豐隆保險(亞洲)有限公司
HongLeong Insurance (Asia) Ltd.

網上索償
掃描二維碼於網上遞交索償申請

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在各方面盡本人所知及所信均為正確無訛。

(二) 本人明白並且同意貴公司可：

(a) 收集、使用和披露本人(及本人的家屬，如適用)的個人資料（包括但不限於信用資料和以往申索紀錄），以用作處理本人的申請、調查和結清申索、以及偵測和防止欺詐行為（無論是否與就本申請而發出的保單有關）所需的目的；及

(b) 把我/我們的個人資料轉移給以下人士，而他們只能在有合理需要履行上述目的之情況下才可收集和使用這些資料：保險理算人、代理和經紀；僱主；醫護專業人士；醫院；會計師；財務顧問；律師；整合保險業申索和承保資料的組織；防欺詐組織；其他保險公司（無論是直接地，或是通過防欺詐組織或本段中指名的其他人士）；警察；和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊（及其運營者）(合稱「該等人士」)。

(三) 本人並同意貴公司之「個人資料政策」(「該資料政策」)會被引用，貴公司可按照該資料政策使用、披露及/或轉移我/我們的個人資料。本人可以向貴公司索取或從網址 www.hl-insurance.com 下載該資料政策。

(四) 本人茲授權持有我/我們之健康、投保資料、索償記錄或任何有關資料之該等人士或其他人士／機構，可以將部份或全部有關我/我們的個人資料及其他有關我/我們之傷患、病歷、投保資料、索償記錄、求診藥方或治療記錄等資料及所有住院、醫療或其他記錄之副本給予貴公司或其代理人。此授權書之影印本與正本具同等效力。發出此索償申請表並不代表貴公司接受本人之任何索償。

日期: _____ 索償者簽署: _____

豐隆保險(亞洲)有限公司
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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

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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	☐ Yes / ☐ No
2. Surgical operation	☐ Yes / ☐ No
3. More than one traumatic cause	☐ Yes / ☐ No
4. Influence of drug or alcohol	☐ Yes / ☐ No
5. Physical defects/congenital anomally	☐ Yes / ☐ No
6. Degenerative changes	☐ Yes / ☐ 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:

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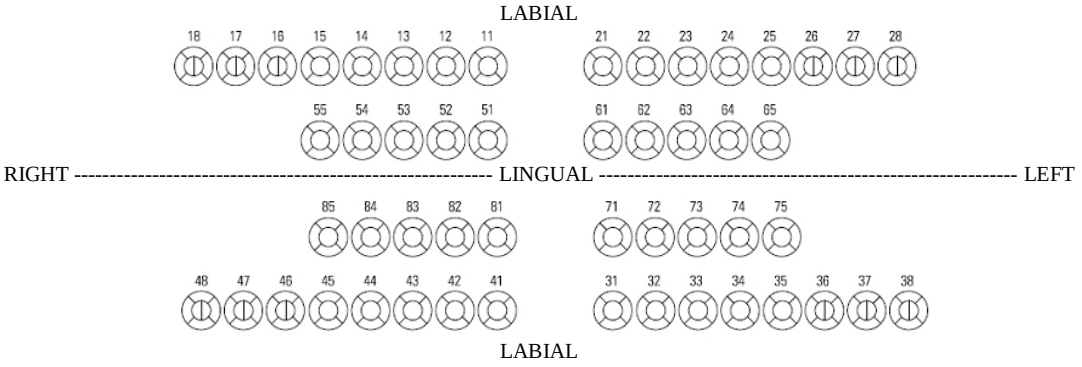
ACCIDENT INSURANCE CLAIM FORM

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: