

Claim Form - Accident

意外賠償申請書

Claim Type 賠償類別

Medical Benefit
 Weekly Accident Indemnity
 Accidental Dismemberment

<input type="checkbox"/> New claim 首次索償	<input type="checkbox"/> Pending claim 待決索償	<input type="checkbox"/> Further claim 再度索償	<input type="checkbox"/> Review/appeal 重批/覆核
Please provide claim no. for reference 請提供賠償編號以作參考			

Part I (To Be Completed by Claimant/Insured) 甲部 (由索償人 / 受保人填寫)

A. Insured's Particulars 受保人資料						
Policy no. 保單編號	Insured's name 受保人姓名	HKID card/passport no. 香港身份證 / 護照號碼	Date of birth 出生日期 DD日MM月YYYY年 / /	Sex 性別	Age 年齡	Tel. no. 電話號碼

B. Employment Particulars 就業詳情		
1. Present occupation 現時職業	Duties 工作範圍	Employer's name, address & tel. no. 僱主名稱、地址及電話

If more than one occupation, state all and exact nature of occupational duties. 若有兼職請全部列明，並詳述職位及職責。

2. Did you file a medical leave certificate to your employer? 有否向僱主遞交病假證明書?	<input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有
3. Did you submit a claim for workmen's compensation for this accident? 有否就此意外申請勞工賠償?	<input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有
Submission date 遞交日期: (/ /) DD日 MM月 YYYY年	

C. Other Insurance Coverage 其他保險資料			
Does the Insured have any other insurance policy covering this case? 受保人會否就是次索償獲得其他保險賠償? <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有			
If "Yes", please complete below particulars. 若有，請詳細填寫以下資料。			
Name of insurer 投保公司	Policy no. 保單號碼	Benefit type 保障類別	Benefit amount 保障金額
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

As part of our endeavour to keep our records updated and to maintain high quality of service, we sincerely invite you to provide us your email address. Please visit our website <https://eservice.chubbliife.com.hk> to update your email address.

為使能為閣下提供更完善的服務及本公司可不時更新客戶個人資料，本公司現誠邀閣下使用本公司網上服務 <https://eservice.chubbliife.com.hk>，以提供閣下的電郵地址。

D. Accident Particulars 意外詳情

1. When (date and time) did the accident occur? 意外在何時（日期及時間）發生？	(/ /) (:) <input type="checkbox"/> AM 上午 DD日 MM月 YYYY年 HR時 MIN分 <input type="checkbox"/> PM 下午
2. Where did the accident occur? 意外在何地發生？	
3. How did the accident occur? (Please describe in details) 意外如何發生？（請描述詳情）	
4. Which part of the body injured and type of injury? 受傷部位及傷勢？	
5. a. Date on which you ceased work after the injury? 受傷後，何時停止工作？	a. (/ /) DD日 MM月 YYYY年
b. Date on which you returned to work? 何時恢復工作？	b. (/ /) DD日 MM月 YYYY年
c. Date on which you expect to return to work if you have not yet done so? 倘若未完全康復，閣下預料何時恢復工作？	c. (/ /) DD日 MM月 YYYY年
6. Any hospital confinement incurred? 有否住院？ If Yes, please state the date of admission. 如有，請提供入院日期	<input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有 (/ /) DD日 MM月 YYYY年

E. Treatment Particulars 治療詳情

Details of hospital confined or physicians consulted for this injury 詳列出此次受傷而就診之醫生 / 醫院詳情

Name of physician(s) &/or hospital(s) 醫生 / 醫院名稱	Address(es) 地址	Date of consultation(s) &/or period of confinement 就診 / 住院日期
_____	_____	_____
_____	_____	_____
_____	_____	_____

