

Please read the following carefully before you retrieve, print or complete this form.
在索取、列印或填寫表格前，請閣下先詳閱下文。

Disclaimer

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免責聲明

閣下凡透過富通保險有限公司 [富通保險] 之電子收發渠道 [如公司網站、互動語音回應系統] 下載或列印任何表格，應自行考慮及衡量需承擔之風險。富通保險概不負責任何因下載或列印表格所引致的列印錯誤及其可能導致之任何損失或毀壞。若閣下提交之下載或列印表格有任何列印錯誤，富通保險有可能在處理閣下的申請前要求閣下填寫一份正確之表格。

當閣下填寫及簽署由網站下載之表格 [互聯網列印表格]，則被視作閣下已詳閱及明白電腦螢幕上出現之表格 [閱覽表格] 之內容，並同意表格內之所有條文。如該閱覽表格與互聯網列印表格出現任何不符、矛盾或分歧時，閣下同意並承諾不會提出任何異議。如閱覽表格與互聯網列印表格出現任何不符、矛盾或分歧時，概以閱覽表格為準。

富通保險有權隨時在認為適當情況下更新表格內容，並保留接受或拒絕閣下遞交之申請表格的權利。

意外保險賠償申請書
Accident Claim Form



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.

- 意外每週入息賠償 **Weekly Indemnity**
 意外醫療費用賠償 **Medical Reimbursement**

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會確認此項索償或同意豁免保單條款中的任何規定。倘若閣下因此次意外亦同時申請住院醫療保險賠償，只需填寫意外索償表格並附上醫院收據正本。

By providing this claim form and subsequently investigating the claim, FTLife Insurance Company Limited shall not be held to admit the validity of the claim nor to waive any requirement as provided under the provisions of the policy. If you also claim for hospital reimbursement due to the same incident, please complete this Accident Claim Form only and submit original hospital receipts.

填表之前請詳細閱讀背頁的“填表須知”。

Please read the Instructions overleaf carefully before you complete this claim form.

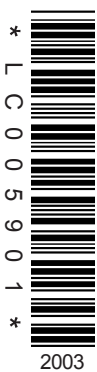
第一部份-由受保人或保單持有人或索償人填寫

Part I - To be completed by the Insured / Owner / Claimant

首次索償 New Claim

再次索償 Further Claim

| A. 受保人個人資料 Personal Particulars of the Insured | | | |
|--|---|--|--------------------------------|
| 1. 受保人姓名 Name of Insured | 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. 現時職業及詳細職責 Current Occupation and Job Duties with details | 6. 僱主名稱 (如僱主與投保時不同，請說明何時轉工) Name of Employer (If the Employer is different from the one stated in the application, please state when it was changed) | | 7. 僱主地址 Address of Employer |
| B. 意外發生情況 Occurrence of Accident | | | |
| 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. a. 意外如何發生? How did the accident happen? b. 有否報警? Was this case reported to police? <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No 如有：請附口供紙或警察報告影印本 If yes, please attach a photocopy of witness statement or police report | |
| 3. 受傷部位? Which parts of your body were injured? | | 4. 受傷程度? What was the extent of the injury? | |
| C. 治療情況 Medical Treatment | | | |
| 1. 首次醫治日期 (日/月/年) Date of first treatment of the injury (DD/MM/YY): | | 2. 診治的醫生名稱和地址 Name and address of the doctor who first treated the injury: | |
| 3. a. 曾否因是次受傷而入住院院? Was the Insured admitted to hospital due to the above injury? | | 有 Yes <input type="checkbox"/> 否 No <input type="checkbox"/> | |
| b. 如有，請說明入院及出院日期：由 (日/月/年) 至 (日/月/年) If yes, please state the exact confinement period: From (DD/MM/YY) to (DD/MM/YY) | | | |
| c. 醫院名稱及地址 Name & address of hospital: | | | |
| d. 有否於上述住院期間一天內請假外出超過6小時? Has the Insured taken any home leave for more than 6 hours a day during the above confinement? | | 有 Yes <input type="checkbox"/> 否 No <input type="checkbox"/> | |
| 如有，請列出有關的確實日期 (日/月/年) If yes, please state the exact date (DD/MM/YY): | | | |
| D. 其它資料 Other Information | | | |
| 1. 受保人是否仍須繼續接受治療? Any further treatment required? <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No | | 2. 受保人是否已經康復? Has the Insured recovered yet? <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No | |
| 3. 最後工作日期 (日/月/年) Date you last worked (DD/MM/YY): 何時恢復工作 (如否，祈望何時可恢復工作) (日/月/年): Date you returned to work (If no, then give expected date of return.) (DD/MM/YY): | | 4. 會否 / 有否就是次意外申請勞工賠償? Does / Did the Insured file a claim for Employee's Compensation for this accident? <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No 如有，請提供由勞工處發出的「補償評估證明書」(表格5)及「評估證明書」(表格7) If Yes, please provide the Certificate of Compensation Assessment (Form 5) and Certificate of Assessment (Form 7) issued by the Labour Department | |
| 5. 會否 / 有否接受任何物理/職業治療? Does / Did the Insured attend physiotherapy/occupational therapy for this accident? <input type="checkbox"/> 有 Yes <input type="checkbox"/> 否 No 如有，請提供物理治療/職業治療報告 If Yes, please provide the Physiotherapy/Occupational therapy report | | 6. 有否就是次意外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，請列明保單號碼及公司名稱。 Any concurrent claim about this accident with our Group Dept or other companies? If yes, please give the policy number & name of the company. | |



