



Liberty
International
Member of Liberty Mutual Group

Liberty International Insurance Ltd
利寶國際保險有限公司

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人身意外及醫療保險賠償申請書

PERSONAL ACCIDENT AND HOSPITALIZATION INSURANCE CLAIM FORM

適合車主及租車司機報遇事受傷
(Applicable to owner/ or Hirer Drivers)

POLICY NO. : _____ Certificate No. _____ (請隨付副本)
(Please attach copy)

EXPIRE DATE : _____

- 申請賠償人姓名 (如不是被保人) 與被保人關係
1. Name of Claimant (other than insured person) : _____ Relationship to insured person _____
2. 被保人姓名 (如屬租車司機，請附上租車合約副本一份)
a. Name of insured person : _____ (if hired driver, please attach a copy of Hire Agreement)
- 身份證號碼 (請隨付副本) 性別 年齡
b. Identity Card No. _____ (Please attach copy) c. Sex _____ d. Age _____
- 地址 電話
e. Address : _____ f. Tel. _____
- 意外發生日期 時間
3. Date of Accident first began : _____ Time : _____
- 詳述該意外失事情形，地點及時間
4. Describe when, how and where accident happened : _____
- 請詳述報案警署名稱及地址和報案號碼
5. State Name and Address of Police Station, and Police Report Number _____
- 有否見證人， 是 否
6. State any witness or not. Yes No
如有請詳述其姓名，地址及電話
If yes, please give name, address and tel. no. _____
- 受傷性質
7. Nature of injury: _____
- 初次治療日期
8. Date of First Treatment : _____
- 主治醫師姓名
9. Name of attending physician : _____
- 請註明是否 留醫/門診 留醫 門診
10. Indicate if In-patient/Out-patient Yes No
如留醫請詳述就診之醫院及名稱及地址，和覆診咭號碼
If In-patient, give name and address of hospital, and your patient Card No. _____
- 病假期間由 至
11. Sick leave period granted from _____ to _____
- 已康復日期 如未康復，估計日期
12. date of recovery _____ 13. If not recovered, expect date of recovery _____
- 閣下曾否向其他保險公司投保同類保險?若有，請列明該保險內容
14. Are you insured with any other insurance company for similar benefits? If so, please give particulars : _____

茲聲明上述各節全屬實情並無虛漏
I represent that the above statements and answers are full, complete and true.

車主
Signature of Taxi Owner _____

的士協會
Taxi Association _____
Chop and authorized Signature

被保人/申請賠償人簽署
Insured Person / Signature of Claimant _____

授權書
AUTHORIZATION

本人茲授權所有醫院，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之醫療診斷報告及藥方等資料供給與利寶國際保險有限公司或其代表人，此授權書，如經攝成影印本，則影印本與原本俱同等之效力。
I hereby authorize any hospital, physician or other person who has attended or examined me to furnish to Liberty International Insurance Ltd. 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.

地區及日期
Place and date

被保人/申請賠償人簽署
Insured Person / Claimant Signature(s)