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

閣下凡透過周大福人壽保險有限公司 [周大福人壽] 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。周大福人壽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，周大福人壽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。

周大福人壽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

CTF Life 周大福人壽

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周大福人壽保險有限公司（以下簡稱“周大福人壽”）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, Chow Tai Fook Life Insurance Company Limited (“CTF Life”) 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後頁的“填表須知”。
Please read the Instructions overleaf carefully before you complete this claim form.

第一部份-由受保人填寫（如受保人未滿18歲，則由保單持有人代填）
Part I - To be completed by the Insured (or Policy owner if insured is under age 18) ❒ 首次索償 New Claim ❒ 再次索償 Further Claim

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

❒ 退回正本收據 return original receipt(s) ❒ 支票直接寄往通訊地址 Mail cheque(s) to corresponding address directly

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? 否 No ❒ 有 Yes ❒
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. 首次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醫院？
Was the Insured admitted to hospital due to the above injury? 否 No ❒ 有 Yes ❒

b. 如有，請說明入院及出院日期： 由 (日/月/年) (DD/MM/YY) 至 (日/月/年) (DD/MM/YY)
If yes, please state the exact confinement period: From to

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? 否 No ❒ 有 Yes ❒

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?
❒ 否 No ❒ 有 Yes

2. 受保人是否經已康復? Has the Insured recovered yet?
❒ 否 No ❒ 有 Yes

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. 有否或將會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? ❒ 否 No ❒ 有 Yes

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. 有否或將會接受任何物理/職業治療？
Does / Did the Insured attend physiotherapy/occupational therapy for this accident?
❒ 否 No ❒ 有 Yes

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 department or other companies? If yes, please give the policy number & name of the company.
❒ 否 No ❒ 有 Yes

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E. 個人資料收集聲明 Personal Information Collection Statement

本人 / 我們確認本人 / 我們已閱讀及明白周大福人壽保險有限公司（以下簡稱 “周大福人壽”）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周大福人壽的網址下載：www.ctflife.com.hk，及可向貴公司索取。

I /We confirm that I/we have read and understood Chow Tai Fook Life Insurance Company Limited (“CTF Life”)’s Personal Information Collection Statement (“PICS”). I/We declare and agree that any personal data CTF Life 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, CTF Life 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 CTF Life’s website: www.ctflife.com.hk, and will be made available upon request.

F. 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、其他機構或人士，均可將該等資料提供給周大福人壽保險有限公司。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 Chow Tai Fook Life 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.

保單持有人姓名 (大寫)
Name of Policy owner (in block letters) :

身份證 / 護照號碼
ID / Passport No. :

保單持有人簽署
Signature of Policy owner : x _____

日期 (日/月/年)
Date (DD/MM/YY) :

受保人姓名 (大寫)
Name of Insured (in block letters) :

身份證 / 護照號碼
ID / Passport No. :

受保人簽署 (如與保單持有人不同及年滿18歲)
Signature of Insured : x _____
(If different with Policy owner & attained age 18)

日期 (日/月/年)
Date (DD/MM/YY) :

見証人姓名 (大寫)
Name of Witness (in block letters) :

身份證 / 護照號碼
ID / Passport No. :

見証人簽署
Signature of Witness : x _____

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的所有問題並簽署。
   Please answer ALL the questions in Part I of this claim form and sign.
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. 如有必要，本公司將要求您提供其他文件，例如病假紙、醫生報告、物理治療報告、x光報告等以便審核。
   We may ask for other documents or information from you if deemed necessary, such as Sick Leave Certificate, Medical Certificate, Physiotherapy Report, X-Ray Report.
4. 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:九龍觀塘海濱道123號綠景NEO大廈7樓。電話:2866 8898。
   Please send the completed claim forms and other supporting documents to our Claims Dept. Address: 7/F, NEO, 123 Hoi Bun Road, Kwun Tong, Kowloon. Tel. 2866 8898.
5. 請注意，閣下於此索償申請表頁一上填寫的保險顧問將會是閣下授權唯一能跟進及處理是次索償的人士。
   Please note that the Insurance consultant that stated on page 1 would be regarded as the only authorized agent to follow up and handle the claim.

保險顧問備註 Consultant’s Remarks

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保單號碼 Policy Number: _____

第二部份-申請人自費由主診醫生填寫
Part II - To be completed by the Attending Doctor at the claimant's own expense

1. a. 病人姓名 Name of patient	b. 身份證/護照號碼 ID / Passport No.	c. 年齡/性別 Age / Sex	d. 職業 Occupation

2. a. 意外日期 (日/月/年)：
Date of accident (DD/MM/YY):

b. 意外發生的地點及經過？
Where and how did the accident happen?

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):

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?

❒ 否 No ❒ 有，請提供其姓名及地址
Yes, please give the name and address of the medical practitioner

e. 表面及明顯証明
External and visible evidence of

否 No	有 Yes	
❒	❒	瘀痕 Bruises
❒	❒	腫脹 Swelling
❒	❒	割傷 / 擦傷 / 傷口 / 挫傷 / 骨折 Laceration / abrasion / wound / contusion / fracture
❒	❒	其他，請説明 Others, please specify

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.

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 ❒ 有 Yes ❒

若有，請填下欄： If yes, please give details below:

檢查日期 (日/月/年) Exam Date (DD/MM/YY)	類別 Type	結果 Result

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?

4. a.有沒有進行任何治療？ Was there any treatment administered? 否 No ❒ 有 Yes ❒

若有，請提供詳情，包括治療日期及進展。
If yes, please give details, including treatment dates and progress.

b.此次受傷有沒有需要住院、或進行手術？ Did injury require hospitalization, or surgery? 否 No ❒ 有 Yes ❒

若有，請提供詳情。If yes, please give details.

5. a. 病人的職業和職業性質 Patient's occupation and exact nature of occupational duties

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)

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)

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)

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 academicqualification, qualified knowledge andtraining, what duties of the insured's job is he/she incapable of performing?

f. 請提供以上傷勢的預後(如適用)
Provide the prognosis for each of the above (if any)

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? 否 No ❒ 有 Yes ❒

7. 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? 否 No ❒ 有 Yes ❒

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

8. 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

9. 病人是否經其他醫生或醫院轉介？
Was the patient referred by other doctor or hospital? 否 No ❒ 是 Yes ❒

若是，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.

10. 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? 否 No ❒ 有 Yes ❒

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.

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

有 Yes	否 No	
❒	❒	自致傷害 (原因及經過) Self-inflicted injury (How it happened & underlying cause)
❒	❒	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)
❒	❒	退化性轉變 (發病日期及求診詳情) Degenerative changes (Onset date & consultation details)
❒	❒	過往受傷/疾病 (原因及求診詳情) Past injury or illness (Cause and details of consultation)
❒	❒	精神病(發病日期及求診詳情) Phychiatric condition (date of onset & details of consultation)
❒	❒	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:

12. 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)

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