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免責聲明

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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。

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傷殘保障賠償申請書
Disability 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.

- 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 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 / 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):		8. 受保人 / 保單持有人是否已經恢復工作? Has the Insured / Owner returned to work? <input type="checkbox"/> 是, 請提供復工日期(日/月/年) Yes, please provide the exact date (DD/MM/YY): <input type="checkbox"/> 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):	
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. 診斷? What was the diagnosis?	
5. 診斷之確實日期(日/月/年) Exact diagnosis date (DD/MM/YY):		6. 首次求診醫生的姓名及地址 Name & address of the doctor who first treated you for this illness	
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? <input type="checkbox"/> 否 No <input type="checkbox"/> 有 Yes 如有, 請附口供紙或警察報告影印本。 If yes, please attach a copy of witness statement or police report.	
D. 受保人 / 保單持有人過往的醫療紀錄 Past medical record of the Insured / Owner			
1. 受保人 / 保單持有人有否因這次傷殘而入院治療? Has the Insured / Owner been admitted into a hospital for this disability? <input type="checkbox"/> 否 No <input type="checkbox"/> 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) (DD/MM/YY) 至 (日/月/年) (DD/MM/YY) Exact confinement period: From to			



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2. 受保人 / 保單持有人有否因這次傷殘而接受任何治療? Has the Insured / Owner ever attended any special treatment for this disability?
 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)

3. 受保人 / 保單持有人因是次傷殘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 current disability 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:
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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 開始領取款項之日期(日/月/年) 款項終止領取之日期(日/月/年) 每月領取之金額(港幣)
 Source of income Date of payment began (DD/MM/YY) Date of payment ended (DD/MM/YY) 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, 請列明保單號碼及公司名稱。
 Any concurrent claim about this disability with our Group Dept or other companies? If yes, please give the policy number and the name of the company.

F. 收集個人資料聲明 Personal Information Collection Statement

在富通保險有限公司(以下簡稱“富通保險”),保護客戶的個人資料私隱是富通保險所持的其中一個核心價值。作為一個提供保險產品和服務的公司,客戶的個人資料收集和使用是富通保險業務的重要一環。我們尊重您的個人資料的私隱,並致力於完全遵守“個人資料(私隱)條例”(以下簡稱“條例”)。
 At FTLife Insurance Company Limited (“FTLife”), we hold as one of our core values the protection of privacy of our customer's personal data. As a provider of insurance products and services, collection and use of personal data of our customers is at the heart of our business. We respect the privacy of your personal data and are committed to fully complying with the Personal Data (Privacy) Ordinance (“the Ordinance”).

