傷殘保障賠償申請書
Disability Claim Form

FTLife 富通保險

保單號碼
Policy Number

保險顧問姓名
Consultant Name

保險顧問編號
Consultant Code

電話
Telephone No.

☐ **豁免保費 Waiver of Premium**

☐ **付款人傷殘豁免保費 Payor Disability Benefit**

☐ **康復保險 Disability Protector**

提供此賠償申請書或進行有關此索償的調查並不表示富通保險有限公司（以下簡稱“富通保險”）會確認此項索償或同意豁免保單條款中的任何規定。
By providing this claim form and subsequently investigating the claim, FTLife Insurance Company Limited ("FTLife") shall not be held to admit the validity of the claim nor to waive any requirement as provided under the provisions of the policy.

填表之前請詳細閱讀後頁的“填表須知”。
Please read the Instructions overleaf carefully before you complete this claim form.

第一部份 — 由受保人 / 保單持有人填寫
Part I – To be completed by the Insured / Owners

☐ 首次索償 New Claim ☐ 再次索償 Further Claim

A. 受保人 / 保單持有人個人資料 Personal Particulars of the Insured / Owner

1. 受保人 / 保單持有人姓名 Name of Insured / Owner	2. 身份證 / 護照號碼 ID / Passport No.	3. 年齡 / 性別 Age / Sex	4. 電話號碼 Telephone No.

5. 剛傷殘前的職業及詳細職責 Occupation and work duties immediately before disability	6. 剛傷殘前的僱主名稱及地址 Name & address of employer immediately before disability

7. 最後工作日期(日/月/年) Last working date (DD/MM/YY): 你曾否向雇主申請病假? Did you report your sick leave to your employer? ☐ 否 No ☐ 是 Yes (DDMMYY(日/月/年) _____ to DDMMYY (日/月/年)_____)	8. 受保人 / 保單持有人是否已經恢復工作? Has the Insured / Owner returned to work? ☐ 否，請提供期望可復工之日期(日/月/年) No, please give the date you expect to return working (DD/MM/YY): ☐ 是，請提供復工日期(日/月/年) Yes, please provide the exact date (DD/MM/YY):

B. 如傷殘是由疾病引致, 請填寫以下部份(如首次索償) To be completed only when the Disability was due to ILLNESS (for first claim only)

1. 此疾病之病徵 Symptoms & complaints for this illness	2. 首次求診之前, 受保人 / 保單持有人患此等症狀的時間有多久? How long has the Insured / Owner been having these symptoms before the first consultation?

3. 首次求診日期(日/月/年) First consultation date (DD/MM/YY):	4. 首次及其他求診醫生的姓名,電話號碼及地址 Name, telephone number & address of the doctor who first treated you and further treated for this illness

5. 診斷之確實日期及診斷? (日/月/年) Exact diagnosis date and what was the diagnosis? (DD/MM/YY):	6. 醫生的姓名及地址,電話號碼, 如果有住院治療，請詳列 Name & address, telephone number of the doctor who admitted you if there was hospitalization.

C. 如傷殘是由意外引致, 請填寫以下部份(如首次索償) To be completed only when the Disability was due to ACCIDENT (for first claim only)

1. a. 意外日期(日/月/年) Date of accident (DD/MM/YY):	b. 意外發生的確實時間 Time of accident	c. 意外發生的地點 Place of accident

2. 意外如何發生? How did the accident happen?	3. 身體受傷部位及受傷程度 Part of body injured and extent of the injury

4. 首次求診日期(日/月/年) First consultation date (DD/MM/YY):	5. 求診醫生的姓名及地址 Name & address of doctor consulted	6. 有否報警? Was this case reported to Police? ☐ 否 No ☐ 有 Yes 如有，請附口供紙、警察報告影印本、警署及檔案編號 If yes, please attach a copy of witness statement, police report, Police Station and Case Ref. no.

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D. 受保人 / 保單持有人過往的醫療紀錄 Past medical record of the Insured / Owner

1.a. 病徵或病因首次出現之日期 (日/月/年)：Date of symptoms/complaints first appeared (DD/MM/YY): _____

b. 首次求診時之病徵或病因：The symptoms/complaints at the first consultation date:

2. 受保人 / 保單持有人有否因以上病徵或病因而入院治療? Has the Insured / Owner been admitted into a hospital for above symptoms / complaints?

☐ 否 No ☐ 有 Yes 請詳述 please state

a. 醫院名稱 Name of the hospital:

b. 住院日期: 由 (日/月/年) 至 (日/月/年)
Exact confinement period: From (DD/MM/YY) to (DD/MM/YY)

3. 受保人 / 保單持有人有否因以上病徵或病因而接受任何治療? Has the Insured / Owner ever attended any special treatment for above symptoms / complaints?

