



## 意外保險索償表格

備注: 所有索償申請須於意外發生後十四天內向本公司提出, 而填妥的索償表格須連同下列證明文件呈交本公司。包括醫療報告、診斷報告、醫療單據正本及出生證明書/結婚證明書以證明索償者與保單持有人關係等。

保單持有人姓名: \_\_\_\_\_ 保單號碼: \_\_\_\_\_  
 索償者姓名: \_\_\_\_\_ 與保單持有人關係: \_\_\_\_\_  
 身份證號碼: \_\_\_\_\_ 性別: \_\_\_\_\_ 出生日期: \_\_\_\_\_ 職業: \_\_\_\_\_  
 聯絡電話: \_\_\_\_\_ 電郵地址: \_\_\_\_\_  
 住址: \_\_\_\_\_

### 第一節 - 由保單持有人填寫

- (一) 意外事件發生之日期、時間及地點: \_\_\_\_\_
- (二) 意外事件是否在工作期間發生?  是 /  否
- (三) 意外事件發生的詳細經過: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- (四) 傷勢描述: \_\_\_\_\_
- (五) 事件目擊者之姓名、電話及地址: \_\_\_\_\_  
 \_\_\_\_\_
- (六) 報案警署名稱、地址及案件編號: \_\_\_\_\_
- | (七) 診治醫生/醫院之名稱及地址 | 應診日期/住院期間 | 索償金額  |
|-------------------|-----------|-------|
| _____             | _____     | _____ |
| _____             | _____     | _____ |
| _____             | _____     | _____ |
- (八) 是否還需要繼續接受治療?  是 /  否
- (九) 意外引致的永久傷殘程度: \_\_\_\_\_
- (十) 索償總額: 醫療費用 \_\_\_\_\_ 住院現金津貼 \_\_\_\_\_  
 永久傷殘 \_\_\_\_\_ (請連同獨立的醫療報告以作證明)
- (十一) 上述意外事故是否受保於其他保險合約?  是 /  否  
 如是, 請提供保險公司名稱及保單號碼: \_\_\_\_\_

備註: 如須專科醫生診治、物理治療、按脊治療、牙科醫生診治或住院接受治療, 請交由醫生填寫本表格的第二節 A, B 或 C 及提交有關的轉介信。

### 聲明及授權

- (一) 本人現聲明上述所填報的資料正確無訛。
- (二) 本人同意貴公司之「個人資料政策」會被引用。本人可以向貴公司索取或從網址 [www.hl-insurance.com](http://www.hl-insurance.com) 下載有關政策。本人同意該政策(按不時之修正)適用於本人所有個人資料。本人現授權貴公司向/從任何豐隆集團成員或其他公司、機構、業務有關人士包括保險公司、信貸機構、金融機構、醫療保健相關機構等提供、收集並比較本人(及本人的家屬, 如適用)於本索償表格的個人資料, 並利用比較結果採取任何行動, 其可能不符合本人利益。本人理解本人有權要求查閱及更正貴公司持有有關本人之個人資料。此等查詢應向貴公司之資料保安主任提出。貴公司有權收取處理該查詢的合理費用。
- (三) 本人茲授權持有本人健康、投保資料、索償紀錄或任何有關資料之警方、醫院、醫生、保險公司、提供服務者、有關人仕或組織, 可以將部份或全部有關本人傷患之病歷、診斷報告、藥方及其他事故等資料給與貴公司或其代理人, 此授權書之影印本與正本均具同等效力, 發出此賠償申請表格並不代表貴公司接受本人之賠償。

日期: \_\_\_\_\_ 索償者簽署: \_\_\_\_\_



ACCIDENT INSURANCE CLAIM FORM

**Part 2A – Hospitalization Treatment (To be completed by the Attending Physician)**

- (a) Name of Patient: \_\_\_\_\_ HKID Card No.: \_\_\_\_\_
- (b) Name of Hospital: \_\_\_\_\_
- (c) Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_
- (d) Chief complaints / diagnosis of the patient: \_\_\_\_\_  
\_\_\_\_\_
- (e) Brief discharge summary (including investigative procedures, results, treatments, and/or any complications and follow up plan)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- (f) Date and details of surgical procedures carried out, if any: \_\_\_\_\_  
\_\_\_\_\_
- (g) Period of confinement in Intensive Care Unit, if any: \_\_\_\_\_
- (h) Are the symptoms of the patient exclusively due to the accident stated in Part 1 of this claim form?  Yes /  No
- (i) Was the patient under the influence of intoxicants at the time of accident?  Yes /  No
- (j) Did the injury of the patient arise out of his / her employment?  Yes /  No
- (k) Date of first consultation for the symptoms / injury: \_\_\_\_\_
- (l) Name and address of the referral doctor, if any: \_\_\_\_\_
- (m) The extent in percentage of any permanent disability expected as a result of the injury: \_\_\_\_\_
- (n) Nature of such permanent disability, if any: \_\_\_\_\_
- (o) Has the patient ever had the same or similar injury?  Yes /  No
- (p) Date and details of such previous injury, if any: \_\_\_\_\_
- (q) Name of the attending doctor for such previous injury, if any: \_\_\_\_\_

