Blue Cross 藍十字
An AIA Company 友邦保險成員公司

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

Sun Flower Insurance Brokers Limited
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Thank you for considering Sun Flower to be one of your selected intermediaries.
We are pleased to get in touch should you have any enquiry regarding the captioned insurance.

Please complete and sign this Claim Form, and provide the relevant documents listed in Part IV to avoid delay in claim process.
請填妥並簽署此賠償申請表，連同第四部分所列相關文件交回，以免延誤索償進程。
The Company is entitled to request for further information or other specific claim form to be completed, and assign an insurance adjuster for investigation.
本公司有權要求索償者提供更多資料或填寫其他專用索償表格，以及委派保險理算人進行調查。
All submitted documents to the Company will not be returned.
所有遞交予本公司之文件將不獲發還。
Completion and submission of this Claim Form shall not be construed as admission of liability on the part of the Company.
填寫及遞交此賠償申請表並不表示本公司承擔賠償責任。

I. Policy and Insured's Particulars 保單及受保人資料

Claim No. (Office use) 索償編號（本公司專用）	

Policy No. 保單編號	Name of Insured 受保人姓名	Age 年齡
		Gender 性別
HKID Card / Passport No. 香港身分證 / 護照號碼		E-mail Address 電郵地址
		Phone No. 聯絡電話
Residential Address 居住地址		Correspondence Address (if different from Residential Address) 通訊地址（如不同於居住地址）
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
Name of Employer 僱主名稱		Address of Employer 僱主地址

II. Claimant's Particulars 申請賠償者資料

Name of Claimant 申請賠償者姓名	Relationship with the Insured 與受保人的關係	HKID Card / Passport No. 香港身分證／護照號碼
Residential Address 居住地址		Correspondence Address (if different from Residential Address) 通訊地址（如不同於居住地址）
E-mail Address 電郵地址		Phone No. 聯絡電話

III. Circumstances of Injury 受傷詳情

Nature of Accident (state in details, how it happens) 意外原因（詳列細節，怎樣發生）		Place of Accident 發生意外地點 Date & time 日期和時間
Please provide details of consultations 請填報診治詳情 All doctors who have been consulted for the Injury 曾診治該傷患的醫生資料	Consultation Date 診治日期 _____ _____ Period of Confinement 留院時間	Name(s) and address(es) of doctor(s) 醫生姓名及地址 _____ _____ Name(s) and address(es) of hospital(s) 醫院名稱及地址
Hospitalization (please attach discharge note) 住院（請附出院記錄）	From 由 _____ to 至 _____ From 由 _____ to 至 _____	_____ _____

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 恢復工作日期	If after you returned to work you were not immediately able to perform all your job duties, please indicate 如已恢復工作，但工作能力未能完全恢復，請列明
Date on which you expect to return to work if you have not already done so 如現時仍不能工作，估計可於何日恢復工作	Are you insured with any other insurance for accident benefits? If so, please give full particulars 閣下是否購有其他意外保險? 如有，請列明 Yes 有 ☐ No 沒有 ☐ Name of insurance company 保險公司名稱: Policy No. 保單編號:	
Amount claimed (HK$) 索償金額（港幣）	Breakdown (HK$) 索償項目金額（港幣）	

IV. Claim Documents 索償文件

This Claim Form must be submitted within 14 days after the accident, even if any of the claim documents is not readily available.
如未能即時提供任何索償文件，此賠償申請表亦必須於意外發生後 14 天內填妥並立即呈遞。

Claim documents to be submitted to the Company must include, but are not limited to the following documents. The Company may reasonably further request you to provide supplementary information or evidence. For details of the Claims Conditions, please refer to the Terms and Conditions of the Policy.
閣下須提交包括但不限於以下列明的索償文件致本公司。本公司可能會在合理的情況下要求閣下提供補充資料及證明。有關詳細索償條件，閣下可參閱保單條款及細則。

