中国太平 CHINA TAIPING

中國太平人壽保險(香港)有限公司
CHINA TAIPING LIFE INSURANCE(HONG KONG)COMPANY LIMITED

保單號碼 Policy Number

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傷殘賠償申請表 第二部份 主診醫生報告
APPLICATION FOR DISABILITY CLAIM PART II ATTENDING PHYSICIAN'S STATEMENT

(申請人自費由主診醫生填寫 To be completed by the Attending Physician at the Claimant's own expenses)

受保人(病人)之資料 Particulars of the Insured ("Patient")

病人姓名 Name of Patient		性別 Gender	
出生日期 Date of Birth		年齡 Age	
香港身份證號碼 HKID Card No.		護照號碼及發出地 Passport No. and Place of Issuance (if no HKID Card)	
病人之職業、職位及負責職務 Insured's Occupation, Position and Nature of duties		最後工作日期 Date of Absence from work (日 DD/月 MM/年 YYYY)	

1 臨床資料 Clinical details

(a)	病人之醫療紀錄自 Medical records of Patient since (日 DD/月 MM/年 YYYY)	(b)	病人是否由其他醫生轉介？如是，請提供： Was the patient referred by other physician? If yes, please give: 醫生姓名 Name of referring Doctor / 聯絡資料 Contact Information
(c)	病徵首次出現 / 意外日期 The date when symptoms 1st appeared / accident happened (日 DD/月 MM/年 YYYY)	(d)	病人主訴的病徵或徵狀 Symptoms presented during by the Insured
(e)	上述病況的首次求診日期 Date of first consultation for this disability (日 DD/月 MM/年 YYYY)	(g)	診斷結果 Final Diagnosis
(f)	診斷日期 Date of diagnosis (日 DD/月 MM/年 YYYY)		

2 意外詳情及治療紀錄 Accident details and Treatment records

2.1 適用於〝喪失功能 / 肢體切除〞For Loss of Function / Amputation of Limbs

(a)	受傷部位及類別 Part of body injured & Type of Injury	(b)	病人是否左手慣用者？ Is the Insured left-handed? ☐ 是 Yes ☐ 否 No
(c)	受傷原因 Cause of injury	(d)	受傷程度(請列出可活動能力數據/喪失功能百分比/斷肢位置及範圍) Extent of injury (please specify ROM of affected joint / % of functional loss of the injured body part / site & extent of amputation)
(e)	現時受傷程度、總體情況及功能狀況 Overall present condition of Injury and Functionality of part of body Injured	(f)	該身體缺陷/喪失功能情況是否屬永久性的損害？如是，請闡述理據。 Do you think the impairment or loss of function mentioned would be Permanent? If so, please elaborate your medical opinion.

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2.2 適用於〝喪失說話能力 / 失聰〞 For Loss of Speech / Loss of Hearing

(a)	受傷部位及類別 Part of body injured & Type of Injury	(b)	導致喪失說話能力、失聰之原因 Cause of loss of speech or hearing loss
(c)	說話能力受損程度及喪失功能的持續時段 Extent of speech inability & Duration of loss of function	(d)	聽覺受損程度及喪失功能的持續時段 Extent of hearing loss & Duration of loss of function 左耳 Left Ear　　右耳 Right Ear
(e)	現時受傷程度、總體情況及功能狀況 Overall present condition of Injury and Functionality of part of body Injured	(f)	該喪失功能情況是否屬永久性的損害？如是，請闡述理據。 Do you think the loss of function mentioned would be Permanent? If so, please elaborate your medical opinion.

2.3 適用於〝喪失視力 / 眼球晶體〞 For Loss of Sight / Lens

(a)	受傷部位及類別 Part of body injured & Type of Injury	(b)	導致失明之原因 Cause of blindness
(c)	現時雙眼的視力程度 Visual acuity of Both Eyes at present 左眼 Left Eye　　右眼 Right Eye	(d)	手術治療詳情 Details of Surgical procedure / Treatment
(e)	現時受傷程度、總體情況及功能狀況 Overall present condition of Injury and Functionality of part of body Injured	(f)	該喪失功能情況是否屬永久性的損害？如是，請闡述理據。 Do you think the loss of function mentioned would be Permanent? If so, please elaborate your medical opinion.

