

# 長期病假賠償申請表 LONG TERM SICK LEAVE CLAIM FORM

保單號碼 Policy 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.)**

<b>A. 病人資料 PARTICULARS OF PATIENT</b>			
1	病人姓名 Name of Patient	<input style="width:60%;" type="text"/>	
2	年齡及性別 Age and Sex	<input style="width:60%;" type="text"/>	
3	身份證/ 護照號碼 I.D. Card / Passport No.	<input style="width:60%;" type="text"/>	
<b>B. 臨床資料 CLINICAL DETAILS</b>			
1	病人之醫療記錄可追溯至 We can trace the medical record of patient back to	年 Year <input type="text"/> 月 Month <input type="text"/> 日 Day <input type="text"/>	
2	首次出現病徵日期發生日期 Date of the symptoms first appeared	年 Year <input type="text"/> 月 Month <input type="text"/> 日 Day <input type="text"/>	
3	病人首次就有關此病症之求診日期 Date of first consultation for this condition or related illness	年 Year <input type="text"/> 月 Month <input type="text"/> 日 Day <input type="text"/>	
4	請詳細說明首次會診時之徵狀和病症 Please describe the symptoms and complaints at first consultation		
<input style="width:100%; height:40px;" type="text"/>			
5	病人是否由其他醫生轉介? 如是, 請提供該醫生之姓名及地址。 Is the patient referred by other physician? If yes, please give the name and address of the referring doctor. <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No		
<input style="width:100%; height:20px;" type="text"/>			
6	診斷 Diagnosis		
<input style="width:100%; height:40px;" type="text"/>			
7	何時確診 When was the diagnosis made	年 Year <input type="text"/> 月 Month <input type="text"/> 日 Day <input type="text"/>	
8	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 indicate the impact of the accident / disablement:		
<input type="checkbox"/> 能夠從事任何工作或職業 Can perform any kind of work and duties			
<input type="checkbox"/> 不能從事其職業本身之部分工作 Cannot perform partial duties of his/ her own occupation			
<input type="checkbox"/> 不能從事其職業本身之任何工作 Cannot perform all duties of his/ her own occupation			
<input type="checkbox"/> 不能從事任何類型的工作或職業 Cannot perform any kind of work and duties			
請提供喪失部分工作能力的時間 Please state period of incapable to perform some of his/her duties			
由 From		年 Year <input type="text"/>	月 Month <input type="text"/> 日 Day <input type="text"/>
至 To		年 Year <input type="text"/>	月 Month <input type="text"/> 日 Day <input type="text"/>
請提供喪失全部工作能力的時間 Please state period of incapable to perform some of his/her duties			
由 From		年 Year <input type="text"/>	月 Month <input type="text"/> 日 Day <input type="text"/>
至 To		年 Year <input type="text"/>	月 Month <input type="text"/> 日 Day <input type="text"/>



**B. 臨床資料(續) CLINICAL DETAILS (Continued)**

9 請詳述完全喪失工作能力原因 Please state the cause of total disability

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10 閣下認為病人之狀況會否有基本/ 明顯的改善? Do you expect a fundamental or marked change of this present condition in the future?  
 會 Yes  否 No

如會, 受保人於何時才能重新工作? If yes, how long do you expect the Insured will take to perform duties?

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11 以病人本身的工作或職業而論, 病人於何時才能恢復工作能力? Bearing in mind the declared duties/occupation of this patient, how long do you expect the patient can resume working capability?

- 一個月內 Within 1 Month  
 一至三個月內 1-3 Months  
 三至六個月內 3-6 Months  
 六至十二個月內 6-12 Months  
 多於十二個月 >12 Months  
 永不 Never

12 請詳述病人如何因是次傷患影響而導致完全不能回復本來之工作崗位 Please state in details on how the disability prevents the patient from resuming his/her own work

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13 所有關於是項診斷之治療、檢查及其結果、有否任何併發症及出院後之覆診或跟進計劃 Any treatments, investigation procedures, results, and/or any complications and follow up plan regarding the subject diagnosis.

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**C. 閣下之專業意見 PROFESSIONAL COMMENT**

1 是次診斷是否復發個案, 或與過往其他病況有關? 如是, 請提供有關診治日期及治療詳情。Is the diagnosis a recurrent episode or related to any previous conditions? If so, please provide details of the diagnosis and treatments.  是 Yes  否 No

診治日期 Date of diagnosis/treatments      年 Year      月 Month      日 Day

詳情(包括診斷/治療/檢查及結果) Details(including diagnosis/ treatments/ investigations and results)

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2 病人之家族史有否增加病人患上此症的風險? Is there any patient's family history which would increase the risk of this illness?

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**C. 閣下之專業意見(續) PROFESSIONAL COMMENT (Continued)**

3 病情預測 The prognosis of the condition

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4 是否與人體免疫缺損病毒有關? Is it HIV related?

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**D. 其他醫療病史 OTHER MEDICAL HISTORY**

1 病人過往有否以下病症/習慣 Does the patient have any medical history or habit as indicated below?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 哮喘 Asthma                      | <input type="checkbox"/> 心臟病 Cardiac problem                          | <input type="checkbox"/> 糖尿病 Diabetes Mellitus    |
| <input type="checkbox"/> 乙型肝炎 Hepatitis B               | <input type="checkbox"/> 高血壓 Hypertension                             | <input type="checkbox"/> 曾接受手術 Previous operation |
| <input type="checkbox"/> 濫藥 Drug abuse                  | <input type="checkbox"/> 飲酒習慣 Drinking                                | <input type="checkbox"/> 吸煙習慣 Smoking             |
| <input type="checkbox"/> 家族性癌症 Family history of cancer | <input type="checkbox"/> 家族病史 Unfavorable family history              |   |
| <input type="checkbox"/> 以上皆沒有 None                     | <input type="checkbox"/> 其他疾病·請說明 Other disease, please specify _____ |   |

2 該病人曾否因患上述疾病或其他嚴重疾病接受醫生或醫院治療? 如是者, 請述詳情。Had the patient previously been treated or hospitalized for the above disease or other major disease? If so, please give details.  是 Yes  否 No

日期 Dates			疾病 Disease	治療/住院詳情 Details of treatment/hospitalization	醫生姓名/醫院名稱 Name of Physician/Hospital
年 Year	月 Month	日 Day			

3 請提供飲酒/吸煙習慣詳情 Please provide details of Drinking & Smoking habit.

習慣始自 Drinking/ Smoking start date since      年 Year      月 Month      日 Day

每日用量 Daily consumption      (支/包/樽/罐 piece/ pack/ bottle/ can)

**E. 主診醫生資料及聲明 ATTENDING PHYSICIAN'S PARTICULARS AND DECLARATION**

本人謹此聲明·就本人所知所信·上述由本人提供的資料均為事實之全部·並確實無訛。I HEREBY DECLARE that all the information provided by me in this form is true and correct to the best of my knowledge and belief.

主診醫生姓名 Name of Attending physician		資歷 Qualification	
地址 Address		聯絡電話 Contact No.	
主診醫生簽署及醫院/診所蓋章 Signature of Attending Physician and Stamp of Hospital / Clinic		日期 Date	年 Year    月 Month    日 Day