Accidental Death or Permanent Disablement 意外身故或永久傷殘	Hospital and/or physician's report giving details on the nature and the extent of the Injury and the period of disablement 詳細闡述受傷的性質、程度及傷殘時段的醫院及 / 或醫生報告
	If death as a result of an accident, a copy of the death certificate and coroner's report 如因意外導致死亡，則需連同死亡證及驗屍報告副本
	Original police report and/or copy of statement to police (if applicable) 警方報告正本及 / 或口供記錄副本 (如適用)
Accidental Medical Expenses 意外醫療費用	Original hospital invoice and/or medical expenses receipt 醫院賬單及 / 或醫療費用收據正本
	Full physician's report stating the diagnosis of the condition treated, the date, time, duration and place of such hospitalization or clinical treatment 列明接受治療的病症及受傷的日期，及入院的日期、時間、持續時間及醫院或診所地址的詳細醫生報告
	Summary of the course of treatment including prescribed medicines and services rendered 治療時所使用的醫生處方藥物及服務的撮要
	If laboratory and/or x-ray expenses and/or physiotherapy treatment is incurred, physician's referral letter is required (if applicable) 如牽涉化驗測試及 / 或 X 光診斷及 / 或物理治療費用，須提交認可醫生發出的轉介信副本 (如適用)
	For trauma counselling benefit (if applicable), additional information including physician's report/certificate certifying the diagnosis of post-trauma stress disorder 倘若涉及索償創傷輔導保障 (如適用)，須提供額外文件包括醫生報告 / 證書，以證明患上創傷後壓力症
Temporary Total Disablement/Weekly Income Protection 暫時完全喪失工作能力 / 每週入息保障	All the required documents listed in "Accidental Medical Expenses" above 以上「意外醫療費用」所列的所需文件
	Physician's report/certificate certifying the disablement period 醫生報告 / 證書，以證明所指稱喪失工作能力的時段
	Officialdocument from the employer stating the duration of the relevant sick leave income proof, such as pay slip, tax return or bank statement 由僱主發出的正式文件，須列明有關的病假入息證明，如糧單、納稅申報單或銀行月結單

Employer's Confirmation of Sick Leave and **Attending Physician's Statement** 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索償，毋須填寫**僱主認可休假證明書**及**醫生證明書**。

V. Authorisation and Declaration 授權及聲明

I/We hereby authorise any hospital, physician, person, party and/or authority that has any records or is holding any information of the insured person or myself/ourselves to disclose to Blue Cross (Asia-Pacific) Insurance Limited ("the Company") or its authorised representative, any and all information with respect to the insured person's or my/our loss, disability, medical history, police statement made and the like for the purpose of assessing my/our claim request(s). A photocopy of this authorisation shall have the same effect as the original.
本人／我們謹此授權任何持有受保人或本人／我們之任何記錄或資料的醫院、醫生、人士、有關人等、及／或有關當局，向藍十字（亞太）保險有限公司（「貴公司」）或其授權代表提供任何或所有有關受保人或本人／我們之損失、損傷、病歷、口供或任何相關資料作評估賠償申請之用途。此授權書之正本及副本皆具同等效力。

I/We hereby declare that all the above information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief. I/We have not withheld any material information and acknowledge that failure to supply true and accurate answers to this request or inform the Company of all material information may render the Company unable to accept or process this request and all rights to recover under the Policy shall be forfeited. I/We understand that the issuance or completion of this Claim Form does not constitute admission of liability or guarantee payment of the claim on behalf of the Company.
本人／我們謹此聲明，上述所有問題的答案包括所有資料及細節均是準確無誤，真實及為事實之全部，並且是盡本人／我們所知及所信而作答的。本人 / 我們並沒有隱瞞任何重要資料及確認如未能提供真實及準確無誤之資料或通知貴公司任何有關此索償申請之重要資料，將可能導致貴公司不能接受或處理此索償申請及喪失所有追討保單權益之權利。本人／我們明白此索償表格之發出及填妥並不代表貴公司確認責任或保證賠償。

I/We confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form. 本人／我們確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。

Signature of Claimant (with company chop if appropriate) (並公司蓋章，如適用)	:	Signature of Insured Person 受保人簽署申請賠償者簽署	:
Name 姓名	:	Name 姓名	:
Date 日期 (dd/mm/yy 日/月/年)	:	Date 日期 (dd/mm/yy 日/月/年)	:

The Chinese version of this Form is for reference only. In case of any discrepancy between the Chinese and English versions, the English version shall prevail. 此表格的中文譯本僅供參考之用，文義如與英文本有歧異，概以英文為準。

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

To be completed by the Insured's employer. 此部分由受保人的僱主填寫。

This is to certify that the Insured _____who is our employee serving the position 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).

