



合群保險有限公司 Concord Insurance Co., Ltd.

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Personal Accident Insurance Claim Form 人身意外保險索償表格

THE INSURED 投保人

Name of Insured 保戶姓名	_____	Policy no. 保單號碼	_____
Occupation 職業	_____		
Address 地址	_____		
Tel. no. 電話號碼	_____	E-mail 電郵地址	_____

B) INSURED PERSON 受保人

Name of Insured Person 受保人姓名	_____	Age 年齡	_____	Sex 性別	_____
Occupation 職業	_____	Relationship with the Insured 與投保人之關係	_____		
(Please attach documentary evidence such as Birth Certificate or Marriage Certificate to show the relationship) 請附上有效證明文件, 如出生證明書或結婚證書, 以便證明受保人與投保人之關係					
Address 地址	_____				
Tel. no. 電話號碼	_____				

C) CIRCUMSTANCES OF ACCIDENT 發生意外情況

Date of accident 意外發生日期	_____	Time 時間	_____	<input type="checkbox"/> a.m. 上午	<input type="checkbox"/> p.m. 下午
Location 地點	_____				
Please state fully how the accident occurred 請詳述意外如何發生					

D) INJURY 傷勢

Part of body injured 受傷部位	Nature of injury 受傷性質			
<input type="checkbox"/> Hand 手	<input type="checkbox"/> Leg 腳	<input type="checkbox"/> Sprain 扭傷	<input type="checkbox"/> Fracture 骨折	<input type="checkbox"/> Burn 燒傷
<input type="checkbox"/> Head 頭	<input type="checkbox"/> Eye 眼	<input type="checkbox"/> Contusion 撞傷	<input type="checkbox"/> Laceration 割傷	
<input type="checkbox"/> Others 其他	_____	<input type="checkbox"/> Others 其他	_____	

Name and address of attending doctor

診症醫生姓名及地址

State the period during which the injured has been totally disabled from attending to his/her normal occupation

傷者完全失去工作能力的期間

From

由 DAY 日 / MONTH 月 / YEAR 年

To

至

DAY 日 / MONTH 月 / YEAR 年

Is the injured still totally disabled? Yes 是 No 否

傷者現時是否仍然完全喪失工作能力?

If "No", from what date was the injured person able to attend some part/all of his/her occupation?

如答“否”，傷者何日恢復部分或全部工作能力?

Whether the injured is hospitalizing/was hospitalized as a result of the accident? Yes 有 No 沒有. If Yes, please state

傷者有否因此意外而住院?

如“有”請說明

Name of Hospital

醫院名稱

Address

地址

Period of Hospital Confinement

住院期間

Date of Admission

入院日期 DAY 日 / MONTH 月 / YEAR 年

Time

時間

Date of Discharge or expected duration of hospitalization

離院日期或預計住院時間

Time

時間

DAY 日 / MONTH 月 / YEAR 年

IMPORTANT NOTES 重要事項

- This form should be submitted to us immediately after the accident together with all supporting documents.
- It is important that the Medical Report attached should be completed by a fully qualified and registered medical practitioner.
- If you are claiming for reimbursement of medical or other expenses, full details and documentary evidence must be provided.
- If compensation is related to Disability Benefit, 'Employer's confirmation of sick leave' must be completed by the employer of the Insured Person.
- 請填妥此表格連同所有索償文件於意外發生後盡快提交本公司以便處理閣下之索償
- 醫療報告必須由認可註冊西醫填寫
- 若閣下索償醫療費用, 請提交所有證明文件正本
- 若閣下索償傷殘津貼, 請提交僱主認可的病假證明書

DECLARATION & AUTHORIZATION 聲明及授權書

I/We hereby declare that to the best of my/our knowledge and belief the above statement and particulars contained herein are in all respects true and complete and are made without reservation of any kind. I/We agree that any of my/our/the Insured's personal information collected or held by Concord Insurance Co Ltd "Concord" (whether contained in this claim form or otherwise obtained) is provided and may be held, used and disclosed by Concord to individuals/organization associated with Concord or any selected third party (within or outside Hong Kong, including reinsurance and claim investigation companies and industry associations/federations and other service providers providing services relevant to insurance business) for the purpose of processing this claim.

本人/我們聲明此表格內填報的資料, 就本人/我們所知所信, 全部正確無訛, 並無任何保留。本人/我們同意如為處理有關本索償事宜, 合群保險有限公司可使用所收集及持有關於我/我們/受保人的個人資料(包括在此索償表格內或其他地方之資料)或將該等資料給予有關人士或機構(包括在香港境內或境外之再保公司)、賠償調查公司、保險業協會/聯會及其他提供保險業有關服務之公司等)。

Signature of Insured

保戶簽署

:

Date

日期

:

Signature of Insured Person

受保人簽署

:

Date

日期

:

MEDICAL REPORT 醫療報告

(To be completed by Insured Person's Attending Doctor)

1. (a) Name of patient _____
(b) Identity Card No. _____ Date of accident _____
(c) Age _____ Sex _____
2. (a) Was there any external and visible evidence of injury at your first consultation? Yes No
(b) Upon what date _____
(c) If Yes, please state type of injury _____
(d) State part of body injured _____
(e) Cause and extent of injury _____
3. (a) Did injury require hospitalization, x-rays, special diagnostic procedures and/or surgery?
 Yes No
(b) If Yes, please give details _____
4. (a) Was the injury induced from or affected by any of the following?
Yes No
 Physical defects/congenital anomaly
 Unfavorable past medical history
 Degenerative changes
 Alcohol or drugs
(b) Please give details if any of the above is "Yes" _____
5. (a) Was healing complicated? _____
(b) If so, state why and any special treatment given _____
6. 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.

7. Present condition of the patient _____
8. (a) Is there any treatment administered? Yes No
(b) If Yes, please give details (such as suturing, physiotherapy, type of dressing, etc. with treatment dates)

9. (a) Any other physicians who treated the patient for the same injury? Yes No
(b) If Yes, please give details (Name, address of doctors and date of treatment)

10. Bearing in mind the patient's occupation, do you feel that the injuries would have totally prevented the patient from working? If yes, please state the period.

Signed by Physician _____
(with chop)

Date _____

Qualifications _____

Tel No. _____

EMPLOYER'S CONFIRMATION OF SICK LEAVE
僱主認可的病假證明書

To be completed by Insured Person's Employer
由受保人的僱主填寫

This is to certify that the injured Mr/Ms/Mrs _____
is our employee serving the position currently as _____
who suffered an injury of _____
occurred on _____ and as result he/she did not attend to work during the
period from _____ to _____.

We further confirm that his/her monthly basic salary at the time of accident was HK\$ _____
(excluding bonus, commission, overtime and other allowance).

茲證明受保人 _____ 君為本公司聘用員工, 其職位
是 _____。因意外受傷(部位) _____
發生於(日期) _____。
因這意外他/她休假由 _____ 起至 _____。

本人/公司證明該受保人每月基本薪金為港幣 _____ (不包括花紅、佣金、超時補薪
及其他津貼)。

Signed by employer : _____ Date : _____
僱主簽署 : _____ 日期 : _____
(with company chop)
公司蓋印

Position : _____
職位 : _____

Signed by Insured Person : _____ Date : _____
受保人簽署 : _____ 日期 : _____