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QBE HONGKONG & SHANGHAI INSURANCE LIMITED

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昆士蘭聯保保險有限公司

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CLAIMS HOTLINE 賠償部熱線: (852) 2877 8608

CLAIMS FAX 賠償部傳真: (852) 3607 0530

FOR AGENT USE:

Agent name:

Tel no.:

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

A. NOTES 注意事項

- All questions must be answered. If not applicable, write "n/a".
所有問題必須作答。如不適用者，請填上「不適用」。
- The issue of this claim form is not an admission of liability by QBE Hongkong & Shanghai Insurance Ltd.
發出此索償申請表並不代表昆士蘭聯保保險有限公司承認任何責任。
- If there is insufficient space or further comment on any area is considered necessary, please use additional pages.
若填報資料的位置不足，請填寫於附加紙上。

B. DETAILS OF THE INSURED 保戶資料

Policy no. 保單號碼:	Name of the insured 保戶姓名:		
Address 地址:			
Home tel. no. 住宅電話:	Office tel. no. 辦公室電話:	Mobile tel. no. 流動電話:	
Contact Person 聯絡人姓名:	Email 電郵:		
Occupation / business 職業 / 行業:	Present position 現時職位:	Present salary 現時薪金:	
Employer's name, tel. no. and address 僱主名稱、聯絡電話及地址:			

C. ACCIDENT DETAILS 意外資料

Date 日期: / /	Time 時間: / /	am / pm 上午 / 下午
Detailed description of accident 意外詳情:		
Nature & extent of injury 受傷性質及程度:		
Have you ever previously met with similar accident or sustained with similar nature of injury? <input type="checkbox"/> YES 是 閣下過往是否遇上類似之意外或損傷? <input type="checkbox"/> NO 否 If "Yes", please give details (including insurance claims). 如「是」，請提供資料(包括保險索償)。		
The following document(s), if any, should be attached with this claim form: 須與此申請表一併遞交之文件(如有): <ul style="list-style-type: none">Hospitalization period certificate 住院證明書: from 由: to 至:Sick leave certificate 病假證明書: from 由: to 至:Receipts issued by registered doctor(s) 由註冊醫生發出之收據: HK\$ 港元Receipts issued by non-registered doctor(s) 由非註冊醫生發出之收據: HK\$ 港元		
Are you fully recovered? 閣下是否已經痊癒? <input type="checkbox"/> YES 是 <input type="checkbox"/> NO 否 If "No", please state what treatment(s) that you are now receiving. 如「否」，請說明現時接受之治療。		

D. DETAILS OF THE POLICE OR OTHER AUTHORITY 警方或其他有關政府機構資料

If the case was reported to the police or other authority, please provide the following information.
若事件已報告警方或其他有關政府機構，請填寫下列資料。
Name & address of the police station / other authority reported to 報案警署或其他有關政府機構名稱和地址:

Report / reference no.
報案 / 檔案號碼: Date of report
報案日期: / /

Please attach the following document(s) with this claim form 請連同以下文件與此申請表一併遞交:

- Letter of consent 同意書
- Copies of report from the police / authority and statement, if applicable 警方或其他有關政府機構之報告文件及口供副本(如適用)

E. OTHER INSURANCE DETAILS 其他保險資料	
Do you also report this case to your employer for employees' compensation claim? <input type="checkbox"/> YES 是 閣下是否同時向僱主報告事件以申請僱員補償索償? <input type="checkbox"/> NO 否	
Was there any other insurance (including employees' compensation insurance) covering this accident at the time of occurrence? <input type="checkbox"/> YES 是 是次意外發生時是否同時享有其他保險之保障(包括僱員補償保險)? <input type="checkbox"/> NO 否 If "Yes", please give details. 如「是」, 請提供資料。	
Name of insurer 保險公司名稱:	Type of insurance 保險種類:
Policy no. 保單號碼:	Claim no. 索償號碼:
Claims amount received / claimable amount 已收取之賠償金額 / 可索償金額: HK\$ 港元	

