中國太平洋人壽保險(香港)有限公司
China Pacific Life Insurance (H.K.) Co. Ltd.

中国太平洋保险
China Pacific Insurance

保單號碼 Policy No.:_____

身故賠償申請書 （醫生報告）由主診醫生填寫 (費用由索償人支付)
Death Benefit Claim Form (Attending Physician's Statement) To be completed by the attending doctor (at claimant's expense)

死者姓名 Deceased's Name	身份證/護照 號碼 ID Card / Passport No.	年齡 Age	性別 Sex

死亡原因 Cause of Death	死亡日期 Date of Death	死亡地點 Place of Death
	(日 DD/ 月 MM/ 年 YY)	

1.	閣下首次診治死者之日期: Date of your first consultation with the deceased:	(日 DD/ 月 MM/ 年YY)
2.	死者是否經其他醫生/醫院轉介予閣下？若是，請提供其轉介原因及該醫生/醫院的名稱及地址。 Was the deceased referred to you by other doctor / hospital? If yes, please provide the reason of referral and the name and address of the referral doctor / hospital.	
3.	請詳述以上死亡原因是否由意外受傷或任何潛在疾病所引致或促成？ Please give details if there was any accident injury or underlying disease that had contributed or predisposed to the cause of death.	
4.	根據閣下記錄，引致上述死亡的病患或受傷於何時首次出現? According to your record, when was the onset date of the illness or injury that led to the above cause of death?	(日 DD/ 月 MM/ 年 YY)
5.	請總括閣下曾給予的治療、檢驗及結果。 Summary of medical treatments that you had given and all investigation tests carried out with results.	
6.	根據閣下記錄，請提供死者生前慣常求診的醫生姓名及地址(如有) 。 According to your record, please provide the name and address of the deceased's usual doctor before death (if any).	
7.	根據閣下所知，請提供死者的過往 5 年的住院紀錄，包括住院日期、醫院名稱及住院原因 (如有)。 According to your knowledge, please state the hospitalization records of the deceased in past five years including confinement date, name of hospital and reason of hospitalization (if any).	
8.	死者的家族史是否有可能增加患上引致死亡之病症的風險? Did the deceased's family history increase the risk of illness that led to the cause of death?	
9.	根據閣下所知，死者是否患有任何其他的嚴重、慢性或先天疾病？ According to your record, did the deceased suffer from any other major, chronic or congenital disease?	
10.	死者是否有酗酒、 濫用藥物習慣或任何自我傷害的行為? 如有，請提相關的求診日期及醫生/醫院名稱。 Did the deceased have the habit of drinking, drug addiction or any self-inflicted behavior? If yes, please give details of the related consultation date and name of doctors/ hospitals ever consulted.	
11.	其他備註 Other remarks	

簽署 (蓋章) Signature (with chop)

醫生姓名 (資格) Name of Doctor (with qualifications)

診所/醫院電話 Clinic / Hospital Phone No.

日期 Date (日 DD/ 月 MM/ 年 YY)

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