中 銀 集 團 保 險 有 限 公 司
BANK OF CHINA GROUP INSURANCE COMPANY LTD.

總公司：香港德輔道中 71 號永安集團大廈八樓　電話：2867 0888　傳真：2521 8985
HEAD OFFICE: 8/F., WING ON HOUSE, 71 DES VOEUX ROAD CENTRAL, HONG KONG.
TEL.: 2867 0888　FAX: 2521 8985

本公司專用
Office Use
賠案編號
Claim No. _________________

人身意外險索償表格
PERSONAL ACCIDENT INSURANCE CLAIM FORM

保單資料
Insurance Policy Details

保戶名稱
Name of Insured ___香港工會聯合會屬下工會及團體___

保單號碼
Policy No. ___________________________

索償人 / 被保人 資料
Particulars of Claimant / Insured Person

索償人 / 被保人 姓名
Name of Claimant / Insured Person ______________________________

所屬工會
Name of Association______________________________

聯絡電話
Contact Tel. No.______________

身份證號碼
Identity Card No. ________________________

性別
Sex _________

出生日期 日 月 年
Date of Birth ______ DD_____ MM _________YY

職業
Occupation ______________________

地址
Address____

索償資料
Particulars of Claim

意外發生日期及時間 (1) Date and time of accident.	________ 日 DD ________ 月 MM __________ 年 YY 時間 Time: _________ ☐ 上午 am ☐ 下午 pm
意外發生地點 (2) Place of accident.	____
意外詳情 (3) a. Description of accident 如有報警，列明報案的警署及報案編號 b. If the accident has been reported to the police, please state which the police station and police report number.	a. ____ ____ b. ____
傷勢及其部位 (4) Nature and region of injury.	____
住院日期 (5) In Hospital 醫院名稱 Name of Hospital	由 From _______ 日 DD _______ 月 MM ________ 年 YY 至 To _______ 日 DD _______ 月 MM _______ 年 YY 合共 Total__________ 天 Days ____.
被保人是否就是次意外向其他保險公司索償 (6) a. Is the Insured Person entitled to claim under any other insurance policies in respect of this accident? 如是，列明保險公司的名稱，保單編號及索償保障項目 b. If yes, state the name of insurance company(s), respective policies Nos and details of benefits.	a. ☐ 否 No ☐ 是 Yes b. ____
被保人以往是否有類似的受傷情況 (7) a. Has the Insured Person ever sustained similar injury? 如是，列明詳情及何時發生 b. If yes, please give detail and date.	a. ☐ 否 No ☐ 是 Yes b. ____

賠款發放方式：
Claim Payment Method:
(自動轉賬祇適用於住院現金津貼索償及賠償額在HK$2,000.00或以下)
(Auto-pay applicable to Hospital Cash Benefit Claim & settlement amount below HK$2,000.00 only)

請在適當的方格內填上“✔”以確定賠款發放方式
Please tick the appropriate box to confirm the claim payment method

☐以支票形式發放
By Cheque

☐以自動轉賬形式發放 銀行名稱 銀行編號 分行編號 戶口號碼
By Auto-pay Name of Bank____________________ Bank Code________Branch Code_________ Account No____________________.
戶口持有人名稱(必須與索償人名稱相符)
Name of Account Holder (Must be same as Insured)________________________________.

聲明及授權
Declaration and Authorization

本人聲明上述資料完整及正確無訛，並無隱瞞任何重要資料。

本人明白本人提供的資料爲 貴公司提供保險業務所需，並可能使用於下列目的:
— 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；-
— 任何索償，或該等索償的調查或分析；
— 行使任何代位權；及

可能移轉予：
— 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或其他服務提供者，以達到任何上述或有關目的；
— 現存或不時成立的任何保險公司協會或聯會或同類組織〔「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
— 透過「聯會」移轉予任何「聯會」的會員，以達到上述或有關目的。

此外，本人授權 貴公司可向「聯會」從保險業收集的資料中查閱及/或核對本人任何資料。本人明白本人有權查閱及要求更正由 貴公司持有有關 本人的個人資料。 如有需要，本人將向
貴公司辦公室提出〔電話:2867 0888，傳真: 2522 1705〕

I declare that the above information is complete and true to the best of my knowledge and belief and I have not withheld any material information connected with this claim.

