閩 信 保 險 有 限 公 司
MIN XIN INSURANCE COMPANY LIMITED
(A WHOLLY-OWNED SUBSIDIARY OF MIN XIN HOLDINGS LIMITED)

香港總行 Head Office : 香港中環紅棉路8號東昌大廈17樓
17/F., Fairmont House, 8 Cotton Tree Drive, Central, Hong Kong
電話Tel: (852) 2826 3660 傳真Fax: (852) 3020 5063
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澳門分行 Macau Branch : 澳門羅保博士街1-3號澳門國際銀行大廈11樓G-H座
11/F., G-H Luso Int'l Bank Bldg., No. 1-3 Rua Dr. Pedro Jose Lobo, Macau
電話Tel: (853) 2888 3876 傳真Fax: (853) 2830 5600
電郵E-mail: macaucs@mxic.com.hk

閩信(澳門)人身意外綜合保險索償申請表
Min Xin (Macau) Personal Accident Comprehensive Insurance Claim Form

索償申請表請電郵至 macaucs@mxic.com.hk 或傳真: 2830 5600

請 閣下於意外發生後填妥本表格並連同下列所需文件於索償事由發生30天內一併交回本公司理賠部。本公司會保留權利在需要時要求閣下提供額外之有關索償資料及文件。發出此索償申請表不代表本公司已承認賠償責任。
Completed claim form must be given to the Company within 30 days from the date of accident together with the following supporting documents. We reserve our right request additional information / documents when needed. The issue of this claim form is not an admission of liability on the part of our Company

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I. 保戶 / 受保人 / 索償人資料 INFORMATION OF POLICY HOLDER / INSURED PERSON / CLAIMANT

投單持有人
Policyholder: _____ 保單號碼 Policy No. _____

受保人
Insured Person: _____ 澳門身份證號碼 Macau ID No. _____ 性別 Sex_____

出生日期
Date of Birth: _____ 聯絡電話號碼 Contact Telephone No. _____

住所/家居地址
Residential Address: _____

僱主名稱
Name of Employer: _____ 職業 Occupation:_____

索償人
Claimant: _____ 澳門身份證號碼 Macau ID No. _____

索償人與受保人關係
Relationship between Claimant and Insured Person: _____

II. 意外詳情 DETAILS OF ACCIDENT

意外日期 / 時間
Date / time of accident _____ 意外事件發生之確切地點 Place of accident _____

請詳述意外如何發生
Describe how the accident occurred in details_____

_____

_____

_____

在事發當時傷者所作何事
What was the injured person doing at the time of accident _____

_____

_____

_____

III. 意外結果 RESULT OF ACCIDENT

受傷部位 Part of body injured:	受傷性質及受傷程度 Nature of injury and Degree or Severity of injury:	
☐ 右手 Right hand	受傷性質 Nature of injury:	受傷程度 Degree or Severity of injury
☐ 左手 Left hand	☐ 扭傷 sprain	
☐ 腳 leg	☐ 骨折 fracture	
☐ 頭 head	☐ 撞傷 contusion	
☐ 眼 eye	☐ 割傷 laceration	
☐ 其他 others _____ (請說明 please specify)	☐ 燒傷 burns	
	☐ 其他 others _____ (請說明 please specify)	

傷者是否曾經在同一部位受傷？ ☐是 ☐否
Has the injured person previously suffered from injury to the same Part? ☐Yes ☐No

如有，請詳述
If yes, please give details: _____

IV. 索償項目、金額及所需索償文件 CLAIMED ITEM, AMOUNT & SUPPORTING DOCUMENTS

索償項目 CLAIMED ITEM	所需索償文件（請打✓） SUPPORTING DOCUMENTS (Please ✓)	索償金額 CLAIMED AMOUNT
意外死亡 Accidental Death	☐ 死亡證 Death certificate ☐ 法醫官報告/ 驗屍報告 Coroner's Report/ Post-mortem Report ☐ 法院宣佈受保人假設死亡的證明 (如屬失蹤) Presumption of death as proclaimed by a court (in the event of disappearance) ☐ 警方報告 (如適用者) Police report (if applicable) ☐ 身故保險金受益人的身份證件或其他相關類似證明，以及受益人關係證明 Identity documents of the beneficiary and relationship proof	
永久完全或部份傷殘、燒傷及/或骨折 Permanent Total or Partial Disablement, Burns, and/or Broken Bones	☐ 醫生發出之有關傷殘程度證明 Certificate issued by a Registered Medical Practitioner certifying the degree or severity of disability ☐ 警方報告 (如適用者) Police report (if applicable)	
意外醫療費用 Accidental Medical Expenses	☐ 經醫生證明的診斷及治療，包括受保人的姓名、症狀、診治日期及收據 Diagnosis and treatment, including Insured Person's name, diagnosis and date of diagnosis, certified by a Registered Medical Practitioner, and receipt ☐ 詳列各項費用之診所或醫院正本賬單 Original receipt with itemized list/ receipts issued by clinic or Hospital	

V. 其他資料 OTHER INFORMATION

警署名稱
Name of Police station _____ 案件編號 Case Ref: _____

主診醫生
Name of attending physician: _____ 聯絡電話號碼 Contact telephone No: _____

醫院/診所名稱及地址
Name of Hospital/ Clinic and address: _____

_____

首次就診日期
Date of first treatment _____

傷者完全失去工作能力的期間
State the period during which the injured person has been totally disabled from attending to his/her normal occupation

由 From _____ 至 To _____
日 Day / 月 Month / 年 Year　　日 Day / 月 Month / 年 Year

傷者現在是否仍然完全喪失工作能力？ ☐ 是 ☐ 否
Is the injured person still totally disabled? ☐ Yes ☐ No

如否，傷者何日恢復工作能力？
If no, from what date was the injured person able to return to his/her occupation?

