



人身意外及醫療保險賠償申請書

PERSONAL ACCIDENT AND HOSPITALIZATION INSURANCE CLAIM FORM

保單號碼 Policy No. : _____ 保單到期日 Expire Date : _____

申請賠償人姓名
1. Name of Claimant : _____

與被保人之關係
2. Relationship to insured person : _____

被保人姓名 Name of insured person : _____ 身份證號碼 Identity Card No. _____

職業 Occupation : _____ 性別 Sex _____ 年齡 Age _____

地址
7. Address : _____

電話
8. Tel. _____

意外發生日期 / 發現疾病日期 Date of Accident / Date of sickness first began : _____ 時間 Time : _____

詳述該意外遇事情形，地點及時間
10. Describe when, how and where accident happened : _____

如有見證人，請詳述其姓名，地址及電話
11. Any Witness? 是 Yes 否 No

If yes, please provide us the name, address and tel. no. of the witness _____

受傷 / 疾病性質
12. Nature of Injury / Sickness : _____

初次治療日期
13. Date of First Treatment : _____

主治醫師姓名
14. Name of attending physician : _____

閣下曾否向其他保險公司投保同類保險?若有，請列明該保險內容
15. Are you insured with any other insurance company for similar benefits? If so, please give particulars : _____

本人相信本人身意外及醫療保險賠償申請書所述事實屬實，而其中所表達的意見屬實誠地持有的。
I believe that the facts stated in this Personal Accident and Hospitalization Insurance Claim Form are true and the opinion expressed in it is honestly held.

日期 Date : _____

被保人/申請賠償人簽署 Insured Person / Signature of Claimant _____

授權書
AUTHORIZATION

本人茲授權所有醫院，醫師及其他曾替本人診治，護理，或檢查之人士，將部份或全部有關本人傷害之醫療診斷報告及藥方等資料供給與利寶國際保險有限公司或其代表人，此授權書，如經攝成影印本，則影印本與原本俱同等之效力。

I hereby authorize any hospital, physician or other person who has attended or examined me to furnish to Liberty International Insurance Ltd. or its authorized representative any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.

地區及日期
Place and date

被保人/申請賠償人簽署
Insured Person / Claimant Signature(s)



Liberty
InternationalTM
Member of Liberty Mutual Group

Liberty International Insurance Ltd
利寶國際保險有限公司

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Tel: (852) 2892 3888

Fax: (852) 2577 9578

ATTENDING PHYSICIAN'S STATEMENT 醫生報告
(to be completed by physician 由主診醫生提供)

Patient's Name 病人姓名: _____ Age 年齡: _____

1. Diagnosis and concurrent conditions 診斷及病人症狀: _____

2. Is present condition due to injury or sickness? 引致症狀的原因是什麼?

2. Is present condition due to pregnancy? 病人是否因懷孕引致症狀? Yes 是/ No 否

3. When did symptoms first appear or when did accident happen? 病人何時發現病徵/遇上意外?

4. When did the patient first receive your consultation about his/her present condition? 病人因上述病徵而首次就診日期

5. Nature of surgical or obstetrical procedure, if any: 如病人需要接受手術，請詳述手術性質或分娩程序

Date Performed 手術進行日期: _____

6. If hospitalized, please provide name and address of hospital: 如需住院，請提供醫院名稱及地址

7. Date of admission 入院日期: _____

8. Date being discharged 出院日期: _____

9. Commencement date of total disability 引致永久性傷殘日期: _____

Date of partial disability 引致局部/短暫性傷殘日期: From 由 _____ To 至 _____

10. Is patient still under your medical attention for this condition? 閣下是否仍為上述病人之主診醫生? Yes 是/ No 否

If not, please advise us the cessation date of medical care 如否，請提供最後為病人診症日期 _____

Signature of Physician 主診醫生簽署: _____

Qualifications 資歷: _____

Address 地址: _____

Date: _____