I understand that the information I provide to Bank of China Group Insurance Co Ltd (“the Company”) is collected to enable the Company to carry on insurance business and may be used for the purpose of:
- any insurance or financial related products or services or any alterations, variations, cancellation or renewal of said products or services;
- any claim or investigation or analysis of such claim;
- exercising any right of subrogation; and

may be transferred to:
- 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;
- 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
- any members of the “Federation” by the “Federation” for any of the above or related purposes.

Moreover, the Company is hereby authorized to obtain access to any / or to verify any of my data with the information collected by the Federation from the insurance industry. I understand I have the right to obtain access to and to request correction of any personal information concerning myself held by the Company. Requests for such access can be made to the Administration Department of the Company. (Tel: 2867 0888 / Fax: 2522 1705)

______________________________	______________________________
索償人 / 被保人 簽署 Signature of Claimant / Insured Person 日期 Date:	香港工會聯合會簽署蓋章 Signature of The Hong Kong Federation of Trade Unions (With Chop) 日期 Date:

所需文件
DOCUMENTS REQUIRED

索償人 / 被保人身份証副本
Copy of Claimant / Insured Person HKID Card

如有報案，請提供所有警方口供紙副本
Copies of all police statements, if any

人身傷亡索償 Death/Permanent Disablement Claim
1. 主診醫生証明書及/或醫療報告
   Complete “Attending Physician’s Statement &/or Medical Report
2. 死亡証副本、合法受益人資料及文件
   Copy of Death Certificated, Information of Lawfully Beneficiary

住院現金津貼索償 Hospital Cash Benefit Claim
1. 住院收據正本
   Original Medical Receipts
2. 出院紙正本
   Original Discharge Slip

註：如有需要，保險公司將另函或致電聯絡索償人索取進一步資料或文件

This statement should be fully completed and signed by Attending Physician. Any expense for completing this statement must be paid by the Insured.
本表格必須由主診醫生填妥和簽署，所需費用由保戶自行支付。

ATTENDING PHYSICIAN'S STATEMENT
主診醫生証明書

Name of Patient:	Identity Card No.:	Date of birth (DD/MM/YY):	Date of Accident (DD/MM/YY) :

Question	Answer
(1) a. What is the exact diagnosis ? b. Is there any external and visible evidence of injury at your first consultation? c. State part of body injured d. Describe the cause and extent of injury	a. ________________________________ b. ☐ No ☐ Yes c. ________________________________ d. ________________________________
(2) Present condition of injury:	
(3) a. Is there any treatment administered? b. If yes, please give details (such as suturing, physiotherapy, type of dressing, etc.)	a. ☐ No ☐ Yes b. Date Time Treatment
(4) a. Did any other physicians treat the patient for the same injury? b. If yes, please give:	a ☐ No ☐ Yes ☐ Unknown b. Name Address Date of Treatment
(5) Did injury require the followings: (If yes, please give details) a. hospitalization b. x-ray? c. special diagnostic procedures? d. surgery?	 a. ☐ No ☐ Yes ________________ b. ☐ No ☐ Yes ________________ c. ☐ No ☐ Yes ________________ d. ☐ No ☐ Yes ________________
(6) a. Did any permanent disablement expected as a result of his/her injury? b. If yes, please state the proportionate disability in percentage	a. ☐ No ☐ Yes b. ________________________________
(7) Did injury cause Temporary Total Disablement from engaging in or attending to usual employment or occupation?	☐ No ☐ Yes From __________ To __________
(8) Was such injury induced from or effected by any of the following which may contribute to the accident and/or lengthen the period of disability? (If yes, please give details) a. physical defects / congenital anomaly b. unfavourable past medical history c. degenerative d. alcohol or drugs	 a. ☐ No ☐ Yes ________________ b. ☐ No ☐ Yes ________________ c. ☐ No ☐ Yes ________________ d. ☐ No ☐ Yes ________________
(9) Bearing in mind the Patient's occupation , do you feel that the injuries would have prevented him/her from working? a. at your first consultation. b. at your last consultation.	 a. ☐ No ☐ Yes From __________ To __________ b. ☐ No ☐ Yes From __________ To __________
(10) If an absence from work of more than two weeks was necessary, please describe in detail the reasons why you feel the Patient could not return to work earlier.	

I hereby certify that I have personally examined & treated the Patient for the above injury and that the facts as given above present my opinion of his /her condition.

Address : ________________________________
____
____

Signature : ________________________________

Telephone No.: ________________________________

Name of Physician :
(with stamp)

Date : ________________________________

Qualification : ________________________________