F. Declaration 聲明

PERSONAL INFORMATION COLLECTION STATEMENT AND CONSENT I/WE UNDERSTAND AND CONSENT THAT, by signing the claim form, any personal data collected or held by Chubb Life Insurance Company Ltd. (the "Company") is provided and may be used, processed, stored, disclosed, transferred by the Company to the companies within the group of which the Company is a subsidiary (the "Group Companies"), its authorized agents, reinsurers, claims investigators, loss adjudicators, medical advisors, recovery agents, insurance industry associations and federations, credit reference bureaus, government or judicial or regulatory bodies or any person to whom the Company is under legal and/or regulatory obligation to make disclosure, and the Company's appointed third party agents, contractors and advisors, in each case whether within or outside of Hong Kong to (i) process and evaluate claims and any future insurance application I/we may make; (ii) provide all services related to this claim, administer and process policy, medical and underwriting checks, payment instructions, premiums collection, data matching, and communicate with me/us for such purposes; (iii) enable the industry associations, the federations, the government or regulatory bodies to carry out the functions and requirements that may be assigned to them from time to time and are reasonably required in their interest and that of the insurance industry; and (iv) provide payment, data processing, administration, communications, computer, security and other services (including medical services, emergency assistance services, mailing and IT services) in connection with the operation of the Company and the provision of services to me/us. Moreover, the Company is hereby authorized to obtain access to and/or to verify any of my/our data with the information collected by the insurance industry associations, the federations, the government and regulatory bodies and medical personnel or organizations. I/We am/are obliged to supply the information required from me/us under the claim form which is a condition precedent for me/us to apply the claim. Failure to supply the required information may result in the Company being unable to process the claim. I/We understand that I/We have the right to obtain access to and to request correction of any personal data held by the Company or be given reasons for any refusal of access or correction. I/We also understand that a reasonable fee may be charged by the Company for processing of any access. Any questions regarding personal data, access to or correction of personal data should be made in writing and forwarded to The Data Protection Officer of Life Administration of Chubb Life Insurance Company Ltd. at 33/F, Chubb Tower, Windsor House, 311 Gloucester Road, Causeway Bay, Hong Kong.. **個人資料收集聲明及授權**就簽署此賠償申請書，本人/吾等明白及同意安達人壽保險有限公司（「貴公司」）可以使用、處理、儲存、透露、轉移任何貴公司所收集或持有任何本人/吾等的個人資料與貴公司隸屬同一集團附屬公司之其他公司（「集團公司」）、其獲授權的代理人、再保險公司、理賠調查員、處理索賠個案的理賠師、醫療顧問、索償代理、保險行業協會及聯會、信貸資料服務公司、政府或司法或監管機構或對貴公司具有法律及/或監管責任而須予以披露的任何人士，及貴公司指定的第三方代理、承包商及顧問，不論屬本地或海外，以 (i) 處理及審批索償及本人/吾等將來提交之保險申請；(ii) 提供所有關於此賠償申請之服務，管理及處理保單、醫療和核保檢查、付款指示、保費收取、資料核對，及因此等用途與本人/吾等聯絡；(iii) 令保險行業協會及聯會、政府或監管機構執行其經不時修定及為合理要求以維護其及保險行業利益的功能及規定；及 (iv) 提供因貴公司營運及給予本人/吾等服務之相關付款、數據處理、行政、通訊、電腦、保安及其它服務（包括醫療服務、緊急救援服務、郵寄服務及資料科技服務）。此外，貴公司獲授權向保險行業協會及聯會、政府及監管機構、及醫務人員或機構取閱及/或核實任何該等機構向本人/吾等收集之資料。本人/吾等有責任提供此賠償申請書上之所需資料，以作為申請賠償之先決條件。如未能提供所需的資料，可能會導致貴公司無法處理本賠償申請。本人/吾等明白本人/吾等有權取閱及要求更正任何貴公司持有之有關本人/吾等的任何個人資料，或被給予拒絕查閱或更正的理由。本人/吾等亦明白貴公司可能會收取任何查閱資料的要求之合理費用。如欲查詢有關個人資料事宜，查閱或更正個人資料必須以書面形式向貴公司壽險行政部的資料保護主任提出，並送交至香港銅鑼灣告士打道三一一號皇室大廈安達人壽大樓三十三樓。

