中国太平洋保险
China Pacific Insurance

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意外急救醫療保險索償表
Emergency Accidental Medical & Hospitalization Insurance Claim Form

For Office Use Only
Claim No.

甲部 由被保險人填寫
Part I To Be Completed By The Insured

被保險人姓名 Name of Insured		保險單編號 Policy No. CPIC/	
保期期限 Period of Insurance			
地址及電話號碼 Address & Telephone No.			
性別 Sex		回鄉証(卡)/護照號碼 Chinese Re-entry Permit/Passport No.	
職業 Occupation		出生日期 Date of Birth	

(1) 是次醫療 / 住院 / 手術是否由於一宗意外引致 ?
Was the Medical Treatment / Hospitalization / Surgery a result of an Accident ?

否 No ☐

是 Yes ☐

日期 Date		時間 Time
地點 Place		
意外經過 Brief Description		
目擊者資料 Witness Information		
警方資料 Police Information		
是次意外，是否有任何人仕需要負上責任 ? 如獲悉， 請詳述該人仕之姓名及資料。 Is anyone responsible for this accident ? If known, please provide details.		

(2) 有關是次醫療 / 住院 / 手術，閣下有否申請其他保險賠償 ?
Are you making any other insurance claim as a result of this medical treatment / hospitalization / surgery ?

否 No. ☐

是 Yes ☐

保險公司名稱 Name of Insurance Company	
保險單編號 Policy No.	

聲明及授權書 :
Declaration and Authorization
本人現聲明上述所填報資料 ， 均屬正確及真實無訛 。
本人茲授權於任何替本人作診療之醫生 、 醫務人員 、醫院或診所提供有關有本人病歷之資料予中國太平洋保險(香港)有限公司 ， 此授權書之影印本與正本具同等效力 。
I hereby declare that the above information given by me in this form is true and correct to the best of my knowledge.
I hereby authorize any physician, medical practitioner, hospital or clinic by whom or where I have been observed or treated, to give full particulars about my health including my whole medical history, to China Pacific Insurance Co., (H.K.) Ltd. A photocopy of this authorization shall have the full effect of the original authorization.

日期 Date _____ 被保險人簽署 Signature of Insured _____

乙部　由主診醫生填寫
Part II　To Be Completed By The Attending Physician / Surgeon

(1)	被保險人姓名 Name of Insured			
有否查核 "意外急救醫療卡" 之資料正確 ? Have you verified the Information on the "Emergency Accidental Medical Card" ?			是 ☐ 否 ☐ (請附上卡之副本) Yes ☐ No ☐ (Please attach a copy of the Card)	
(2)	住院　Hospitalization			
	醫院名稱　Name of Hospital			
	入院日期　Date of Admission			
	出院日期　Date of Discharge			
(3)	手術　Surgical Procedure			
	手術日期　Date of Operation			
	手術名稱　Name of the Procedure			
	手術性質　Nature of the Operation			
(4)	此次醫療 / 住院 / 手術的主要病因 : Chief complaints of the patient relating to this Medical Treatment / Hospitalization / Surgery			
(5)	診斷 : Diagnosis of Conditions			
(6)	出院撮要 (治療計劃， 包括診查辦法 、 結果) Brief discharge summary (Including treatments, investigation procedure, results)			
(7)	病人是否經其他醫生轉介 ? Is the patient referred by another doctor ?			
	否　No ☐			
	是　Yes ☐	轉介醫生姓名及地址 Name and Address of the referral doctor		
(8)	根據閣下意見 ， 是次受傷是否由前述意外引起 ? In you opinion, was the injury resulted from the aforementioned accident ?		是 / 否 Yes / No	如否 ， 請敘述受傷原因 If not, please state the cause of injury.

主診 / 專科醫生姓名 Name of Attending Physician / Specialist	地址 Address
	電話 / 傳真 Telephone / Fax
主診 / 專科醫生簽名及蓋印 Signature of Attending Physician / Specialist with Official Stamp Chop	日期　Date

重要事項 :

為免閣下的索賠程序有延誤 ， 請於索賠時 ， 確定連同以下文件一併附上

1. 被保險人及主診醫生必須填妥本意外急救醫療保險索償表上列明的所有項目
2. 醫療單據的正本 (包括所有費用的明細)
3. 警方報告及 / 或負責是次意外的政府有關部門之報告 (若不能附上 ， 請說明原因)

IMPORTANT :

In order to avoid unnecessary delay in processing of your claim, please ensure that the following documents are attached when submitting your claim :

1. The Claim Form must be fully completed and signed by the Insured and the attending doctor.
2. Original Medical Bills / Receipts with detail breakdown of the costs / expenses.
3. Original Police Report and / or Original Report issued by the official authorities concerned to confirm the alleged accident. If not available, you must state the reason why the police or the official authorities concemed was not informed after accident occurred.