中國人壽 CHINA LIFE | 海外

身故賠償申請表 DEATH CLAIM FORM

保單號碼 Policy No.										

第三部份 – 主診醫生報告書 (由主診醫生填寫，所有費用由索償人自行承擔)
PART III – ATTENDING PHYSICIAN'S STATEMENT(To be completed by attending physician at the Claimant's own expenses)

A. 死者資料 PARTICULARS OF DECEASED

死者姓名 Name of Deceased

身份證/護照號碼 I.D / Passport No.

身故時報稱住址 Deceased's Address at time of death

身故時報稱職業 Occupation at the time of death

最後工作日期 Last date of working — 年 Year / 月 Month / 日 Day

身故地點 Place of death

身故日期 Date of death — 年 Year / 月 Month / 日 Day

身故原因 Cause of death

是否已經或將會進行驗屍？如有，請提供解剖驗屍日期和報告副本。Whether an autopsy report will be or has been done? If so, please provide the date and a copy of autopsy report.

☐ 沒有 No ☐ 不確定 Uncertain ☐ 有,日期 Yes, date — 年 Year / 月 Month / 日 Day

B. 診治資料 CONSULTATION DETAILS

1 閣下為死者診症多久了？How long have you been the medical physician for the Deceased?

2 首次診治診斷結果及日期 Diagnosis and Date of your first visit — 診斷 Diagnosis; 年 Year / 月 Month / 日 Day

3 閣下有否替死者診治與其身故原因相關之最後疾病？ Had you attend the deceased during his/her last illness related to the cause of death? ☐ 是 Yes ☐ 否 No

C. 由意外導致身故 DEATH CAUSED BY ACCIDENT

1 意外日期和時間 Date and time of accident — 年 Year / 月 Month / 日 Day; 時 Hr : 分 Min; 上/下午 AM/ PM

2 意外地點及詳情 Place and Details of accident

D. 由疾病導致身故 DEATH CAUSED BY ILLNESS

1 死者最後疾病的診斷結果及首次求診日期 The first treatment date of the for the last illness — 診斷 Diagnosis; 年 Year / 月 Month / 日 Day

2 死者最後疾病在求診前已存在多久? How long did the deceased suffer from the last illness before seeking medical treatment?

3 治療摘要 Medical Treatment Summary

4 死者是否經由其他醫生或醫院轉介? 如有，請說明詳情。Had the Deceased been previously referred by other Physician / Hospital? If so, please specify details.

☐ 沒有 No ☐ 有，醫生姓名/醫院名稱 Yes，Name of Physician / Hospital

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5 身故原因是否與舊病復發或其他慢性/嚴重疾病有關? 如有，請說明詳情。Was the cause of death secondary to a recurrent or other chronic / critical condition? If so, please specify details.

☐ 沒有 No ☐ 有 Yes 首次求診 First consultation 年 Year ____ 月 Month ____ 日 Day ____

首次徵狀出現 Symptom onset 年 Year ____ 月 Month ____ 日 Day ____

疾病 Disease ____

治療/住院詳情 Details of Treatment / Hospitalization ____

醫生姓名/醫院名稱 Name of Physician/Hospital ____

6 死者是否因以下原因，直接或間接引致或加劇死亡? Was the Deceased's death directly or indirectly due to or aggravated by the following?

☐ 不是 No ☐ 是，請在適當的位置上剔號及提供詳情 Yes, please tick where it is appropriate and give details

☐ 家族病史 unfavorable family health history

☐ 酗酒 / 酒精 / 毒品 / 藥物 alcoholism / alcohol / narcotics / drugs

☐ 精神紊亂 mental disorders

☐ 參與危險性運動 / 活動 / 職業 engaging in hazardous sport / activity / occupation

☐ 中毒 / 氣體 / 濃煙 (自願或非自願)poison / gas / fumes (voluntarily or involuntarily)

☐ 如有其他，請說明: others, please specify:

☐ 先天 / 遺傳性情況 congenital / inherited condition

☐ 後天免疫力缺乏症 / 與後天免疫力缺乏症相關的綜合症 AIDS / AIDS related complex disease

☐ 妊娠 / 分娩 pregnancy / childbirth

☐ 自殺 / 自我傷害 suicide / self-inflicted

E. 其他醫療病史 OTHER MEDICAL HISTORY

1 死者的飲酒/吸煙習慣 Details of drinking & smoking habit of the deceased

每日用量 (支/包/樽/罐) Daily consumption (piece/ pack/ bottle/ can) ____

習慣始自 Drinking/ Smoking start date since 年 Year ____ 月 Month ____ 日 Day ____

2 死者之死亡是否由飲酒之習慣促成？Did the drinking habit contribute to the death of the Deceased? 是 Yes ☐ 否 No ☐

3 死者之死亡是否由吸煙之習慣促成？Did the smoking habit contribute to the death of the Deceased? 是 Yes ☐ 否 No ☐

4 死者是否有使用藥物之習慣？如有，請陳述藥物之類別，每日用量及以維持多少年。Did the Deceased use of any drugs? If yes, please state the type of drugs used and also the no. of years of this habit. 是 Yes ☐ 否 No ☐

每日用量 Daily consumption ____ 藥物類別 Type of drugs ____

用藥始自 Using drugs start date since 年 Year ____ 月 Month ____ 日 Day ____

5 請詳述其他直接或間接導致死者身故之特殊因素，包括死者之其他習慣及其職業。Please state any other special cause, direct or indirect, for the death in the habits or occupation of the Deceased.

6 其他閣下認為可幫助我們審理此賠償之資料。Any further information which, in your opinion, will assist us in assessing this claim.

F. 主診醫生資料及聲明 ATTENDING PHYSICIAN'S PARTICULARS AND DECLARATION

本人謹此聲明，就本人所知所信，上述由本人提供的資料均為事實之全部，並確實無訛。I HEREBY DECLARE that all the information provided by me in this form is true and correct to the best of my knowledge and belief.

主診醫生姓名 Name of Attending Physician		**資歷 Qualification**			
地址 Address		**聯絡電話 Contact No.**			
主診醫生簽署及醫院/診所蓋章 Signature of Attending Physician and Stamp of Hospital / Clinic		**日期 Date**	年 Year	月 Month	日 Day