聯豐亨保險有限公司
Luen Fung Hang Insurance Company Limited

僱員賠償保險 工作意外索償申請書
Employees' Compensation Claim Form

本公司專用 FOR OFFICE USE ONLY

賠案編號 Claim No. _____

附上證明文件 Required Documents attached	☐ 勞動合同/工程合同/分判合同副本 Copy of employment contract/ construction contract/ sub-contract	☐ 最近3個月支薪證明及出勤記錄副本 Copy of latest three months' salary pay slip and attendance record	☐ 最近3季社保基金供款名單副本 Copy of latest three quarters' FSS contribution receipt	☐ 僱員由休假至復工的支薪單據副本 Copy of salary pay slips during sick leave until recovery
	☐ 澳門居民身份證/外地僱員身份認別證副本 Copy of BIR/Non- resident workers ID	☐ 本澳醫生或醫院發出之醫療費用單據/醫院帳單正本 Original medical receipts/ hospital bills issued by physician or hospital in Macau	☐ 本澳醫生或醫院發出之休假證明書正本 Original sick leave certificate issued by physician or hospital in Macau	☐ 醫療診斷/化驗/出院/康復報告正本 Original medical report/ laboratory report/discharge summary/recovery certificate
	☐ 其他 Others			

填表須知 Instructions	1. 發出此申請書並不表示本公司已接納是次索償申請或接納僱主的彌補責任轉移予本公司。 The issue of this form is in no way an admission of liability or the transfer of liability as Entity Responsible from the Employer. 2. 請正確及詳細填報申請書內所有問題及在適當空格加上✓號，若表格空間不敷使用，請另加附頁填寫。 Please complete ALL the questions under this claim form and ✓where appropriate by supplying full and accurate information. If you need additional space, please continue on a separate sheet. 3. 請遞交此申請書時，必須盡快向本公司提交以上所有證明文件以避免延誤賠償程序。 Please submit all required documents as above as soon as possible in order to avoid delay in processing. 4. 本公司只接受已簽署聲明及授權的索償申請書。此索償申請書僅供申報用途，並不代表本公司已承認任何責任。 Claims will not be processed unless declaration and authorization is signed by the Insured. The acceptance and processing of this form is NOT an admission of liability by any party.

僱主資料 Insured Employer Information

僱主名稱 Name of Insured					行業 Business	
保單號碼 Policy no.		保險期限 Insurance period	由 日 DD/月 MM/年 YY	至 日 DD/月 MM/年 YY	電郵/傳真 Email/Fax no.	
地址 Address				聯絡人 Contact person		聯絡電話 Contact no.

受傷僱員資料 Injured Employee Information

受傷僱員姓名 Name of Injured			國籍 Nationality		性別 Sex	男(M)	婚姻狀況 Marital status	
出生日期 Date of Birth	日 DD/月 MM/年 YY	澳門居民身份證/外地僱員身份認別證號碼 BIR/Non-resident worker ID no.			受僱職務 Employed occupation		
地址 Address						手提電話 Mobile no.	
直接僱主名稱 Name of direct employer					行業 Business		
受僱日期 Date of employment	日 DD/月 MM/年 YY	關係 Relationship	☐ 僱傭 Employer ☐ 僱主的家庭成員 Family member of employer ☐ 其他 Others _____		受僱形式 Employment type	☐ 全職 Full time ☐ 非全職 Part time	
直接僱主地址 Address of direct employer				聯絡人 Contact person		聯絡電話 Contact no.	

意外詳情 Accident Details

1. 意外發生日期、時間、地點 Date, Time, and Place of accident	日期 Date	日 DD/月 MM/年 YY	時間 Time	☐上午 a. m. ☐下午 p. m.	地點 Place	
2. 意外發生時從事何種職務 Duties served at the time of the accident			往返途中意外? During to and from workplace?	☐ 是，請詳述 Yes, please give details _____		☐ 否 No
3. 意外發生的詳細經過 How did the accident happen? (請附上新聞剪報，如有) (attach newspaper clippings, if any)						
4. 受傷部位、原因或受傷類型(骨折/割傷/扭傷/其他)及嚴重程度 Please state which part(s) of body injured, cause, nature and severity			原因或受傷類型 Cause/ Injury nature			
			嚴重程度 Severity	☐ 輕傷 Minor	☐ 普通 Moderate	☐ 嚴重 Serious
5. 過往就類似病症曾求診? Did any doctors consult in the past for same or similar or related condition	☐ 是，請詳述醫生姓名及診所地址 Yes, please give name of physician and address _____					☐ 否 No

6. 受傷僱員在意外發生時 Please state at the time of accident if the Injured was	i) 受酒精或藥物影響 under influence of alcohol or drugs ☐ 是 Yes ☐ 否 No	ii) 存在身體殘障或疾病 suffering previous incapacity or disease ☐ 是 Yes ☐ 否 No	iii) 違反僱主所定安全措施 in contravention of the security measures imposed by the employer ☐ 是 Yes ☐ 否 No	iv) 僱主有否就工作需要提供合適的安全設備 Did the employer provide appropriate safety measure ☐ 是 Yes ☐ 否 No

