



THE PACIFIC GROUP

太平洋保險有限公司 THE PACIFIC INSURANCE CO., LTD.

(INCORPORATED IN HONG KONG IN 1960)

賠償部：香港灣仔皇后大道東43-59號東美中心10字樓
Claims Department: 10/F., Dominion Centre, 43-59 Queen's Road East, Wanchai, H.K.電話: 2876 0288 傳真: 2876 0222
Tel : 2876 0288 Fax : 2876 0222

Official Use : Date of Intimation _____ Claim No. _____

EMPLOYEES' COMPENSATION INSURANCE

僱員補償保險 NOTICE OF ACCIDENT 意外通知書

Completing and submitting this form must not be construed that the insured injured or family member(s) of the injured or deceased is/are making or will make, a claim, and this form is sent without prejudice to the terms and conditions of the Policy.

填送此表格不能解作受保人傷者或死者家屬，係在要求或將會要求賠償；而與此案有關之保單內之條款，亦不因填送此表格而受任何影響。

Particulars of The Employer/Insured

僱主/受保人資料

Name 名稱		Policy No. 保單號碼	
Address 地址			
Nature of business 業務性質	Responsible Person 負責人	Telephone No. 電話號碼	Email Address 電郵地址

Particulars of Principal Contractor (If Employer is a Subcontractor)

總承判商資料(如僱主屬承判商)

Name 名稱			
Address 地址			
Nature of business 業務性質	Responsible Person 負責人	Telephone No. 電話號碼	Email Address 電郵地址
Have the Principal Contractor taken out any policy of employees' compensation insurance providing indemnity in respect of the same accident? 總承判商有否持有任何僱員補償保險單可以就同一意外提供賠償？ If "yes", please state and provide a copy of the policy: 若“有”，請列明及提供該保單副本乙份：Name of Insurer 保險公司名稱			
		<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 否
		Policy No. 保單號碼	

Particulars of Injured or Deceased Employee

受傷或死亡僱員資料

Name in English 英文姓名		Name in Chinese 中文姓名	
I.D./Passport No. 身份證/護照號碼	Telephone No. 電話號碼	Date of Birth 出生日期	Sex 性別
Residential address 住址			
Marital Status 婚姻狀況			
<input type="checkbox"/> Single 未婚			
<input type="checkbox"/> Married 已婚			
<input type="checkbox"/> Others (please specify) 其他(請說明) _____			
If applicable, please list the child(ren)'s particulars 如適用，請列出子女資料			

Particulars of Injured or Deceased Employee (Cont'd)**受傷或死亡僱員資料（續）**

Was the injured/deceased an apprentice? 傷者/死者是否學徒？	<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否	Position, Job Duties & Period of Employment 職位、工作 及 受僱時期
Total earnings (including all allowances) for the month immediately preceding the month in which accident occurred were: 意外發生月份之前一個月的總收入（包括一切津貼）為：			
HK\$ _____			
Average monthly earnings for the 12 months (or total period of employment, if less than 12 months) preceding the month in which the accident occurred were: 意外發生月份之前十二個月（或受僱期內，如少於十二個月者）的每月平均收入為：			
HK\$ _____			

Particulars of the Accident**意外資料**

Date 日期	Time 時間	Result of accident 意外結果	<input type="checkbox"/> Injury 受傷	<input type="checkbox"/> Death 死亡
Detailed address of the place of accident 意外地點之詳細地址				
Course of accident 意外經過				
If machinery is involved in the accident, please specify: 如意外牽涉機器，請說明：				
Type of machine: 機器類型： _____				
a. whether it was manually operated? 甲·該機器是否以人手操作？		<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否	
b. whether it was operating? 乙·該機器是否在運作中？		<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否	
Part of the machine causing accident: 導致意外之機器部份： _____				
a. whether it was fenced or guarded? 甲·該部份有否護罩？		<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 無	
Was the injured/deceased sent to hospital/clinic? 傷者/死者有否被送往醫院/診所？		<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 無	
If yes, please name the hospital/clinic to which the injured/deceased was sent: 如有，請述明該醫院/診所之名稱：				

What was the date and time when the injured/deceased entered or was sent to hospital/clinic? 傷者/死者於何時進入醫院/診所？				

Meanwhile, did the injured/deceased receive any special medical treatment? 其間，傷者/死者有否接受任何特別診治？		<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 無	
What was the date and time when the injured left the hospital/clinic? 傷者於何時離開醫院/診所？				

Particulars of the Accident (Cont'd)**意外資料（續）**

Nature of injury 傷害之性質 <input type="checkbox"/> Amputation 切斷 <input type="checkbox"/> Fracture 折骨 <input type="checkbox"/> Contusion 撞傷 <input type="checkbox"/> Laceration 割傷 <input type="checkbox"/> Burn 燒傷 <input type="checkbox"/> Sprain 扭傷 <input type="checkbox"/> Others (please specify) 其他（請說明）_____		Part of body injured (please state right or left, if applicable): 受傷之部位（如適用，請說明右邊或左邊）：
Has the sick leave ended yet? <input type="checkbox"/> Yes <input type="checkbox"/> No 病假是否已經完結？ 是 否 If yes, please give the last day of the sick leave: 如是，請說明最後之病假日期：		Whether police or labour department was notified? <input type="checkbox"/> Yes <input type="checkbox"/> No 有否通知警方 或 勞工處？ 有 無 If yes, please give the relevant police station and report no. / branch office of labour department and reference no. 如有，請說明有關警署及報案號碼 / 勞工處辦事處及檔案號碼
What date did the employer first receive notice of accident? 僱主於何日首次接到意外通知？		From whom (the reporter) did the employer receive such notice? 僱主從何人（報告者）獲悉意外之發生？
Was the reporter directly employed by the employer? 報告者是否直接受僱於僱主？ <input type="checkbox"/> Yes <input type="checkbox"/> No 是 否		Has the injured/deceased taken any alcohol or drugs before the accident? 傷者/死者於意外前曾否服用酒精或藥物？ <input type="checkbox"/> Yes <input type="checkbox"/> No 是 否
Was there any disobedience to orders, rules or misconduct by the injured/deceased? 傷者/死者有否違反命令、守則或不當之行為？ <input type="checkbox"/> Yes <input type="checkbox"/> No 有 無		Did the accident arise out of and in the course of employment? 意外是否於執行受僱工作期間發生？ <input type="checkbox"/> Yes <input type="checkbox"/> No 是 否
Witness(es) of the accident 意外之目擊者	Name 姓名 _____ Contact Numbers 聯絡號碼 _____ Address 地址 _____	

Particulars of Accident Causer(s) (If other than the Injured/Deceased)**導致意外者資料（如非傷者/死者）**

Name(s) 姓名	Respective Company(-ies) 所屬公司
Address(es) 住址	Telephone No(s). 電話號碼

Declaration**聲明**

I/We hereby declare I/we believe that the facts stated in this Notice of Accident are true in every respect and that I/we have no other policy of insurance indemnifying me/us in respect of this accident and I/we undertake to give the Company all assistance in my/our power in dealing with the matter. I/We also have read and fully understood the contents printed overleaf and hereby give my/our consent thereto. 本人/吾等謹此聲明，本人/吾等相信本意外通知書所述事實乃屬真實，本人/吾等就有關意外並無重複保險，並且答應提供所有協助辦理一切有關事宜。此外，本人/吾等亦已閱讀及完全明白並同意背頁所列印之內容。	
Signature : _____ 簽署	(for and on behalf of the employer) 代替及代表僱主
Date: _____ 日期	Chop of Company 公司蓋印

* Please supply us with the medical examination report(s)/sick leave certificate(s).

請提供醫療報告/病假證明書予本公司

Personal Information Collection Statement

The information you provided in this Notice of Accident is collected to enable us to carry on insurance business and may be used for the purpose of:

- any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or service;
- any claim or investigation or analysis of such claim;
- exercising any right of subrogation; and

may be transferred to:

- any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
- any association, federation or similar organisation of insurance companies ("Federation") that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation; and
- any members of the Federation by the Federation for any of the above or related purposes.

Moreover, The Pacific Insurance Company, Limited is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance industry.

You have the right to obtain access to and to request correction of any personal information concerning yourself held by The Pacific Insurance Company, Limited. Requests for such access can be made to The General Manager at 10th Floor, Dominion Centre, 43-59 Queen's Road East, Wanchai, Hong Kong.

收集個人資料聲明

閣下在此意外通知書內所提供的資料，為本公司提供保險業務所需，並可能使用於下列目的：

- 任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期；
- 任何索償，或該等索償的調查或分析；
- 行使任何代位權；及

可能移轉予：

- 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；
- 現存或不時成立的任何保險公司協會或聯會或類同組織（「聯會」），以達到任何上述或有關目的，或以便聯會執行其監管職能，或其他基於保險業或任何聯會會員的利益而不時在合理要求下賦予聯會的職能；及
- 或透過聯會移轉予任何聯會的會員，以達到任何上述或有關目的。

此外，在此授權太平洋保險有限公司由聯會從保險業內收集的資料中查閱及/或核對閣下任何資料。

閣下有權查閱及要求更正由太平洋保險有限公司持有有關閣下的個人資料。如有此項要求，可向香港灣仔皇后大道東43-59號東美中心十字樓本公司總經理提出。