Insurance
**GAN** **Assurances**
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賠償號碼
Claim No. ____________________________________

保單號碼
Policy No. ____________________________________

# 人身意外 / 疾病保險申請賠償表格
# PERSONAL ACCIDENT / SICKNESS CLAIM FORM

注意: 供給本申請賠償表格，並不表示本公司承認提供賠償責任
*N.B.* By furnishing this form the Company makes no admission of liability.
若申請賠償者，不能親自填寫本表格，則可請他人代填
If the claimant is unable to fill up this form personally it may be filled up on behalf of him/her.
所有填妥之賠償表格，應連同各有關單據及醫生証明書，列明一切病歷同時付上。
Each completed claim form must be submitted together with itemised bill(s) and statement from the attending physician certifying the diagnosis of the insured person.

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1. 保戶姓名
Name of Insured________________________________________________
地址
Address________________________________________________
電話
Phone No.____________________________ 職業 Present Occupation____________________________

2. 申請賠償者姓名（如非保戶本人）
Name of Claimant (if other than Insured)__________________________ 出生日期 Date of Birth__________________________
地址
Address ________________________________________________
電話
Phone No.____________________________ 職業 Present Occupation____________________________

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3. 受傷 / 疾病
Injury / Sickness
a. 請述受傷 / 疾病性質
Describe the nature of injury / sickness________________________________________________
(IN BLOCK LETTER) （請用正楷填寫）
b. 意外發生日期 / 發現疾病日期
Date of Accident / Date of sickness first began________________________________________________
c. 初次治療日期
Date of first treatment________________________________________________
d. 如曾留院，請敘明醫院名稱及地址
If hospitalized, give name and address of the hospital________________________________________________
入院日期
Date Admitted____________________________ 出院日期 Date Discharged____________________________
e. 完全不能工作（期間）
Totally and absolutely disabled from__________________________ 至 to __________________________
f. 局部不能工作（期間）
Partial disabled from__________________________ 至 to __________________________

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4. 發生意外之詳細資料（如因意外受傷方需填寫）
Details of Accident (To be completed for injury resulting from ACCIDENT)
a. 意外發生地點時間及日期
Date, time and place of accident________________________________________________
b. 敘述該意外之失事情形
How did the accident occur________________________________________________
c. 敘明於出事後爲閣下診治醫師或醫院之名稱及地址
State name(s) and address(es) of the physician(s) or hospital that you were attending during your disability__________________________
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5. 閣下曾否向其他保險公司，投保人身意外 / 疾病保險？若然，請敘請明該保險情形
Are you insured with any other insurance company for Accident / sickness benefits? If so, please give particulars__________________________
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6. a. 本人茲証明上述各項資料正確無誤
I hereby warrant the truth of the above statements.
b. 本人茲授權任何醫院，醫師及其他曾替本人診治，護理，或檢查之人士，將部份或全部有關本人傷害及疾病之醫療診斷報告及藥方等資料供給與法國敬邦保險或其代表人，此授權書，如經攝影成影印本，則影印本與原本具同等之效力。
I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the GAN Assurances or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorization shall be considered as effective and valid as the original.
c. 本人確認貴保險公司會依靠本人/保單持有人/保戶所提供的資料 (該等提供的資料本人誠實地相信是真實和正確的), 作爲將來進行或辯護任何索賠及訴訟程序之用。 如貴保險公司要求, 本簽署人/保單持有人/保戶將會及必定同意簽署任何有關倚靠該等資料所準備之法律文件。
I acknowledge that Insurers will rely upon the information supplied by me / the policyholder / the Insured, which I verily and honestly believe to be true and correct, in prosecuting or defending any claims or proceedings in future, and the signatory / the policyholders / Insured under this policy, if so required by the Insurers, will be asked and are bound to sign any court documents on the basis of information provided herein.

____________________________
日期
Date

____________________________
保戶 / 申請賠償者簽署
Insured / Claimant Signature(s)

P.T.O.

# Certificate Of Medical Attendant

No claims can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expense of the Insured.

1. Name of Patient ______________________________

   Identity card no. ______________________________ Age ______________________________

2. Date of accident ______________________________

   Cause of injury ______________________________

   Part of the body injured ______________________________

   Nature and extent of the injuries (Describe complications, if any) ______________________________

3. Is the condition due to pregnancy ? ______________________________

   Date on which the patient first consulted you for this condition ______________________________

   State whether there is evidence of a visible bruise or wound at **1st consultation** ______________________________

   ______________________________

4. Treatment given (e.g. suturing, physiotherapy, type of dressing etc.)

   Date ______________ Time ______________ Treatment ______________________________

5. Did injury require (If yes, please give details)

   a) Hospitalization ? No☐ Yes☐ Date admitted ______________ Date discharged ______________

   b) X-rays ? No☐ Yes☐ ______________________________

   c) Special diagnostic procedures ? No☐ Yes☐ ______________________________

   d) Surgery ? No☐ Yes☐ ______________________________

6. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries would have prevented him/her from performing his/her duties? If yes, please give details

   No☐ Yes☐ a) Total and absolutely disabled (unable to work) from ______________ to ______________

   b) Partially disabled from ______________ to ______________

7. Give details of any circumstances, such as physical impairments, medical history or intoxication which may have contributed to the accident and/or lengthen the period of disability

   ______________________________

8. Names and addresses of other doctors who have treated Insured for the same injury

   Name ______________________________ Date ______________________________

   Address ______________________________

I hereby certify that I have personally examined/treated the Insured for the above injuries and that the facts as given above present my opinion of his/her condition.

Name of Physician

______________________________

Qualification

______________________________

______________________________

Signature of Physician

Address

______________________________

______________________________

______________________________

Telephone

______________________________

Date

______________________________

For identity purpose, the Claimant must sign below in the presence of the Physician

______________________________ ______________________________

Claimant Signature Date