中国太平
CHINA TAIPING

中國太平保險(香港)有限公司
China Taiping Insurance (HK) Company Limited
香港銅鑼灣新寧道8號中國太平大廈19字樓
19/F, China Taiping Tower,8 Sunning Road,Causeway Bay, Hong Kong
Tel:(852) 2815 1551 Fax: (852) 2541 6567 E-mail: info@hk.cntaiping.com Website: www.hk.cntaiping.com Customer Service Hotline: (852) 3716 1616

教育局綜合保險計劃 - 團體人身意外保險申請理賠表格
EDUCATION BUREAU BLOCK INSURANCE POLICY - GROUP PERSONAL ACCIDENT CLAIM FORM

請注意：
此部分之 A 項需由受傷學生 / 家長或監護人填寫及簽署；
此部分之 B 及 C 項需由主診醫生填寫，有關費用由索償人負責支付。
Please Note:
Part A of this Section is to be completed by the injured student / parent or legal guardian and signed;
Parts B & C are to be completed by the attending physician at the claimant's expense.

* **此部分只適用於因意外事故引致死亡或身體永久受損。**
This section only applicable to death or permanent total disablement due to accident.

第二部分
SECTION 2

請填報以下項目資料，並在適當的空格填上☑，如有變更必須通知保險公司
Please answer items below and tick the boxes where appropriate ☑ and inform Co. if any of them has been altered

A 項. 學生詳情 **PART A. PARTICULARS OF STUDENT**	
學生姓名：(請先填寫姓氏) **Name of Student: (surname first)**	**香港身分證號碼：** **HKID Card No.:**
學校名稱： **Name of School:**	
學生通訊地址： **Student's Address:**	
電話號碼： **Tel. No.:**	**傳真號碼 / 電郵地址：** **Fax No. / E-mail Address:**

收集個人資料聲明 PERSONAL INFORMATION COLLECTION STATEMENT

閣下提供的資料，爲本公司提供保險業務所需，並可能使用於下列目的：
- 任何與保險或其他保險有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期；
- 任何索償，或該等索償的調查或分析；及本公司行使任何代位權。

上述資料可能移轉予：
- 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；
- 現存或不時成立的任何保險公司協會或聯會或類同組織（統稱爲「聯會」），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；及
- 或透過「聯會」移轉予任何「聯會」的會員，以達到任何上述或有關目的。

此外，在此授權本公司可向「聯會」從保險業內收集的資料中查閱及／或核對 閣下任何資料。閣下有權查閱及要求更正由本公司持有有關 閣下的個人資料。如有需要，請以書面形式向本公司總經理辦公室經理提出，地址爲香港銅鑼灣新寧道8號中國太平大廈19字樓。

The information you provide to us is collected to enable us to carry on insurance business and may be used for the purpose of -
- any insurance or other insurance related product or service or any alterations, variations, cancellation or renewal of such product or service;
- any claim or investigation or analysis of such claim; and exercising any right of subrogation.

The said information may be transferred to -
- any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claim or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
- any association, federation or similar organization of insurance companies (collectively called “the Federation") 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, and
- any members of the Federation by the Federation for any of the above or related purposes.

Moreover, the Company is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance industry. You have the right to obtain, to access to and to request correction of any personal information concerning yourself held by the Company. Requests for such access can be made in writing to our Manager of the Office of the General Manager at 19/F., China Taiping Tower, 8 Sunning Road, Causeway Bay, Hong Kong.

聲明及授權書 DECLARATION AND AUTHORISATION

本人／我們謹茲聲明上述所填報之資料皆爲確實詳情，並沒有隱瞞任何與此索償有關之重要資料。

本人／我們謹此代表本人／我們／所有被保險人授權任何註冊西醫、醫院、診所或政府機構，凡知道或持有任何有關本人／我們／所有被保險人記錄者，及／或曾診驗或可能將會診驗本人／我們／所有被保險人者，均可將該等資料提供給**中國太平保險(香港)有限公司**，此授權對本人／我們之繼承人及被保險人具有約束力；即使死亡或喪失行爲能力時，此授權仍具效力，本授權書的影印本與正本均有同等效力。

本人／我們聲明及同意已獲被保險人授權及同意本人／我們作出上述授權。

I/We hereby warrant the truth of the above statements and declare that I have not withheld any material information connected with this claim.

I/We hereby authorize on behalf of myself/ourselves/the Insured Person any registered medical practitioner, hospital, clinic or government institution that has any records or knowledge of me/us/the Insured Person and who has attended or may hereafter to myself/ourselves/the Insured Person to disclose such information to **China Taiping Insurance (HK) Company Limited**. This authorization shall bind my successors and assignees and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

I/We declare and agree that I/we have the full authority from and consent of the Insured Person to make the above authorizations.

日期：
Date : _____
(日/月/年 dd/mm/yyyy)

學生 / 家長或監護人簽署：
Signature of Student / Parent or Legal Guardian : _____

中国太平
CHINA TAIPING

中國太平保險(香港)有限公司
China Taiping Insurance (HK) Company Limited

請填報以下項目資料，並在適當的空格填上☑，如有變更必須通知保險公司
Please answer items below and tick the boxes where appropriate ☑ and inform Co. if any of them has been altered

PART B. PATIENT'S CONDITION

Name of Patient:	**ID No.:**

1. CONSULTATION FOR PRESENT ILLNESS / INJURY(IES)

(a) Are you the patient's usual physician? If “Yes”, since what date?

☐ Yes ☐ No

(b) When did the patient first consult you for this illness or injury(ies)?

(c) If consultation was for illness, please provide the following information:

i. Symptoms presented:

ii. Duration of these symptoms:

iii. Diagnosis:

iv. Was the diagnosis made known to the patient? If “Yes”, when? If “No”, why?

☐ Yes ☐ No

(d) If consultation was for injury(ies), please describe the injuries.

2. Please describe the nature and severity of the patient's disability.

3. Please describe treatment, including any operations performed.

中国太平
CHINA TAIPING

中國太平保險(香港)有限公司
China Taiping Insurance (HK) Company Limited

4. If the patient was referred from a clinic or hospital, please state:

(a) Name of physician: _____

(b) Name of clinic / hospital: _____

(c) Date referred:

5. Has the patient been admitted to hospital before for the same illness / injury(ies)? If "Yes", please state:

(a) Date admitted: _____

(b) Date discharged: _____

(c) Name of hospital: _____

(d) Admission No.:

6. (a) Has the patient suffered or is suffering from any other disease or ailment? If so, please give details:

_____

_____

(b) Date he / she first suffered from the disease or ailment: _____

(c) Name and address of physician consulted: _____

_____

_____

In your opinion, does the patient suffer from any kind of permanent disablement? If yes, please state the percentage of permanent disablement caused by the accident.

_____

_____

7. In your opinion, would the patient's condition lead to death within the next 12 months from the date of diagnosis?

_____

_____

8. Please provide us with any other additional information that will enable the company to assess this claim.

_____

_____

_____

_____

_____

_____

_____

_____

_____

中国太平
CHINA TAIPING

中國太平保險(香港)有限公司
China Taiping Insurance (HK) Company Limited

請填報以下項目資料，並在適當的空格填上☑，如有變更必須通知保險公司
Please answer items below and tick the boxes where appropriate ☑ and inform Co. if any of them has been altered

PART C. ACTIVITIES OF DAILY LIVING

Please comment on whether the patient is able to perform the following activities of daily living:

1. WASHING, BATHING - Ability to wash in bath or shower or by other means to maintain personal cleanliness.	☐ Yes ☐ No
2. DRESSING - Ability to dress and undress.	☐ Yes ☐ No
3. TOILETING - Ability to do all the following: to get to and from the lavatory, to get on and off the lavatory, to maintain an adequate level of personal hygiene.	☐ Yes ☐ No
4. CONTINENCE - Ability to voluntary control bowel and bladder functions.	☐ Yes ☐ No
5. FEEDING - Ability to consume food and drink unaided.	☐ Yes ☐ No
6. MOBILITY - Ability to move in and out of a chair or bed.	☐ Yes ☐ No

Name of Physician : _____

Signature of Physician : _____

Date : **(dd/mm/yyyy)** _____

Clinic Address : _____

_____

Stamp : _____