

**CLAIM FORM FOR ACCIDENT**  
**意外索償表格**

Branch code 分行編號 \_\_\_\_\_ Location 地點 \_\_\_\_\_  
 Advisor code 保險顧問編號 \_\_\_\_\_  
 Advisor's name 保險顧問姓名 \_\_\_\_\_  
 Contact no. 聯絡電話 \_\_\_\_\_

**PART I — TO BE COMPLETED BY THE INSURED**

**第一部份 — 由受保人填寫**

For document requirements of this claim, please refer to the Accident Claims Instructions. 有關此索償的所需文件，請參考「意外索償指引」。

1. Policy No(s) 保單編號	2. Name of Insured 受保人姓名	3. HKID/ Passport No. 香港身份證/ 護照號碼 (please attach copy 請附上副本)	4. Age 年齡
5. Residential Address 住宅地址	6. a) Business Tel. No. 辦公電話號碼		b) Residential Tel. No. 住宅電話號碼
7. Present Occupation (state all) 現時職業 (請列出所有從事的職業)	8. Exact Nature of Occupational Duties 實際工作性質		
9. Name and Address of Business or Employer 僱主姓名/ 公司名稱及地址	10. Your Average Monthly Income 每月平均收入		
11. Date and Time of Accident 意外發生日期及時間	12. Did you file a medical leave certificate to your employer? 有否向僱主呈交病假證明?		
13. Nature of Accident 意外性質 a) Where did it take place 意外發生地點  b) How did it happen 意外發生經過	14. Describe the injuries in details 詳述受傷情況 a) Part(s) of body injured 身體受傷部位  b) Type(s) of injury (e.g. fracture, cut, bruise etc.) 受傷類型 (例如骨折、割傷、挫傷等)		
15. Date on which you last worked prior to disability 傷殘前工作日期	16. Date you have returned to work or expect to return to work 重返工作或預計可重返工作之日期		

17. Details of Hospitals confined or Physicians consulted for the injury (Please attach discharge note)

受傷後留院治療或由醫生診治詳情 (請附上出院通知)

Name of Physician(s) and/or Hospital(s) 醫生姓名及/ 或醫院名稱	Address(es) 地址	Date of Consultation(s) and/or Period of Confinement(s) 診治及/ 或留院日期
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**Declaration and Authorization 聲明及授權**

I hereby declare that the answers in the above statement are full and true to the best of my knowledge. I further authorize any physician, hospital, insurance company, claims investigation company, government authority or organization that has any record or knowledge of me, my health or my activities (including records relating to Social Security, Workers' Compensation, credit, financial, earnings and employment history) to furnish such information to Manulife (International) Limited ("the Company") or its authorized representative, and all information with respect to any illness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photostatic copy of this authorization shall be as effective and valid as the original.

本人現聲明填報於本表格內之資料已是本人所知之全部並為真實無訛。本人茲授權任何醫生、醫院、保險公司、賠償調查公司、政府有關部門或其他持有本人個人資料、健康狀況或記錄 (包括有關本人所獲之社會福利及勞工賠償、本人之存款、財政狀況、入息及就業記錄) 之組織可以將部份或全部有關本人傷患之病歷、診斷報告、藥方或治療等資料予宏利人壽保險 (國際) 有限公司 ("貴公司") 或其代理人。此授權書之複製本與正本具同等效力。

All information in this form together with any subsequent alterations or supplements of it are collected to enable the Company to carry on insurance business and may be transferred to and/or used by the Company (including its subsidiaries, affiliated companies and associated companies, regardless of where they are located or registered) and any service providers (regardless of where they are located or registered) for the purpose of adjudicating this insurance or related claims thereof, approving and underwriting the application, administering and reinsuring the policy, marketing or promoting products and services, and/or preventing money laundering and/or terrorist financing activities. Supply of information under this form is a condition precedent to claim for the relevant benefit(s) available under the policy. Any request for access to or correction of the personal data under this form should be made by writing to the Company's Home Office (at Individual Financial Products, Manulife (International) Limited, 22/F., Manulife Financial Centre, 223-231 Wai Yip Street, Kwun Tong, Kowloon, Hong Kong). The personal data of this form may be transferred to any relevant regulatory bodies to enable them to carry out their regulatory functions.

本表格所提供之所有資料與任何日後作出之修訂或補充，目的在於確保貴公司之保險業務得以順利運作，而該等資料可供貴公司 (包括其附屬公司、關聯公司及聯繫公司，不論它註冊或設於何處) 及任何服務供應商 (不論它註冊或設於何處) 轉移及/ 或用以處理有關之保險或索償申請、批核此申請、管理此保單並安排分保、推廣或宣傳貴公司的產品及服務及/ 或防止洗黑錢及/ 或恐怖分子融資活動。於本表格內提供之資料將作為索取保單所列明之賠償的先決條件。本人可向貴公司之總辦事處 (香港九龍觀塘偉業街223-231號宏利金融中心22樓宏利人壽保險 (國際) 有限公司個人理財產品業務部) 提出要求修改及取得本表格之個人資料。本表格之個人資料可轉移予相關機構以執行監管職權。

Date (DD/MM/YYYY) 日期 (日/月/年)

X

Signature of Insured (if Aged 18 or Above) \* 受保人簽署 (如十八歲或以上) \*


\* For insured aged below 18, signature of the policyowner should be provided for the claim. 十八歲以下受保人之索償申請必須由保單持有人簽署。

X

Signature of Policyowner 保單持有人簽署

The Chinese version of this claim form is for reference only. In the event of conflicts between the Chinese and English versions, the English version shall prevail. 此索償表格之中文譯本只供參考之用，若與英文有異，一概以英文為準。

**PART II — ATTENDING PHYSICIAN'S STATEMENT****(to be completed by a qualified and registered physician at the insured's expense)****第二部份 — 應診醫生報告 (由受保人自費聘請之合資格註冊醫生填寫)**

1. Name of Patient (the insured) 病人 (受保人) 姓名	2. Age 年齡	3. HKID/ Passport No. 香港身份證/ 護照號碼	4. Date of Accident 意外發生日期
5. a) Had the patient any external and visible evidence of injury at your first consultation. (e.g. bruise and swelling etc.) 病人於第一次會診時有否外傷及可見之受傷證明。(例如各類挫傷及瘀腫等情況) <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 否 b) If yes, state the type of injury 若「有」, 請註明受傷類型 c) Describe the cause and extent of injury 請註明受傷原因及受傷程度			
6. Present condition of injury 現時受傷情況			
7. Did injury require: (if yes, give details) 是否因受傷而需要接受下列各項治療或檢查? (若「是」, 請註明詳情) a) Hospitalization? 留院治療 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是      Date admitted 入院日期 _____ b) X-rays? X光檢查 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是      Date discharged 出院日期 _____ c) Surgery? 進行手術 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是      Details 詳情 _____ d) Medical Treatment? 醫學治療 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 (e.g. stitches, physiotherapy, type of dressing etc. 例如縫針、物理治療、包紮類型等) e) Others? 其他      Please specify 請註明: _____			
8. Was such injury induced from or effected by any of the following which may contribute to the accident and/or lengthen the period of disability? 該受傷是否由下列任何一項引致或受其影響而導致發生意外及/ 或加長傷殘時間? a) Physical defects/congenital anomaly 身體缺陷/ 先天異常 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 b) Unfavourable past medical history 過往不良健康狀況記錄 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 c) By drugs or alcohol 藥物或酒精 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 If any of the above is yes, give details. 如上述任何一項為「是」, 請註明詳情。 _____			
9. Was healing complicated? 康復過程是否複雜? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 If yes, state the reason(s) and any special treatment(s) given. 如「是」, 請註明原因及曾採用之任何特別治療。			
10. Name(s) and address(es) of other physician(s) who have treated the patient for the same injury. 其他曾就是次受傷為病人診治之醫生姓名及地址。			
11. Do you feel that the injury would have prevented the patient from working? (Patient's occupation is stated overleaf) 你認為是次受傷會否令病人不能工作? (病人的職業見背頁) a) at your first consultation 第一次會診時? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 b) at your recent consultation 最近一次會診時? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是			
12. If an absence from work of more than two weeks was necessary, please describe in details the reasons why you feel the patient could not return to work earlier. 如病人需暫停工作超過兩星期, 請詳細註明原因, 解釋為何病人不能提早恢復工作。			
13. I hereby certify that I have personally examined and treated the patient (the insured) for the above injury and that the facts as given above present my opinion of his/her condition. 謹此證明本人已親自為病人 (受保人) 就上述受傷進行檢查及治療, 並確認表格內之資料為本人對病人 (受保人) 之情況作出的意見。  Signature 簽署  _____ Name of Physician (with stamp) 醫生姓名 (連印章) _____ Date 日期 _____ Address 地址 _____ Qualification 資格 _____ Tel. No. 電話號碼 _____			

