

教育局綜合保險計劃 – 僱員補償保險呈遞醫療費用收據表格  
EDUCATION BUREAU BLOCK INSURANCE POLICY – EMPLOYEES' COMPENSATION INSURANCE  
MEDICAL EXPENSES RECEIPTS SUBMISSION FORM

保險公司賠案編號 Insurance Claim No. : \_\_\_\_\_ (首次申報不需要填寫)  
受傷僱員姓名 Name of Injured Employee : \_\_\_\_\_  
意外日期 Date of Accident : \_\_\_\_\_  
身份證號碼 HKID Card No. : \_\_\_\_\_

請注意： Please note:

1. 每份表格呈遞單一賠案的正本醫療費用收據 Each form for submission of medical expenses receipt(s) of ONE case only.
2. 每一個序號條錄一張正本醫療費用收據 Please record each medical expenses receipt in one row.
3. 校方應於 2 個月內呈交一次 Please submit medical expenses receipt(s) within 2 months.

序號 No.	收據日期 Issue Date	簽發醫院/診所 Issuing Hospital / Clinic	金額 Amount
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

必需填寫 (請 3 選 1)			Must Complete (please tick 1 of 3)		
<input type="checkbox"/>	未康復，仍需要複診及/或治療。 Not yet recovered. Still under follow up treatment.	<input type="checkbox"/>	已康復，無需複診及治療。不用退回收據正本。 Recovered. No further treatment. No need to return the original medical expenses receipt(s).	<input type="checkbox"/>	已康復， <b>無需</b> 複診及治療。 <b>需</b> 退回收據。 Recovered. <b>No</b> further treatment. <b>Need</b> to return the original medical expenses receipt(s).
			傷者確認簽署： Confirmed & Signed by the Injured employee: _____		

學校聯絡人：  
School Contact Person: \_\_\_\_\_

聯絡電話：  
Contact Phone No. \_\_\_\_\_

日期：  
Date : \_\_\_\_\_  
(日/月/年 dd/mm/yyyy)

學校蓋章：  
School Chop : \_\_\_\_\_