



**MSIG Insurance (Hong Kong) Limited**  
 9/F Cityplaza One 1111 King's Road  
 Taikoo Shing Hong Kong  
 Tel: (852) 2894 0555 Fax : (852) 2902 9109  
 Website : www.msig.com.hk

**Macau Branch**  
 Avenida Da Praia Grande No. 693  
 Edif Tai Wah, 13<sup>th</sup> Andar A & B, Macau  
 Tel : (853) 2892 3329  
 Fax : (853) 2893 3349

## Personal Accident Claim Form 人身意外索償表格

(Please complete in BLOCK letters)

### Procedures and Notes:

1. Please submit the Claim Form to us within 30 days from the date of accident.
2. Please submit a completed Claim Form, together with original copies of all relevant documents to:

MSIG Insurance (Hong Kong) Limited  
 Claims Division  
 9/ F Cityplaza One  
 1111 King's Road  
 Taikoo Shing Hong Kong

3. Incomplete Claim Form cannot be accepted for processing of payment.
4. For all medical reports and original medical receipts, please provide the treatment date, patient's name, diagnosis and countersigned by the attending physician with stamp on it.
5. All medical reports, information and evidences as required by us shall be furnished at the Claimant's own expenses.
6. Further information may be needed.
7. For inquiry, please call our Customer Service Hotline at 3122 6922.

(請以正楷填寫)

### 程序及備註:

1. 請將索償表格於事發後之 30 天內呈交本公司。
2. 請將填妥之索償表格連同有關證明文件之正本寄回:

MSIG Insurance (Hong Kong) Limited  
 理賠部  
 香港太古城  
 英皇道 1111 號  
 太古城中心一期 9 樓

3. 未經填妥之索償表格，將不獲接受索償處理。
4. 請提供治療日期、病者姓名、病症及由主診醫生之印鑑及簽署在所有醫療報告及醫療費用之正本收據上。
5. 本公司要求遞交所有醫療報告、資料及證據之費用須由索償人支付。
6. 稍後可能需要提供進一步資料。
7. 如有任何查詢，請致電我們的客戶服務熱線 3122 6922。

### Insured's Information 受保人資料

Name of Insured 受保人姓名		Policy No. 保單號碼	
HKID No. 香港身份證號碼		Daytime Contact No. 日間聯絡電話號碼	
Correspondence Address 通訊地址			
Present Business or Occupation 現時職業		Name of Employer 僱主名稱	
Business Address 辦公室地址			
Date & Time of Accident 意外發生之日期及時間	DD 日/	MM 月/	YY 年
	am 上午/pm 下午		Place of Accident 意外發生地點
Have you applied for medical claims in other insurance company for this event/accident? If yes, please specify. <input type="checkbox"/> Yes, please specify 有, 請註明 <input type="checkbox"/> No 沒有 閣下醫療費用是否同時另有其他保險承保?			
Note: Please send copy of the payment document if other insurance company has already paid of the part of medical expenses. 注意: 若曾申請其他保險公司作出賠償, 請提供該保險公司之賠償證明。			
Please indicate your current status: <input type="checkbox"/> Fully recovered from this injury 完全康復 <input type="checkbox"/> Still under treatment 治療中 <input type="checkbox"/> Please ✓ the appropriate one (請 ✓ 適用者) 請指出你現在的情況:			
Note: Benefit stated in the Schedule shall be payable when you are fully recovered and the total amount of the Benefit shall have been ascertained and agreed. 附註: 本公司將待至閣下完全康復, 保障金額確定及協定後, 方會一筆整付賠償。			

### Claim Settlement Method 賠償方法

To quicken our settlement for any valid claim, please provide your banking details if you prefer direct credit. We must stress that this request should not be treated as an admission of our liability whatsoever means by law. Finally, we hereby reserve all rights for assessing your claim subject to terms, conditions and exclusions of the related policy.

在成功審批賠償後, 本公司可以將賠款直接過戶。如閣下選擇此項服務, 敬請提供銀行名稱和戶口號碼。本公司特此聲明, 此項要求並不代表閣下之索償現正獲成功審批。有關決定, 本公司在收齊證明文件後, 將根據保單一切條款才作最後審批, 敬請留意。

For claim payment (if any) direct credit to Policyholder's bank account, please complete all of the following:

本公司將賠償款項(如有)直接存入閣下之戶口, 請填寫以下資料:

Account Holder's Name (Must be the same as the Policyholder 必須與保單持有人相同)

戶口持有人姓名

Bank Name 銀行名稱	Bank Code 銀行編號	Branch No. 分行號碼	Bank A/C No. 銀行帳戶號碼																
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Please put a ✓ in the appropriate box of your claim below, please list item & indicate the amount of your claim in details.

請在格內用✓選擇索償之項目及詳細列出索償之內容及數目。

(If there is insufficient space on the claim form, please specify the details on a separate sheet clearly and indicate which section the information relates to. 如空位不足，請另附紙張填寫，並列明所述的項目名稱。)

<b><input type="checkbox"/> Accidental Death 意外死亡</b>	
State fully what happened: 請詳述意外如何發生: _____ _____	
What was the Injured Person doing at the time? 在事發當時傷者所作何事? _____ _____	
Documents Attached 附加文件	
<input type="checkbox"/> Medical Report 醫療報告	<input type="checkbox"/> Police Report 警方報告 (case no. 檔案編號 _____)
<input type="checkbox"/> Death Certificate 死亡證明書	<input type="checkbox"/> <b>Original Receipts</b> of Travel Expenses and Air Ticket 旅程費用及機票之 <b>收據正本</b>
<input type="checkbox"/> Others (please specify) 其他 (請註明) _____	