E. 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.

F. 聲明及授權書 (由受保人簽署，如受保人未滿18歲，則由其家長或合法監護人簽署)

Declaration and Authorization (To be signed by the insured OR to be signed by the insured’s parent / legal guardian if the insured is under age 18)

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、其他機構或人士，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。本授權書的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 / 我們明白若此意外保險賠償申請書的中、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 Accident Claim Form, the English versions should prevail.

受保人 / 索償人簽署

Signature of Insured / Claimant

: x _____

見證人簽署

Signature of Witness

: x _____

受保人 / 索償人姓名 (大寫)

Name of Insured / Claimant (in block letters) :

見證人姓名 (大寫)

Name of Witness (in block letters) :

身份證 / 護照號碼

ID / Passport No. :

身份證 / 護照號碼

ID / Passport No. :

日期 (日/月/年)

Date (DD/MM/YY) :

日期 (日/月/年)

Date (DD/MM/YY) :

若受保人未滿18歲，請填寫下列資料。

If the insured is under age 18, please complete the following information.

受保人姓名及身份證號碼

Name and ID/Passport No of Insured :

索償人與受保人關係

Claimant’s relationship with the Insured :

| G. 所需文件指引 Document Checklist | |
|---|--|
| 基本文件 Basic | <input type="checkbox"/> 賠償申請書第一部份及第二部份 Claim Form I and II <input type="checkbox"/> 被保人/保單持有人身份證明/護照文件副本(若之前未曾提交) Copy of ID or passport of the Insured/Policy Owner (If not provided before) <input type="checkbox"/> 化驗/X光/電腦斷層掃描/磁力共振/病理檢驗報告 Laboratory/x-ray/CT Scan/MRI report/Pathology report <input type="checkbox"/> 醫生轉介信 Doctor's referral for specialist or therapeutic treatment <input type="checkbox"/> 病假紙(包括診斷) Sick leave certificate <input type="checkbox"/> 醫療費用收據正本 Original medical expenses receipt(s) <input type="checkbox"/> 住院收據及收費單正本 Original hospital receipt(s) and Statement of charges <input type="checkbox"/> 物理治療/職業治療報告 Physiotherapy/Occupational therapy report |
| 入住香港政府醫院/私家醫院 Hospitalised in Hong Kong public/private hospital | <input type="checkbox"/> 醫院出院摘要 Hospital discharge summary |
| 入住中國醫院 Hospitalised in China hospital | <input type="checkbox"/> 醫院出院摘要 Hospital discharge summary <input type="checkbox"/> 醫院入院紀錄 Hospital admission record |
| 已有其他保險公司或機構作出賠償 Settlement has been arranged by other insurer | <input type="checkbox"/> 其他保險公司或機構發出的賠償細算表 Claims settlement advice from other insurer/party |
| 由意外引起 Caused by accident | <input type="checkbox"/> 警察報告或道路交通事故責任認定書 Police report/Traffic accident report |
| 僱員補償保險 Employee compensation | <input type="checkbox"/> 由勞工處發出的「補償評估證明書」(表格5)及「評估證明書」(表格7) Certificate of Compensation Assessment (Form 5) and Certificate of Assessment (Form 7) issued by the Labour Department |
| *** 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:香港干諾道中111號永安中心27樓。電話:2866 8898。如有必要,本公司將要求您提供其他文件。 *** Please send the completed claim forms and other supporting documents to our Claims Dept. Address: 27/F, Wing On Centre, 111 Connaught Road Central, HK. Tel. 2866 8898. We may ask for other documents or information from you if deemed necessary. | |

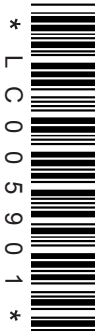
| 填表須知 INSTRUCTIONS | |
|--|---------------------------|
| 1. 請回答申請書第一部份的所有問題並簽署聲明及授權書。 Please answer ALL the questions in Part I of this claim form and sign the declaration and authorization. 2. 此申請書第二部份必須由主診醫生填寫並由您支付有關費用。 Part II of this claim form MUST be completed and signed by the doctor who attended the Insured for his injury or illness. The completion of this part is at the Insured's own expenses. 3. 請附上有關文件以便審核: Please attach the following documents to enable us to consider the claim: (i) 附有保單持有人簽署之身份證副本(如未曾於本公司存檔)。 ID copy of the policy owner with signature on it (if not in our company's record). (ii) 有關報告或文件,例如病假紙、醫生報告、物理治療報告、x光報告等以便審核。 Other reports or papers, such as Sick Leave Certificate, Medical Certificate, Physiotherapy Report, X-Ray Report. 4. 如有必要,本公司將要求您提供其他文件。 We may ask for other documents or information from you if deemed necessary. 5. 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:香港干諾道中111號永安中心27樓。電話:2866 8898。 Please send the completed claim forms and other supporting documents to our Claims Dept. Address: 27/F, Wing On Centre, 111 Connaught Road Central, HK. Tel. 2866 8898. | |
| 退件及郵遞安排 Return Documents & Postal Arrangement 請於下列適當之方格內加上“✓”號 Please tick the appropriate box(es) below | 其他備註 Other Remarks |
| <input type="checkbox"/> 退回正本收據 Return Original Receipt(s) <input type="checkbox"/> 支票直接寄給客戶 Mail Cheque(s) to Customer Directly | |

第二部份-申請人須交由主診醫生填寫並須自付費用

Part II - To be completed by the Attending Doctor at the claimant's own expense

A. 受保人個人資料 Personal Particulars of the Insured

| <p>1. a. 病人姓名 Name of patient</p> | <p>b. 身份證/護照號碼 ID / Passport No.</p> | <p>c. 年齡/性別 Age / Sex</p> | <p>d. 職業 Occupation</p> | | | | | | |
|---|--------------------------------------|--|-------------------------|--------------------------------------|------------|--------------|--|--|--|
| <p>2. a. 意外日期 (日/月/年) : Date of accident (DD/MM/YY):</p> <p>b. 意外發生的地點及經過? Where and how did the accident happen?</p> <p>c. 閣下首次診治該傷患之日期 (日/月/年) : Your first Consultation Date for this injury(DD/MM/YY):</p> <p>d. 在向閣下求診之前, 病人曾否向其他醫師求診? Did the patient consult any other medical practitioner before consulting you? <input type="checkbox"/> 否 No <input type="checkbox"/> 有, 請提供其姓名及地址 Yes, please give the name and address of the medical practitioner</p> | | <p>e. 表面及明顯證明 External and visible evidence of</p> <p>否 No 有 Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> 瘀痕 Bruises</p> <p><input type="checkbox"/> <input type="checkbox"/> 腫脹 Swelling</p> <p><input type="checkbox"/> <input type="checkbox"/> 割傷 / 擦傷 / 傷口 / 挫傷 / 骨折 Laceration / abrasion / wound / contusion / fracture</p> <p><input type="checkbox"/> <input type="checkbox"/> 如有其他, 請說明 Others, please specify</p> <p>若有, 請詳述受傷部位、範圍及其程度。 If yes, please describe the location, size and the severity.</p> | | | | | | | |
| <p>3. a. 病人有否作X光或其他診斷性檢查? Had the patient been X-rayed or undergone any diagnostic examination? 否 No <input type="checkbox"/> 有 Yes <input type="checkbox"/></p> <p>若有, 請填下欄: If yes, please give details below:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">檢查日期 (日/月/年) Exam Date (DD/MM/YY)</th> <th style="text-align: left; border-bottom: 1px solid black;">類別 Type</th> <th style="text-align: left; border-bottom: 1px solid black;">結果 Result</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"> </td> <td> </td> <td> </td> </tr> </tbody> </table> <p>b. 有沒有發現任何骨骼/韌帶受傷或退化性轉變? Was there any bony / ligament injury or degenerative change detected?</p> | | | | 檢查日期 (日/月/年) Exam Date (DD/MM/YY) | 類別 Type | 結果 Result | | | |
| 檢查日期 (日/月/年) Exam Date (DD/MM/YY) | 類別 Type | 結果 Result | | | | | | | |
| | | | | | | | | | |
| <p>4. a. 有沒有進行任何治療? Was there any treatment administered? 否 No <input type="checkbox"/> 有 Yes <input type="checkbox"/></p> <p>b. 若有, 請提供詳情 (如縫針, 物理治療, 包紮等) 及治療日期。 If yes, please give details (such as suturing, physiotherapy, type of dressing, etc. with treatment dates).</p> <p>c. 此次受傷有沒有需要住院、或進行手術? Did injury require hospitalization, or surgery? 否 No <input type="checkbox"/> 有 Yes <input type="checkbox"/></p> <p>若有, 請提供詳情。If yes, please give details.</p> | | | | | | | | | |
| <p>5. a. 病人的職業和職業性質 Patient's occupation and exact nature of occupational duties</p> <p>b. 請列明病人喪失部分工作能力的時間(日/月/年) Please state period in which patient is not able to perform some of his job duties (DD/MM/YY)</p> <p>c. 請列明病人喪失全部工作能力的時間 (日/月/年) Please state period in which patient is not able to perform all of his job duties (DD/MM/YY)</p> <p>d. 請列明所有身體或精神損傷 - 其影響, 受傷程度和持續時間 (請提供能力喪失程度鑑定證明文件) Specify all physical or mental impairment - impact, severity and duration as a result of this disability (Provide documentation supporting the degree of disability)</p> <p>e. 根據受保人申報之學歷、認可知識及訓練, 請評估受保人能夠從事之工作或職業。 According to the insured's academic qualification, qualified knowledge and training, what duties of the insured's job is he/she incapable of performing?</p> <p>f. 請提供以上傷勢的預後(如適用) Provide the prognosis for each of the above (if any)</p> | | | | | | | | | |



