中国太平
CHINA TAIPING

中國太平保險(香港)有限公司
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「意 外 急 救 醫 療 保 險」賠 償 申 報 表
"ACCIDENTAL EMERGENCY MEDICAL INSURANCE" CLAIM FORM

注意： 呈上本申請賠償表格，並不表示本公司承認提供賠償責任。各項有關單據正本及有關證明文件，請隨附於本表格，一併送交予本公司，以免延誤理賠。
Note: By furnishing this form the Company makes no admission of liability. Original itemized bill(s) and supporting document(s) must be submitted together with this form in order to avoid delay.

保單號碼 Policy No.	賠償號碼 (由本公司填寫) Claim No. (For Office Use)	
申請賠償者姓名 Name of Claimant	性別 Sex	年齡 Age
住址 Address		
聯絡電話 Contact No.	傳真機號碼 Fax No. :	電子郵件 E-mail Address :

意外詳情 Particulars of Accident

請陳述
Please state: 意外發生日期 Date _____ 時間 Time _____ a.m./p.m.

地點 Place of Accident _____

敘述意外發生情況
Describe exactly how accident occurred?

請述受傷性質
Describe the nature and extent of injury

請註明申請賠償金額 Please state amount claimed	金額 Amount：_____
閣下是否舊傷復發？ Have you ever suffered this or similar condition or a recurrence of such previous related injury?	否 NO ☐ 是 YES ☐

若「是」，請敘述詳情 If yes, please give full details.

備 註： 請提供有關資料如意外報告、警方報告、死亡證及其他有關文件等，如屬交通意外，請提供公安證明文件及／或道路交通事故責任認定書。
Remarks: Please provide the supporting documents e.g. accident report, police report, death certificate and/or any relevant documents. In the event of a traffic accident, please provide documentary evidence from the police and/or a Traffic Accident Liability Confirmation Statement.

診治資料 Consultation Information

醫院名稱
Name of Hospital：_____

主診醫生姓名
Name of Attending Medical Practitioner：_____

診治日期
Consultation Date：_____

☐ 門診 Out-patient
☐ 住院 Hospitalization

醫療費用 Medical Expenses： RMB/HK$_____
醫療費用 Medical Expenses： RMB/HK$ _____

入院日期
Date of Admission _____ (日/月/年) (D/M/Y)

出院日期
Date of Discharge _____ (日/月/年) (D/M/Y)

是否已痊癒？ Are you completely recovered?	否 NO. ☐ 是 YES ☐
是否一切醫療收據已呈上？ Have you presented all medical receipts?	否 NO ☐ 是 YES ☐
若「否」，請註明 If No, please specify:	

備　註：　請提供主診醫生之診斷書正本（詳細列明損傷之程度及原因、診斷結果及所提供之醫療方法）和所有由網絡醫院蓋章簽發之住院費用清單及醫療費用收據正本。

Remarks: Please provide the original medical certificate issued by the attending medical practitioner (stating the nature and extent of injuries, diagnosis and the treatments provided) and all original bills/receipts issued by the hospital concerned with detailed breakdown of costs/expenses.

主診醫生聲明 Declaration by the Attending Medical Practitioner

本人特此證明已親自爲_____(傷者姓名)就上述受傷進行檢查及治療，詳情如下：

I hereby certify that I have personally examined & treated _____(name of the injured) for the above injury and details are as follows:

診斷 Diagnosis:

治療 Treatment:

結果 Result:

此是否原有之傷病? Is this pre-existing disease?	否 NO ☐ 是 YES ☐
若「是」，已存在多久? If yes, how long? _____ 此是否先天性缺陷? Is condition congenital?	否 NO ☐ 是 YES ☐
據閣下所知，是次受傷是否因其他情況導致? To the best of your knowledge, are there any other factors that may have contributed to this accident?	否 NO ☐ 是 YES ☐
若「是」，請註明 If yes, please state specify	
是次意外是否導致傷者完全永久喪失任何工作謀生能力? Does this accident result in Permanent Total Disablement of the claimant? 若「是」，請提供詳細報告 If yes, please provide the detailed medical report	否 NO ☐ 是 YES ☐

醫生簽署 Signature: _____

醫生姓名 Name of Medical Practitioner(with stamp): _____

地址 Address / 電話 Telephone : _____

備註：受傷性質 / 程度等詳情亦可由主治醫生另出具證明書 Remarks : The attending medical practitioner may issue his own diagnosis report.

其他保險 Other Insurance

是否受保於其他保險合約？ Any other policy is covering the expenses involved?	否 NO ☐ 是 YES ☐
若「是」，請敘述詳情 If yes, please give full details	
保險公司名稱 Name of Insurance Company_____	保單號碼 Policy No._____

備註：請附保單副本及已賠付的收據文件 Remarks: please attach copy of policy & discharge receipt

本人／我們茲聲明上述所填報之資料皆爲確實詳情，並沒有隱瞞任何與此索償有關之重要情況。

I/We hereby warrant the truth of the above statements and declare that I have not withheld any material information connected with this claim.

本人／我們謹此代表本人／我們／所有被保險人授權任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、或其他機構、組織或人士，凡知道或持有任何有關本人／我們／所有被保險人記錄者，及／或曾診驗或可能將會診驗本人／我們／所有被保險人者，均可將該等資料提供給中國太平保險(香港)有限公司，此授權對本人／我們之繼承人及被保險人具有約束人；即使死亡或無行爲能力時，此授權仍具效力，本授權書的影印本與正本均有同等效力。

I/We hereby authorize on behalf of myself/ourselves/the Insured Person any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of me/us/the Insured Person and who has attended or may hereafter to myself/ourselves/the Insured Person to disclose such information to China Taiping Insurance (HK) Company Limited. This authorization shall bind my successors and assignees and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

本人／我們聲明及同意已獲被保險人授權及同意本人／我們作出上述授權。

I/We declare and agree that I/we have the full authority from and consent of the Insured Person to make the above authorizations.

日期
Date ……

申請賠償者簽署
Claimant Signature ……

註：　爲避免影響 貴客戶之索償權利，請填妥本申請理賠表格並簽署後，連同一切所需文件在本保單之規定期限內親交或按以下地址郵寄本公司意外及健康險部。

Note: In order not to prejudice your claim, please complete this Claim Form with signature and submit full documentation within stated deadline in the policy in person or post to Accident & Health Department at below address.