PERSONAL ACCIDENT CLAIM FORM
個人意外索償申請表

It is important that a complete answer be given to every question. If insufficient space is provided for your answers, please continue on a separate sheet.
請詳細填報表格上每一項目。如空位不足，可自備補充頁填寫。

POLICY NUMBER 保單號碼	NAME OF AGENT 保險代理人

INSURED 受保人

Full Name 姓名 _____

Corresponding Address 通訊地址 _____

_____ Tel No. 電話 _____ Fax No. 傳真 _____

INJURED PERSON 傷者

Full Name 姓名 _____ Occupation 職業 _____

Corresponding Address 通訊地址 _____

_____ Tel No. 電話 _____ Fax No. 傳真 _____

ACCIDENT 意外情況

Date and time of accident 意外發生日期及時間 _____

Place of accident 意外發生地點 _____

State how did the accident occur 意外發生經過 _____

_____

_____

Nature of claim 索償項目 (please put a √ in the appropriate box 請在格內用√選擇適合項目)

□ Medical expenses 醫療費用 □ Chinese bonesetter / acupuncturist treatment expenses 中國跌打及針灸費用

□ Temporary total disablement 暫時性完全喪失工作能力 □ Hospital Allowance 住院現金津貼

□ Accidental death 意外身故 □ Permanent disablement 永久傷殘 □ Others 其他 _____

Total amount claimed 索償總額 _____

INJURY 受傷情形

Nature of injury 受傷之性質 _____

Part of body injured 受傷部位 _____

Has he/she previously suffered from injury to the same part? YES/NO*
傷者是否曾經在同一位部位受傷? 是/否*

If YES, please give details 若有，請詳述: _____

How long has he/she been totally disabled from engaging in or attending to his/her usual employment or occupation as the result of the injury? 傷者因受傷而完全喪失工作能力的期間？

From 由 _____ to 至 _____

Name and address of the Doctor attending the injured person 應診醫生姓名及地址

_____

Is he/she the injured person's usual doctor? YES/NO*
該醫生是否傷者慣常求診之醫生? 是/否*

Date of Hospitalisation (if applicable) 住院日期(如適用) : From 由 _____ Time 時間 _____

To 至 _____ Time 時間 _____

Name and address of the Hospital 醫院名稱及地址:

_____

Has the insured person fully recovered? YES/NO*
傷者是否已完全康復? 是/否*

If NO, please give details 若否，請詳述: _____

*Please delete whichever is inapplicable 請刪去不適用者

CL8 08/13

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OTHER INSURANCE OR COMPENSATION 其他保險及賠償

Any other insurance policy covering the expenses involved? YES/NO*
上述項目是否受保於其他保險合約? 是/否*

If YES, please provide the following information 如有，請提供以下資料:

Name of Insurance Company 保險公司名稱 _____

Class of Insurance 保險種類 _____ Policy No. 保單號碼 _____

Amount claimed 索償金額 _____ Currency 貨幣 _____

DECLARATION 聲明

I/We declare that these particulars are true to the best of my/our knowledge and belief.
本人／吾等聲明上列資料乃本人／吾等所知一切據實填報。

In accordance with the provisions of the Personal Data (Privacy) Ordinance of Hong Kong, by signing below, I/we consent that the personal information collected or held by FWD General Insurance Company Limited (whether contained in this Application or otherwise obtained) is provided and may be disclosed to individuals or organisations within or outside of Hong Kong for the purpose of administration of claim or analysis of it.
根據香港個人資料 (私隱) 條例，本人／吾等簽署如下，同意富衛保險有限公司得到或持有之本人個人資料 (該等資料可能在此表格提供或從其他途經得到) 可透露予本港或海外之個人或組織機構以作為處理任何索償分析之用途。

Injured Person's Signature 傷者簽名	H.K.I.D. Card No. 香港身份證號碼	Date 日期
Insured's Signature (& Company Chop, if applicable) 受保人簽名 (及公司蓋章，如適用)	H.K.I.D. Card No./B.R. No. 香港身份證號碼/商業登記號碼	Date 日期