Please ensure all questions on Part I\* and Part II of the Claim Form for Accident are answered and check that all required claims documents are submitted. Otherwise, the claim may not be processed due to incomplete information. The policyowner may be requested to provide additional information relating to this claim.

請確保已回答「意外索償表格」第一\*及第二部份所有問題及提交所需索償文件，否則此索償申請可能因資料不足而未能被處理。保單持有人可能被要求就此項索償提供額外資料。

Below required documents must be received by Manulife within 30 days after the date of injury caused by an accident.

以下所需索償文件須在意外受傷後三十日內提交本公司。

Claims Document Checklist - Basic Requirements 索償文件清單：基本要求		
<input type="checkbox"/>	Claim Form for Accident (C12); and 「意外索償表格」(C12) ;及	
<input type="checkbox"/>	Copy of Sick Leave Certificate(s) with Diagnosis; and 列明診斷結果的病假證書副本；及	
<input type="checkbox"/>	HKID Card/ passport copy of both Policyowner and Claimant 保單持有人及索償人的香港身份證/ 護照副本	
Additional Requirements (if applicable) 額外要求 (如適用)		
<input type="checkbox"/>	Diagnostic/ Laboratory Test done 接受診斷/ 化驗	Diagnostic/ laboratory reports 診斷/ 化驗報告
<input type="checkbox"/>	Attended by Specialist/ Physiotherapist/ Occupational Therapist 接受專科/ 物理治療師/ 職業治療師治療	Referral Letter from Attending Physician 主診醫生轉介信
<input type="checkbox"/>	Traffic Accident involved 涉及交通意外	Copy of Police Report/ Traffic Accident Report/ Police Statement 警察報告/ 交通意外報告/ 警察口供紙副本
<input type="checkbox"/>	Claim from other insurer(s) 已獲其他保險公司支付賠償	Copy of compensation breakdown from other insurer(s) 其他保險公司賠償結算明細表的副本
<input type="checkbox"/>	Claim for Medical Reimbursement 申請醫療賠償	Original Medical Receipt(s) 醫療收據正本
<input type="checkbox"/>	Physiotherapy/ Occupational Therapy done 接受物理/ 職業治療	Physiotherapy/ Occupational Therapy Report 物理/ 職業治療報告
<input type="checkbox"/>	Hospitalized 入住醫院	(i) Original Statement of Charges/ Account ; and 收費單正本；及 (ii) Original Hospital Receipt(s) 醫院收據正本

Unless request to the contrary is specifically made, the claim reimbursement cheque will be drawn in HKD for Hong Kong policies and MOP for Macau policies. The cheque will be forwarded to the Policyowner with the Payment Advice after approval of the claim.

除特別要求外，於香港簽發的保單的賠償支票將以港元支付，而於澳門簽發的保單的賠償支票則以澳門幣支付。當索償獲批准後，支票將連同通知書一併送交保單持有人。

Please submit aforesaid required documents to Individual Financial Products, Manulife (International) Limited, 22/F., Manulife Financial Centre, 223-231 Wai Yip Street, Kwun Tong, Kowloon, Hong Kong. 請將上述所需文件寄回香港九龍觀塘偉業街223-231號宏利金融中心22樓宏利人壽保險（國際）有限公司個人理財產品業務部。

Note 註

\* For Question No. 7 in Part I of the form, please fill in "self-employed" if that is the case. 如屬自僱人士，請於表格第一部份第7題填寫「自僱」。