聯豐亨人壽
Luen Fung Hang Life

意外保障索償申請書
Accidental Benefit Claim Form

營業員姓名 Agent Name		營業員號碼 Agent Code		聯絡電話 Contact Tel. No.	

索償類別 Coverage claiming for	☐ 綜合意外保障 AI	☐ 意外死傷保障 ADD	☐ 其他 Others

附上文件 Documents attached	☐ 病假證明書 Sick Leave Certificate	☐ 醫院帳單正本 Original Hospital Bills	☐ 出院報告 Discharge Summary	☐ 其他 Others		幣值 Currency	☐ HK$	☐ US$

填表須知 Instructions	1. 發出此申請書並不表示本公司已接納是次索償申請。在此索償過程中，索償人無需支付任何性質之手續費予本公司之僱員或營業員。 The issue of this form is in no way an admission of liability. No fee, commission or charge of whatever nature is required to pay to the employees or agents of the company with respect to this claim. 2. 請回答申請書第一部份所有問題。申請書第二部份必須由主診醫生填寫並由索償人支付有關費用。 Please answer ALL the questions in Part I of this claim form. Part II of this claim form MUST be completed and signed by the attending physician. The completion of this part is at claimant's own expenses. 3. 請附上有關報告或文件，例如病假紙、醫療報告、物理治療報告、詳細列明每項費用之醫院帳單正本、醫院發出的出院報告並列明實際病因等以方便審核。 Please attach other reports or relevant documents, such as sick leave certificate, medical report, physiotherapy report, original hospital bills with breakdown details, discharge summary issued by hospital containing the exact diagnosis, etc. to enable us to assess the claim. 4. 請確保索償人在此申請書的簽署必須和投保書簽署一致。 Please make sure the signature of claimant on this claim form is in consistent with that appearing on the policy application form.

第一部份 - 索償人聲明(由索償人/被保人填寫)
PART I - CLAIMANT'S STATEMENT (to be completed by Claimant/Insured)

☐ New Claim 首次索償 ☐ Further Claim 再度索償 ☐ Review/Appeal 重批/覆核

保單號碼 Policy No.		被保人姓名 Name of Insured	英文 in English			中文 in Chinese		
身份證號碼 ID Card No.		出生日期 Date of Birth	年 YY /	月 MM /	日 DD	年齡 Age		性別 Sex ☐ 男 Male ☐ 女 Female
聯絡地址 Mailing address						聯絡電話 Contact Tel. No.		

就業詳情 Employment Details

1. 僱主名稱及地址 Name and Address of employer		聯絡電話 Contact Tel. No.	
如僱主與投保時不同，請說明何時轉工 If the employer is different from the one stated in the application, please state when it was changed	年 YY /	月 MM /	日 DD
現時職業及職務(倘有兼職請列明) Present occupation & job duties (if more than one, state all)			

意外詳情 Accident Details

2. a. 意外發生日期、時間和地點 Date, Time and Place of accident	日期 Date 年 YY /	月 MM /	日 DD	時間 Time ☐ 上午 a.m. ☐ 下午 p.m.	地點 Place
b. 意外發生經過? How did the accident happen? (請附上新聞剪報，如有) (attach newspaper clippings, if any)					
c. 受傷部位? Which part(s) of body injured?					
d. 受傷程度? What is the extent of the injury?					
e. 是否有報警? Had reported to police?	☐ 是， Yes, 報案警署名稱 Police station		檔案編號(請附上副本，如有) Police reference number (submit photocopy if any)		☐ 否 No

診治詳情 Consultation Details

3. 就此意外求診之醫生資料 Details of consultation for the injury	求診日期(年/月/日) Consultation Date (YY/MM/DD)	原因/病因 Reason/Diagnosis	醫生姓名及地址(請附上病歷咭，如有) Name and Address of doctor (please attach patient card copy if available)
a. 首次求診的醫生 Doctor first consulted			
b. 建議入院的醫生 Doctor referred to hospital			
c. 過往就同類或有關類似病症曾求診的醫生 Doctors consulted in the past for same or similar or related condition			