G. Authorization 授權

I hereby irrevocably authorize or authorize on behalf of the Insured (if different) (i) any employer, doctor, hospital, clinic, insurance company, government office or any organizations or persons who have any records, knowledge or information (whether medical or otherwise) of me or the Insured (if different) to disclose, release or transfer to Chubb Life Insurance Company Ltd. "the Company" or its representative such information pertinent to this claim; (ii) the Company or any of its appointed medical/para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate my or the Insured (if different) health status in relation to this claim. This authorization shall bind my and the Insured's successors and assignees and remain valid notwithstanding my or the Insured's death or incapacity in so far as legally possible. A photocopy of this Authorization shall be valid as the original. 本人或受保人授權（如有不同）(i) 任何僱主、醫生、醫院、診所、保險公司、政府部門，或其他機構及人士，如具有本人/受保人（如不同）的任何紀錄、知識或資料，可將該等資料向貴公司或貴公司代表透露、發放或移交，用以作為該份索償申請的參考；(ii) 貴公司或貴公司委任的醫療/輔助醫療檢查員或檢驗所，就有關索償的申請，進行醫療評估或測驗，以檢定本人/受保人（如有不同）的健康狀況。該授權書對本人/受保人的繼承人及承讓人均有約束力，即使在本人/受保人（如有不同）死亡或喪失行為能力後仍然有效。該授權書的影印本具有與正本同等的效力。

Agent's/intermediary's code 保險代理/中介人號碼	Signature of insured 受保人簽署	Signature of policyowner (if other than insured) 保單持有人簽署（如並非受保人）
Signature of witness/agent/intermediary 見證人/保險代理/中介人簽署	Date 日期	Date 日期
	Full name of insured 受保人姓名	Full name of policyowner* 保單持有人姓名*
Name of witness/agent/intermediary in full 見證人/保險代理/中介人姓名	HKID card/passport no. of insured 受保人香港身份證/護照號碼	HKID card/passport/BR no. of policyowner* 保單持有人香港身份證/護照/商業登記號碼*
	Date of birth of insured 受保人出生日期	Date of birth of policyowner* 保單持有人出生日期*
Date 日期	Nationality of insured 受保人國籍	Nationality of policyowner* 保單持有人國籍*

* In compliance with the Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance and the Guideline on Anti-Money Laundering and Counter-Terrorist Financing which is issued by the Office of the Commissioner of Insurance as amended from time to time, Chubb Life Insurance Company Ltd. is required to collect the identity information for the above items with asterisk (*) and verify the identity of the Policyowner. Your agent/intermediary, therefore, is needed to verify the original identification documents and collect the copies of the relevant and other documents as deemed necessary of the Policyowner.

* 根據打擊洗錢及恐怖分子資金籌集（金融機構）條例及保險業監理處所發出及不時修訂之「打擊洗錢及恐怖分子資金籌集指引」，安達人壽保險有限公司必須收取以上註有星號（*）項目之保單持有人身份資料並核實保單持有人之身份。閣下之保險代理/中介人必須核實保單持有人之正本身份證明文件，並收取有關及其他所須文件之副本。

Part II - Attending Physician's Statement (To Be Completed by Attending Physician at the Claimant's Own Expense)

乙部－主診醫生報告（由申請人自費，由主診醫生填寫）

Policy No.

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A. General Information 一般資料

Patient's name 病人姓名	HKID card/passport no. 香港身份證 / 護照號碼	Date of birth 出生日期	Sex 性別	Age 年齡
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Are you the patient's usual doctor? 閣下是否病人之慣常醫生? Yes 是 No 否

