



中國交銀保險有限公司
CHINA BOCOM INSURANCE CO., LTD.

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Certificate No. 202608

中國意外急救醫療保險索償表
CHINA ACCIDENTAL EMERGENCY MEDICAL INSURANCE CLAIMS FORM

甲部 由被保險人填寫

Part I To Be Completed By The Insured

被保險人姓名 Name of Insured		保險單編號 Policy No.	
保期期限 Period of Insurance			
地址及電話號碼 Address & Telephone No.			
性別 Sex		回鄉証〔卡〕/護照號碼 Chinese Re-entry Permit/Passport No.	
職業 Occupation		出生日期 Date of Birth	
(1)	是次醫療 / 住院 / 手術是否由於一宗意外引致? Was the Medical Treatment / Hospitalization / Surgery a result of an Accident ? 否 No <input type="checkbox"/> 是 Yes <input type="checkbox"/>		
	日期 Date	時間 Time	
	地點 Place		
	意外經過 Brief Description		
	目擊者資料 Witness Information		
	警方資料 Police Information		
	是次意外, 是否有任何人仕需要負上責任? 如獲悉, 請詳述該人仕之姓名及資料。 Is anyone responsible for this accident? If known, please provide details.		
(2)	有關是次醫療 / 住院 / 手術, 閣下有否申請其他保險賠償? Are you making any other insurance claim as a result of this medical treatment / hospitalization / surgery ? 否 No. <input type="checkbox"/> 是 Yes <input type="checkbox"/>		
	保險公司名稱 Name of Insurance Company		
	保險單編號 Policy No.		
聲明及授權書: Declaration and Authorization 本人現聲明上述所填報資料, 均屬正確及真實無訛。 本人茲授權於任何替本人作診療之醫生、醫務人員、醫院或診所提供有關有本人病歷之資料予中國交銀保險有限公司, 此授權書之影印本與正本具同等效力。 I hereby declare that the above information given by me in this form is true and correct to the best of my knowledge. I hereby authorize any physician, medical practitioner, hospital or clinic by whom or where I have been observed or treated, to give full particulars about my health including my whole medical history, to CHINA BOCOM INSURANCE CO., LTD. A photocopy of this authorization shall have the full effect of the original authorization.			
日期 Date		被保險人簽署 Signature of Insured	

乙部 由主診醫生填寫

Part II To Be Completed By The Attending Physician / Surgeon

(1)	被保險人姓名 Name of Insured		
有否查核 "意外急救醫療卡" 之資料正確？ 是 <input type="checkbox"/> 否 <input type="checkbox"/> (請附上卡之副本) Have you verified the Information on the "Emergency Accidental Medical Card" Yes <input type="checkbox"/> No <input type="checkbox"/> (Please attach a copy of the Card)			
(2)	住院 Hospitalization		
	醫院名稱 Name of Hospital		
	入院日期 Date of Admission		
	出院日期 Date of Discharge		
(3)	手術 Surgical Procedure		
	手術日期 Date of Operation		
	手術名稱 Name of the Procedure		
	手術性質 Nature of the Operation		
(4)	此次醫療 / 住院 / 手術的主要病因： Chief complaints of the patient relating to this Medical Treatment / Hospitalization / Surgery		
(5)	診斷： Diagnosis of Conditions		
(6)	出院撮要 (治療計劃，包括診查辦法、結果) Brief discharge summary (Including treatments, investigation procedure, results)		
(7)	病人是否經其他醫生轉介？ Is the patient referred by another doctor ?		
	否 No <input type="checkbox"/>		
	是 Yes <input type="checkbox"/> 轉介醫生姓名及地址 Name and Address of the referral doctor		
(8)	根據閣下意見，是次受傷是否由前述意外引起？ 是 / 否 如否，請敘述受傷原因 In you opinion, was the injury resulted from the aforementioned accident Yes / No If not, please state the cause of injury.		
主診 / 專科醫生姓名 Name of Attending Physician / Specialist			
地址 Address			
電話 / 傳真 Telephone / Fax			
主診 / 專科醫生簽名及蓋印 Signature of Attending Physician / Specialist with Official Stamp Chop			
日期 Date			
Personal Information Collection Statement 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 financial related product or service or any alterations, variation, cancellation or renewal of them and any claim or analysis of it; and may be transferred to any of our related companies 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 or any association or federation of insurance companies that exists or is formed from time to time. You have the right to obtain access to and to request correction of any personal information concerning yourself held by CHINA BOCOM INSURANCE CO., LTD. Requests for such access can be made to our Compliance Officer.			
收集個人資料聲明 閣下提供的資料，為本公司提供保險業務所需，並可能使用於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、續期、索償或索償分析；及可能移轉給現存或不時成立之任何與我們有關的公司，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，或任何保險公司的協會或聯會。閣下有權要求查閱及更正由中國交銀保險有限公司持有之閣下的個人資料，如有此項要求，請與我們的個人資料主任聯絡。			
重要事項： 為免閣下的索賠程序有延誤，請於索賠時，確定連同以下文件一併附上。			
1. 被保險人及主診醫生必須填妥本意外急救醫療保險索償表上列明的所有項目。 2. 醫療單據的正本 (包括所有費用的明細)。 3. 警方報告及 / 或負責是次意外的政府有關部門之報告 (若不能附上，請說明原因)。			
IMPORTANT : In order to avoid unnecessary delay in processing of your claim, please ensure that the following documents are attached when submitting your claim :			
1. The Claim Form must be fully completed and signed by the Insured and the attending doctor. 2. Original Medical Bills / Receipts with detail breakdown of the costs / expenses. 3. Original Police Report and / or Original Report issued by the official authorities concerned to confirm the alleged accident. If not available, you must state the reason why the police or the official authorities concerned was not informed after accident occurred.			