**I declare that the above information and statements are in all respects true and correct to the best of my knowledge and belief.**

\_\_\_\_\_  
Name of Attending Physician (with qualifications)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Contact Telephone No.:

\_\_\_\_\_  
Signature of Attending Physician

\_\_\_\_\_  
Date



**ACCIDENT INSURANCE CLAIM FORM**

**Part 2B – Specialist, Physiotherapy, Chiropractic Treatment (To be completed by the Attending Physician)**

(a) Name of Patient: \_\_\_\_\_ HKID Card No.: \_\_\_\_\_

(b) Chief complaints / diagnosis of the patient: \_\_\_\_\_  
 \_\_\_\_\_

(c) Nature and extent of injury: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(d) According to the patient, how the injury was caused? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**(If the injury arose out of his/her employment, please specify.)**

(e) Details of investigations, treatment, therapy and surgical procedures done: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(f) Future treatment plan: \_\_\_\_\_  
 \_\_\_\_\_

(g) Date of first consultation for the symptoms / injury: \_\_\_\_\_

(h) Name and address of referral doctor, if any: \_\_\_\_\_  
 \_\_\_\_\_

(i) Was the patient's injury/medical conditions caused by or in anyway associated with the conditions stated below?

- |  |  |
|--|--|
| 1. Any kind of sickness or disease     | <input type="checkbox"/> Yes / <input type="checkbox"/> No |
| 2. Surgical operation                  | <input type="checkbox"/> Yes / <input type="checkbox"/> No |
| 3. More than one traumatic cause       | <input type="checkbox"/> Yes / <input type="checkbox"/> No |
| 4. Influence of drug or alcohol        | <input type="checkbox"/> Yes / <input type="checkbox"/> No |
| 5. Physical defects/congenital anomaly | <input type="checkbox"/> Yes / <input type="checkbox"/> No |
| 6. Degenerative changes                | <input type="checkbox"/> Yes / <input type="checkbox"/> No |

If yes, please give details: \_\_\_\_\_  
 \_\_\_\_\_

(j) The extent in percentage of any permanent disability expected as a result of the injury: \_\_\_\_\_

**(Medical report detailing the assessment of permanent disability is required.)**

**I declare that the above information and statements are in all respects true and correct to the best of my knowledge and belief.**

\_\_\_\_\_  
 Name of Attending Physician (with qualifications)

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Contact Telephone No.:

\_\_\_\_\_  
 Signature of Attending Physician

\_\_\_\_\_  
 Date:



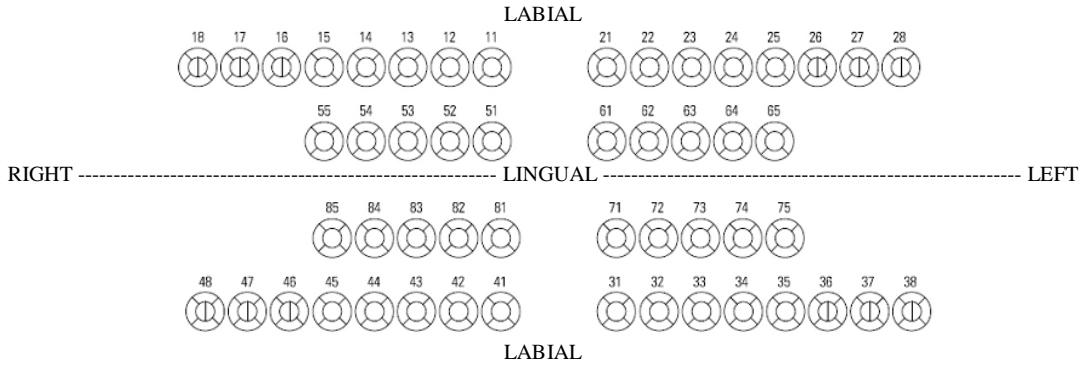
**ACCIDENT INSURANCE CLAIM FORM**

**Part 2C – Dental Treatment (To be completed by the Attending Dentist)**

(a) Name of Patient: \_\_\_\_\_ HKID Card No.: \_\_\_\_\_

Tooth No.	Date	Cause of services	Description of services	Fee

Please mark the treated teeth on the chart below:



(b) Chief complaints / diagnosis of the patient: \_\_\_\_\_

(c) According to the patient, how the dental injury was caused? \_\_\_\_\_

**(If the injury arose out of his/her employment, please specify.)**

(d) In your opinion, was the injury SOLELY caused by the circumstances as stated (c) above?  Yes /  No

If no, please specify the other contributory cause: \_\_\_\_\_

(e) Date of first consultation for the symptoms / injury: \_\_\_\_\_

**I declare that the above information and statements are in all respects true and correct to the best of my knowledge and belief.**

\_\_\_\_\_  
 Name of Attending Dentist (with qualifications)

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Contact Telephone No.:

\_\_\_\_\_  
 Signature of Attending Dentist

\_\_\_\_\_  
 Date: