中銀集團保險有限公司
BANK OF CHINA GROUP INSURANCE COMPANY LIMITED

總公司：香港德輔道中 71 號永安集團大廈八樓　電話：2867 0888　傳真：3906 9921
HEAD OFFICE: 8/F., Wing On House, 71 Des Voeux Road Central, Hong Kong. Tel: 2867 0888 Fax: 3906 9921

本公司專用 Office Use
賠案編號
Claim No. _____

人身意外險索償表格
PERSONAL ACCIDENT INSURANCE CLAIM FORM

索償步驟：
Claim procedure:
請於意外發生後30天內將填妥之索償表格連同一切文件郵寄至：香港德輔道中 71號永安集團大廈八樓
Please send the completed Claim Form together with all relevant documents to 8/F., Wing On House, 71 Des Voeux Road Central, Hong Kong within 30 days from the date of accident.
註：「所需文件」只是概括要求，本公司保留權利在有需要時要求提供更多文件以處理有關的索償申請。如所遞交的索償表格未填妥或有關資料或文件不足，可能會引致延誤或被拒絕處理。
Documents required are not exhaustive and we reserve our right to request from you any additional information/documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim

保單資料
Insurance Policy Details
保戶名稱
Name of Insured _____ 保單號碼 Policy No. _____
身份證號碼 性別 出生日期 日 月 年 職業 聯絡電話
Identity Card No. _____ Sex ____ Date of Birth ___ DD ___ MM _____ YY Occupation _____ Contact Tel No. _____
地址 電郵
Address _____ E-mail _____

索償人 / 被保人 資料 (如非保戶)
Particulars of Claimant / Insured Person (if not the Insured)
索償人 / 被保人 姓名 與保戶關係 聯絡電話
Name of Claimant / Insured Person _____ Relationship with the Insured _____ Contact Tel No._____
身份證號碼 性別 出生日期 日 月 年 現時 職業
Identity Card No. _____ Sex _____ Date of Birth _____ DD_____ MM _____YY Present Occupation_____
地址 電郵
Address_____ E-mail _____

索償資料
Particulars of Claim

(1) 索償項目 Nature of claim	☐ 醫療費用 Medical Expenses ☐ 暫時完全喪失工作能力 Temporary Total Disablement ☐ 意外身故 Accidental Death ☐ 永久傷殘 Permanent Disablement
(2)意外發生的日期及時間 Date and time of accident.	日 月 年 時間 上午 下午 __ _____ DD _____ MM _____ YY Time: _____ ☐ am ☐ pm
(3) 意外發生的地點 Place of accident.	_____
(4) a. 該意外的詳情 Description of accident b. 如有報警，列明報案的警署及報案編號 If the accident has been reported to the police, please state which police station and police report number.	a. _____ _____ b. _____
(5) a. 傷勢及其部位 Nature and region of injury. b. 索償人是否曾經在同一個部位受傷? Has he/she previously suffered from injury to the same part? c. 應診醫生姓名及地址 Name and address of the Doctor attending the injured person d 索償人是否已完全康復? Has the Claimant fully recovered?	a._____ b. ☐ 否No ☐ 是 Yes c. _____ d. ☐ 否No ☐ 是 Yes
(6) 暫時完全喪失工作能力的期間 Period of Temporary Total Disablement from engaging in or attending to usual employment or occupation.	由 日 月 年 至 日 月 年 From _____ DD _____ MM _____YY To _____DD _____ MM _____YY

(7) a. 意外是否在受僱期間因工作引致 Was this accident occurred in the course of and/or arising out of your employment? b. 如是，列明承保僱員補償險的保險公司的名稱及保單編號 If yes, state the name of insurance company of Employees Compensation Insurance and the respective policy No.	否 是 a. ☐ No ☐ Yes b. _____
(8) a. 被保人是否就是次意外向其他保險公司索償 Is the Insured Person entitled to claim under any other insurance policies in respect of this accident? b. 如是，列明保險公司的名稱，保單編號及索償保障項目 If yes, state the name of insurance company(s), respective Policies Nos. and details of benefits.	否 是 a. ☐ No ☐ Yes b. _____
(9) a. 被保人以往 是否有類似的受傷情況 Has the Insured Person ever sustained similar injury? b. 如是，列明詳情及何時發生 If yes, please give detail and date.	否 是 a. ☐ No ☐ Yes b. _____

附註：本公司將待索償人完全康復，保障金額確定及協定後，方會一筆整付賠償。
Note: Benefit stated in the Schedule shall be payable when the claimant is fully recovered and the total amount of the Benefit shall have been ascertained and agreed.

賠款發放方式 Claim Payment Method：

請在適當的方格內填上“✓” Please tick the appropriate box:

☐ 本人同意以支票方式發放賠款。 I agree that the claim payment be made by cheque.