澳門新口岸宋玉生廣場398號中航大廈四樓
Tel: (853) 2870 0033 Fax: (853) 2870 0088
No.398 Alameda Dr. Carlos D'Assumpção, Edifício CNAC, 4º Andar, Macau
Website: http://www.luenfunghang.com E-mail: info@luenfunghang.com

7. 由其他人引致意外 Please state whether the accident was caused by	i) 其他勞工或第三者 other employees or third parties ☐ 是 Yes ☐ 否 No	ii) 僱主或其受託人 the employer or his representative ☐ 是 Yes ☐ 否 No	iii) 交通意外 traffic accident ☐ 是 Yes ☐ 否 No 若是，有否申報交通部? If Yes, was the accident report to police? ☐ 是 Yes ☐ 否 No	若是，請提供相關姓名及保險公司名稱 If Yes, please provide relevant name and name of insurer

8. 是否有目擊者? Any witnesses ?	☐ 是， Yes,	姓名 Name	手提電話 Mobile no.	☐ 否 No
9. 是否申報勞工局? Was the accident reported to DSAL?	☐ 是， Yes,	申報日期 Date of report 日 DD/月 MM/年 YY	工傷申報編號 (請附上副本) Case no. (please submit copy)	☐ 否 No
	若是，是否被檢控或罰款? ☐ 是 If Yes, any charge or fine? Yes		檢控/罰款單編號 (請附上副本) Case no. (please submit copy)	☐ 否 No

10. 診治詳情，診斷及目前康復情況 Please state consultation details, diagnosis and recovery status	i) 完全康復 Fully recovered ☐ 是，於 ☐ 否 Yes, on_____ No	ii) 復工 Resumed duty ☐ 是，於 ☐ 否 Yes, on_____ No	iii) 門診治療 Out-patient treatment ☐ 是，由 ☐ 否 Yes, since_____ No	iv) 住院治療 Hospitalization ☐ 是，由 ☐ 否 Yes, since_____ No	v) 休假 Sick leave ☐ 是，共 日 ☐ 否 Yes, total ____days No
請提供醫生/診所/醫院名稱及地址 Please provide name of physician/ clinic/hospital and address					

受傷僱員於受傷前三個月之收入 Earnings of Injured Employee during last three months

年份 Year	月份 Month	工作總時/日數 Total hours/days of work	基本薪酬 Basic salary and wages	非固定性津貼 Non-recurrent allowances	總收入 Total earnings
		☐時薪 hourly_____小時 ☐日薪 daily____日 ☐月薪 monthly			
		☐時薪 hourly_____小時 ☐日薪 daily____日 ☐月薪 monthly			
		☐時薪 hourly_____小時 ☐日薪 daily____日 ☐月薪 monthly			

聲明及授權
Declaration and Authorization

本公司/本人聲明上述資料完整及正確無訛，並無隱瞞任何資料。本公司/本人明白及同意若本公司/本人提供的資料有虛假或隱瞞，本公司/本人的索償權利將會作廢。
本公司/本人明白本公司/本人提供的資料為貴公司提供保險業務所需，並可能使用於下列目的:
— 任何與保險或財務有關的產品或服務，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；
— 行使任何代位權；及
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同類組織〔「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
— 透過「聯會」移轉予任何「聯會」的會員，以達到上述或有關目的。
此外，本公司/本人授權貴公司可向「聯會」從保險業收集的資料中查閱及/或核對本公司/本人任何資料。本公司/本人明白本公司/本人有權查閱及要求更正由貴公司持有有關本公司/本人的個人資料。 如有需要，本公司/本人將向貴公司辦公室提出〔電話: 28700033，傳真: 28700088〕。

I declare that the above information is complete and true to the best of my knowledge and belief and I have not withheld any information connected with this claim. I further understand and agree that if I have made or shall make any false statement or concealment, all rights to recovery under the policy shall be forfeited.
I hereby authorize any hospital, physician, or other person and/or authority who has attended or examined me, to furnish to Luen Fung Hang Insurance Company Limited or its authorized representative and permit the said insurance company or its representative to view any and all information requested with respect to my loss, illness or injury, medical history, consultation, prescription or treatment, and copies of police reports, accident reports, airlines or other carriers irregularity reports, statements, all hospital or medical records. I further declare and agree that a photocopy of this authorization shall be considered as effective and valid as original.
I understand that the information I provide to Luen Fung Hang Insurance Company Limited ("the Company") is collected to enable the Company to carry on insurance business and may be used for the purpose of:
- any insurance or financial related products or services or any alterations, variations, cancellation or renewal of said products or services;
- any claim or investigation or analysis of such claim;
- exercising any right of subrogation; and

may be transferred to:
- 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;
- any association, federation or similar organization of insurance companies ("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 any / or to verify any of my data with the information collected by the Federation from the insurance industry. I understand 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 Administration Department of the Company (Tel: 28700033 / Fax: 28700088).

/ /			
日期 (日/月/年) Date (DD /MM/ YY)	填表人姓名 Name of Applicant	簽署人(僱主/僱主代表)姓名 Name of Signatory (Insured Employer/Employer's Representative)	僱主/僱主代表簽署及公司蓋章 Signature of Insured Employer/Employer's representative and Company Chop

公司專用 FOR OFFICE USE ONLY	Claim no.	Date received	Signature verified by	Checked by	Approved by	Remarks