Total & Permanent Disablement Claim Attending Physician's Statement

傷殘賠償 - 醫生報告



Please print in <u>BLOCK</u> letters/ 請以<u>正楷</u>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.	Name of Patient
保單號碼	病人姓名
Occupation	I.D. No. / Date of Birth (dd/mm/yy)
職業	身份証號碼 / 出生日期

TOTAL AND PERMANENT DISABLEMENT	In order for the claim to be valid, the following definition must be fulfilled: The Insured resulting solely and independently of any other cause, from bodily injury caused by accidental, violent, external and visible means, and shall exclude Total Permanent Disablement cuased by sickness or disease, bacterial or viral infection. The bodily injury resulting in Accidental Total Permanent Disablement must occur while this policy is in force and while the Insured is less than 65 years of age. In addition, if an accident results in Total Permanent Disablement, such Total Permanent Disablement must occur within 90 days of the accident, in order to constitute an "Accidental Total Permanent Disablement."

Section A: General 甲部: 基本資料							
1. Are you the Insured's usual medical attendant?閣下是否被保人慣常求診之醫師? Yes 是□ No 否□							
	rst consultation date						
請提供被保人首次求診的日期。					d 日 /	m 月/	y 年)
Please state from your	records, the date and tre	atment details of all	I subsequent consultati	ions with t	he Insured		
	則被保人過往所有診症		i subsequent consultati	ons with	ine moureu.		
	I	T	T		T		
Date (dd/mm/yy)	Complaints & Symptoms (dd/mm/yy)	Duration of Illness	Diagnosis			ntments/Test 8 de copy of tests i	& Results reports if possible
診症日期	求診原因及病徵	病情持續時間	診斷			治療 / 檢驗及 供檢驗報告副	

Section B: Medical Details 乙部: 醫療詳情					
1. Medic	al History / 醫療紀錄				
	ay when did symptoms mist appear or accident happens			(a)	(/ / / /) DD/MM/ YY 日/月/年
	首次病徵出現或意外E			(b)	(/ /)
	病人何時開始因此傷死	•			DD/ MM/YY 日/月/年
		d same or similar condition?		(c)	Yes/是
}	病人過往有否患上同類	頁或類似之情況?			
		en and describe/ 若'是',請詳		(d)	
	ls condition due to injui 病人之傷殘是否因其]	ry or sickness arising out of p	atient's employment?		,, = _ ,, , , _
		s) of other attending Physicia	uns/甘州士診嫛生性夕T	3 	
(6)	name(s) and address(e.	sy of other attending rifysicia	1137 关他工的各工处罚》	()UPIL	
Date (dd	/mm/yy)	Physician's Name or Hospit	al's Name		Address
日期		醫生姓名或醫院名稱		1	也址
2.Diagno	 sis / 診斷				
				1	a) (/ /)
(a)	Date of first examinat	ion / consultation? 首次檢驗	》/求診日期?	(。,
(b)	Date of last examinati	on / consultation? 最後檢驗	/	(b) (/ /)
(0)	Date of last examinati	OII / COIISUITATIOII:與1交1以同以	/ 小心 口知:		DD/ MM/YY 日/月/年
(c)	Diagnosis (including a	ny complications) 診斷(包括	任何拼發症)		
				••••••	
(d)	Objective findings (inc	cluding current X-rays, ECG's,	Laboratory Data and any	clinical findi	ngs) 客觀診斷(包括任何化驗或臨床診斷)
3.Dates o	of Treatment / 治療日期				
	Date of first visit / con	(a)	(/ /)	
	首次就診日期	cultation (b)	DD/ MM/YY 日/月/年 (/ /	<u> </u>	
(b)	Date of last visit / con	sultation (b)	DD MM//YY 日/月/年	, <u>=</u>	
(c)	最後就診日期 Frequency	(c)	Weekly Mor		Other(specify)
(0)	就診頻率		每週 每月		其它(請說明)
4.Nature	of Treatment (Includin	g surgery and medications p	rescribed, if any) 治療性質	質(包括手術)	及葯物治療)