2.4 適用於〝三級燒傷〞 For Third Degree Burn

(a)	燒傷部位及類別 Part of body burned & Type of Injury	(b)	燒傷原因 Cause of major burns
(c)	燒傷程度是否屬於第三級燒傷(皮膚全層燒傷)？ Is the burn considered as Third Degree Burns (full thickness skin destruction)? □ 是 Yes　□ 否 No	(d)	身體表面燒傷之程度(百分比) Extent of the burn covering the body surface (in %)
(e)	現時燒傷程度、總體情況及身體缺陷狀況 Overall present condition of Burn and current physical impairment	(f)	手術治療詳情 Details of Surgical procedure / Treatment

3 傷殘詳情及健康紀錄 Disability details and Health condition records

(a) 請提供此傷病的所有求診及檢驗詳情(請提供報告包括磁力共振掃瞄或電腦斷層掃瞄檢查等)。
Please provide all the consultation history and diagnostic test(s) of this disability (please enclose reports including MRI or CT brain etc).

日期 Date (DD/MM/YYYY)	醫生/醫院資料 Information of Doctor/Hospital	檢驗項目及結果 Type(s) of Test & Result(s)

(b) 請提供此傷病的所有治療詳情包括日期、手術 / 療法 / 藥物名稱。
Please provide all the treatment details of this disability includes Date & Name of Surgery / Therapy / Medication.

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(c) 請詳述病人現時之身體缺陷/損害 或 精神缺陷/損害之情況。
Please describe Patient's current physical or mental impairment.

(d) 受保人現時的健康狀況 Current Health Conditions of the Insured：

(i) 康復進度 Progress of recovery：
□ 完全康復 Recovered □ 康復中 Improving □ 情況穩定 Static □ 情況惡化 Retrogressed

(ii) 活動日常 Status of mobility：
□ 行動自如 Ambulatory □ 家中活動 Home confined □ 家中臥床 Stay on bed □ 需住院/康復中心 Hospital / Rehab. Confined
醫院/中心名稱及住院日期 Name of Hospital/Centre & the period of confinement：

(iii) 按日常生活活動評估，受保人在不受輔助下，可否完成下列的事項？
Can the Insured perform the following 'Activities of Daily Living' without the use of mechanical equipment, special devices or other aids and adaptations?

• 上下床或從椅子坐起 Transfer (to get in bed and out of bed or chair) ：	□ 可以 can	□ 不可以 cannot
• 行動 Mobility：	□ 可以 can	□ 不可以 cannot
• 穿衣Dressing：	□ 可以 can	□ 不可以 cannot
• 洗澡及梳洗 Bathing & Washing：	□ 可以 can	□ 不可以 cannot
• 進食 Eating：	□ 可以 can	□ 不可以 cannot
• 如廁 Toileting：	□ 可以 can	□ 不可以 cannot

(iv) 就受保人現時之健康狀況而言，請評估其工作能力。
With the current health condition of the Insured in mind, what would you rate the present working capacity of the insured?
□ 能夠從事任何體力勞動工作
No limitation of functional capacity, capable of heavy work without restrictions
□ 能夠從事中度體力勞動工作
Capable of medium manual activity
□ 只可從事輕度體力勞動工作
Slight limitation of functional capacity, capable of light work
□ 只可從事非體力勞動或文書工作
Moderate limitation of functional capacity, capable of clerical / administrative activity
□ 不可從事任何體力勞動甚或文書工作
Severe limitation of functional capacity, incapable of minimum activity

(v) 就受保人現時之精神狀況而言，請評估其社交活動及溝通能力。
With the current mental status of the Insured as described above, what would you rate the present ability for interpersonal relations and communication of the insured?
□ 社交活動及溝通能力均為完全正常
Able to engage in all interpersonal relations and communication (without limitations)
□ 能應付大部份社交活動及與人溝通
Able to engage in most interpersonal relations and communication (slight limitations)
□ 只能有限度地參加社交活動及與人溝通
Able to engage in only limited interpersonal relations and communication (moderate limitations)
□ 嚴重缺乏社交活動及溝通能力
Unable to engage in interpersonal relations and communication (marked limitations)
□ 嚴重缺乏心理、生理、個人及社會適應能力
Has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