住院詳情 Hospitalization Details

4. 就此意外入住的醫院資料 Details of hospital confinement for the injury	入院日期(年/月/日) Date of Admission (YY/MM/DD)	出院日期(年/月/日) Date of Discharge (YY/MM/DD)	原因/病因 Reason/Diagnosis	醫院名稱及地址(請附上病歷咭，如有) Name and Address of hospital (please attach patient card copy if available)

5. 有否於住院期間離院? Have you taken any home leave during confinement?	☐ 是， Yes, 時間及原因 Duration & Reason		☐ 否 No

受傷情況 Extent of Injury

6. a. 請詳述現時受傷情況 Please describe the current condition of the injury	

b. 閣下何時開始不能工作？ When did you become unable to engage in employment or business?	年 YY / 月 MM / 日 DD

c. 請詳述由受傷至今，不能工作之時期 Please state period of absence from work since the injury	受傷日期(年/月/日) Date of Injury (YY/MM/DD)	原因/病因 Reason	不能工作之時期 Period absent from work

d. 閣下是否已恢復工作或預料恢復工作? Did you return or expect to return to work?	☐ 是 Yes	年 YY / 月 MM / 日 DD	☐ 否 No	原因 Reason

其他資料 Other Information

7. a. 有否向僱主遞交病假證明書? Did you file a sick leave certificate to your employer?	☐ 是， Yes, 從 From 年 YY / 月 MM / 日 DD	至 to 年 YY / 月 MM / 日 DD	☐ 否 No
b. 有否就此次意外申請勞工賠償? Did you file a claim for Employee's Compensation?	☐ 是， Yes, 申請日期 Date of Submission 年 YY / 月 MM / 日 DD		☐ 否 No

8. 閣下曾否因同一事故申索/接受其他機構包括保險公司、政府及僱主之傷殘保障賠償? (如是者，請提供以下資料)
Are you claiming/receiving similar benefit for the same event with any other organizations including insurance company, the government, and employer compensation? (If yes, please provide the following information) ☐ 是 Yes ☐ 否 No

保險公司/機構 Insurance Company/Organization	保障類別/保單號碼/團體保險編號 Benefit Type / Policy No. / Group Member No.	申索/接受之傷殘保障賠償 Benefits Amount Claimed/Received	結果/狀況 Result/Status

聲明及授權

本人謹此明白及同意：

(1) 所有在本申請書的一切陳述及答案，不論是否本人親手所寫，就本人所知所信，均為事實無訛；

(2) 本人/我們明白本人/我們提供的資料為聯豐亨人壽保險股份有限公司(以下簡稱「貴公司」)提供保險業務所需，並可能使用於下列目的：
- 任何與保險或財務有關的產品或服務，包括但不限於保險、理財、退休金或退休金計劃，或該等產品或服務的申請及任何更改、變更、取消、續期及/或復效的申請；
- 不時向本人/我們推薦及提供產品及/或服務，及執行、維持、管理及營運該等產品及/或服務；
- 任何索償，或該等索償的調查、分析、處理、評估、釐定或回應該等索償；
- 行使任何代位權；
- 防止及/或偵查罪行、欺詐及其他不誠實的行為；及

可能移轉予下述各方（無論在澳門特別行政區境內或境外）作為上述列出目的之用：
- 任何再保險及索償調查公司、有關的保險行業協會及聯會和該等協會及聯會的會員；
- 任何向貴公司及/或其相關聯公司提供業務運作有關的行政、電訊、電腦、市場推廣及/或其他服務的代理人、承包人、商業夥伴及第三方服務供應者；
- 根據對貴公司具法律約束力的規定，或因監管或其他管理機構所要求貴公司遵守的指引，履行對任何人士的披露責任；
- 任何對貴公司有保密責任的人。

(3) 本人/我們明白本人/我們有權查閱及要求更正由貴公司持有有關本人/我們及/或受保人的個人資料；及/或要求不將該等個人資料用於直接促銷的用途。如有需要，本人/我們可向貴公司提出，地址：澳門新口岸宋玉生廣場 398 號中航大廈四樓。