- 富通保險所收集及/或持有的個人資料 Personal Data collected and/or held by FTLife**
 我們所收集及/或持有的個人資料(不論是否從此表格或以其他方式獲得)包括您的個人資料,聯絡資料,保單資料,交易記錄,學歷及培訓資料,就業資料,財政資料,醫療及健康記錄和您的家庭、生活方式及社會環境資料。
 The personal data that we collect and/or hold (whether contained in this form or otherwise obtained) includes your personal details, contact information, policy details, transaction records, education and training details, employment details, financial details, medical and health records and information on your family, lifestyle and social circumstances.
- 收集個人資料的重要性 Importance of Personal Data Collection**
 富通保險會不時地要求您提供您的個人資料。您提供個人資料予富通保險是出於自願的。然而,如果您沒有按我們所要求而提供您的個人資料予富通保險,富通保險可能無法提供或繼續提供產品和服務給您。
 From time to time, you will be requested to provide your personal data to FTLife. Provision of personal data to FTLife by you is voluntary. However, FTLife may not be able to provide or continue to provide products and services to you if you fail to provide your personal data as requested by us.
- 個人資料收集和使用的目的 Purposes of Personal Data Collection and Usage**
 富通保險所持有您的個人資料可能會用於以下目的:
 Your personal data held by FTLife may be used for the following purposes:
 - 保險管理或再保險業務有關的用途,其中包括承保,處理和評估申請,身份和信用檢查,適用性檢查,保單服務,理賠處理,調查,帳戶/債務追收,訴訟,通訊,製作統計,數據分析和研究,內部/外界審計,保持優質的服務,銷售和促銷,建設企業品牌和建設客戶忠誠度的活動;
 administration of insurance or reinsurance related business, which includes underwriting, processing and evaluation of applications, identity and credit checking, suitability checking, policy servicing, claims processing, investigation, account/debt collection, litigation, communications, preparing statistics, data analysis and research, internal and external audit, maintaining quality services, sales and marketing, corporate brand building and customer loyalty building;
 - 直接促銷,包括透過電子或其他的渠道推廣,促銷或銷售富通保險的保險或保險相關的產品或服務及/或由第三者金融機構所提供及/或促銷的任何金融相關的產品或服務;及
 direct marketing, which includes promoting, marketing or selling, of FTLife insurance or insurance related products or services and /or any financial related products or services provided and/or marketed by third party financial institutions by electronic or other means; and
 - 為遵守下列適用於富通保險或富通保險應該遵守的有關披露及使用資料的責任、規定或安排:
 complying with the obligations, requirements or arrangements for disclosing and using data that apply to FTLife or with which it is expected to comply according to:
 - 在香港境內或境外,現行或將會存在的,並對其具約束力或適用於其的任何法律;
 any law binding or applying to it within or outside Hong Kong existing currently and in the future;
 - 在香港境內或境外,現行或將會存在的,並由任何法定、監管、政府、稅務、執法或其他機構,或由金融服務提供者的自我監管或業界的團體或組織所發出或提供之任何指引或指導;
 any guidelines or guidance given or issued by any legal, regulatory, governmental, tax, law enforcement or other authorities, or self-regulatory or industry bodies or associations of financial services providers within or outside Hong Kong existing currently and in the future;
 - 富通保險因其在本地或海外的司法管轄區或與該司法管轄區相關的金融、商業、營業或其他利益或活動而須承擔與該本地或海外的法定、監管、政府、稅務、執法或其他機構或金融服務提供者的自我監管或業界的團體或組織之間的現有或將來之任何合約承諾或其他承諾。
 any present or future contractual or other commitment with local or foreign legal, regulatory, governmental, tax, law enforcement or other authorities, or self-regulatory or industry bodies or associations of financial services providers that is assumed by or imposed on FTLife by reason of its financial, commercial, business or other interests or activities in or related to the jurisdiction of the relevant local or foreign legal, regulatory, governmental, tax, law enforcement or other authorities, or self-regulatory or industry bodies or associations.
- 直接促銷 Direct Marketing**
 在獲得您的同意下,富通保險可能會使用您的姓名,電話號碼,電郵地址和通訊地址作如第3(ii)段所載的直接促銷。請您在以下第8段確認您的同意。如果在您提交此表格後,您不希望收到我們的推廣性要約或信息,請通知我們,我們將立即停止使用您的個人資料,並不收取任何費用。請把您的有關要求以書面通知我們的保障資料主任,其聯絡地址載於第7.3段。
 FTLife may use your name, telephone number, email address and correspondence address for direct marketing as set out in section 3(ii) only with your consent. Please confirm if you consent in section 8 below. If subsequent to your submission of this form you do not wish to receive our promotional offers or information, please let us know and we will cease to use your personal data immediately, without any charge. Please send your written request to our Data Protection Officer at the address provided in section 7.3.
- 個人資料保密 Personal Data Confidentiality**
 富通保險會對您提供的個人資料加以保密,除了可能會與下列各方共享:
 The personal data you provide to FTLife will be kept confidential, except that it may be shared with the following parties:
 - 代表你的任何保險經紀,獨立財務顧問作在第3(i)段中所列出的任何用途;
 any insurance broker, independent financial advisor acting on your behalf for any of the purposes set out in section 3(i);

- ii 任何富通保險的附屬公司、控股公司、聯營公司或聯屬公司作為第3(i)-(iii)段中所列出的任何用途；
any subsidiary, holding company, associated company or affiliates of FTLife for any of the purposes set out in section 3(i)-(iii);
- iii 任何富通保險的代理人、承包商或會向富通保險提供行政、電訊、電腦、網際網路、付款或其他服務的第三方服務供應商（包括但不限於風險分析顧問、損失公估人、私人調查員、信函裝封服務機構及債務追收員）作為第3(i)和3(ii)段中所列出的任何用途；
any agent, contractor or third party service provider, including but not limited to providers of risk intelligence, loss adjusters, private investigators, letter shopping service providers and debt collectors who provides administrative, telecommunications, computer, Internet, payment or other services to FTLife for any of the purposes set out in section 3(i) and (ii);
- iv 任何富通保險的實際或建議再保險公司作為第3(i)段中所列出的任何用途；及
any actual or proposed reinsurers of FTLife for any of the purposes set out in section 3(i); and
- v 富通保險在根據對其本身或其任何集團公司具約束力或適用的任何法律規定下的責任或其他原因，或按照及為實施其應該遵守的由任何法定、監管、政府、稅務、執法或其他機構或金融服務提供者的自我監管或業界的團體或組織所提供或發出的指引或指導，或根據與本地或海外之法定、監管、政府、稅務、執法或其他機構或金融服務提供者的自我監管或業界的團體或組織之間的任何合約承諾或其他承諾，而必須對其作出披露的任何人士，而該等人士可能處於香港境內或境外及可能是已存在、現有或將來出現的人士。
any person to whom FTLife is under an obligation or otherwise required to make disclosure under the requirement of any law binding on or applying to FTLife or any of its group companies, or any disclosure under and for the purposes of any guidelines or guidance given or issued by any legal, regulatory, governmental, tax, law enforcement or other authorities, or self-regulatory or industry bodies or associations of financial services providers with which FTLife is expected to comply or any disclosure pursuant to any contractual or other commitment of FTLife with local or foreign legal, regulatory, governmental, tax, law enforcement or other authorities, or self-regulatory or industry bodies or associations of financial services providers, all of which may be within or outside Hong Kong and may be existing currently and in the future.

6. 移轉個人資料至香港以外的地方 Transfer of Personal Data Outside Hong Kong

富通保險可能會不時地將您的個人資料移轉至香港以外的地方作為第3(i)和3(ii)段中所列出的任何用途，包括資料處理或貯存。

FTLife may from time to time transfer your personal data outside Hong Kong for any of the purposes set out in section 3(i) and (ii) including data processing or storage.

7. 個人資料的查閱/改正要求 Personal Data Access / Correction Request

7.1 根據條例的規定，您有下列權利：

In accordance with the Ordinance, you have the right to:

- 查詢富通保險是否持有您的個人資料，如有，您有權獲得這些資料的副本；
check whether FTLife holds personal data about you and, if so, obtain a copy of such data;
- 要求富通保險糾正任何有關您的不準確的個人資料；及
require FTLife to correct any personal data relating to you which is inaccurate; and
- 確定富通保險對個人資料處理的有關政策和做法，並獲告知由富通保險持有您個人資料的種類。
ascertain FTLife policies and practices in relation to personal data and to be informed of the kind of personal data held by FTLife.

7.2 富通保險有權就處理任何個人資料查閱要求收取合理的費用。

FTLife has the right to charge a reasonable fee for the processing of any personal data access request.

7.3 有關要求可向位於香港特別行政區上環干諾道中111號永安中心27樓富通保險有限公司客戶服務中心的「保障資料主任」以書面形式提出。

Requests shall be made in writing to our Data Protection Officer, FTLife Customer Service Centre, FTLife Insurance Company Limited, 27/F, Wing On Centre, 111 Connaught Road Central, Hong Kong SAR.

8. 同意使用個人資料作直接促銷 Consent for Use of Personal Data for Direct Marketing

富通保險只可在您的同意下使用從您收集的個人資料作直接促銷用途。如果您不希望收到我們的推廣性要約或信息，請在左邊的框中打勾。

FTLife Insurance Company Limited may use the data collected from you for direct marketing purpose only with your consent. If you do not wish to receive our promotional offers or information, please put a tick in the box on the left.

由此文件所示之日開始，此收集個人資料聲明將被視為您與富通保險之間已經簽署或準備簽署的所有合約，協定和其他具有約束力的安排的一個組成部分。

This Personal Information Collection Statement shall from the date hereinafter appearing be deemed to form an integral part of all contracts, agreements and other binding arrangements which you have entered into or intend to enter into with FTLife.

在英文和中文版本之間出現差異的情況下，應以英文版本為準。

In case of discrepancies between the English and Chinese version, the English version shall prevail.

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.

受保人/保單持有人簽署 : **X** _____
Signature of Insured / Owner

見證人簽署 : **X** _____
Signature of Witness

受保人/保單持有人姓名(大寫) : _____
Name of Insured / Owner
(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)

填表須知 INSTRUCTIONS

1. 請回答申請書第一部份A、B或C、D及E的所有問題及簽署聲明及授權書。

Please answer ALL the questions in Section (A), Section (B) or Section (C), (D) and Section (E) of Part I 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 all the Insured's own expenses.

3. 請附上(i)連同保單持有人簽署的身份證副本(如未於本公司存檔)、(ii)有關報告或文件，例如病假紙、醫生報告、物理治療報告、化驗報告等以便審核。

Please attach (i) ID copy of the policy owner with signature on it; (ii) other reports or appropriate documentation, such as sick leave, medical certificate, physiotherapy report, laboratory report, etc. to enable us to assess your claim.

