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.

被保險人／保單持有人 Insured or Policyholder

保單編號 Policy No.：_____

全名 Full Name：_____

地址 Address：_____

_____ 電話 Tel No.：_____

傷者 Injured Person

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：_____

意外詳情 Accident

日期 Date：_____ 時間 Time：_____ ☐ 上午 a.m. ☐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?_____

_____

_____

傷害或疾病 Injury or Illness

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? ☐是 yes ☐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? ☐是 Yes ☐否 No

聲明 Declaration

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 _____

身份証號碼 I/D No. _____

日期 Date _____

被保險人簽名
Insured's signature _____

身份証號碼 I/D No. _____

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，請提供詳細書面証據。
  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

1. 病人姓名 Name of Patient	
2. 病人遭受甚麼傷害或患甚麼病？ From what injuries or illness is the Patient now suffering?	
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?	
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?	完全沒法工作 Totally 從 _____ 至 _____ from to 部分喪失工作能力 Partially 從 _____ 至 _____ from to
5. 您認為這種狀況會持續多久? How much longer do you consider such disablement will continue?	完全沒法工作 Totally 從 _____ 至 _____ from to 部分喪失工作能力 Partially 從 _____ 至 _____ from to
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?	☐ 有 Yes ☐ 沒有 No If Yes, a) What is the nature? b) To what extent may recovery be affected thereby?

醫生簽署及蓋章：
Signature & Chop:

醫生牌照：
Qualification:

地址：
Address:

日期：
Date: