Total & Permanent Disablement Claim
Attending Physician's Statement
傷殘賠償 – 醫生報告

Please print in **BLOCK** letters/ 請以**正楷**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. 保單號碼	Name of Patient 病人姓名
Occupation 職業	I.D. No. / Date of Birth 身份証號碼 / 出生日期

In order for the claim to be valid, the following definition must be fulfilled :-

TOTAL AND PERMANENT DISABLEMENT This is defined as the patient becomes incapacitated to such an extent as to wholly present him/her from ever engaging in any occupation, business or profession for which he/she is fitted or qualified by experience training ability or knowledge.

定義詮釋 完全永久殘廢指被保人因疾病或意外受傷引致殘廢，連續不能從事任何工作，並由本公司指定的醫生作出具體証明，証明被保人完全及永久不能從事任何賺取薪金或利潤之工作。
(注:此中文譯本祇供參考之用，如有爭議，應以英文原義爲準)

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☐
   Please state the first consultation date
   請提供被保人首次求診的日期。 (m 月/ d 日/ y 年)

Please state from your records, the date and treatment details of all subsequent consultations with the Insured.
請根據閣下之紀錄, 列明被保人過往所有診症日期及診療詳情

Date **診症日期**	Complaints **& Symptoms** **求診原因及病徵**	Duration of **Illness** **病情持續時間**	Diagnosis **診斷**	**Treatments/Test & Results** ***Please provide copy of tests reports if possible*** **治療 / 檢驗及結果** **請提供檢驗報告副本(如有)**

Section B: Medical Details 乙部: 醫療詳情

1. Medical History / 醫療紀錄

(a) When did symptoms first appear or accident happen? 首次病徵出現或意外日期? (a) (/ /) MM/DD/YY 月/日/年

(b) Date patient ceased work because of disability? 病人何時開始因此傷殘而不能工作? (b) (/ /) MM/DD/YY 月/日/年

(c) Has the patient ever had same or similar condition? 病人過往有否患上同類或類似之情況? (c) Yes/是☐ No/否☐
If 'Yes", please state when and describe/ 若'是',請詳列患病日期及情況。 ……..

(d) Is condition due to injury or sickness arising out of patient's employment? 病人之傷殘是否因其工作而引起? (d) Yes/是☐ No/否☐

(e) Name(s) and address(es) of other attending Physicians/ **其他**主診醫生姓名**及**地址

Date 日期	Physician's Name or Hospital's Name 醫生姓名或醫院名稱	Address 地址

2.Diagnosis / 診斷

(a) Date of first examination / consultation? 首次檢驗/求診日期? (a) (/ /) MM/DD/YY 月/日/年

(b) Date of last examination / consultation? 最後檢驗/求診日期? (b) (/ /) MM/DD/YY 月/日/年

(c) Diagnosis (including any complications) 診斷(包括任何拼發症)

……

(d) Objective findings (including current X-rays, ECG's, Laboratory Data and any clinical findings) 客觀診斷(包括任何化驗或臨床診斷)

……

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3.Dates of Treatment / 治療日期

(a) Date of first visit / consultation 首次就診日期 (a) (/ /) MM/DD/YY 月/日/年

(b) Date of last visit / consultation 最後就診日期 (b) (/ /) MM/DD/YY 月/日/年

(c) Frequency 就診頻率 (c) Weekly ☐ 每週 Monthly ☐ 每月 Other(specify) ☐ …….. 其它(請說明)

4.Nature of Treatment (Including surgery and medications prescribed, if any) 治療性質(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(/ /) MM/DD/YY 月/日/年

Until 至(/ /) MM/DD/YY 月/日/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。

Yes 是☐ No 否☐ Period 時間: …… Days 日數: ……

6. Cardiac (If applicable) 心臟科(如適用)

(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)/ 血壓(最後一次求診) (b) / Systolic 上壓 / Diastolic 下壓

7. Physical Impairment (If applicable) 身體狀況(如適用)

☐ No Limitation of functional capacity; capable of heavy work. No restriction. 無任何功能之限制,可以作體力勞動。無限制。

☐ 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。

. ☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity.中度功能受限,可作文書工作。

☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity. 重度功能受限,不能作任何工作。

☐ 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爲何。

……

(b) What stress and problem in interpersonal relations has the patient had on job? 病人在工作上之人際關係遇到何種壓力和問題?

☐ 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. Prognosis 預斷病情

(a) Is the patient now totally disabled/ 病人是否完全傷殘? Yes/是☐ No/否☐

(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 **USUAL** occupation/ 病人將在何時康復並從事**原來職業**?

1 Month/ 1 個月☐ 1-3 Months/ 1-3 個月 ☐ 3-6 Months/ 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', 請解釋。

……

(d) When will the patient recover sufficiently to return to **ANY SUITABLE** occupation/ 病人將在何時康復並從事**任何適合的職業**?

1 Month/ 1 個月☐ 1-3 Months/ 1-3 個月 ☐ 3-6 Months/ 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', 請解釋。

……

10. Do you believe the patient is competent to endorse cheque and direct the use of the proceeds thereof? Yes/是☐ No/否☐
你認爲該病人是否有能力確認簽收支票和指示其用途?

11. According to your opinion, any information will be assisting us in processing this claim? Please specify.
根據閣下的意見，**是否有**其他資料可以協助我們處理是次賠償? 請詳述。

12. Do you consent the FWD Medical Director and/or claim assessor to release the information provided by you in this report to the patient when we are requested by the patient to explain our claim decision? Yes/是☐ No/否☐
閣下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透露閣下所提供之資料，以作解釋有關之賠償決定。

Signature and chop: _____ Date: _____
醫生簽名及蓋章 **日期**

Name of Attending Physician: _____ Qualification: _____
主診醫生姓名 學歷及資格

Address: _____ Telephone No.: _____
地址 電話號碼