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# Personal Accident Insurance Claim Form
# 人身意外保險索償表格

## THE INSURED 投保人

Name of Insured 保戶姓名 _____ Policy no. 保單號碼 _____

Occupation 職業 _____

Address 地址 _____

Tel. no. 電話號碼 _____ E-mail 電郵地址 _____

## B) INSURED PERSON 受保人

Name of Insured Person 受保人姓名 _____ Age 年齡 _____ Sex 性別 _____

Occupation 職業 _____ Relationship with the Insured 與投保人之關係 _____

(Please attach documentary evidence such as Birth Certificate or Marriage Certificate to show the relationship)
請附上有效證明文件, 如出生證明書或結婚證書, 以便證明受保人與投保人之關係

Address 地址 _____

_____

Tel. no. 電話號碼 _____

## C) CIRCUMSTANCES OF ACCIDENT 發生意外情況

Date of accident 意外發生日期 _____ Time 時間 _____ ☐ a.m. 上午 ☐ p.m. 下午

Location 地點 _____

Please state fully how the accident occurred
請詳述意外如何發生 _____

_____

_____

_____

## D) INJURY 傷勢

Part of body injured 受傷部位

☐ Hand 手 ☐ Leg 腳

☐ Head 頭 ☐ Eye 眼

☐ Others 其他 _____

Nature of injury 受傷性質

☐ Sprain 扭傷 ☐ Fracture 骨折 ☐ Burn 燒傷

☐ Contusion 撞傷 ☐ Laceration 割傷

☐ Others 其他 _____

Name and address of attending doctor
診症醫生姓名及地址

State the period during which the injured has been totally disabled from attending to his/her normal occupation
傷者完全失去工作能力的期間

From 由 DAY 日 / MONTH 月 / YEAR 年 To 至 DAY 日 / MONTH 月 / YEAR 年

Is the injured still totally disabled? ☐ Yes 是 ☐ No 否
傷者現時是否仍然完全喪失工作能力?
If "No", from what date was the injured person able to attend some part/all of his/her occupation?
如答〝否〞, 傷者何日恢復部分或全部工作能力?

Whether the injured is hospitalizing/was hospitalized as a result of the accident? ☐ Yes 有 ☐ No 沒有. If Yes, please state
傷者有否因此次意外而住院 ? 如〝有〞請說明
Name of Hospital
醫院名稱
Address
地址
Period of Hospital Confinement
住院期間
Date of Admission 入院日期 DAY 日 / MONTH 月 / YEAR 年 Time 時間
Date of Discharge or expected duration of hospitalization
離院日期或預計住院時間
DAY 日 / MONTH 月 / YEAR 年 Time 時間

## IMPORTANT NOTES 重要事項

- This form should be submitted to us immediately after the accident together with all supporting documents.
- It is important that the Medical Report attached should be completed by a fully qualified and registered medical practitioner.
- If you are claiming for reimbursement of medical or other expenses, full details and documentary evidence must be provided.
- If compensation is related to Disability Benefit, 'Employer's confirmation of sick leave' must be completed by the employer of the Insured Person.
- 請填妥此表格連同所有索償文件於意外發生後盡快提交本公司以便處理閣下之索償
- 醫療報告必須由認可註冊西醫填寫
- 若閣下索償醫療費用, 請提交所有證明文件正本
- 若閣下索償傷殘津貼, 請提交僱主認可的病假證明書

### DECLARATION & AUTHORIZATION 聲明及授權書

I/We hereby declare that to the best of my/our knowledge and belief the above statement and particulars contained herein are in all respects true and complete and are made without reservation of any kind. I/We agree that any of my/our/the Insured's personal information collected or held by Concord Insurance Co Ltd "Concord" (whether contained in this claim form or otherwise obtained) is provided and may be held, used and disclosed by Concord to individuals/organization associated with Concord or any selected third party (within or outside Hong Kong, including reinsurance and claim investigation companies and industry associations/federations and other service providers providing services relevant to insurance business) for the purpose of processing this claim.

本人／我們聲明此表格內填報的資料，就本人／我們所知所信，全部正確無訛，並無任何保留。本人／我們同意如為處理有關本索償事宜，合群保險有限公司可使用所收集及持有關於我／我們／受保人的個人資料（包括在此索償表格內或其他地方之資料）或將該等資料給予有關人士或機構（包括在香港境內或境外之再保公司）、賠償調查公司、保險業協會／聯會及其他提供保險業有關服務之公司等）。

Signature of Insured 保戶簽署 : _____ Date 日期 : _____

Signature of Insured Person 受保人簽署 : _____ Date 日期 : _____

# MEDICAL REPORT 醫療報告

(To be completed by Insured Person's Attending Doctor)

1. (a) Name of patient _____
   (b) Identity Card No. _____ Date of accident _____
   (c) Age _____ Sex _____
2. (a) Was there any external and visible evidence of injury at your first consultation? ☐ Yes ☐ No
   (b) Upon what date _____
   (c) If Yes, please state type of injury _____
   (d) State part of body injured _____
   (e) Cause and extent of injury _____
3. (a) Did injury require hospitalization, x-rays, special diagnostic procedures and/or surgery?
   ☐Yes ☐ No
   (b) If Yes, please give details _____
4. (a) Was the injury induced from or affected by any of the following?

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Physical defects/congenital anomaly |
| ☐ | ☐ | Unfavorable past medical history |
| ☐ | ☐ | Degenerative changes |
| ☐ | ☐ | Alcohol or drugs |

   (b) Please give details if any of the above is "Yes" _____
5. (a) Was healing complicated? _____
   (b) If so, state why and any special treatment given _____
6. 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.
7. Present condition of the patient _____
8. (a) Is there any treatment administered? ☐ Yes ☐ No
   (b) If Yes, please give details (such as suturing, physiotherapy, type of dressing, etc. with treatment dates)
9. (a) Any other physicians who treated the patient for the same injury? ☐ Yes ☐ No
   (b) If Yes, please give details (Name, address of doctors and date of treatment)
10. Bearing in mind the patient's occupation, do you feel that the injuries would have totally prevented the patient from working? If yes, please state the period.

Signed by Physician _____ Date _____
( with chop)

Qualifications _____ Tel No. _____

# EMPLOYER'S CONFIRMATION OF SICK LEAVE
# 僱主認可的病假證明書

To be completed by Insured Person's Employer
由受保人的僱主填寫

This is to certify that the injured Mr/Ms/Mrs _____
is our employee serving the position currently as _____
who suffered an injury of _____
occurred on _____ and as result he/she did not attend to work during the
period from _____ to _____.

We further confirm that his/her monthly basic salary at the time of accident was HK$ _____
(excluding bonus, commission, overtime and other allowance).

茲証明受保人 _____ 君為本公司聘用員工, 其職位
是 _____。 因意外受傷(部位) _____
_____ 發生於(日期) _____。
因這意外他/她休假由 _____ 起至 _____。

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

Signed by employer
僱主簽署 : _____ Date
日期 : _____
(with company chop)
公司蓋印

Position
職位 : _____

Signed by Insured Person
受保人簽署 : _____ Date
日期 : _____