



**Internal Use Only 只供內部使用**  
Claim No. 理賠編號

## Waiver of Premium Claim Form – Part II

### 傷殘豁免保費賠償申請表 – 第二部份

Policy Number

保單號碼

--	--	--	--	--	--	--	--	--	--

**Private & Confidential 私人及機密**

**TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT'S OWN EXPENSES**  
由主診醫生填寫，所需費用由索償人自行承擔

**Important note 重要事項**

Your patient is insured with us and to enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement.

閣下的病人為本公司的受保人，請閣下詳細填寫此申請表並盡可能提供一切有關資料，以便本公司審核此索償。閣下的協助可使本公司加快索償安排。

1. Name of the Patient (Insured) 病人(受保人)姓名		2. HKID Card / Passport No. 香港身份證 / 護照號碼	
3. Patient's occupation and exact nature of duties 病人的職業及確實職務			
4. Details of the disability 傷殘的詳情	First consultation date for this disability (dd/mm/yyyy) 就此傷殘的首次求診日期 _____ / _____ / _____ (日/月/年)  Start date of this disability (dd/mm/yyyy) 是次傷殘的開始日期 _____ / _____ / _____ (日/月/年)  Cause of disability <input type="checkbox"/> Due to accident <input type="checkbox"/> Due to illness 導致傷殘的原因 因意外導致 因疾病導致  Final diagnosis _____ 最終確診  Last consultation date for this disability (dd/mm/yyyy) 就此傷殘的最後求診日期 _____ / _____ / _____ (日/月/年)		
5. If disability due to accident, please describe the accident in details. 若因意外導致傷殘，請描述意外詳情。	Date of accident (dd/mm/yyyy) _____ / _____ / _____ (日/月/年) Place _____ 意外日期 地點  Cause of Injury _____ 受傷成因  Injured part, nature & severity of injury _____ 受傷部位、傷勢及嚴重程度		
6. If disability due to illness, please describe the illness in details. 若因疾病導致傷殘，請描述疾病詳情。	Date symptoms first appeared (dd/mm/yyyy) _____ / _____ / _____ (日/月/年) 病徵首次出現日期  Chief complaints / symptoms _____ 主訴 / 病徵  Underlying cause for the illness _____ 引起此疾病的主因  Previously treated for same/related disorder? <input type="checkbox"/> Yes (please provide details) <input type="checkbox"/> No 是否曾因同類或相關疾病接受治療？ 是(請提供詳情) 否		
7. Is it possible that this disability was related to the factors listed in the right side? 是次傷殘是否有機會與右列之情況有關？	<input type="checkbox"/> Yes (please check appropriate and give details) 是(請選擇適當情況及提供詳情) <input type="checkbox"/> No 否 <input type="checkbox"/> Self-inflicted condition or suicide 自殘情況 / 自殺 <input type="checkbox"/> Under influence of alcohol or other psychoactive substances 受酒精或精神藥物影響 <input type="checkbox"/> Involvement in high risk activities 高危活動 <input type="checkbox"/> Past injury or illness 過往受傷 / 疾病 <input type="checkbox"/> AIDS and/or other sexually transmitted disease 愛滋病或其他性病 <input type="checkbox"/> Psychological condition 心理因素  Please provide details _____ 請提供詳情		