本人/我們明白及授權，且不得撤回：

(1) 本人/我們授權貴公司可向有關的保險行業協會及聯會和該等協會及聯會的會員從保險業內收集的資料中查閱及/或核對本人/我們及/或受保人任何資料。

(2) 任何知悉或擁有本人/我們/被保人之工作、病假記錄、意外或損失(任何類別)之詳情、健康狀況、病歷或任何治療或諮詢記錄及曾為或將為本人/我們/被保人診治之機構、組織或人士，向貴公司透露有關資料。即使本人/我們/被保人死亡或喪失能力，此授權書仍然存有法律效力，而本人/我們/被保人之繼承人及轉讓人亦會受此授權書約束。此授權書之正本與副本同屬有效。

(3) 貴公司或任何其認可之驗身醫生或化驗所，替本人/我們/被保人進行所需之醫療評估及測試，並對本人/我們/被保人之健康狀況進行審核及評估，作為處理本申請及其後與之有關的賠償事宜。此等化驗包括，但並不限於，膽固醇及有關之血脂肪、糖尿病、腎或肝功能失常、愛滋病或感染人體免疫力缺乏症病毒、免疫系統失常或體內藥物、毒品、尼古丁及其他代謝產物之含量等化驗。

Declaration & Authorization

IT IS UNDERSTOOD AND AGREED:

(1) All statements and answers in this application whether or not written by my own hand are complete and true to the best of my knowledge and belief;

(2) The information provided by me/us to Luen Fung Hang Life Limited (hereinafter called "the Company") is collected to enable the Company to carry on insurance business and may be used for the purpose of：
- processing and/or approving applications for products and/or services and additions, alterations, variations, cancellations, renewals, and reinstatements of such products and/or services which may include, without limitation, insurance, provident fund or scheme, or other financial products or services;
- offering and providing products and/or services to me/us from time to time, and administering, maintaining, managing and operating such products and/or services;
- any claim or investigation, analyzing, processing, assessing, determining or responding of such claims;
- exercising any right of subrogation;
- preventing and/or detecting crimes, fraud and other dishonest behavior; and

may be transferred to the following parties (whether within or outside the Macau Special Administrative Region) for the purposes set out as above：
- reinsurance and claims investigation companies, relevant insurance industry associations and federations, and members of such industry associations and federations;
- agents, contractors, business partners, and third party service providers who provide administration, telecommunications, computer, marketing, and/or other services to the Company and/or any of its affiliated companies in connection with the operation of business;
- any person to whom the Company is under an obligation to make disclosure under the requirements of any law binding on the Company or under and for the purposes of any guidelines issued by regulatory or other authorities with which the Company are expected to comply;
- any other person under a duty of confidentiality to the Company which has undertaken to keep such information confidential.

(3) I/We understand that I/We have the right to obtain access to and to request correction of any personal information concerning myself/ourselves and/or the Insured Person(s) held by the Company and/or not to use data for direct marketing purpose. Requests for such access can be made to the Company, address: No. 398 Alameda Dr. Carlos D'Assumpcao, Edificio CNAC, 4 Andar, Macau.

IT IS UNDERSTOOD AND IRREVOCABY AUTHORIZED:

(1) The Company is hereby authorized to obtain access to and/or to verify any data provided by me/us and/or the Insured Person(s) with the information collected by the relevant insurance industry associations and federations, and members of such industry associations and federations from the insurance industry.

(2) any organization, institution, or individual that has any record or knowledge of my/our/the Insured's employment, sick leave records, accident or loss details (of any sorts), health, medical history or any treatment or advice, that when requested by an authorized representative of the Company may disclose any such information. This authorization shall bind my/our/the Insured's successors and assigns and remain valid notwithstanding my/our/the Insured's death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

(3) The Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate my/our/the Insured's health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications drugs, nicotine or their metabolites.

