聯豐亨人壽
Luen Fung Hang Life

死亡索償申請書
Death Claim Form

保單號碼 Policy No.	

第二部份 - 醫生診斷報告(索償人自費由主診醫生填寫)
PART II - ATTENDING PHYSICIAN'S STATEMENT (to be completed by attending physician at claimant's expense)

1.	Name of Deceased 死者姓名		Age / Sex 年齡/性別		ID Card No. 證件號碼	

2.	Date and Time of death 死亡日期和時間	YYYY 年 / MM 月 / DD 日 ☐ a.m. 上午 ☐ p.m. 下午	Place of death 死亡地點	
	Cause of death 死亡原因			
	Underlying diseases 潛在疾病			
	Complications 併發症			

3.	a. Date of your first consultation 首次求診日期	YYYY 年 / MM 月 / DD 日	Date when symptoms first appeared or accident happened 首次出現病徵或發生意外的日期	YYYY 年 / MM 月 / DD 日

b. What did the deceased first complain of in relation to the stated cause of death? 死者在最初自訴與死亡原因相關的情況是什麼？

c. If the death was caused by an accident, was there evidence of an external and visible bruise or wound at first visit? ☐ Yes 是 ☐ No 否
Please describe which part of the body injured and the cause, character and extent of the injury.
如是意外死亡，首次診治時有否外部及表面之受傷痕跡？請詳述身體受傷部位和原因，以及受傷的特徵和程度。

d. According to the deceased, has he/she been having same or similar conditions or symptoms before? If yes, please give details. ☐ Yes 是 ☐ No 否
按照死者情況，他/她過往是否有相同或類似的狀況或病徵？如是，請提供詳情。

Date of occurrence 發生日期 (YY 年/MM 月/DD 日)	Exact Nature/Cause of Attack 性質/原因	Test/Treatment received 曾接受的檢查/治療	Duration of Disability 殘障持續時間	Physician Attended 主診醫生

e. In your opinion, has the deceased ever had same or similar conditions or symptoms before? If yes, please give details. ☐ Yes 是 ☐ No 否
根據閣下所知，該死者過往是否有相同或類似的狀況或病徵？如是，請提供詳情。

f. Diagnosis 診斷

Underlying cause of diagnosis 病因

Date of diagnosis 確診日期
YYYY 年 / MM 月 / DD 日

g. Has the deceased received any surgical procedure, medical treatment and laboratory tests? ☐ Yes 是 ☐ No 否
死者是否接受過任何外科手術，藥物治療和檢測？
(such as X-ray, CT scans, ultrasound or other imaging studies, ECG, etc.(如 X 光檢查，CT 掃描，超聲波或其他影像學檢查，心電圖等)
If yes, please give details and provide us with a set of the results if available. 如是，請給予詳情以及請提供一系列檢查結果。

Date Performed 進行日期 (YY 年/MM 月/DD 日)	Details of Procedure/Treatment/Test (type, frequency, result/readings) 手術程序/治療/測試的詳情(類型，次數，結果/讀數)	Physician Attended / Hospital Confined 主診醫生/醫院

h. Are you the deceased's usual physician? 閣下是否為死者的常規醫生？ ☐ Yes 是 ☐ No 否
Please list down the date and details of each visit of the deceased to your clinic/ hospital in the order of dates.
請按日期順序列出死者到閣下的診所/醫院的日期和詳情。

Consultation Date 求診日期 (YY 年/MM 月/DD 日)	Complaints 主訴	Diagnosis 診斷	Treatment/Physiotherapy (Length of Course) 治療/物理治療(療程)

i. When and by whom was the disease first diagnosed? Please give details below. 該疾病首次求診的日期及主診醫生姓名？請在下面提供詳細信息。
Other physicians who had treated the deceased for same/related conditions or for any other serious disorders. Please give details below.
其他曾為死者就相同/相關疾病或任何其他嚴重疾病治療的醫生，請於下面提供詳情。

Consultation Date 求診日期 (YY 年/MM 月/DD 日)	Diagnosis (if any) 診斷(如有)	Name and Address of physicians/hospitals 醫生/醫院的姓名和地址

4. Was the death of the deceased caused by or in any way associated with any of the following? Please tick where appropriate and give details.
死者的死因是否由於下列情況所引致? 請選擇並提供有關資料.。

☐ Past injury or illness 故有病史
☐ Suicide or self-inflicted injury 自殺或自致之傷害
☐ Smoking 吸煙
☐ Alcohol or drugs 酒精或毒品
☐ HIV/AIDS related illness 愛滋病相關的疾病
☐ Others 其他
☐ Mental or nervous disorder 精神或神經疾病
☐ Congenital deformities or anomalies 先天性畸形或異常
☐ Childbirth or pregnancy 分娩或懷孕
☐ Family Health History 家庭健康史
☐ Poisons, gas or fumes 吸入毒藥，瓦斯或濃煙

Details 詳情:

5. Any further information you consider relevant to this claim 任何與此索償有關之進一步資訊。

I hereby declare that the information given on this form is true and complete to the best of my knowledge and belief.
本人特此聲明，本人以所知和所信地完成此表格，以及所提供的信息是真實的。

Name & Qualification of Attending Physician 主診醫生的姓名和授權

Signature and Chop of Attending Physician 主診醫生簽字和蓋章

Date (YY/MM/DD) 日期 (年/月/日)

Address 地址

Telephone No.電話號碼