補充資料(如有) Supplement (if any)：

(e) 根據受保人之學歷、知識及訓練，他/她現時是否**完全喪失工作能力**？請評估：
According to the insured's qualification, knowledge and training, is he/she now **totally disabled**? Please comment:

受保人現時的能力 Insured's current capability

□ 能夠從事**任何**工作或職業
Capable of performing **any** kind of work and duties
□ 只能從事**其本身**之工作或職業
Capable of performing **his / her own duties** and occupation only
□ 不能從事或參與**任何**類型的工作或職業
Incapable of performing **any** kind of work and duties

預計受保人何時能重新工作 Estimate when will the Insured able to work

	就**本身**工作而言 In terms of **own** job	就**其他**工作而言 In terms of **any** jobs
一個月內 Within 1 Mth	□	□
一至三個月內 1-3 Mths	□	□
三至六個月內 3-6 Mths	□	□
六至十二個月內 6-12 Mths	□	□
多於十二個 >12Mths 月	□	□
永不 Never	□	□

(f) 請建議任何治療 / 康復計劃；及評估將可見怎樣的明顯改善。
Please advise any further treatment / rehabilitation plan, and what would you expect a marked change in the future

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4 過往病歷 Past history

(a)	病人曾否在求診中透露其過往的醫療健康紀錄史？ Has the patient disclosed past medical health history during consultation(s)?	□ 否 No □ 是 Yes，請填寫問題(b)至(d) Please fill in question (b) to (d)
(b)	病人過去曾否患有同類病況？如有，請詳細說明。 Has the patient ever had the same or similar conditions or symptom before? If yes, please give a brief summary.	日期 Date (DD/MM/YYYY) / 醫生/醫院資料 Information of Doctor/Hospital / 疾病及治療 Disease & Details of Treatment
(c)	病人是否因任何家族病史或其他因素促使增加患上此疾病的機會？ Is there any patient's family history or any precipitating factors which would have increased the risk of this illness?	□ 是 Yes □ 否 No 請提供詳情 Please provide details：
(d)	病人過往有否右列之病歷 / 習慣？ Has the patient ever had the medical illness(es) or the habit(s) as listed on the right column?	□ 否 NO □ 是 YES，請在適當位置劃上剔號，並提供詳情 Please tick where it is appropriate and give details ○ 高血壓 Hypertension ○ 高血脂 Hyperlipidaemia ○ 心臟病 Cardiac problem ○ 哮喘 Asthma ○ 糖尿病 Diabetes mellitus ○ 乙型肝炎 Hepatitis B ○ 人類免疫力缺乏病毒感染 HIV infection ○ 曾接受手術 Previous operation ○ 其他嚴重、慢性或先天性/遺傳疾病 Other major, chronic or congenital / heredity illness _____ 詳情 Details: 診斷日期及醫生名稱 Diagnosis date and name of physician _____ 病歷之現況 Current condition of the above medical history □ 完全康復 Fully recovered □ 治療中 On Treatment _____ 病人習慣 Patient's habit： ○ 濫用藥物 Drug addiction ○ 吸煙習慣 Smoking habit ○ 飲酒習慣 Drinking habit 上述習慣始於 The above habit since (日 DD/月 MM/年 YYYY) 每日服用量 Daily consumption

5 主診醫生聲明書 Declaration of Attending Physician

主診醫生姓名 Name of Attending Physician		電話 Telephone No.	
專業資格 Field of Specialization and Qualification		電郵 Email Address	

本人謹此聲明本人曾親自為病人的病情和疾病進行了檢查、建議和治療，以上陳述是按本人專業所知所信真實及完整的填報。 我在此聲明並同意將上述陳述作為索賠表的一部分。
I hereby declare that I have personally examined, advised and treated the Patient in connection to the conditions and illnesses herein and that the foregoing statements are true and complete to the best of my professional knowledge and belief. I hereby declare and agree to make my statements above as part of the claim form.

_____
主診醫生簽署和蓋章
Signature and Official Chop of Attending Physician

_____ _____
簽署日期 Date of Signing
(日 DD/月 MM/年 YYYY)

簽署地 Place of Signing