日期 (年/月/日) Date (YY/MM/DD)	索償人/被保人身份證號碼 ID Card No. of Insured Claimant	索償人/被保人姓名 Name of Insured/Claimant	索償人/被保人簽署 Signature of Claimant/Insured
/ /			

日期 (年/月/日) Date (YY/MM/DD)	代理人/見證人身份證號碼 ID Card No. of Agent/Witness	代理人/見證人姓名 Name of Agent/Witness	代理人/見證人簽署 Signature of Agent/Witness
/ /			

公司專用 FOR OFFICE USE ONLY	Claim No.	Date Received	Captured By	Signature Verified by	Checked By	Approved By	Remarks

第二部份 - 醫生診斷報告(索償人自費由主診醫生填寫)

PART II - ATTENDING PHYSICIAN'S STATEMENT (to be completed by attending physician at claimant's expense)

1. Name of Patient		Age / Sex		ID Card No.	

2. a. Date of first consultation for the patient's injury: ____ / ____ / ____ (YYYY / MM / DD) | Date of accident: ____ / ____ / ____ (YYYY / MM / DD)

b. Was there evidence of an external and visible bruise or wound at first visit? ☐ Yes ☐ No

c. Which part of the body injured?

d. Describe the cause, character and the extent of injury

e. As a result of the injury, has the patient been treated for any of the following? If yes, please give details. ☐ Yes ☐ No

Treatment	Date (YY/MM/DD)	Details of Treatment (type, frequency, result, etc.)
1. Hospitalization ☐ Yes ☐ No		Name of Hospital : Date of Admission (YY/MM/DD) : Date of Discharge (YY/MM/DD) :
2. Surgery ☐ Yes ☐ No		
3. X-rays ☐ Yes ☐ No		
4. Special diagnostic procedures ☐ Yes ☐ No		
5. Suturing ☐ Yes ☐ No		
6. Physiotherapy ☐ Yes ☐ No		
7. Dressing ☐ Yes ☐ No		
8. Others		

f. Did the patient consult any other physicians or admit in hospital for the same injury? If yes, please give details. ☐ Yes ☐ No

Consultation Date/ Period of Confinement (YY/MM/DD)	Diagnosis/Treatment	Name and Address of other physicians/hospitals

3. a. What is the current condition and prognosis of the patient?

b. Current state of mobility

☐ Ambulatory ☐ Home confined ☐ Hospital confined ☐ Bed confined

Please give details (the causes, areas of involvement, and whether permanent in nature)

c. With the current health condition of the patient, please rate the class of the patient's physical impairment as follows:

☐ Class 1 No limitation of functional capacity; capable of heavy work without restrictions
☐ Class 2 Capable of medium manual activity
☐ Class 3 Slightly limitation of functional capacity; capable of light manual work
☐ Class 4 Moderate limitation of functional capacity; capable of clerical or administrative work
☐ Class 5 Serious limitation of functional capacity; incapable of minimal activity

Please give details:

4. a. Patient's Occupation and Job Duties | Date first become unable to engage in employment or business | / / YYYY MM DD

b. In your opinion, is the patient now totally incapable to work? If yes, please estimate and explain when the patient can resume working. ☐ Yes ☐ No

c. According to the occupation of the patient, please indicate the effect on the disability:

☐ Inability to perform one or more duty of his/her OWN job
for ☐ less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-24 months ☐ > 24 months

☐ Inability to perform each and every duty of his/her OWN job
for ☐ less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-24 months ☐ > 24 months ☐ Permanently

☐ Inability to engage in ANY work, occupation or business for which he is reasonably suited by education, training or experience
for ☐ less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-24 months ☐ > 24 months ☐ Permanently

Please give reasons:

d. What are the limitations to the patient's occupational activities?

e. If the patient cannot resume his/her past occupation, could he/she engage in any other occupation? ☐ Yes ☐ No
If yes, what type of job would you suggest him/her to do and from when he/she can perform?

f. Is there any planned treatment or rehabilitation plan to the patient? If yes, please give details with dates. ☐ Yes ☐ No

5. Was the illness or injury caused by or in any way associated with any of the following? Please tick where appropriate and give details.

☐ Past injury or illness
☐ Pre-existing physical or mental defects
☐ Suicide or self-inflicted injury
☐ Alcohol or drugs
☐ Poison, gas or fumes taken
☐ Degenerative changes
☐ Congenital deformities or anomalies
☐ Physical defects
☐ Others

Details:

6. Any further information you consider relevant to this claim

I hereby certify that I have personally examined and treated the patient for the above illness or injury and that the information as stated above is true and complete to the best of my knowledge and belief.

Name & Qualification of Attending Physician

Signature and Chop of Attending Physician

/ /
Date (YY/MM/DD)

Address

Telephone No.