☐ 否 No ☐ 有 Yes 請詳述 please state

a. 療程類別 Type of treatment:

b. 治療地點 Place of treatment provided:

c. 治療時間 由 (日/月/年) 至 (日/月/年)
Period of treatment taken: From (DD/MM/YY) to (DD/MM/YY)

4. 受保人 / 保單持有人因以上病徵或病因及其他疾病而曾求診之醫生姓名及地址
Name & address of all doctors who have ever attended the Insured / Owner for above symptoms / complaints and other illness.

姓名 Name	地址 Address	求診日期 Consultation date	疾病名稱 Disease or condition

E. 其他資料 Other information

1. 每星期工作多少小時 Total working hours per week	2. 文職工作和體力工作之百分比 Percentage of clerical work and manual work	3. 受保人 / 保單持有人慣常用右手或左手 Is the Insured / Owner right-handed or left-handed

4. 工作時需要使用的特別機器、工具、裝備(如有) Machines / Tools / Equipment used at work (if any)	5. 剛傷殘前的每月收入 Monthly income immediately before disability:

6. 受保人 / 保單持有人曾否從僱主或政府領取其他入息保障計劃或補償?
Does the Insured / Owner have any other income protection coverage or compensation from employer or Government?

☐ 否 No ☐ 有 Yes, 請填寫下欄 please state as below:

入息來源 Source of income	開始領取款項之日期(日/月/年) Date of payment began (DD/MM/YY)	款項終止領取之日期(日/月/年) Date of payment ended (DD/MM/YY)	每月領取之金額(港幣) Amount per month (HK$)

7. 有否就此傷殘同時向本公司之團體保險部或其他保險公司提出索償? 如有，請列明如下。
Any concurrent claim about this disability with our Group department or other companies? If yes, please give the policy number and the name of the company.

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F. 個人資料收集聲明 Personal Information Collection Statement

本人 / 我們確認本人 / 我們已閱讀及明白富通保險有限公司（以下簡稱 “富通保險”）之個人資料收集聲明 (“該聲明”)。本人 / 我們聲明及同意貴公司可根據該聲明所述的任何目的收集及 / 或持有、使用及/或披露/分享任何個人資料（不論是否從此表格或以其他方式獲得）。本人 / 我們明白本人 / 我們必須於此表格提供所須資料，否則貴公司將可能無法執行該聲明之目的及 / 或向本人 / 我們提供產品或服務。本人 / 我們確認及同意本人 / 我們的個人資料可能披露/共享給該聲明所指明的第三方; 執法機構; 保險業就現有資料而對所提供的資料作出分析和檢查而使用的數據庫或登記冊作出於該聲明所述的任何目的。本人 / 我們明白該聲明的最新版本可於富通保險的網址下載：www.ftlife.com.hk，及可向貴公司索取。

I / We confirm that I / we have read and understood FTLife Insurance Company Limited (“FTLife”)'s Personal Information Collection Statement (“PICS”). I / We declare and agree that any personal data FTLife may collect and/or hold, use and / or disclose/share with (whether contained in this form or otherwise obtained) in accordance with the Purposes as set out in the PICS. I / We understand that if I / we do not provide the required personal data, FTLife may not be able to perform the Purposes and/or provide products or services to me/us. I / We acknowledge and agree that my/our personal data may be disclosed/shared with specified parties in the PICS; law enforcement authorities; databases or registers used by the insurance industry to analyse and check information provided against existing information for any of the Purposes stated in the PICS. I / We understand the updated version of the PICS is available for download from FTLife's website: www.ftlife.com.hk, and will be made available upon request.

G. 聲明及授權書 Declaration and Authorization

本人 / 我們聲明上述一切陳述及對問題的所有答案，就本人/我們所知所信均為事實之全部，並確實無訛。
I / We declare that the above statements and answers made by me/us are true and complete to the best of my knowledge.

本人 / 我們茲授權凡知道或擁有任何有關本人或受保人記錄的僱主、任何註冊西醫、醫院、診所、保險公司、其他機構或人仕，均可將該等資料提供給富通保險有限公司。即使本人或受保人死亡或喪失能力，此授權書仍然有效，所有本人及受保人之繼承人及轉讓人亦會受此授權書約束。本授權書影印本與正本具有同等效力。
I / We hereby authorize any employer, any registered medical practitioner, hospital, clinic, insurance company or other institution or person, that has any records or knowledge of me/us or the Insured(s) named to give such information to FTLife Insurance Company Limited. This authorization shall bind the successors and assignees of me/the Insured(s) and remain valid notwithstanding the death or incapacity of me/the Insured(s). A photocopy of this authorization shall be as valid as the original.

