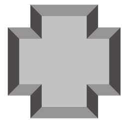

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Blue Cross 藍十字

Member of BEA Group 東亞銀行集團成員

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PERSONAL ACCIDENT CLAIM FORM 人身意外保險賠償申請表

Please complete this form in full and return together with all supporting documents to: **Blue Cross (Asia-Pacific) Insurance Limited.**
請填妥此申請表，連同有關文件盡速交回「藍十字（亞太）保險有限公司」。

Claimant's Particulars 申請賠償者資料

Name of Insured 投保人姓名	Policy No. 保單號碼	Claim No. (Office Use) 賠償號碼（本公司填寫）
Name of the Claimant 申請賠償者姓名		
Sex 性別	Age 年齡	I.D. Card No. 身分證號碼
Residential address 住址		
Name of Employer 僱主名稱	Address of Employer 僱主地址	
Telephone No. (Office) 電話號碼（公司）	(Home) （住宅）	
Present Occupation (if more than one, state all) 現時職業（如多於一項，請詳細列明）		
Main nature of occupational duties at time of accident 發生意外時的主要職業及職責		

Circumstances of Injury 受傷情形

Place of Accident 發生意外地點	Date 日期	Time 時間
Nature of Accident (state in details, how it happen) 意外原因（詳列細節，怎樣發生）		
Name(s) of Doctor (s) who treated you for the injury 受傷時，替你診治的醫生姓名	Address(es) of Doctor (s) 醫生地址	
Date Consulted 醫治日期		

Details of hospitalization 住院詳情 (please attach discharge note 請附收據)

Name of Hospital 醫院名稱	Period of Hospitalization 住院日期
Date on which you last worked prior to disability 不能工作前之最後工作日期	
Date on which you returned to work 恢復工作之日期	
Date on which you expect to return to work if you have not aleardy done so? 如現時仍不能工作，估計可於何日恢復工作?	
If after you return to work you were not immediately able to perform all your duties, please indicate: 如已恢復工作，但工作能力未能完全恢復，請列明:	
Are you insured with any other insurance company for accident benefits? If so, please give full particulars. 你是否於其他保險公司購有意外保險？ 如有，請列明：	☐ Yes 是 ☐ No 否

Details of claim and the amount you wish to claim under the Policy
請列明您欲依據此保險單索償的項目

Total Amount Claimed:
索償總數

HK$

Notes 注意

1. By furnishing this form the Company makes no admission of liability.
   呈上此表格非視爲本公司承認有關責任。
2. All original itemized bills must be submitted together with this form in order to avoid delay.
   呈上填妥之表格及附上醫療單據正本。

Authorization / Declaration 授權/聲明

I hereby authorize the Police Station concerned to release my statement to Blue Cross (Asia-Pacific) Insurance Limited. A photostat copy of this authorization shall be considered as effective and valid as the original.
本人授權警方向藍十字（亞太）保險有限公司提供本人之口供記錄。此授權書之副本具有正本之同等效力。

I / We hereby declare to the best of my / our knowledge and belief that the above statements and particulars are true and correct and I / We have no other insurance policy indemnifying me / us in respect of this accident. I / We hereby further agree that if I / we have made or shall make any false statement or concealment, the Policy shall be void and all rights of recovery under the Policy shall be forfeited.
本人/我等在此聲明以上一切資料均屬眞實，及在此次意外中，本人/我等並無得到其他保險賠償。
本人/我等亦同意，如以上或將來提供之資料有虛假成分或有隱瞞，此保險單將被作廢，而一切索償權利亦將喪失。

Personal Information Collection Statement 收集個人資料聲明

I/We hereby understand and agree that the any personal information is collected or held by Blue Cross (Asia-Pacific) Insurance Limited ("the Company") (whether contained herein or otherwise obtained) to enable the Company to carry on insurance business and may be used, stored, disclosed and transferred (whether within or outside Hong Kong) to any individuals/organizations associated with the Company or any selected third party as the Company may consider necessary including any other company carrying on insurance or reinsurance related business, any intermediary, claims investigator, medical facilities, other service provider providing services relevant to insurance business, professional advisor, government authority or industry association/federation for the purpose of: (1) any insurance or financial related product or service or any addition, alteration, variations, cancellation or renewal or reinstatement of them; (2) any scope of insurance coverage, claim processing/investigation, any analysis and data matching; (3) statistical or actuarial research; (4) promotion of financial products and services by the Company and its affiliated companies; and (5) communication with me/us/the insured or any relevant organization/person as the Company may consider necessary. I/We have the right to obtain the "Privacy Policy Statement", access to and to request correction of any personal information concerning myself/ourselves held by the Company. Such request can be made in writing to the Company's Corporate Data Protection Officer at 29th Floor, BEA Tower, Millennium City 5, 418 Kwun Tong Road, Kwun Tong, Kowloon, Hong Kong.
本人/我們明白並同意藍十字(亞太)保險有限公司("貴公司")可收集或持有本人/我們之個人資料(不論在本表格或其他途徑所得)用於保險業務之用途，並可將此等資料使用、儲存、透露及轉交(於本地或以外)予任何與貴公司有關之人士/機構或被選定之第三者，包括其他從事與保險或再保險業務有關之公司、中介人、理賠調查員、醫療機構、有關提供保險業務服務之公司、專業顧問、政府機關、或保險業組織或聯會，作以下用途:(1)有關保險或財務之產品或服務，或該等產品或服務之增加、更改、轉變、取消、更新或復效;(2)任何保障範圍，處理理賠/調查或其有關分析及資料核對;(3)統計或精算研究用途;(4)任何貴公司及其附屬公司之財務計劃、商品及服務之推廣活動;及(5)與本人/我們/受保人或貴公司認爲有關之機構/人仕聯絡。本人/我們有權致函香港九龍觀塘道418號創紀之城5期東亞銀行中心29樓向貴公司之個人資料保護主任索取「私隱政策聲明」,查詢及要求更正貴公司所持有有關之個人資料。

