

1. 投保客戶資料 POLICYHOLDER INFORMATION			
保單編號 Policy No.			
投保人名稱 Name of Insured			
聯絡人 Contact Person		電話號碼 Phone No.	傳真號碼 Fax No.
地址 Address			
2. 受傷僱員資料 INJURED EMPLOYEE INFORMATION			
姓名 Name		性別 Gender	
證件類別及號碼 ID Type & No.	出生日期 Date of Birth	國籍 Nationality	
地址 Address		婚姻狀況 Marital Status	
		電話號碼 Phone No.	
開始受僱之日期(日/月/年) Start Date of Employment (DD/MM/YY)	受僱形式 Type of Employment	<input type="checkbox"/> 長工 Regular employment	<input type="checkbox"/> 散工 Casual employment
受僱之職業或職責 Employed Occupation			
意外發生時正從事該等受僱之工作或職責? Engaged in this occupation when accident happened? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No			
3. 意外詳情 DETAILS OF ACCIDENT			
發生日期、時間及地點 Date, Time & Place of Incident			
事件詳細經過 Details of Incident			
傷者在意外發生時是否受酒精或藥物所影響? Was the injured person under the influence of alcohol or drugs at the time of the accident? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No			
傷者在意外發生時是否有違背指令或規則，或疏忽職守之行爲? Was the injured person in violation of any order or rule, or guilty of misconduct at the time of the accident? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No			
傷者在意外發生時是否身體虛弱、有殘障或有疾病? Was the injured person suffering from any physical infirmity, disability or sickness at the time of the accident? <input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No			
若閣下對上列問題之回應為「是」，請詳細說明 Please give details if you answer "Yes" to any of the questions above			
如意外由機器引致： For accident caused by machinery:			
a) 機器類型 Type of machinery		_____	
b) 是否設有圍欄或安全罩? Was it fenced or guarded?		<input type="checkbox"/> 是 Yes	<input type="checkbox"/> 否 No
如意外並非由機器引致： For accident not caused by machinery:			
a) 僱主是否有提供安全設施? Did the employer provide any safety measure?		<input type="checkbox"/> 是 Yes	<input type="checkbox"/> 否 No
b) 僱員是否有應用? Did the employee use it?		<input type="checkbox"/> 是 Yes	<input type="checkbox"/> 否 No
目擊者 Witnesses	姓名及身份 Name & Capacity	_____	
	電話號碼 Phone No.	_____	
	地址 Address	_____	

**4. 傷勢及康復情況 DETAILS OF INJURY AND RECOVERY**

受傷部位 Regions Injured	受傷類型 Nature of Injury
醫院、診所或醫生名稱 Name of Hospital, Clinic or Physician	
治療情況 Treatment Status	<input type="checkbox"/> 門診 Outpatient <input type="checkbox"/> 仍然留醫 Still hospitalized <input type="checkbox"/> 留醫後出院日期(日/月/年) Discharged from hospital on (DD/MM/YY)
康復情況 Recovery Status	<input type="checkbox"/> 經已全面恢復工作 Already resuming full duty <input type="checkbox"/> 僅能擔任部分原有工作 Only able to resume partial duty
受傷僱員開始停工日期(日/月/年) Date Injured Person Ceases to Work(DD/MM/YY)	受傷僱員恢復工作日期(日/月/年) Date Injured Person Resumes Work(DD/MM/YY)

**5. 受傷僱員最近三個月之收入 INCOME OF INJURED EMPLOYEE IN LAST THREE MONTHS**

月/年 Month / Year	基本薪金 Basic Salary & Wages	津貼 Allowances	雙糧及花紅 Double Pay & Bonus	合計 Subtotal
<b>總計 Total</b>				

受傷僱員在上列三個月內是否曾經停工？（如「是」，請詳述停工時期及原因）  
Has the injured employee been absent from work at any time during the 3 months above? (If "Yes", please give details of period and reason)  是 Yes  否 No

**6. 引致意外之第三者 THIRD PARTY CAUSING ACCIDENT**

受傷僱員是否有權向第三者追索？（例如肇事者之汽車保險、民事責任保險等）  
Any right of indemnity against third party? (e.g. motor or civil liability insurance of third party causing the accident)  是 Yes  否 No

第三者名稱 Name of Third Party	證件類別及號碼 ID Type & No.
地址 Address	車牌號碼 License Plate No.
	電話號碼 Phone No.
保險公司名稱 Name of Insurer	保險類型 Type of Insurance

**7. 聲明及文件 DECLARATIONS AND DOCUMENTS**

僱主獲悉意外之日期(日/月/年)  
Date Employer Informed of Accident DD/MM/YY

如非意外發生當日，請說明原因  
Reason if not on same day as accident

本人(等)聲明上述各項資料均為真實無誤且無任何隱瞞或遺漏。本人(等)明白且同意忠誠澳門保險股份有限公司(下稱“忠誠澳門”)可將本表格或從其他途徑所得關於本宗索償之資料用於保險業務用途，並可使用、儲存、透露及轉交該等資料予任何與忠誠澳門有關之人士、機構或選定之第三者，包括其他與保險或再保險業務有關之公司、中介人、理賠調查員、醫療機構、顧問、政府機關或保險業組織。

I/We declare that all the statements and particulars above are true and correct, and without any omission or concealment. I/We understand and agree that Fidelidade Macau – Insurance Company Limited (hereinafter referred to as “Fidelidade Macau”) may use any of the information related to this claim, contained herein or obtained otherwise, in its insurance business and may use, store, disclose and transfer such information to any individual or organization associated with or appointed by Fidelidade Macau, including any company carrying on insurance or reinsurance related business, intermediary, claims investigator, medical facility, advisor, government authority or industry association.

僱主簽署及公司蓋章 Signature & Company Stamp of Employer

日期 Date

**注意  
Attention**

- 法例規定僱主在獲悉發生工作意外或職業病時，須於二十四小時內通知保險公司。  
The employer is under legal obligation to inform the insurance company within 24 hours of an accident or occupational disease coming to his/her knowledge.
- 為免延誤處理索償程序，請盡快提交所有相關文件及正本單據，包括：  
To avoid any claims handling delay, please submit all relevant documents and original receipts as soon as possible, e.g.:
  - M7 醫療費收據、醫院及/或衛生中心醫藥費單據、醫療報告、化驗報告、X光報告、休假證明、康復證明等  
M7 medical receipts, hospital &/or SS Clinic medical receipts, medical report, laboratory report, X-ray report, sick leave certificate, recovery certificate, etc.
  - 受傷僱員之身份證明文件副本、出勤紀錄及糧單  
ID copy, attendance record and salary payment slip of injured employee