茲證明受保人_____（受保人姓名），為本公司_____(職位) 因於_____發生之意外而致_____受傷由_____至_____休假共_____天。

本人／本公司證明該受保人，每月的基本薪金（不包括花紅、佣金、超時補薪及其他津貼)為港幣_____元。

Signed by Employer 僱主簽署	Company Chop 公司蓋章	Date 日期

To be completed by the Insured 此部分由受保人填寫

A. State your Basic Salary (HK$) [excluding bonus, commission, overtime and other allowance]. 請列明閣下的基本薪金（港幣$)[不包括花紅、佣金、超時補薪及其他津貼] or	HK$ 港幣$
B. If you are self- employed: State gross income for previous 12 months (HK$) [*after deduction of all operating expenses of your business]* 如果閣下是自僱者: 請列明最近 12 個月的總收入[扣除所有營業支出後]	HK$ 港幣$
Signature of Insured (Signed to confirm the above statements are true and correct) 受保人簽署（證明以上資料真實無誤)	Date 日期

Attending Physician's Statement 醫生證明書

To be completed by the Insured's attending physician at the Claimant's cost. 此部分由受保人的主診醫生填寫，有關費用須由申請賠償者支付。

Patient's name 病人姓名	HKID Card/Passport No. 香港身分證／護照號碼	Sex 性別	Age 年齡

Date of Accident 意外日期	Describe and locate cause, character and extent of injury 描述傷患位置、起因、徵狀及程度

Is there any external and visible evidence of injury at the 1st /first consultation 首次診症時，傷患是否由外在及可見因素引致

Severity of the injury and the present condition 傷患的嚴重情度及現況

Where did you see him/her after the accident 意外發生後，閣下在那診治病	Treatment administrated (as numbered of stitches, dressing, etc.) 傷勢處理(如多少縫針，包紮傷口等) Time (am/pm) 時間 Date 日期 Treatment 治療手法 _____

Did injury require (if any, please give details) 傷勢是否需要 (如是，請提供詳情)

(a) Hospitalization 住院	Yes 是 ☐ No 否 ☐	Date admitted 入院日期 _____	Date discharged 出院日期 _____
(b) X-ray X 光	Yes 是 ☐ No 否 ☐		
(c) Special diagnostic Procedure	Yes 是 ☐ No 否 ☐	Please specify 詳情特別診斷的程序 _____	
(d) Surgery 手術	Yes 是 ☐ No 否 ☐	Please specify 詳情 _____	

Was healing complicated 癒合情況是否複雜 If so, state what special treatment was given? 如是，請列明特別治療方法	Yes 是 ☐ No 否 ☐ Date 日期 _____	Details 詳情 _____

Bearing in mind the patient's occupation, do you feel that the injuries would have prevented him/her from working? Yes 會 ☐ No 不會 ☐
依據閣下的意見，病人之傷患會否引致他/她不能從事意外發生前之工作。

If "Yes" and an absence from work of more than 3 days was necessary, please describe the reasons why you feel the patient could not return to work earlier.
如"會"及病人必須休假 3 日或以上，請提供閣下認為病人不能早日返回工作之原因。

_____

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. 請詳述任何可能引致上述意外及／或令傷殘康復期延長之因素， 如醉酒、身體缺陷或病歷。

_____

In your opinion how long was he/she disabled from performing any kind of duty pertaining to his/her occupation. 依據閣下的意見，病人將於下列期間不能從事其正常職業。

Total disablement 完全不能從事其正常職業_____ days 日 from 由 _____ to 至_____

In your opinion how long was he/she disabled from performing one or more important daily duties performing to his/her occupation. 依據閣下的意見，病人將於下列期間不能從事其慣常職務中 1 項或多項日常工作。

Partial disablement 暫時無法復工 _____ days 日 from 由 _____ to 至_____

Name(s) and Address(es) of other Physicians who treated the Patient for the same injury 其他有參與治療病人是次傷患的醫生姓名及地址

Approximate Date 大約日期 Name 醫生姓名 Address 地址

Date of first consultation or treatment 第一次診斷及治療日期	Date of last consultation or treatment 最近一次診斷及治療日期

I hereby certify that I have examined and treated the above Patient for the above injuries and that the fact as given above present my opinion of his/her condition 本人謹此證明以上病人之傷患是經本人診斷及治療並以他／她的實況來表達本人上述之意見。

Signature 簽署	Name of physician & chop 醫生姓名及蓋章	Date 日期
Qualification 資格	Address 地址	Phone No. 電話號碼