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, Hong Kong. Tel.: 2866 8898.

CONSULTANT'S REMARKS

REMARKS FOR RM OR ABOVE

第二部份 — 申請人需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 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																												
<p>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)?</p> <p>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)?</p> <p>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?</p> <p>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 (日/月/年)起或已存在 日 月 年 Since (DD/MM/YY) or for days months years</p>																															
<p>2. a. 最後的診斷為何? What is the final diagnosis?</p> <p>b. 診斷日期(日/月/年) Diagnosis date (DD/MM/YY):</p> <p>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:</p>																															
<p>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</p> <p>若有，請提供轉介醫生姓名或醫院名稱地址? <input type="checkbox"/> <input type="checkbox"/> If yes, please provide name and address of referral doctor/hospital?</p> <p>轉介日期(日/月/年) Date of Referral (DD/MM/YY):</p>																															
<p>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 是 Yes</p> <p>若有，請提供醫生姓名或醫院名稱及地址? <input type="checkbox"/> <input type="checkbox"/> If yes, please provide name and address of doctor/hospital?</p>																															
<p>5. a. 住院時期(日/月/年) Hospitalization period (DD/MM/YY):</p> <p>b. 醫院名稱 Name of hospital confined:</p>																															
<p>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?</p> <p><input type="checkbox"/> 否 No <input type="checkbox"/> 是，請提供詳情如下 Yes, please give details below:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">日期(日/月/年) Exam Date (DD/MM/YY)</th> <th style="width:30%;">檢驗 Investigation</th> <th style="width:40%;">結果 Result</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>				日期(日/月/年) Exam Date (DD/MM/YY)	檢驗 Investigation	結果 Result																									
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<p>7. 治療之詳情 Details of medical and surgical treatment:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">類別 Type</th> <th style="width:20%;">日期 / 時段(日/月/年) Dates/Period (DD/MM/YY)</th> <th style="width:20%;">併發症或後遺症 Complication or side-effects</th> <th style="width:30%;">康復情況 Healing condition</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> 手術 Operation</td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td><input type="checkbox"/> 物理治療 Physiotherapy</td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td><input type="checkbox"/> 職業治療 Occupational Therapy</td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td><input type="checkbox"/> 化學治療 Chemotherapy</td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td><input type="checkbox"/> 放射治療 Radiotherapy</td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td><input type="checkbox"/> 其他 Others</td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>				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	<input type="checkbox"/> 手術 Operation				<input type="checkbox"/> 物理治療 Physiotherapy				<input type="checkbox"/> 職業治療 Occupational Therapy				<input type="checkbox"/> 化學治療 Chemotherapy				<input type="checkbox"/> 放射治療 Radiotherapy				<input type="checkbox"/> 其他 Others			
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<p>8. 其後之覆診日期及詳情 Subsequent consultation records and details:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">求診日期(日/月/年) Consultation Date (DD/MM/YY)</th> <th style="width:30%;">醫生 / 醫院名稱 Name of doctor/hospital</th> <th style="width:20%;">診斷 Diagnosis</th> <th style="width:20%;">進展 Progress</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>				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																								
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<p>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:</p> <p><input type="checkbox"/> 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)</p> <p><input type="checkbox"/> 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)</p> <p><input type="checkbox"/> 不能從事任何工作 Unable to perform ANY occupation: 由 From _____ 至 to _____ (日/月/年) (DD/MM/YY)</p>																															



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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 Slight 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 是，請提供詳情(病發、診斷日期及醫生名稱) Yes, please state details (onset date, diagnosis, name of doctor)

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 | |
|--------------------------|--------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 自致傷害 Self-inflicted injury (原因及經過 How it happened & underlying cause) |
| <input type="checkbox"/> | <input type="checkbox"/> | 酗酒 Alcoholic abuse (酒類名稱、份量及維持多年 Name of alcohol, quantity & duration of consumption) |
| <input type="checkbox"/> | <input type="checkbox"/> | 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) |
| <input type="checkbox"/> | <input type="checkbox"/> | 退化性轉變 Degenerative changes (發病日期及求診詳情 Onset date & consultation details) |
| <input type="checkbox"/> | <input type="checkbox"/> | 先天性缺陷 Congenital anomalies (診斷、發病日期及求診詳情 Diagnosis, onset date & consultation details) |
| <input type="checkbox"/> | <input type="checkbox"/> | 過往受傷 / 疾病 Past injury or illness (原因及求診詳情 Cause & consultation details) |

若有，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)