



人身意外及醫療保險賠償申請書

PERSONAL ACCIDENT AND HOSPITALIZATION INSURANCE CLAIM FORM

POLICY NO. : _____

EXPIRE DATE : _____

申請賠償人姓名
1. Name of Claimant : _____

與被保人之關係
2. Relationship to insured person : _____

被保人姓名 身份證號碼
3. Name of insured person : _____ Identity Card No. _____

職業 性別 年齡
4. Occupation : _____ 5. Sex _____ 6. Age _____

地址
7. Address : _____

電話
8. Tel. _____

意外發生日期 / 發現疾病日期 時間
9. Date of Accident/Date of sickness first began : _____ Time : _____

詳述該意外遇事情形，地點及時間
10. Describe when, how and where accident happened : _____

如有見證人，請詳述其姓名，地址及電話 是 否
11. State my witness or not. Yes No

If yes, please give name, address and tel. no. _____

受傷 / 疾病性質
12. Nature of injury / Sickness : _____

初次治療日期
13. Date of First Treatment : _____

主治醫師姓名
14. Name of attending physician : _____

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
15. 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.

日期
Date : _____

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)



Liberty
InternationalTM
 Member of Liberty Mutual Group

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

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ATTENDING PHYSICIAN'S STATEMENT
 (to be completed by physician)

Patient's Name: _____ Age: _____

1. Diagnosis and concurrent conditions: _____

2. Is Condition due to injury or sickness? _____

3. Is Condition due to pregnancy? Yes/No _____

4. When did symptoms first appear or accident happen? _____

5. When did the patient first consult you for this condition? _____

6. Nature of surgical or obstetrical procedure, if any : _____

Date Performed: _____

7. If hospitalized, give name and address of hospital: _____

8. Date admitted: _____ Date Discharged: _____

9. Totally and absolutely disabled from _____ to _____

10. Partially disabled from _____ to _____

11. Is patient still under your care for this condition? Yes/No If not, give date your services terminated.

Signature of Physician _____

Medical Degree(s) _____

Address _____

Date: _____