本人 / 我們明白若此傷殘保障賠償申請書的中、英文兩個版本有任何抵觸或不相符之處，應以英文版本為準。
I / We understand that if there is any inconsistency or ambiguity between the English versions and the Chinese versions of this Disability Claim Form the English versions should prevail.

保單持有人姓名 (大寫) Name of Policy owner (in block letters) :	身份證 / 護照號碼 ID / Passport No. :
保單持有人簽署 Signature of Policy owner : x _____	日期 (日/月/年) Date (DD/MM/YY) :
受保人姓名 (大寫) Name of Insured (in block letters) :	身份證 / 護照號碼 ID / Passport No. :
受保人簽署 (如與保單持有人不同及年滿18歲) Signature of Insured (If different with Policy owner & attained age 18) : x _____	日期 (日/月/年) Date (DD/MM/YY) :
見証人姓名 (大寫) Name of Witness (in block letters) :	身份證 / 護照號碼 ID / Passport No. :
見証人簽署 Signature of Witness : x _____	日期 (日/月/年) Date (DD/MM/YY) :

填表須知 Instructions

1. 請回答申請書第一部份的所有問題及簽署。
   Please answer ALL the questions of Part I and sign.
2. 此申請書第二部份必須由主診醫生填寫並由您支付有關費用。
   Part II of this claim form MUST be completed and signed by the doctor who attended the Insured for his injury or illness. The completion of this part is all the Insured's own expenses.
3. 如有必要，本公司將要求您提供其他文件，例如病假紙、醫生報告、物理治療報告、x光報告等以便審核。
   We may ask for other documents or information from you if deemed necessary, such as Sick Leave Certificate,Medical Certificate, Physiotherapy Report, X-Ray Report.
4. 請將填妥的索償申請書連同其他所需文件一併交予本公司理賠部辦理。地址：九龍觀塘海濱道123號綠景NEO大廈7樓。電話: 2866 8898.
   Please send the completed claim forms and other supporting documents to our Claims Dept. Address: 7/F, NEO, 123 Hoi Bun Road, Kwun Tong, Kowloon. Tel.: 2866 8898.
5. 請注意，閣下於此索償申請表頁一上填寫的保險顧問公司 將會是閣下授權唯一能跟進及處理是次索償的人士。
   Please note that the Insurance consultant that stated on page 1 would be regarded as the only authorized agent to follow up and handle the claim.

保險顧問備註 Consultant's remarks

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第二部份 — 申請人自費由主診醫生填寫
Part II – To be completed by the Attending Doctor at the claimant's own expenses

病人姓名 Name of Patient	身份證 / 護照號碼 ID / Passport No.	年齡 / 性別 Age / Sex	職業 Occupation

1. a. 你自何時開始診治此病人(日/月/年)? Since when did you first know the patient professionally (DD/MM/YY)?

   b. 病人何時就是次傷殘而首次向你求診(日/月/年)? When did the patient first consult you for this disability (DD/MM/YY)?

   c. 在你診所或醫院，首次求診時之病徵為何? What were the symptoms complained at the first consultation at your clinic or hospital?

   d. 根據病人提供的資料，在首次求診於你時，上述病徵出現已有多久?
   According to the patient, how long has he/she first had these symptoms before the first consultation at your clinic or hospital?

由 Since	(日/月/年)起或已存在 (DD/MM/YY) or for	日 days	月 months	年 years

2. a. 最後的診斷為何? What is the final diagnosis?

   b. 診斷日期(日/月/年)
   Diagnosis date (DD/MM/YY):

   c. 診斷醫生或醫院之名稱及地址
   Name and address of doctor or hospital who made the above diagnosis:

3. 病人是否經其他醫生轉介? Was the patient referred to you by other doctor? 否 No ☐ 是 Yes ☐

   若是，請提供轉介醫生姓名或醫院名稱地址?
   If yes, please provide name and address of referral doctor/hospital?

   轉介日期(日/月/年)
   Date of Referral (DD/MM/YY):

4. 你曾否轉介病人往其他醫生? Did you refer the patient to other doctors for management? 否 No ☐ 有 Yes ☐

   若有，請提供醫生姓名或醫院名稱及地址?
   If yes, please provide name and address of doctor/hospital?

5. a. 住院時期(日/月/年) Hospitalization period (DD/MM/YY):

   b. 醫院名稱 Name of hospital confined:

6. 病人有否接受X光檢驗或其他診斷檢查? Had the patient been X-rayed or undergone any diagnostic examination?