☐ 本人同意以自動轉帳方式發放賠款(只適用於HK$500,000或以下的賠款)，並提供以下資料。I agree that the claim payment be made by auto-pay (only applicable for claim amount equivalent to or less than HK$500,000) and provide the following information:

銀行名稱 戶口號碼
Name of Bank _____ Bank Account No. _____
戶口持有人名稱(必須與被保人名稱相符)
Name of Account Holder (Must be same as Insured Person)

所需文件
REQUIRED DOCUMENTS

請在適當空格填上“✓”
Please tick as appropriate

☐ 1. 病假證明書正本
Original sick leave certificate(s)

☐ 2. 醫療清單副本及收據正本
Copies of statement of account and original receipt(s)

☐ 3. 如有報案，請提供所有警方口供紙副本
Copies of all police statements, if any

☐ 4. 有關暫時完全喪失工作能力的索償，需提供意外前12個月的入息証明文件副本
Copies of documentary proof of income over the 12 months preceding to the accident for claim under Temporary Total Disablement from engaging in or attending to usual employment or occupation

☐ 5. 如申索永久傷殘一項，請提供有關醫療報告
For Permanent Disablement, please submit with the medical report

☐ 6. 若是意外身故的索償，請附交有關意外報告、警方報告、死亡證、索償人與被保人之關係證明(如結婚證明書、出生證明書、遺產管理書或遺囑認證書等及其他有關文件
For accidental death, please submit the accident report, police report, Death Certificate, relationship proof of the Claimant and the Insured Person, (e.g. marriage certificate, birth certificate, letter of administration or probate, etc and/or any relevant documents

☐ 7. 如人身意外綜合保障計劃(粵港澳大灣區專享)的索償，除上述所需文件外，請提供保戶及被保人的身份證明文件副本及意外前 6 個月居住粵港澳大灣區＊的證明文件副本
For the claim of Personal Accident Comprehensive Protection Plan (Privilege for Guangdong - Hong Kong - Macau Bay Area), except the required document mentioned above, please provide the copies of documentary proof of identity and residence for the 6 months preceding to the accident in Guangdong - Hong Kong - Macau Bay Area＊ of the Insured and the Insured Person.

＊粵港澳大灣區是指香港、澳門、廣州、深圳、珠海、佛山、中山、東莞、肇慶、惠州、江門
＊Guangdong - Hong Kong - Macau Bay Area refers to Hong Kong, Macau, Guangzhou, Shenzhen, Zhuhai, Foshan, Zhongshan, Dongguan, Zhaoqing, Huizhou and Jiangmen

聲明及授權
Declaration and Authorization

本人聲明上述資料完整及正確無訛，並無隱瞞任何重要資料。

本人明白本人提供的資料，為中銀集團保險有限公司(“貴公司”)提供保險業務所需，並可能使用於下列目的:

(i) 處理及審批本人的保險申請或本人將來提交的保險申請；
(ii) 執行本人保單的行政工作及提供與本人保單相關的服務；
(iii) 分析或調查、處理及支付本人保單有關的索償、以及偵測和防止欺詐行為(無論是否與此申請而發出的保單有關)；
(iv) 發出繳交保費通知及向本人收取保費及欠款；
(v) 任何與保險有關的產品或服務的任何更改、變更、取消或續期；
(vi) 就以上用途聯絡本人；
(vii) 貴公司行使任何代位權；
(viii) 其它與上述用途有直接關係的附帶用途；及
(ix) 遵循適用法律，條例及業內守則及指引。

貴公司亦可因應上述用途將本人的個人資料移轉予下列各方：

(a) 就上述用途，向 貴公司提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問（包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商）；
(b) 處理索賠個案的理賠師、理賠調查員及醫療顧問；
(c) 追討欠款的收數公司或索償代理；
(d) 保險資料服務公司及信貸資料服務公司；
(e) 再保公司及再保經紀；
(f) 本人的保險經紀（若有）；
(g) 貴公司的法律及專業業務顧問；
(h) 貴公司的關連公司(以《公司條例》內的定義為準)；
(i) 現存或不時成立的任何保險公司協會或聯會或類同組織(「聯會」)及其會員，以達到任何上述或有關目的，或以便「聯會」執行其監管職能，或其他基於保險業或任何「聯會」會員的利益而不時在合理要求下賦予「聯會」的職能；
(j) 透過「聯會」移轉予任何「聯會」的會員，以達到任何上述或有關目的；
(k) 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；
(l) 保險索償投訴局及同類的保險業機構；
(m) 整合保險業申索和承保資料的組織；防欺詐組織；其他保險公司（無論是直接地，或是通過防欺詐組織或本段中指名的其他人士）；警察；和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊（及其運營者）及
(n) 法例要求或許可的政府機關。

本人在此授權 貴公司可向「聯會」從保險業內收集的資料中查閱及/或核對本人任何資料。

此外，經本人同意，貴公司可能會以其它方式使用及披露本人的個人資料。

本人有權查閱及要求更正由 貴公司持有有關本人的個人資料。如有需要，可向 貴公司法律與合規部提出 (電話：2867 0888，傳真：3906 9939)。

I declare that the above information is complete and true to the best of my knowledge and belief and I have not withheld any material information connected with this claim.

I understand that the information I provide to Bank of China Group Insurance Company Limited ("the Company") is collected to enable the Company to carry on insurance business and may be used for the purpose of:

(i) processing and evaluating my insurance application and any future insurance application I may make;
(ii) administering my insurance policy and providing services in relation to my insurance policy;
(iii) analysis or investigating, processing and paying claims made under my insurance policy and detect and prevent fraud (whether or not relating to the policy issued in respect of this application)
(iv) invoicing and collecting premiums and outstanding amounts from me;
(v) any alterations, variations, cancellation or renewal of any insurance related product or service;
(vi) contacting me for any of the above purposes;
(vii) exercising any right of subrogation;
(viii) other ancillary purposes which are directly related to the above purposes; and
(ix) complying with applicable laws, regulations or any industry codes or guidelines.

The Company may disclose my personal data for the above purposes to the following classes of transferees:

(a) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist the Company to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors);
(b) in the event of a claim, loss adjudicators, claims investigators and medical advisors;
(c) in the event of default, debt collectors and recovery agents;
(d) insurance reference bureaus or credit reference bureaus;
(e) reinsurers and reinsurance brokers;
(f) my insurance broker (if I have one);
(g) the Company’s legal and professional advisors;
(h) the Company’s related companies (as that term is defined in the Companies Ordinance);
(i) any association, federation or similar organization of insurance companies ("Federation") and its members that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation;
(j) any member(s) of the "Federation" by the "Federation" for any of the above or related purposes;
(k) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
(l) the Insurance Claims Complaints Bureau and similar industry bodies;
(m) organisations that consolidate claims and underwriting information for the insurance industry; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information and
(n) government agencies and authorities as required or permitted by law.

The Company is hereby authorized to obtain access to and/or to verify any of my data with the information collected by the Federation from the insurance industry.

Moreover, the Company may also use and disclose my personal data otherwise with my consent.

I have the right to obtain access to and to request correction of any personal information concerning myself held by the Company. Requests for such access can be made to the Company’s Legal and Compliance Department (Tel: 2867 0888 / Fax: 3906 9939).

索償人/被保人 簽署
Signature of Claimant / Insured Person
日期
Date:

保戶簽署 (如屬公司請蓋章)
Signature of Insured (with company chop if applicable)
日期
Date:

This statement should be fully completed and signed by Attending Physician. Any expense for completing this statement must be paid by the Insured.
本表格必須由主診醫生填妥和簽署，所需費用由保戶自行支付。

ATTENDING PHYSICIAN'S STATEMENT
主診醫生証明書

Name of Patient:	Identity Card No.:	Date of birth (DD/MM/YY):	Date of Accident (DD/MM/YY) :

(1) a. What is the exact diagnosis ?	a. _____
b. Is there any external and visible evidence of injury at your first consultation?	b. ☐ No ☐ Yes
c. State part of body injured	c. _____
d. Describe the cause and extent of injury	d. _____
(2) Present condition of injury:	
(3) a. Is there any treatment administered? b. If yes, please give details (such as suturing, physiotherapy, type of dressing, etc.)	a. ☐ No ☐ Yes b. Date Time Treatment
(4) a. Did any other physicians treat the patient for the same injury? b. If yes, please give:	a ☐ No ☐ Yes ☐ Unknown b. Name Address Date of Treatment
(5) Did injury require the followings: (If yes, please give details) a. hospitalization	a. ☐ No ☐ Yes _____
b. x-ray?	b. ☐ No ☐ Yes _____
c. special diagnostic procedures?	c. ☐ No ☐ Yes _____
d. surgery?	d. ☐ No ☐ Yes _____
(6) a. Did any permanent disablement expected as a result of his/her injury?	a. ☐ No ☐ Yes
b. If yes, please state the proportionate disability in percentage	b. _____
(7) Did injury cause Temporary Total Disablement from engaging in or attending to usual employment or occupation?	☐ No ☐ Yes From _____ To _____
(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? (If yes, please give details) a. physical defects / congenital anomaly	a. ☐ No ☐ Yes _____
b. unfavourable past medical history	b. ☐ No ☐ Yes _____
c. degenerative	c. ☐ No ☐ Yes _____
d. alcohol or drugs	d. ☐ No ☐ Yes _____
(9) Bearing in mind the Patient's occupation , do you feel that the injuries would have prevented him/her from working? a. at your first consultation.	a. ☐ No ☐ Yes From _____ To _____
b. at your last consultation.	b. ☐ No ☐ Yes From _____ To _____
(10) If an absence from work of more than two weeks was necessary, please describe in detail the reasons why you feel the Patient could not return to work earlier.	

I hereby certify that I have personally examined & treated the Patient for the above injury and that the facts as given above present my opinion of his /her condition.

Address : _____

_____

_____ Signature : _____

Telephone No.: _____ Name of Physician :
(with stamp)

Date : _____ Qualification : _____