The following document should be submitted (if applicable) 請呈交以下相關文件:

1. Please attach the relevant medical report, original medical expenses receipt, sick leave certificate and Doctor's referral letter to certify the expenses. 請附交有關之醫療報告、收條正本、病假證明及醫生轉介信等以證明索償金額。
2. For accidental death, please submit your claim with the supporting documents (e.g. Accident Report, Police Report, Death Certificate and/or any relevant documents.) If the next of kin(s) is/are minors (persons not yet 18 years of age) please give particulars of the Official Administrator(s) and provide copies of the documentation authorising that person to act in this capacity. 若為意外身亡索償，請附交有關資料如意外報告、警方報告、死亡證及有關文件等，如受益人為未成年人士，請提供其代理人之資料，以及有關之授權代理證明文件。

Notes 注意:

1. By submission of this form this Company makes no admission of liability. 呈上此表格非視為本公司承認有關責任。
2. Completed claim form together with supporting documents should be forwarded to this Company within the time stipulated in the insurance policy. 請將已填妥之表格及有關證明文件，在保單指定日期內呈上本公司。
3. Claims will not be processed unless declaration is signed by the claimant. 本公司只接受已簽署之索償申請表。
4. If you are claiming for reimbursement of medical or other expenses, full details and documentary evidence must be provided. 若要申索醫療或其他費用的賠償，請提供詳細資料及證明文件

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It is important that the Certificate of Medical Attendant should be completed by a fully qualified and registered medical practitioner.
醫生證明書必須由政府註冊及批准執業之醫師填寫

CERTIFICATE OF MEDICAL ATTENDANT 醫生證明書					
1. Name of Patient		ID Card No.		Age	
2. Date of accident					
3. Cause of injury					
4. Diagnosis					
5. When were you first consulted for these injuries?					
6. Treatment given (e.g. suturing, physiotherapy, type of dressing, etc) Date: Treatment:					
7. Other medical treatment or examination required (if yes, please give details) (a) Hospitalisation?..... (b) X-rays?..... (c) Special diagnostic procedures?..... (d) Surgery?.....			YES/NO* Date admitted _____ Date discharged _____ YES/NO* YES/NO* Please specify YES/NO* Please specify		
8. How long has the Patient been totally disabled from engaging in or attending to his usual employment or occupation as a result of these injuries or illnesses?			From _____ to _____		
9. How much longer do you consider such disablement will continue?			From _____ to _____		
10. Has the Patient any other disease or physical defect? If YES, (a) What is the nature?..... (b) To what extent may recovery be effected thereby?.....			YES/NO* (a) (b)		
Signature: Address:			Qualifications: Date:		

*Please delete whichever is inapplicable 請刪去不適用者

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If compensation is related to Temporary Total Disablement, the Employer's Confirmation of Sick Leave must be filled by the Injured Person's employer.
若是有關暫時性完全喪失工作能力索償，僱主認可休假證明書必須由傷者僱主填寫

EMPLOYER'S CONFIRMATION OF SICK LEAVE 僱主認可休假證明書

To be completed by injured person's employer 由傷者僱主填寫

This is to certify that the injured _____ who is our employee serving the position 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 monthly salary during the twelve months prior to the accident was HK$_____.

茲證明 _____ (傷者姓名)， 為本公司 _____ (職位)因發生於 _____ 之意外而致 _____ 受傷由 _____ 至 _____ 休假共 _____ 天。

本人/本公司證明該傷者在意外前 12 個月的每月基本薪金 (不包括花紅，佣金，超時補薪及其他津貼) 為港幣 _____。

_____ _____
Employer's Signature & Company Chop
僱主簽名及公司蓋章

Date
日期

_____ _____
Injured Person's Signature
傷者簽名

Date
日期

If Injured Person is self-employed: State gross income for previous 12 months: (after deduction of all operating expenses of your business)
若傷者是自僱人士： 請列明最近 12 個月的總收入（扣除所有營業支出後計）

Amount 金額: HK$_____

(Please provide the relevant income statement 請附上相關收入文件)

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