   ☐ 否 No ☐ 有，請提供詳情如下 Yes, please give details below:

日期(日/月/年) Exam Date (DD/MM/YY)	檢驗 Investigation	結果 Result

7. 治療之詳情 Details of medical and surgical treatment:

類別 Type	日期 / 時段(日/月/年) Dates/Period (DD/MM/YY)	併發症或後遺症 Complication or side-effects	康復情況 Healing condition

   ☐ 手術 Operation
   ☐ 物理治療 Physiotherapy
   ☐ 職業治療 Occupational Therapy
   ☐ 化學治療 Chemotherapy
   ☐ 放射治療 Radiotherapy
   ☐ 其他 Others

8. 其後之覆診日期及詳情 Subsequent consultation records and details:

求診日期(日/月/年) Consultation date (DD/MM/YY)	醫生 / 醫院名稱 Name of doctor/hospital	診斷 Diagnosis	進展 Progress

9. 根據病人之康復情況，請自傷殘開始日起評估對病人工作的影響:
   According to the patient's condition during rehabilitation, please assess the effect to the patient's work capability since commencement of disability:

   ☐ 不能從事原來工作之**所有**職務 Unable to perform **ALL** tasks of the original duty: 由 From _____ 至 to _____ (日/月/年) (DD/MM/YY)

   ☐ 不能從事原來工作之**部份**職務 Unable to perform **PARTS** of the original duty: 由 From _____ 至 to _____ (日/月/年) (DD/MM/YY)

   ☐ 不能從事**任何**工作 Unable to perform **ANY** occupation: 由 From _____ 至 to _____ (日/月/年) (DD/MM/YY)

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10.a. 最後之診治日期為(日/月/年) Last consultation date (DD/MM/YY):

b. 於最後求診時，精神或身體之缺陷為何? What was the mental or physical limitation at the last consultation?

c. 根據受保人的職業，病人於最後求診時之傷殘情況為:
Based on your last assessment, please rate the physical impairment in accordance with the patient's occupation:

- ☐ 第一級 Class 1 可從事任何體力勞動工作 No limitation of functional capacity & capable of heavy work
- ☐ 第二級 Class 2 可從事中度體力勞動工作 Some limitation of functional capacity & capable of medium manual work
- ☐ 第三級 Class 3 只可從事輕度體力勞動工作 Sight limitation of functional capacity & capable of light manual work
- ☐ 第四級 Class 4 只能從事文職工作 Moderate limitation of functional capacity & capable of clerical/administrative work
- ☐ 第五級 Class 5 不可從事任何勞動或文職工作 Serious limitation of functional capacity & capable of minimal activity

d. 於最後求診時, 估計康復程度為 Recovery at last consultation was estimated to be _____ %

e. 病人是否已到達醫療上可復原的極限? Has the patient reached maximum medical improvement? ☐ 否 No ☐ 是 Yes

f. 導致病人未能恢復工作之原因? What was the main problem that restricted the patient from resume work?

11.a. 將來的治療計劃 Details of future treatment plan

b. 病人的預後情況 Prognosis of the patient

c. 復工日期預計在 The expected date to resume duty would be on: _____(日/月/年) (DD/MM/YY)

12.有否因其他因素而延長傷殘時段, 例如: 傷口感染、糖尿病、再次受傷或其他潛在疾病等?
Was there any contributory factor that lengthened the disability period, e.g. wound infection, diabetes, re-injury and other underlying disease?

☐ 否 No ☐ 有，請提供詳情 Yes, please state details

13.此傷殘是否由以下因素導致? Was such disability caused by the following factors?

否 No	是 Yes	
☐	☐	自致傷害 Self-inflicted injury (原因及經過 How it happened & underlying cause)
☐	☐	酗酒 Alcoholic abuse (酒類名稱、份量及維持多年 Name of alcohol, quantity & duration of consumption)
☐	☐	藥物濫用 Drug abuse (藥物名稱、份量及服食年期 Name & dosage of drug and duration of consumption)
☐	☐	退化性轉變 Degenerative changes (發病日期及求診詳情 Onset date & consultation details)
☐	☐	先天性缺陷 Congenital anomalies (診斷、發病日期及求診詳情 Diagnosis, onset date & consultation details)
☐	☐	過往受傷 / 疾病 Past injury or illness (原因及求診詳情 Cause & consultation details)

若是，請詳述。 If yes, please give details.

14.其他資料 Other remarks

本人謹此證明本人已親自為此病人就上述之病症或受傷進行檢查及治療, 並確認上述病人現時及過去的情況乃本人所知的實情及其全部。
I hereby certify that I have personally examined & treated the patient and attended to his/her illness or injury, and that the information about his/her current and past condition as stated above is true to the best of my knowledge and belief.

主診醫生姓名(專業資歷)
Name of Attending Doctor (with qualification)

簽署(及印章)
Signature (with chop)

地址及電話號碼
Address & Phone No.

日期(日/月/年)
Date (DD/MM/YY)

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