



聯豐亨保險有限公司

Luen Fung Hang Insurance Company Limited

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個人意外險索償表  
PERSONAL ACCIDENT INSURANCE CLAIM FORM

- 請詳細回答每一個問題，如果表格預留空格不足，請另附頁填寫。
- It is important that a complete answer be given to every question. If insufficient space is provided for your answer, please continue on a separate sheet.

<b>被保險人／保單持有人 Insured or Policyholder</b>	
保單編號 Policy No. : _____	
全名 Full Name : _____	
地址 Address : _____	
_____	電話 Tel No. : _____
<b>傷者 Injured Person</b>	
全名 Full Name : _____ 年齡 Age : _____	
居住地址 Private Address : _____	
_____	電話 Tel No. : _____
工作地址 Business Address : _____	
_____	電話 Tel No. : _____
職業 Employment / Occupation : _____	
<b>意外詳情 Accident</b>	
日期 Date : _____ 時間 Time : _____ <input type="checkbox"/> 上午 a.m. <input type="checkbox"/> 下午 p.m.	
地點 Place : _____	
事件發生詳情 State fully what happened : _____	
_____	
_____	
傷者當時正在做甚麼? What was the Injured Person doing at the time? _____	
_____	
_____	

<b>傷害或疾病 Injury or Illness</b>	
受傷或疾病狀況 Nature of Injury or illness _____	
他以前是否曾在相同部份受傷或患過類似疾病? Has he previously suffered from an injury to the same part or a similar illness? <input type="checkbox"/> 是 yes <input type="checkbox"/> 否 No	
如是，請詳述 If yes, give details _____	
傷者有多長時間不能從事現有工作或職業? How long has been disabled from engaging in or attending to his usual employment or occupation as a result of the injury or illness?	
(a) 完全不能工作 TOTALLY	從 From _____ 至 To _____
(b) 部分喪失工作能力 PARTIALLY	從 From _____ 至 To _____
診治傷者的醫生姓名及地址 Name and Address of the Doctor attending the injured person _____	
該醫生是否傷者的日常醫生? Is he the injured persons usual doctor? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	
<b>聲明 Declaration</b>	
我／我們聲明這些詳情細節盡我所知並確信其真實性。 I / We declare that these particulars are true to the best of my / our knowledge and belief.	
傷者簽名 Injured person's signature _____	被保險人簽名 Insured's signature _____
身份証號碼 I/D No. _____	身份証號碼 I/D No. _____
日期 Date _____	日期 Date _____

**註釋 Notes :**

- 醫生報告須由已向澳門衛生局註冊之醫師填寫。  
It is important that the Medical Report opposite should be completed by a fully qualified and registered medical practitioner.
- 如果索償醫療賠償金或其他費用，請提供詳細書面證據。  
If you are claiming for reimbursement of medical or other expenses full details and documentary evidence must be provided.
- 由衛生局印製的 M7 表格方為有效的私家醫生收據。  
Official Medical Receipt must be printed by S.A.M. must be provided.

醫生報告 Medical Report

<p>1. 病人姓名 Name of Patient</p>	
<p>2. 病人遭受甚麼傷害或患甚麼病? From what injuries or illness is the Patient now suffering?</p>	
<p>3. 您甚麼時候第一次診治這些傷患或疾病? When were you first consulted for these injuries or illness?</p>	
<p>4. 病人有多長時間不能從事現有工作或職業? How long has the Patient been disabled from engaging in or attending to his usual employment or occupation as a result of these injuries or illnesses?</p>	<p>完全沒法工作 Totally 從 _____ 至 _____ from to</p> <p>部分喪失工作能力 Partially 從 _____ 至 _____ from to</p>
<p>5. 您認為這種狀況會持續多久? How much longer do you consider such disablement will continue?</p>	<p>完全沒法工作 Totally 從 _____ 至 _____ from to</p> <p>部分喪失工作能力 Partially 從 _____ 至 _____ from to</p>
<p>6. 病人還有其他疾病或生理缺陷嗎? Has the Patient any other disease or physical defect? 若有， a) 其病況如何? b) 其疾病或生理缺陷對病人康復之影響有多大?</p>	<p><input type="checkbox"/> 有 Yes <input type="checkbox"/> 沒有 No</p> <p>If Yes, a) What is the nature? b) To what extent may recovery be affected thereby? .....</p>
<p>醫生簽署及蓋章： Signature &amp; Chop:</p> <p>地址： Address:</p>	<p>醫生牌照： Qualification:</p> <p>日期： Date:</p>