_____

有否其他保險的保障? ☐ 有 ☐ 否
Any other Insurance covering this event? ☐ Yes ☐ No

如有，請隨表附上該保險單的保單號碼、保險公司名稱、副本及賠償記錄。
If yes, please provide the policy no., name of insurance company, copy of the policy and the respective claim/payment record.

保單號碼
Policy No. _____ 保險公司名稱 Name of Insurance Company: _____

注意： 1. 所有醫療報告或意外証明，需由申索人自費提供。
2. 如需要更多空間填寫，可另加紙張，並須附有簽署。

Noted: 1. Any documentary proof of accident and/or other reports shall be furnished at the expenses of the Claimant.
2. If more space is required, please write on a separated sheet and sign your name on a separated sheet.

聲明及授權書Declaration and Authorization

1. 本人/吾等謹此聲明，本人/吾等確信，以上所填報之資料及所列各項之事件乃屬完全真確並無對保險公司作任何資料之保留。
   I/We declare that all information and particulars contained above are true and complete to the best of my knowledge and belief and they are made without reservation of any kind.
2. 本人/吾等授權於任何曾替本人/吾等作診療之醫生、醫務人員、醫院或診所提供有關本人/吾等病歷之資料予**閩信保險有限公司**（「**本公司**」）或其代理人。
   I/We hereby authorize any physician, medical practitioners, hospitals or clinics by whom or where I/We have been observed or treated to give full particulars about my/our health to the **Min Xin Insurance Company Limited** (**"Company"**) or its agents.
3. 此授權書之影印本亦屬有效。

A photocopy of this authorization shall be considered as effective and valid as the original.

收集個人資料聲明 Personal Data Collection Statement

1. 閣下提供的資料，為**本公司**提供保險業務所需，並可能使用於下列目的：
   The information you provide to the **Company** is collected to carry on insurance business and may be used for the purpose of
   - 任何與保險或財務有關的產品或服務或該等產品或服務的任何更改、變更、取消或續期
     Any insurance or financial related product or service or any alternations, variations, cancellation or renewal of them;
   - 處理任何對客戶的索償、訴訟及/司法程序；以及行使本公司的權利（詳情見適用保單條款所定），包括但不限於代位權；
     To manage any claim, action and/or proceedings brought against the customers, and to exercise the Company's rights as more particularly defined in applicable policy wording, including but not limited to the subrogation right;
   - 任何索償或索償分析及可能轉移予現存或不時成立的任何有關的公司或任何其他從事與保險或再保險業務 有關的公司或與保險業務有關的中介人或索償或調查或其他服務提供者或任何保險公司的協會或聯會。
     Any claim or analysis of it. and may be transferred to any related business partners, companies carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business or any association or federation of insurance companies that exists or is formed from time to time.
2. 所有客戶均有權以書面向**本公司**要求查閱、修正及/或更改由**本公司**所持有有關其本身的任何個人資料。
   All customers have the right to access to, correct, or change any of their own personal information held by the **Company** by request in writing to the **Company**.

_____	_____
保單持有人(如屬公司請印章) / 父母 / 合法監護人簽署 (適用於受保人未滿18歲) Signature of Policyholder (with Company chop if applicable) / / Parent / Legal Guardian (if Insured Person below age of 18)	受保人 / 索償人簽署 Signature of Insured Person / claimant
日期 Date:	日期 Date:

如有任何查詢，請電理賠熱線：(853) 2888 3876 傳真熱線：(853) 2830 5600
For any inquiry, please call our Claims hotline: (853) 2888 3876 Fax hotline: (853) 2830 5600

請將此表格連同一切有關文件交回：
Please return this form together with supporting documents to:

閩信保險有限公司 (澳門分行)
澳門羅保博士街1-3號澳門國際銀行大廈11樓G-H座
理賠部
Min Xin Insurance Company Ltd (Macau Branch)
11/F., G-H Luso Int'l Bank Bldg., No. 1-3 Rua Dr. Pedro Jose Lobo, Macau
Claims Department
電話 Tel: (853) 2888 3876 傳真Fax: (853) 2830 5600 網址Website: www.mxic.com.hk

Certificate of Medical Attendant

To be completed in full by an attending registered medical practitioner

Name of Patient: _____ Macau ID No.: _____ Age: _____

1. Date of accident: _____
2. Diagnosis: _____
3. Are you the above patient's usual medical attendant? ☐ Yes ☐ No
4. When was the first time you attended to the patient? _____
5. When did the patient first consult you in relation to the injury concerned? _____
6. What are the details of the injury _____

   _____
7. Are the symptoms/injury exclusively due to the accident? ☐ Yes ☐ No

   If not, please elaborate _____
8. Was the patient under the influence of intoxicants at the time of accident? ☐ Yes ☐ No
9. What are the details of the medical treatment given? _____

   _____
10. Was other medical treatment or examination required? (If yes, please give details) ☐ Yes ☐ No

    a) Hospitalization? _____

    b) X-rays? _____

    c) Special diagnostic procedures? _____

    d) Surgery? _____
11. Is the patient still under your care for the injury? ☐ Yes ☐ No

    If yes, please state his/her current condition _____

    _____
12. Period of total disablement: From _____ to _____
    (i.e. wholly prevented from attending to his/her usual employment or occupation)
13. Period of partial disablement: Form _____ to _____
    (i.e. prevented from attending to a substantial portion of his/her present business)
14. Will the patient sustain any permanent disablement? _____

    Please state the percentage of permanent total disablement: _____
15. If burns injury, please state the percentage of body surface suffered: _____

I hereby certify that the above statements are true and correct to the best of my knowledge and belief.

Signature and chop: _____ Tel No.: _____

Name: _____ Date: _____