F. DECLARATION & AUTHORIZATION 聲明及授權	
I declare that the answers given above are true and complete to the best of my knowledge. 本人鄭重聲明就本人所知, 上述各項均屬真確完備。	
I hereby authorize all physicians, hospitals, clinics, insurance companies or organizations (including employers) that have any records or knowledge of the insured person or his / her medical and health conditions to disclose to QBE Hongkong & Shanghai Insurance Ltd. or its representative all information and / or documents about the insured person with reference to the incident, his / her other insurance covers and / or insurance claim history, his / her health and medical history and any hospitalization, advice, treatment, disease, injury or ailment, or attendance record. Such authorization shall survive me and be binding on my estate in any event even if I may be suffering from any kind of mental incapacity in so far as legally possible. A Photostatic copy of this authorization shall be as effective and valid as the original. 本人在此授權所有醫生、醫院、診所、保險公司或擁有有關受保人資料或其醫療和健康記錄之機構(包括僱主), 向昆士蘭聯保保險有限公司或其代表披露及提供受保人此次意外之所有有關資料及 / 或文件、其他保險之保障及索償申請資料記錄、過往之健康記錄及病歷。任何住院、診斷、治療、疾病、受傷或患病或出勤記錄。如法律上可行, 本授權書在本人身故或有任何程度的精神不健全後仍然有效, 並對本人之遺產具有約束力。此授權書之影印本亦屬有效。	
HK I.D. no. 香港身份證:	Signature of the patient 病人簽署:
Date 日期:	

G. ATTENDING PHYSICIAN'S STATEMENT 主診醫生證明書 (To be completed by the claimant's attending physician at the claimant's own expense. 此欄須由申請索償人之主診醫生填寫, 所需費用由申請索償人自行承擔)	
IN RESPECT OF THE DISABILITY DESCRIBED ON THE CLAIM FORM 有關索償申請表描述之殘疾	
Diagnosis 診斷:	
Are you the patient's regular physician? <input type="checkbox"/> YES 是 閣下是否病人慣常求診之醫生? <input type="checkbox"/> NO 否	Date of first consultation 首次求診日期:
Date unfit for work 須休假期:	Date fit for work (If uncertain, please estimate) 可復工日期(如不確定, 請估計):
If there is a prior history of same or similar condition, please give details. 如曾患有相同或類似病症, 請詳細說明。	
In my opinion the patient is / was totally disabled from engaging in his usual occupation as 本人認為病人完全無法擔任以下慣常職位	
(state briefly the nature of duties required 簡述要求的職責性質)	from 由: to 至:
I CERTIFY that to the best of my knowledge the foregoing statements are correct. 茲證明就本人所知, 以上陳述均屬正確。	
Doctor's name 醫生姓名:	
Qualification(s) 資歷:	
Address 地址:	
Tel no. 電話:	
Date 日期:	Chop & signature 印章及簽署:

PERSONAL INFORMATION COLLECTION STATEMENT 收集個人資料聲明
The information you provide to us is collected to enable us to carry on insurance business and may be used for the purpose of any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or service; any claim or investigation or analysis of such claim; and exercising any right of subrogation, and may be transferred to 1) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; 2) any association, federation or similar organization of insurance companies ("Federation") that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation, and 3) any members of the Federation by the Federation for any of the above or related purposes. Moreover, we are hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance industry. You have the right to obtain access to and to request correction of any personal information concerning yourself held by us. Requests for such access can be made in writing to the General Administration Officer, QBE Hongkong & Shanghai Insurance Limited, 17/F, Warwick House, West Wing, Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong (Telephone: 2877 8488, Fax: 3607 0300)
閣下提供的資料, 為本公司提供保險業務所需, 並可能使用於: 任何與保險或財務有關的產品或服務, 或該等產品或服務的任何更改、變更、取消、或續期; 或任何索償, 或該等索償的調查或分析; 或行使任何代位權之用。以上資料, 及可能轉移予: 1) 任何有關的公司, 或任何其他從事保險或再保險有關的公司, 或與保險業務有關的中介人或索償或調查或其他服務提供者, 以達到任何上述有關目的; 2) 現存或不時成立之任何保險公司協會或聯會或類同組織(聯會), 以達到任何上述或有關目的, 或以便聯會執行其監管職能, 或其他基於保險業或任何聯會會員的利益而不時在合理要求下賦予聯會的職能; 及 3) 或透過聯會轉移予任何聯會的會員, 以達到任何上述或有關目的。此外, 本公司亦據此獲授權由聯會從保險業內收集的資料中查閱及 / 或核對閣下任何資料。閣下有權查閱及要求更正由本公司持有有關閣下的個人資料。如有需要查閱, 可用書面寄香港鰂魚涌英皇道979號太古坊和域大廈西翼17樓(電話: 2877 8488, 圖文傳真: 3607 0300) 向本公司行政事務主任提出。