending to usual employment or occupation?	<input type="checkbox"/> No <input type="checkbox"/> Yes From _____ To _____		
(8) Was such injury induced from or effected by any of the following which may contribute to the accident and/or lengthen the period of disability? (If yes, please give details) a. physical defects / congenital anomaly b. unfavourable past medical history c. degenerative d. alcohol or drugs	a. <input type="checkbox"/> No <input type="checkbox"/> Yes _____ b. <input type="checkbox"/> No <input type="checkbox"/> Yes _____ c. <input type="checkbox"/> No <input type="checkbox"/> Yes _____ d. <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
(9) Bearing in mind the Patient's occupation , do you feel that the injuries would have prevented him/her from working? a. at your first consultation. b. at your last consultation.	a. <input type="checkbox"/> No <input type="checkbox"/> Yes From _____ To _____ b. <input type="checkbox"/> No <input type="checkbox"/> Yes From _____ To _____		
(10) If an absence from work of more than two weeks was necessary, please describe in detail the reasons why you feel the Patient could not return to work earlier.			
I hereby certify that I have personally examined & treated the Patient for the above injury and that the facts as given above present my opinion of his /her condition.			
Address : _____ _____ _____		Signature : _____	
Telephone No.: _____		Name of Physician : _____ (with stamp)	
Date : _____		Qualification : _____	