6. 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，估計康復程度為 _____ % Recovery at last consultation was estimated to be _____ %.

c. 未來之治療計劃。What is the future treatment plan?

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

7. 病人有否接受任何物理/職業治療？ Did patient attend physiotherapy/occupational therapy? 是 Yes 否 No

若有，請提供資料包括 a) 醫院/診所名稱 b) 治療時段 c) 治療種類 d) 進展 e) 次數

If yes, please state details including a) Hospital/clinic name b) Period of therapy c) Type of therapy d) Progress e) Frequency.

請提供物理治療/職業治療報告(如適用)

please provide the Physiotherapy/Occupational therapy report (If any)

8. 有否其他原因延長其傷殘時間？例如：傷口感染、糖尿病、再次受傷或其他原因？

Was there any contributory factor that lengthened the disability period, e.g. wound infection, diabetes, re-injury and other underlying disease?

是 Yes 否 No

若有，請詳述： If yes, please state the details as below:

| | | |
|--------------------|-----------------|------------------------------------|
| 病發日期 Onset date | 診斷 Diagnosis | 醫生/醫院名稱 Name of doctor/hospital |
|--------------------|-----------------|------------------------------------|

9. 其他求診日期及詳情：

Subsequent consultation dates & details:

| | |
|--|----------------|
| 求診日期 (日/月/年) Consultation date (DD/MM/YY) | 進展 Progress |
|--|----------------|

10. 病人是否經其他醫生或醫院轉介？

Was the patient referred by other doctor or hospital?

是 Yes 否 No

若有，請提供轉介醫生姓名或醫院名稱及地址。 If yes, please provide name & address of referral doctor or hospital.

11. 你曾否轉介該病人往其他醫生或醫院？

Did you refer the patient to other doctor or hospital?

是 Yes 否 No

若有，請提供醫生或醫院名稱及地址。 If yes, please give name & address of doctor or hospital.

12. 此受傷是否由以下因素導致？ Was such injury caused by the following factors?

有 Yes 否 No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 自致傷害 (原因及經過) Self-inflicted injury (How it happened & underlying cause) |
| <input type="checkbox"/> | <input type="checkbox"/> | 酗酒及濫用藥物 (酒類/藥物名稱、份量及飲食/服食多久) Drug abuse and Alcohol abuse (Name & dosage of drug/alcohol, quantity and duration of consumption) |
| <input type="checkbox"/> | <input type="checkbox"/> | 退化性轉變 (發病日期及求診詳情) Degenerative changes (Onset date & consultation details) |
| <input type="checkbox"/> | <input type="checkbox"/> | 過往受傷/疾病 (原因及求診詳情) Past injury or illness (Cause and details of consultation) |
| <input type="checkbox"/> | <input type="checkbox"/> | 精神病 (發病日期及求診詳情) Psychiatric condition (date of onset & details of consultation) |
| <input type="checkbox"/> | <input type="checkbox"/> | 愛滋病或其他性病 AIDS and/or other sexually transmitted diseases (date of onset & details of consultation) |

若有，請詳述： If yes, please give details:

13. 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 illness or injury, and that the information about his 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)