B. Extent Of Injury 受傷詳情

<p>1. a. Date of accident 意外發生日期</p> <p>b. When were you first consulted for this injury? 就是次受傷之首次求診日期?</p> <p>c. Was there any evidence of a visible contusion, an accidental cut or wound on the exterior of the patient's body at the first consultation? 於首次診治療時，病人身體是否有明顯之瘀痕或傷口?</p> <p>d. Please provide the cause of this injury. 請提供受傷原因。</p> <p>e. Please provide details on type of injuries sustained. 請描述受傷類別</p> <p>f. Please provide details on which part of body injured. 請描述受傷部位。</p> <p>g. Please provide details on extent of injuries. 請描述受傷程度。</p>	<p>a. (/ /) DD日 MM月 YYYY年</p> <p>b. (/ /) DD日 MM月 YYYY年</p> <p>c. <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有</p> <p>d. _____</p> <p>e. _____</p> <p>f. _____</p> <p>g. _____</p>
<p>2. What was the condition of the injury as at the last consultation date? Any complications? 最後一次求診的受傷情況如何? 是否有併發症?</p>	<p>a. Date 日期 _____</p> <p>b. Physical finding 身體情況 _____</p> <p>c. Treatment 治療 _____</p> <p>d. Complications 併發症 _____</p>
<p>3. Did this injury require hospitalization? If "yes", please state: 此次受傷是否需要住院? (如是, 請提供詳情)</p>	<p><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>Date of admission 入院日期 (/ /) DD日 MM月 YYYY年</p> <p>Date of discharge 出院日期 (/ /) DD日 MM月 YYYY年</p> <p>Name of hospital 醫院名稱 _____</p>
<p>4. Did this injury require: (if "yes", please give details including date, result and finding) 此次受傷是否需要: (如是, 請提供詳情)</p> <p>a. Surgery? 進行手術?</p> <p>b. X-rays? X光檢查?</p> <p>c. Magnetic resonance imaging (MRD)? 磁力共振?</p> <p>d. Computerized Tomography (CT) Scan? 電腦斷層掃描?</p> <p>e. Physiotherapy/occupational treatment? 物理治療 / 職業治療?</p> <p>f. Other diagnostic procedures? 其他診斷程序?</p>	<p>a. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 _____</p> <p>b. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 _____</p> <p>c. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 _____</p> <p>d. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 _____</p> <p>e. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 _____</p> <p>f. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 _____</p>

<p>5. Please provide the prognosis of the injury. 請提供是次受傷之預期治療計劃。</p>	
<p>6. a. Any physical loss of joint was resulted from this accident? If yes, please specify the joint involved. 病人是否因此意外而導致喪失關節？如有，請說明那一個關節喪失？</p> <p>b. Any total functional disablement of joint and the condition is same as total physical severance of the said joint resulting from this accident? If yes, please specify the joint involved. 病人是否因是次受傷導致關節完全喪失其功能及其情況如同喪失該關節？如有，請說明那一個關節。</p>	<p>a. _____</p> <p>b. _____</p>
<p>7. Was such injury induced from or effected by any of the followings, which may have contributed to the accident? If “yes”, please give details. 受傷是否由以下情況導致或影響？（如是，請提供詳情）</p> <p>a. Physical defects/congenital abnormality 身體缺陷 / 先天毛病</p> <p>b. Past medical history 過往病史</p> <p>c. Degenerative changes 退化轉變</p> <p>d. By drugs or alcohol 藥物或酒精</p>	<p>a. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 _____</p> <p>b. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 _____</p> <p>c. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 _____</p> <p>d. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 _____</p>
<p>8. With reference to the patient's occupation stated overleaf. 就前頁所示，病人之職業而言</p> <p>a. Do the injuries totally prevent him/her from performing each and every duty of his/her occupation? 此次受傷會否完全阻礙病人履行該等職業之任何職務？</p> <p>b. If the patient is still disabled, please give approximate date he/she should be able to return to work? 如病人未能恢復工作，閣下估計病人何時能夠工作？</p>	<p>a. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 From 由 (/ /) To 至 (/ /) DD日 MM月 YYYY年 DD日 MM月 YYYY年</p> <p>b. (/ /) DD日 MM月 YYYY年</p>
<p>9. If an absence from work for more than two weeks was necessary, please describe in details the reasons why you feel the patient could not return to work earlier. 若不能工作兩星期或以上，請詳述閣下認為病人不可提早復工之原因。</p>	
<p>10. a. Was the healing complicated? 痊癒是否有困難？</p> <p>b. If “yes”, please state the reason and any special treatment given? 如是，請提供原因及施行之任何特別治療。</p>	<p>a. <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>b. _____</p>
<p>11. To your best knowledge, please give name(s) and address(es) of other physician(s) who treated the patient for the same injury and the date of consultation. 據閣下所知，請詳列就是次受傷曾對病人作出治療之醫生姓名、地址及診治日期。</p>	<p>Dr. name 醫生姓名 _____</p> <p>Address 地址 _____</p> <p>Date of consultation 診治日期 (/ /) DD日 MM月 YYYY年</p>
<p>Signature (with chop) 簽署</p>	<p>Name of physician 主診醫生姓名</p>
<p>Date 日期</p>	<p>Qualification 資歷</p>
<p>Address 地址</p>	<p>Tel. no. 電話號碼</p>

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