Generali Life (Hong Kong) Limited

Assicurazioni Generali S.p.A.
Hong Kong Branch

21/F, Cityplaza One, 1111 King's Road,
Taikoo Shing, Hong Kong
T +852 2521 0707
F +852 2521 8018
info@generali.com.hk
generali.com.hk

忠意人壽（香港）有限公司

忠意保險有限公司
香港分行

香港英皇道 1111 號
太古城中心一期 21 樓
電話 + 852 2521 0707
傳真 + 852 2521 8018
info@generali.com.hk
generali.com.hk

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 BYTHE 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。

Name of the Patient (Insured) 病人（受保人）姓名		HKID Card / Passport No. 香港身份證 / 護照號碼	

Patient's occupation and exact nature of duties
病人的職業及確實職務

Details of the disability
傷殘的詳情

First consultation date for this disability
就此傷殘的首次求診日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年)

Start date of this disability
是次傷殘的開始日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年)

Cause of disability 導致傷殘的原因 ☐ Due to accident 因意外導致 ☐ Due to illness 因疾病導致

Final diagnosis
最終確診 _____

Last consultation date for this disability
就此傷殘的最後求診日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年)

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
意外日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年) Place 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 _____

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
病徵首次出現日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年)

Chief complaints / symptoms
主訴 / 病徵 _____

Underlying cause for the diagnosis
引起確診結果的主因 _____

Previously treated for same/related disorder? ☐ Yes (please provide details) 是（請提供詳情） ☐ No 否
是否曾因同類或相關疾病接受治療？

_____

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？

☐ Yes (please check appropriate and give details) 是（請選擇適當情況及提供詳情） ☐ No 否

- ☐ Self-inflicted condition or suicide 自殘情況 / 自殺
- ☐ Under influence of alcohol or other psychoactive substances 受酒精或精神藥物影響
- ☐ Involvement in high risk activities 高危活動
- ☐ Past injury or illness 過往受傷 / 疾病
- ☐ AIDS and/or other sexually transmitted disease 愛滋病或其他性病
- ☐ Psychological condition 心理因素

Please provide details
請提供詳情 _____

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？	☐ Yes (please provide details) 是（請提供詳情） ☐ No 否 Period of Hospitalization 住院時期 _____ Name of Hospital 醫院名稱 _____ Any surgery performed during hospitalization? ☐ Yes (please provide details) ☐ No 住院期間是否有進行手術？ 是（請提供詳情） 否 Date of surgery (dd/mm/yyyy) 手術日期 _____ / _____ / _____ (日/月/年) Name of surgery 手術名稱 _____ Other treatment & investigation 其他治療及檢查 _____ Treatment plan after discharge 出院後治療安排 _____
Had the patient previously referred by other physician? 病人是否經其他醫生轉介？	☐ Yes (please provide name & address of the doctor) 是（請提供醫生姓名及地址） ☐ No 否
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	
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。 *Please provide supporting documentation.* *請提供證明文件。*	☐ No limitation of functional capacity & capable of heavy work without restriction 能夠從事任何體力勞動工作 ☐ Capable of medium manual activity 能夠從事中度體力勞動工作 ☐ Slight limitation of functional capacity & capable of light manual work only 只可從事輕度體力勞動工作 ☐ Moderate limitation of functional capacity & capable of clerical / admin work 只可從事非體力勞動或文書工作 ☐ Severe limitation of functional capacity, incapable of minimum activity 不可從事任何勞動或文書工作 Remarks 備註 _____
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。	From (dd/mm/yyyy) 由 (日/月/年) To (dd/mm/yyyy) 至 (日/月/年) ☐ Unable to perform **ALL** tasks of the original duty 不能從事原來工作的**所有**職務 _____ _____ ☐ Unable to perform **PARTS** of the original duty 不能從事原來工作的**部份**職務 _____ _____ ☐ Unable to perform **ANY occupation** 不能從事**任何工作** _____ _____ Remarks 備註 _____
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 / 或延長康時間？	☐ Yes (please provide details) 是（請提供詳情） ☐ No 否
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？	☐ Yes (please provide name & address of the doctor) 是（請提供醫生姓名及地址） ☐ No 否
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、慢性或先天疾病？	☐ Yes (please provide details) 是（請提供詳情） ☐ No 否
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？	☐ Yes (please provide details) 是（請提供詳情） ☐ No 否 ☐ Smoking 吸煙 ☐ Drinking 飲酒 ☐ Drug taking 服用藥物 Duration 持續時間 _____ Consumption per day 每天用量 _____

Please list details of all medical conditions (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況詳情（除上述已提及外）。	Consultation date 求診日期	Complaints/Symptoms 主訴 / 病徵	Diagnosis 確診	Treatment given 所提供治療
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Any additional information you consider relevant to this claim. 其他與是次索償有關的資料。				

Declaration 聲明

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.

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。

Name of Attending Physician / Specialist and Qualifications
主診 / 專科醫生姓名及資歷

Address and Contact No.
地址及聯絡電話號碼

Signature of Attending Physician / Specialist (with chop)
主診 / 專科醫生署名（蓋印）

Date (dd / mm / yyyy)
日期 (日 / 月 / 年)