<p>8. Was the patient hospitalized for treatment due to this disability? 病人是否就此傷殘曾入住醫院接受治療？</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p> <p>Period of Hospitalization 住院時期 _____</p> <p>Name of Hospital 醫院名稱 _____</p> <p>Any surgery performed during hospitalization? <input type="checkbox"/> Yes (please provide details) <input type="checkbox"/> No 住院期間是否有進行手術？ 是 (請提供詳情) 否</p> <p>Date of surgery _____ (dd/mm/yyyy) 手術日期 _____ (日/月/年)</p> <p>Name of surgery 手術名稱 _____</p> <p>Reason of surgery 手術原因 _____</p> <p>Other treatment performed 曾進行的其他治療 _____</p> <p>Brief discharge summary (including investigation tests &amp; results, results of the treatments, any complications and follow-up plans) 出院撮要 (包括確診測試及結果、治療結果、有否併發症及跟進計劃) _____</p>												
<p>9. Had the patient previously referred by other physician? 病人是否經其他醫生轉介？</p>	<p><input type="checkbox"/> Yes (please provide name &amp; address of the doctor) 是 (請提供醫生姓名及地址) <input type="checkbox"/> No 否</p>												
<p>10. Please specify all physical or mental impairment – impact, severity and duration as a result of this disability. 請列明所有身體或精神損傷 - 其影響、受傷程度和持續時間</p>													
<p>11. According to patient's health condition, please rate his/her current working capacity. 就病人現時的健康狀況，請評估其工作能力。</p> <p><i>Please provide supporting documentation. (Such as physical examination assessment report)</i> 請提供證明文件 (如體驗評估報告)</p>	<p><input type="checkbox"/> No limitation of functional capacity &amp; capable of heavy work without restriction 能夠從事任何體力勞動工作</p> <p><input type="checkbox"/> Capable of medium manual activity 能夠從事中度體力勞動工作</p> <p><input type="checkbox"/> Slight limitation of functional capacity &amp; capable of light manual work only 只可從事輕度體力勞動工作</p> <p><input type="checkbox"/> Moderate limitation of functional capacity &amp; capable of clerical / admin work 只可從事非體力勞動或文書工作</p> <p><input type="checkbox"/> Severe limitation of functional capacity, incapable of minimum activity 不可從事任何勞動或文書工作</p> <p>Remarks 備註 _____</p>												
<p>12. According to patient's occupation, please indicate the effect of this disability and the prognosis. 根據病人的職業，請詳述是次傷殘對其影響及預後情況。</p>	<table border="0"> <thead> <tr> <th></th> <th style="text-align: center;">From (dd/mm/yyyy) 由 (日/月/年)</th> <th style="text-align: center;">To (dd/mm/yyyy) 至 (日/月/年)</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Unable to perform <b>ALL</b> tasks of the original duty 不能從事原來工作的<b>所有</b>職務</td> <td style="text-align: center;">_____ / _____ / _____</td> <td style="text-align: center;">_____ / _____ / _____</td> </tr> <tr> <td><input type="checkbox"/> Unable to perform <b>PARTS</b> of the original duty 不能從事原來工作的<b>部份</b>職務</td> <td style="text-align: center;">_____ / _____ / _____</td> <td style="text-align: center;">_____ / _____ / _____</td> </tr> <tr> <td><input type="checkbox"/> Unable to perform <b>ANY occupation</b> 不能從事<b>任何</b>工作</td> <td style="text-align: center;">_____ / _____ / _____</td> <td style="text-align: center;">_____ / _____ / _____</td> </tr> </tbody> </table> <p>Remarks 備註 _____</p>		From (dd/mm/yyyy) 由 (日/月/年)	To (dd/mm/yyyy) 至 (日/月/年)	<input type="checkbox"/> Unable to perform <b>ALL</b> tasks of the original duty 不能從事原來工作的 <b>所有</b> 職務	_____ / _____ / _____	_____ / _____ / _____	<input type="checkbox"/> Unable to perform <b>PARTS</b> of the original duty 不能從事原來工作的 <b>部份</b> 職務	_____ / _____ / _____	_____ / _____ / _____	<input type="checkbox"/> Unable to perform <b>ANY occupation</b> 不能從事 <b>任何</b> 工作	_____ / _____ / _____	_____ / _____ / _____
	From (dd/mm/yyyy) 由 (日/月/年)	To (dd/mm/yyyy) 至 (日/月/年)											
<input type="checkbox"/> Unable to perform <b>ALL</b> tasks of the original duty 不能從事原來工作的 <b>所有</b> 職務	_____ / _____ / _____	_____ / _____ / _____											
<input type="checkbox"/> Unable to perform <b>PARTS</b> of the original duty 不能從事原來工作的 <b>部份</b> 職務	_____ / _____ / _____	_____ / _____ / _____											
<input type="checkbox"/> Unable to perform <b>ANY occupation</b> 不能從事 <b>任何</b> 工作	_____ / _____ / _____	_____ / _____ / _____											
<p>13. Were there any precipitating factors which may have contributed to or hastened this disability and/or lengthen the period of disability? 是否有任何因素促使或導致是次傷殘及 / 或延長康復時間？</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p>												
<p>14. Is there any patient's family history or other precipitating factors which would have increased the risk of this illness? 是次疾病是否因任何家族病史或其他因素促使增加患上此疾病的風險？</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p> <p>_____</p> <p>_____</p>												

