儲存表格 | 列印表格 | 重置表格

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.

教育局綜合保險計劃-團體人身意外保險索償表格
EDUCATION BUREAU BLOCK INSURANCE POLICY – GROUP PERSONAL ACCIDENT CLAIM FORM

請注意：
此部份之 **A** 項需由受傷學生/家長或監護人填寫及簽署；
此部份之 **B** 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;
Part B is to be completed by the attending physician at the claimant's expense.

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

請將索償表格及有關文件郵寄至本公司。
Please submit this Claim Form and Required Documents to our Company by mail.

第二部份
SECTION 2

請填報以下項目的資料，並在適當的空格填上☑，如有變更必須通知本公司。
Please provide information for the items listed below and tick the boxes where appropriate and inform our Company if any of them has been altered.

A項: 學生詳情 PARTICULARS OF STUDENT	
學生姓名 (請先填寫姓氏)： Name of Student (Surname first):	身份證號碼： ID Card No.:
學校名稱： Name of School:	
學生通訊地址： Address of Student:	
電話號碼： Tel No. :	傳真號碼 / 電郵地址： Fax No. / E-mail Address:

所需文件
REQUIRED DOCUMENTS

1. 索償人身份證副本
   Copy of the claimant's ID Card
2. 學生出生證明書副本
   Copy of the student's Birth Certificate
3. 相關醫療報告副本
   Copy of the relevant medical report
4. 如有報警，請提供所有警方口供紙副本
   Copy of all police statements, if any
5. 死亡證副本，如有
   Copy of Death Certificate, if any

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) 分析或調查、處理及支付本人保單有關的索償；(ii) 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；(iii) 就以上用途聯絡本人；(iv) 貴公司行使任何代位權；(v)其它與上述用途有直接關係的附帶用途；及(vi) 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）；(b) 處理索賠個案的理賠師、理賠調查員及醫療顧問；(c) 索償代理；(d) 保險資料服務公司；(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；及(m) 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) analysis or investigating, processing and paying claims made under my insurance policy;(ii) any alterations, variations, cancellation or renewal of any insurance related product or service;(iii) contacting me for any of the above purposes;(iv) exercising any right of subrogation;(v) other ancillary purposes which are directly related to the above purposes; and (vi) 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);(b) in the event of a claim, loss adjudicators, claims investigators and medical advisors;(c) recovery agents;(d) insurance 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; and (m) 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).

日期 （日/月/年 dd/mm/yyyy）
Date:

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

B項: 傷者情況 (本表格必須由主診醫生填妥和簽署，所需費用由索償人自行支付。)
Part B: PATIENT CONDITION (This statement should be fully completed and signed by Attending Physician. Any expense for completing this statement must be paid by the Claimant)

主診醫生証明書 Attending Physician's Statement

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 expect as a result of his/her injury?	a. ☐ No ☐ Yes
b. If yes, please state the proportionate disability in percentage	b. _____
(7) Please comment on whether the patient is able to perform the following activities of daily living:	
a. Washing Bathing -- Ability to wash in bath or shower or by other means to maintain personal cleanliness.	a. ☐ No ☐ Yes _____
b. Dressing -- Ability to dress and undress.	b. ☐ No ☐ Yes _____
c 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.	c. ☐ No ☐ Yes _____
d. Continence – Ability to voluntary control bowel and bladder functions.	d. ☐ No ☐ Yes _____
e. Feeding -- Ability to consume food and drink unaided.	e. ☐ No ☐ Yes _____
f. Mobility -- Ability to move in and out of a chair or bed	f. ☐ No ☐ Yes _____
(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 _____

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 : _____