<b><input type="checkbox"/> Loss of Limbs or Sight or Hearing or Speech 四肢傷殘或失明或失聰或喪失說話能力</b>	
<b><input type="checkbox"/> Permanent Total Disablement 永久完全傷殘</b>	
State fully what happened: 請詳述意外如何發生: _____ _____	
What was the Injured Person doing at the time? 在事發當時傷者所作何事? _____ _____	
Documents Attached 附加文件	
<input type="checkbox"/> Medical Report 醫療報告	<input type="checkbox"/> Police Report 警方報告 (case no. 檔案編號 _____)
<input type="checkbox"/> Consent Letter for Medical Record 索取醫療報告的授權信	<input type="checkbox"/> Others (Please specify) 其他 (請註明) _____
<input type="checkbox"/> Copy of HKID/ Birth Certificate* (*applicable if Insured is below age 18) 身份證/出世紙副本* (*適用於 18 歲以下之受保人)	

<b><input type="checkbox"/> Temporary Total Disablement 短期完全失去活動能力</b>	
State fully what happened: 請詳述意外如何發生: _____ _____	
What was the Injured Person doing at the time? 在事發當時傷者所作何事? _____ _____	
Documents Attached 附加文件	
<input type="checkbox"/> Medical Report 醫療報告	<input type="checkbox"/> Confirmation from Employer stating the Leave Period that Insured has taken and Monthly Salary 僱主發出之信件證明受保人因病請假之日期及月薪證明
<input type="checkbox"/> Copy Medical Certificate showing the period of Sick-Leave 醫生發出之病假證明書副本	<input type="checkbox"/> Others (Please specify) 其他 (請註明) _____
<input type="checkbox"/> Copy of HKID/ Birth Certificate* (*applicable if Insured is below age 18) 身份證/出世紙副本* (*適用於 18 歲以下之受保人)	

**Hospitalisation Allowance 住院現金津貼**

**Medical Expenses 醫療費用**

**Bonesetter's Fee 跌打費用**

State fully what happened: 請詳述意外如何發生: \_\_\_\_\_  
\_\_\_\_\_

What was the Injured Person doing at the time? 在事發當時傷者所作何事? \_\_\_\_\_  
\_\_\_\_\_

Currency/ Claim Amount 索償金額 \_\_\_\_\_

Documents Attached 附加文件

**Original Medical Receipt 醫療費用之單據正本**

**Medical Report 醫療報告**

**Copy of HKID/ Birth Certificate\* (\*applicable if Insured is below age 18)**  
身份證/出世紙副本\* (\*適用於 18 歲以下之受保人)

**Others (Please specify) 其他 (請註明)** \_\_\_\_\_

### **Declaration & Authorisation 聲明及授權**

1. I/We declare that the above information is in all respect true and complete to the best of my/our knowledge and belief;

我/我們就此作出聲明，以上所述事項均根據我/我們所知及信的情況下提供，並且為正確及並無遺漏。

2. It is agreed that upon request by MSIG Insurance (Hong Kong) Limited. I/We shall make a statutory declaration to re-affirm the genuineness of all the information contained in this claim form; and

若 MSIG Insurance (Hong Kong) Limited 提供有關要求，我/我們同意作出索償表格內資料均屬真確的法定聲明；及

3. I, the undersigned claimant, hereby authorise any party concerned to disclose to MSIG Insurance (Hong Kong) Limited or its representative any and all information with respect to my medical history regarding illness or injuries and my claimed loss/damage under the above Section(s). A photostat copy of this authorisation shall be as effective and valid as the original.

本人為下方簽署之索償人。本人現授權有關人士向 MSIG Insurance (Hong Kong) Limited 或其代表提供任何一切本人於上述索償項目中申報有關本人患病、受傷及損毀/損失的資料記錄。本授權書的法律效力等同正本。

\_\_\_\_\_  
Signature of Insured 受保人簽署

I.D. Card No. 身份證號碼

Date 日期

\_\_\_\_\_  
Signature of Claimant 索償人簽署

I.D. Card No. 身份證號碼

Date 日期

Medical Report 醫療證明	
1. Name of Patient 傷者／病者姓名	
2. From what injuries or illnesses is the Patient now suffering? 傷勢或病情詳解	_____ _____ _____
3. Is disability/ sickness due to an accident? 此疾病是否意外所引致？	
4. Was the condition congenital or inherited or pre-existing? 病人的病況是否先天性或遺傳或舊患？	
5. When you first consulted for these injuries or illnesses? 何時首次接受治療該傷勢或病情？	
6. How long has the Patient been disabled from engaging in or attending to his usual employment or occupation as a result of these injuries or illnesses? 因是次受傷或疾病，傷者／病者未能工作期間有多久？	Totally from _____ to _____ 完全未能工作由 _____ 至 _____  Partially from _____ to _____ 局部未能工作 _____ 至 _____
7. How much longer do you consider such disablement will continue? 該工作障礙會否延續？	Totally from _____ to _____ 完全未能工作由 _____ 至 _____  Partially from _____ to _____ 局部未能工作 _____ 至 _____
8. Has the Patient suffered from any other disease or physical defect? If YES, (a) What is the nature? (b) To what extent may recovery be effected thereby? 傷者／病者有否其他疾病或身體缺陷？ 若有：(甲) 其性質為何？ (乙) 復原機會情況多大？	YES 有／NO 否  (a) (甲) _____ _____  (b) (乙) _____ _____
Signature: 主理醫生簽署： _____	Qualifications: 資歷： _____
Name: 主理醫生姓名： _____	Date: 日期： _____
Address: 執業地址： _____ _____	