<p>15. Did the patient have any of the following habits - smoking, drinking or drugs taking? 病人是否有以下習慣 - 吸煙、飲酒或服用藥物?</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <span style="float: right;"><input type="checkbox"/> No 否</span></p> <p><input type="checkbox"/> Smoking 吸煙      <input type="checkbox"/> Drinking 飲酒      <input type="checkbox"/> Drug taking 服用藥物</p> <p>Duration 持續時間 _____ Consumption per day 每天用量 _____</p>																
<p>16. Do you know whether the patient was suffering from any other major, chronic or congenital disease? 你是否知道病人曾患有任何其他嚴重、慢性或先天性疾病?</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <span style="float: right;"><input type="checkbox"/> No 否</span></p>																
<p>17. Please list details of all medical history (apart from what have mentioned above) that the patient had ever consulted you with. 請提供病人過去曾向你求診的所有醫療病歷詳情 (除上述已提及外)。</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Consultation date 求診日期</th> <th style="width: 25%;">Complaints/Symptoms 主訴 / 病徵</th> <th style="width: 25%;">Diagnosis 確診</th> <th style="width: 25%;">Treatment given 所提供治療</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Consultation date 求診日期	Complaints/Symptoms 主訴 / 病徵	Diagnosis 確診	Treatment given 所提供治療	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Consultation date 求診日期	Complaints/Symptoms 主訴 / 病徵	Diagnosis 確診	Treatment given 所提供治療														
_____	_____	_____	_____														
_____	_____	_____	_____														
_____	_____	_____	_____														
<p>18. Was there any usual physician of the patient other than you? 病人是否有其他慣常求診的醫生?</p>	<p><input type="checkbox"/> Yes (please provide name &amp; address of the doctor) 是 (請提供醫生姓名及地址) <span style="float: right;"><input type="checkbox"/> No 否</span></p>																
<p>19. Have the biological parents or siblings of the patient been diagnosed prior to age 60 with any of the illnesses listed in the right side? 請問病人的親生父母或兄弟姐妹在六十歲之前有否患有右列之疾病?</p>	<p><input type="checkbox"/> Yes (please check appropriate and give details) 是 (請選擇適當情況及提供詳情) <span style="float: right;"><input type="checkbox"/> No 否</span></p> <p><input type="checkbox"/> Cancer 癌症</p> <p><input type="checkbox"/> Heart disease 心臟病</p> <p><input type="checkbox"/> Stroke 中風</p> <p><input type="checkbox"/> Diabetes 糖尿病</p> <p><input type="checkbox"/> Alzheimer's Disease 阿茲海默症</p> <p><input type="checkbox"/> Parkinson's Disease 帕金森病</p> <p><input type="checkbox"/> Polycystic Kidney Disease 多囊性腎病</p> <p><input type="checkbox"/> Other inherited disease or disorder 其他遺傳性疾病</p> <p>Please provide details 請提供詳情</p> <p>_____</p>																
<p>20. Any additional information you consider relevant to this claim. 其他與是次索償有關的資料。</p>																	
<b>Declaration 聲明</b>																	
<p>I hereby certify that I have personally examined and treated the patient in connection to the above condition and that the facts as given above present my opinion of his/her condition and all are true to the best of my knowledge and belief. I hereby declare that no information has been withheld by me at the request of the patient or his/her family.</p> <p>本人謹此聲明曾親自為病人檢查及作出診治，以上填報的各項資料乃本人基於病人的情況而提供意見，所有答案，就本人所知所信，均為事實全部並確實無訛。本人在此聲明，沒有任何病人或其家屬要求本人隱瞞任何資料。</p>  <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <p>_____ Name in block letters of Attending Physician / Specialist and Qualifications 主診 / 專科醫生姓名及資歷</p> </td> <td style="width: 50%; border: none;"> <p>_____ Address and Contact No. 地址及聯絡電話號碼</p> </td> </tr> <tr> <td style="border: none;"> <p>_____ Signature of Attending Physician / Specialist with chop 主診 / 專科醫生署名及蓋印</p> </td> <td style="border: none;"> <p>_____ Date (dd / mm / yyyy) 日期 (日 / 月 / 年)</p> </td> </tr> </table>		<p>_____ Name in block letters of Attending Physician / Specialist and Qualifications 主診 / 專科醫生姓名及資歷</p>	<p>_____ Address and Contact No. 地址及聯絡電話號碼</p>	<p>_____ Signature of Attending Physician / Specialist with chop 主診 / 專科醫生署名及蓋印</p>	<p>_____ Date (dd / mm / yyyy) 日期 (日 / 月 / 年)</p>												
<p>_____ Name in block letters of Attending Physician / Specialist and Qualifications 主診 / 專科醫生姓名及資歷</p>	<p>_____ Address and Contact No. 地址及聯絡電話號碼</p>																
<p>_____ Signature of Attending Physician / Specialist with chop 主診 / 專科醫生署名及蓋印</p>	<p>_____ Date (dd / mm / yyyy) 日期 (日 / 月 / 年)</p>																