5. Progress 治療進度					
(a) Has patient 病人現在 Recovered/完全康復? □ Improved/改善中? □ Stabilized/穩定? □ Retrogressed/退化? □					
(b) Is patient 病人是否 Ambulatory/行動自如?□ House confined/在家休養?□ Bed confined/臥床?□ Hospital confined/住院?□					
(c) If patient was confined to Hospital, please provide the confinement period. 若病人曾經住院,請提供其住院時間.					
Confined from 住院由(/ /) DD/ MM/YY 日/月/年					
Until 至(/) DD/ MM/YY 日/月/年					
(d) Has the patient taken "Home Leave" within the confinement? If yes, please state the periods and No. of days.					
病人曾否於住院期間"自行離院"? 如有,請詳列其離院時間及日數。					
6. Cardiac (If applicable) 心臟科(如適用)					
o. Cardiac (II applicable) · D 加州 (XI) 起力)					
(a) Functional Capacity/ 工作能力 (a) No limitation/ 無限制 Slight limitation/ 部份限制 🗌					
Marked limitation/ 顯著的限制 □ Completed limitation/ 完全的限制 □					
(b) Blood Pressure (Last Visit)/ (b) /					
血壓(最後一次求診) Systolic 上壓 / Diastolic 下壓					
7. Physical Impairment (If applicable) 身體狀況(如適用)					
│ 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。					
□ Mederate limitation of functional conscitus canable of clarical/administrative /sadantam/ activity 中庭功纶平阳 可作立事工作					
│ │					
Severe limitation of functional capacity; incapable of minimal (sedentary) activity. 重度功能支限,小能行行工門工行。					
□ Remarks: 其它					
8. Mental / Nervous Impairment (If applicable) 精神狀況(如適用)					
(a) Please define stress as it applies to the patient. 請指出病人所受之壓力為何。					
(b) What stress and problem in interpersonal relations has the patient had on job: ///// (上土 F上之 / (赤側 (水色 五) 円 単座 / J / 山)					
Patient is able to function under stress and engage in interpersonal relations (No limitation).					
病人能夠在壓力下工作及融入人際關係 (無限制)。					
Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).					
病人能夠在大部份的壓力下工作及融入大部份的人際關係(輕度限制)。					
Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).					
病人能夠在有限度的壓力下工作及融入有限度的人際關係(中度限制)。					
Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)					
病人不能夠在壓力下工作及融入人際關係(顯著的限制)。					
Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).					
病人明顯地喪失心理的,生理的,個人的及對社會的適應(重度限制)。					
□ Remarks: 其它					

9. Progno	osis 預斷病情					
(a)	Is the patient now totally disabled/ 病人是否完全傷殘?	Yes/是				
(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 <u>USUAL</u> occu	·····································				
(-)		nths/ 3-6 個月				
	If 'Never' or 'Unknown', please comment. 若答案是'永不'或'未知	_ · · · · · — · · · · · — · · · · · —				
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	17 11301 1				
(d)	When will the patient recover sufficiently to return to ANY SUITA	BLE occupation/ 病人將在何時康復並從事 任何適合的職業 ?				
	1 Month/ 1 個月	onths/ 3-6 個月 🗌 Never/永不 🗌 Unknown/未知 🗌				
	If 'Never' or 'Unknown', please comment. 若答案是'永不'或'未知	1′,請解釋。				
10. Do yo	ou believe the patient is competent to endorse cheque and direct t	he use of the proceeds thereof? Yes/是 \(\simeg \) No/否 \(\simeg \)				
-	該病人是否有能力確認簽收支票和指示其用途?					
	ou consent the FWD Medical Director and/or claim assessor to re					
	eport to the patient when we are requested by the patient to expla 目示日辛労庁人方電西は、大八ヨウ殿双人目式取増批が目記					
	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: 當社中	透路阁 N 所提供之員科,以TF 胜梓 相關				
/ 賠1	賞決定。					
Section	C: Other Information 丙部: 其他資料					
1. In y	our opinion, does the condition suffered by the Insure	d fulfill the definition stated on Page 1?				
根据	蒙閣下之專業意見,被保人所患的疾病是否符合此報告第	一頁所列之定義? Yes 是□ No 否□				
2. If th	2. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such					
information below. 根據閣下之專業意見,請詳列任何可協助辦理此賠償的資料。						
Ciana atuu	sound shou 廢伍交欠及辛	Data IIII				
Signatur	e and chop 醫師簽名及蓋章	Date 日期				
No mana and	f Attackding Dbusision 十六/KggaTuth/7	Ouglification 閉底T次枚				
ivarne of	f Attending Physician 主診醫師姓名	Qualification 學歷及資格				
Address	14h1h	 Talanhana Na. 雲託時研				
Audress	NR-NT	Telephone No. 電話號碼				
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