Date 日期	Signature of Claimant 申請賠償者簽署

Notes 注意

Employer's Confirmation of Sick Leave and Certificate of Medical Attendant have to be filled in only if you are claiming for Permanent Total or Temporary Total Disablement Benefit.
如非申請永久或暫時完全喪失工作能力賠償，毋須填寫僱主認可休假證明書及醫生證明書。

Employer's Confirmation of Sick Leave 僱主認可休假證明書

To be completed by claimant's employer
由申請賠償者的僱主填寫

This is to certify that the claimant ____________________ who is our employee serving the postition currently as ____________________ had suffered an injury of ____________________ occurred on ____________________ and as a result of the said injury he/she did not attend to work for a total of __________ days during the period from __________ to __________.

We further confirm that his/her basic salary at the time of accident was HK$ ____________________

(excluding bonus, commission, overtime and other allowance)

茲證明____________________（申請賠償者姓名），爲本公司____________________（職位）

因發生於____________________之意外而致____________________受傷

由____________________至____________________休假共____________________天。

本人/公司證明該申請賠償者，每月的基本薪金（不包括花紅、佣金、超時補薪及其他津貼）爲港幣____________________元。

Date 日期	Signed by Employer 僱主簽署 Company Chop 公司蓋章
Date 日期	Signature of Claimant (Signed to confirm the above statements are ture and correct) 申請賠償者簽署（證明以上資料眞實無誤）

A. State your Basic Salary: (excluding bonus, commission, overtime and other allowances)
請列明你的基本薪金（不包括花紅、佣金、超時補薪及其他津貼）

HK$

Or B. If you are self-employed: State gross income for previous 12 months: (after deduction of all operating expenses of your business)
或 如果你是自僱者：請列明最近12個月的總收入（扣除所有營業支出後計）

HK$

Certificate of Medical Attendant 醫生證明書

No claim can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expenses of the insured.
醫生證明書必須由政府註册及批准執業之醫師證明簽字否則無效，此項費用由保戶負責。

Patient's Name	Age	Identity Card No.	Date of Accident

1. Describe and locate cause, character and extent of injury

2. Is there any **external** and **visible** evidence of injury at the **1st consultation**

3. **Present** condition of the injury

4. Treatment administrated (as number of stitches, dressing, etc.)

Date	Time (am/pm)	Treatment

5. Names and Addresses of other Physicians who treated the insured for the same injury

Names	Addresses	Approximate Dates

6. Where did you see him after the accident?

7. Did injury require (if yes, please give details)

(a) hospitalizaton?	☐ No	☐ Yes	Date admitted	Date discharged
(b) X-rays?	☐ No	☐ Yes		
(c) Special diagnostic procedures?	☐ No	☐ Yes	Please specify:	
(d) Surgery?	☐ No	☐ Yes	Please specify:	

8. (a) Was healing complicated? ☐ No ☐ Yes

   (b) If so, state what special treatment was given?

9. Bearing in mind the patient's occupation, do you feel that the injuries would have prevented him/her from working? ☐ No ☐ Yes

10. If answer to the above is "Yes" and an absence from work of more than three days was necessary, please describe in detail the reasons why you feel the patient could not return to work earlier.

11. Given details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident and/or lengthen the period of disability.

12. Give date of first and last consultation or treatment.

First Date	Last Date

13. In your opinion how long was he/she disabled from performing any kind of duty pertaining to his/her occupation.

    Total disablement days from to

14. In your opinion how long was he/she disable from performing one or more important daily duties performing to his/her occupation ?

    Partial disablement days from to

I hereby certify that I have examined and treated the patient for the above injuries and that the facts as given above present my opinion of his/her condition.

Signed	Name of Physician & Chop	Date
Qualification	Address	Tel. No.

For identity purpose, the Claimant must sign his/her name in the presence of the Physician.	Signature of Claimant 申請賠償者姓名及簽署