



滙業保險股份有限公司
Companhia de Seguros Delta Asia, S.A.

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僱員賠償保險意外報告表
EMPLOYEES' COMPENSATION INSURANCE
NOTICE OF ACCIDENT

OFFICE USE
CLAIM NO.

THE POLICY 保單

1. Policy Number 保單編號	2. Expiry Date 到期日
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THE EMPLOYER 僱主

3. Name of Insured 保戶	
4. Name of Employer 姓名	
5. Nature of Business 行業	
6. Address 地址	
7. Telephone 電話	
8. Fax 傳真	

THE INJURED PERSON 傷者

9. Name 姓名	
10. Identity Card No. 身份證號碼	
11. Nationality 國籍	
12. Local Address 地址	
13. Whether married or single 已婚或未婚	
14. State occupation in which the injured person is employed? 僱用時訂明何種工作?	
15. On what work was the injured person engaged at the time of the accident? 受傷時擔任何種工作?	
16. Is the injured person under your direct employment? If not please give Name and Address of Contractor. 傷者是否直接僱用，否則請列明其判頭姓名地址。	
17. When did the injured person enter your service? 傷者何時開始被僱用?	
18. If taken to hospital please state: - (a) Name of Hospital (b) Whether still in hospital (c) The discharged date? 如傷者被送往醫院請列明以下各點： 甲、 醫院名稱 乙、 是否仍在留醫 丙、 如傷者已出院，何時出院?	
19. If not taken to hospital, please state whether being medically attended and if so by whom 如未送往醫院，請列明在何處醫治	
20. State whether returned to work, and if so, when? 是否已復工?如是，請報明日期	
21. Are you satisfied the injured person has met with a bona-fide accident of employment and was not under influence of drink or drugs? 僱主是否認定該傷者絕非因酒後或服食藥物後受傷?	
22. Is the injured person able to do partial work? 傷者能否局部工作?	

THE ACCIDENT 意外之詳情

23. As regards the accident please state 請說明肇事時間地點等	Date : 日期 Place : 地點	Time : 時間 Date ceased work : 停止工作日期
24. Who reported the accident to employer? 意外發生時何人向僱主報告?		
25. Describe in full details how the accident occurred 列明意外發生之詳細情形		
26. State nature and extent of injury 說明受傷部位及其傷勢之程度		
27. Was the injured person guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars 傷者是否因行為不端或不服從指揮並說明其情形		
28. State if the accident occurred due to the negligence of a third party 說明如因第三者之疏忽而引致發生意外		
29. State the names of any persons who witnessed the accident 受傷時之目擊證人及其姓名		

以上答覆全屬真確 The replies are correct to the best of my/our knowledge and belief.

Date
日期

僱主簽名並蓋公司印章 Signature of Employer

NOTE: - On receipt of the particulars the Company may, if it so requires, ask for a medical certificate.

N.B. - IT IS ESSENTIAL THAT THE EMPLOYER SHOULD COMPLETE THE WAGES STATEMENT BELOW

工資報告表 WAGES STATEMENT

The purpose of the figures to be given below is to enable calculation of the amount of compensation due. It is essential, therefore, that the figures should be as accurate as possible.

下列數目乃賠償計算之標準故請列明之數目必須確實

The figures, in view of the provisions of the Employees' Compensation laws, require to be based upon the circumstances of the employee's employment. There are three sets of circumstances, with corresponding variations in the basis of calculations as follows: -

僱員賠償辦法乃根據該僱員之工作範圍而定，以下為三種計算方法：

- (1) Where the employee has been employed by you continuously for not less than 12 months immediately preceding the accident - the figures to represent wages etc. received from you during those 12 months;
由受僱至受傷時止其工作已超過一年而在該一年內應領取之工資及津賠合共若干。
- (2) Where the employee has been employed by you continuously for more than 1 month but less than 12 months immediately preceding the accident - the figures to represent wages etc. received by the employee during his last continuous period of employment under you immediately preceding the accident - the number of days the period comprises to be stated.
由受僱至受傷時止其工作已超過一個月但未足十二個月其應領取之工資及日數若干。
- (3) Where the employee has been employed by you continuously for less than 1 month immediately preceding the accident the figures to represent wages etc. receivable during 12 months by employees in similar employment under you or in your locality;
由受僱至受傷時止其工作未超過一個月，則依據同一業務之僱員在十二個月應領取工資若干

Month (or daily) 每月 (或每日)	Wages Paid 已支付工資	Other allowances 其他收入	Total 合計
\$.....	\$.....	\$.....	\$.....

Date
日期

Employer's Signature

僱主簽名並蓋公司印章