

意外賠償申請表 ACCIDENT CLAIM FORM											
				伢	R單號碼 Po	olicy No.					
第二部份–主診醫生報告書(由主診醫生填寫,所有費用由受保人/保單持有人/索償人自行承擔) PART II – ATTENDING PHYSICIAN'S STATEMENT (To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.) A.病人資料 PARTICULARS OF PATIENT											
		RTICULAR	S OF PATIENT		← IFA . Lat. Et al.	1			1 47% -445 PT D 5 TT		
病人姓 Name o	E名 of patient				年齡/性別 sex of patient		/		}證/護照號碼 port No. of patie	ent	
	治資料 COM	ISULTATIO	ON DETAILS	719070	ock or putions			1.571 000	port No. or pane		
1	意外發生日	l期 Date of	Accident	í	≢ Year		月 Month	日 Day	時 Hour	分 Minute	上午/下午 AM/PM
				Ĺ	1 1						
2(a)	如有住院, Period of ho		院時段 nement if hospital		年 Year		月 Month	⊟ Day	時 Hour	分 Minute	上午/下午 AM/PM
				Ĺ	1 1						
2(b)	醫院名稱 N	lame of hos	pital								
3	受傷後首次 consultation		日期 Date of first ury	í	¥ Year		月 Month	⊟ Day	□ 上午 /	AM □⊤	午 PM
4(a)	意外發生經	函 Circum	stances of accider	nt							
4(b)	身體受傷之	Z部位 Part	of body injured								
4(c)	受傷類別和	1程度 Type	and extent of inju	ry							
4(d)			人時・其身體有 onsultation? If yes			_		nere any visib	le contusion, cu	it or wound on	the exterior
5			last consultation	年	F Year	1 1	月	Month	日 Day		
6	hospitalizati	on, surgery	(例如留院、手術 , physiotherapy, X	-ray, speci	al diagnostic	procedure	-	stigation etc.			
	年 Year 月	Month	Day 治	療詳情 Tr	eatment detail	S		檢查結果/	治療時期 Resul	t/ Treatment dur	ation



中國人壽保險(海外)股份有限公司(於中華人民共和國註冊成立之股份有限公司) China Life Insurance (Overseas) Company Limited (incorporated in the People's Republic of China with limited liability) HK-CL-ICLA03/202412-01 P. 1 of 3

E No 全 No 2 No	7 受保人就此次意外受傷·有否接受其他 Insured for the same injury? If yes, please	カラック		山 走	
Insured for the same injury? If yes, please give details	Insured for the same injury? If yes, please	give details		山 走	
「			cian(s)		
該文受傷是否由下列任何一項而傳致加長傷殘時間?如下述任何一項為"是",請註明詳情 Was such injury induced from or affected by at the following which may contribute to and/or lengthen the period of disability? If any of the below is "yes", please give details. (a) 身體缺陷 / 先天異常 Physical defects / congenital anomaly	年 Year 月 Month 日 Day	醫生姓名 Name of physic	cian(s)	電話及地址 Telepho	one No. & Address(es)
the following which may contribute to and/or lengthen the period of disability? If any of the below is "yes", please give details. (a) 身體缺陷 / 先天異常 Physical defects / congenital anomaly					
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(b) 過往不良健康狀況記錄 Unfavourable past medical history	and ronouning trinoin may contain and to unare	or longition and portou or all	ability i ii uliy or allo bolon	io you , ploudo give uo	
(c) 退化性轉變 Degenerative changes	(a) 身體缺陷 / 先天異常 Physical defe	ects / congenital anomaly	□ 是 Yes		□ 否 №
(d) 藥物或酒精 By drugs or alcohol	(b) 過往不良健康狀況記錄 Unfavourab	ble past medical history	□ 是 Yes		□ 否N
(d) 藥物或酒精 By drugs or alcohol	(c) 退化性轉變 Degenerative changes		□ 是 Yes		 「 否 N
有沒有其他因素影響痊癒進度?如有.請註明詳情及採用之任何特別治療	4.0				
Was healing complicated? If yes, please state details & any special treatment given. D. 以病人本身的工作或職業而論・請詳述此意外/ 傷勢對其的影響: Bearing in mind the declared duties/occupation of this patient, please indictive impact of the accident / disablement: D. 能夠從事任何工作或職業 Can perform any kind of work and duties D. 不能從事其職業本身之部分工作 Cannot perform partial duties of his/ her own occupation D. 不能從事其職業本身之任何工作 Cannot perform all duties of his/ her own occupation T. 不能從事任何類型的工作或職業 Cannot perform any kind of work and duties D. 不能從事任何類型的工作或職業 Cannot perform any kind of work and duties D. T. A. W. A	、, 亲物或油油 by drugs of according		正 tes		
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			保單號碼	Policy No.									
B. 診	台資料(續)CONSULTATION	N DETAILS (Continu	ued)										
	若不能工作兩星期以上.請 describe in details why you thin			bsence	from v	work for	more t	than tw	o week	s is necessa	ary, ple	ease	
	如是次意外導致該病人永久(to the patient, please assess the									aused a	any perman	ent dis	ability
44	病人在發生意外當時・是否 ī	口鬼上任何疾疾或缺	LR公 2 la tha n	ationt now/ Was	the ne	tiont o	t the tin	no of t	hio so	oidont s	ufforing/out	fored	from any
	illness, disease or infirmity?	古思工任内疾病或最 青提供詳情 Yes・Pl	•		тие ра	itient a	t the tin	ne or u	nis acc	Juent s	unering/su	ierea	irom any
15 請提供病人的預計復職/康復日期 年 Year 月 Month 日 Day Please state when the patient can resume duties or the recovery date													
C. 主	診醫生資料及聲明 ATTEN	NDING PHYSICIAN'	S PARTICU	LARS AND DE	CLAR	ATION	N						
	比聲明.就本人所知所信.上刻ect to the best of my knowledge and		均為事實之全	部・並確實無計	· IHEF	REBYD	ECLARE	that all	the info	rmation p	rovided by m	e in this	form is true
主診醫生 Name of	b姓名 Attending physician						歷 ialificatio	on					
地址 Ad	dress						絡電話 Intact No).					
士章◇医⋧୵	上簽署及醫院/診所蓋章								年	Year	月 Month		日 Day
Signatur	E 政省及舊阮/ 62月 蓋早 e of Attending Physician and f Hospital/Clinic					日 Da	期 te						