Accident Dismemberment Claim - Attending Physician's Statement
意外傷殘賠償 – 醫生報告

Please print in **BLOCK** letters/ 請以**正楷**填寫

(To be completed by the attending Physician 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。)

Policy No. 保單號碼	Name of Patient 病者姓名	
Occupation 職業	I.D. No. 身份証號碼	Date of Birth 出生日期

1. Medical History / 醫療紀錄

(a) When and How did the accident happen?
意外日期及意外經過?

(a) (/ /)
DD/MM//YY 日/月/年

(b) When did the patient ceased work because of disability?
病者何時開始因此傷殘而不能工作?

(b) (/ /)
DD/MM//YY 日/月/年

(c) Has the patient ever had same or similar condition?
病者過往有否患上同類或類似之情況?
If 'Yes", please state when and describe/ 若'是',請詳列患病日期及情況。

(c) Yes/是☐ No/否☐

(d) Is condition due to injury arising out of patient's employment?
病者之傷殘是否因其工作而引起?

(d) Yes/是☐ No/否☐

(e) Name(s) and address(es) of other attending Physicians/ 其他主診醫生姓名及地址

Date 日期	Physician's Name or Hospital's Name 醫生姓名或醫院名稱	Address 地址

2. Diagnosis / 診斷

(a) Date of first examination / consultation? 首次檢驗/求診日期?

(a) (/ /)
DD/MM/YY 日/月/年

(b) Date of last examination / consultation? 最後檢驗/求診日期?

(b) (/ /)
DD/MM/YY 日/月/年

(c) Diagnosis (Please state the part of the injured areas) 診斷(請詳述受傷部位)

(d) Was there any external and visible evidence of injury? If yes, please state the type of injury. 是否有外部及可見之損傷? 如是，請詳述其受傷種類。

(e) Please describe the patient's Present Condition. What are the **degree and range of movement** of the injured areas? 請詳述病者之現時情況 **(包括其受傷部位之移動程度及範圍)**

3. Dates of Treatment 治療日期

(a) Date of first visit / consultation / / (DD/MM/YY)
首次就診日期 / / (日/月 /年)

(b) Date of last visit / consultation / / (DD/MM/YY)
最後就診日期 / / (日/月 /年)

(c) Frequency 就診頻率 ☐ Weekly 每週 ☐ Monthly 每月 ☐ Other(specify) 其它(請說明) _____

4. Did the patient require having any further operation or continuously treatment? If yes, please give details.
病者是否需要再次進行手術或接受長期治療? 如是，請詳述。

5. **Physical Impairment (If applicable) 身體狀況(如適用)**

☐ No Limitation of functional capacity; capable of heavy work. No restriction.
無任何功能之限制,可以作體力勞動。無限制。

☐ Capable of medium manual activity.
可作中量之勞動。

☐ Slight limitation of functional capacity; capable of light work.
輕度之功能受限,可作輕度工作。

☐ Moderate limitation of functional capacity; capable of clerical /administrative (sedentary) activity.
中度功能受限,可作文書工作。

☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity. 重度功能受限,不能作任何工作。

☐ Remarks:
其它

6. **Prognosis 預斷病情**

(a) Is the patient now totally disabled
病人是否完傷殘? ☐ Yes 是 ☐ No 否

(b) What duties of the patient's job is he/she incapable of performing/ 在病人的工作中,他/她有何種職務不能執行?

(c) When will the patient recover sufficiently to return to USUAL occupation? If 'Never' or 'Unknown', please comment.
病人將在何時康復並從事原來職業? 若答案是'永不'或'未知', 請解釋。
☐ 1 Month 1 個月 ☐ 1-3 Months 1-3 個月 ☐ 3-6Months 3-6 個月 ☐ Never 永不 ☐ Unknown 未知

7. According to your opinion, any information will be assisting us in processing this claim? Please specify.
根據閣下的意見，是否有其他資料可以協助我們處理是次賠償? 請詳述。

8. Do you consent the ING Medical Director to explain our claim decision? and/or claim assessor to release the information provided by you in this report to the patient when we are requested by the patient.
閣下是否同意當病人有需要時，本公司之醫務人員或賠償批核員可透露閣下所提供之資料，以作解釋有關之賠償決定。
☐ Yes 是 ☐ No 否

Signature and chop of Attending Doctor 主診醫生簽名及蓋章:	Date (DD/MM/YY) 日期 (日/月/年)
Name of Attending Doctor 主診醫生姓名	Qualification 資歷
Address 地址	Telephone No. 電話號碼: