



香港護士協會

九龍佐敦白加士街 25-27 號慶雲商業大廈三樓
總機電話及二十四小時傳真熱線：2314 6900

親子天地
電話：2314-6925/6945
傳真：3521-0321

福利部
2314-6910/6961
3521-0434

電器部
2314-6924/6941
3521-0434

保險部
2314-6912/6944
3521-1540

教育部
2314-6911/6977
3521-1540

會籍部
2314-6927/6915
3521-1540

勞資及公共關係部
2314-6962
2314-1997

ASSOCIATION OF HONG KONG NURSING STAFF

3/F., Hing Wan Commercial Building, 25-27 Parkes Street, Jordan, Kowloon.

Website: <http://www.nurse.org.hk>

E-mail: info@nurse.org.hk

護士專業責任保險(第一層)續保通知

投保人姓名:(英文) _____

地址:(英文) _____

**必需於
30/04/2018
前續保**

OFFICE USE ONLY
Receipt No: PINSR
Record No: FPI

閣下參加本會之護士專業責任保險計劃,將於本年 **4月30日**屆滿,故致函通知閣下辦理續保。2018 年度護士專業責任保險(第一層)承保期及所有受保人共享最高賠償額(包括訴訟及法律代表之費用)為(有關條文解釋及引用,以英文保單為準):

承保期: 2018 年 5 月 1 日至 2019 年 4 月 30 日
單一索償: HK\$17,500,000; 每一保險年度: HK\$52,500,000; 自付額: HK\$20,000

如閣下斷保或遲交保費,於再次申請此份保險時,累積之「追朔期保障」將被取消,即祇保障新生效日後發生之護理事故。故請於此份保險到期日前辦理續保,以確保閣下得到全面保障。請填妥下列之表格。如果有索償個案和/或引致索償之護理事故(包括曾經被要求呈交書面聲明),請填報護理事故紀錄表格(包括有關書面聲明副本及事件經過),然後請連同填妥之此表格遞交致本會。

The Malpractice Liability Master Policy is held by the Association as the Policyholder, arranged by the Broker and insured with the Insurance Company named below:-

此護士專業責任保險計劃由本會持有、下列之保險經紀安排及保險公司承保:-
Broker 保險經紀: Arvuda Insurance Services Ltd 富利達保險服務有限公司 (Member of Professional Insurance Brokers Association 香港專業保險經紀協會會員 PIBA-0328)
Insurance Company 保險公司: China Merchants Insurance Co Ltd 招商局保險有限公司

(所有項目必須填寫)

會員證號碼:	身份證:
電話:(M)	電話:(H)

Claim History Related to Profession 有關專業責任的索償紀錄:

Have you ever been subject to disciplinary proceedings for medical malpractice or professional misconduct in the last one year? No 否
閣下曾否在過去一年內因醫療失誤或專業失德被紀律聆訊? Yes 有

Have any claims ever been made against you in the last one year? No 否
閣下曾否在過去一年內被索償? Yes 有 Settled 已完結 In Progress 處理中

Has there been any circumstance or fact coming to your knowledge or awareness in the last one year which could reasonably be expected to give rise to a claim? No 否
在過去一年中,閣下是否知道或意識可預見會引起索賠之任何情況或事實? Yes 有

在索償紀錄欄內選擇“有”之答案的受保人須填妥下頁之護理事故紀錄表格交予保險公司。保險公司將保留最終決定權是否接受此份申請。In case of a “Yes” answer to any of above questions, please complete the Nursing Incident Record Form overleaf. The Insurance Company reserves the rights to change or withdraw the renewal terms.

付款方法: 續保會員之保費: **HK\$2501** 包括 0.04% 保費徵費*
(保險費由香港護士協會代會員收取後集中處理) *詳情可瀏覽保險公司網頁 www.cm-insurance.com 或 致電 2890 5940 查詢

- 親臨保險部(慶雲四樓)以現金/易辦事/護協信用卡辦理
- 連同此表格郵寄支票回本會(☑為免耽誤續保請付足郵資),抬頭請寫“香港護士協會”。號碼: _____ 銀行: _____
- 護協信用卡(持卡者必須與受保人相同),可傳真(2736 6020)或郵寄(如需確認傳真,請於兩個工作天後致電: 2314 6961 / 2314 6945):

4	5	5	2	7							
4	3	8	4	3	7	1	3				

持卡者英文姓名: _____
有效日期: _____ 月 / _____ 年 持卡者簽署: _____

****如需即時領取收據,必須親臨本會辦理;否則所有保單及正本收據將於保單生效日期起計三個月後以平郵方式寄回給閣下。**

Note 注意: You must ensure that the information in this form is accurate and complete because inaccuracy or non-disclosure of the requested information or other material facts could render the insurance voidable. 請提供正確及全面資料,因錯誤資料或隱瞞重要事實可導致保險無效。
The Renewal Premium and Terms is subject to no deterioration of Nursing Incident Record and no change of material fact 續保保費和條款受制或基於沒有任何資料或索賠/護理事故紀錄之變更。

Declaration and Signature 聲明及簽署:
I declare the statements and particulars in this Renewal Notice are true and that I have not mis-stated or suppressed any material facts. I agree that this proposal, together with any other information supplied by me, shall form the basis of any Contract of Insurance effected thereon. I undertake to inform the Insurance Company of any material alteration to these facts occurring before commencement of the Contract of Insurance which is deemed to be 0:01am on the date of inception. I hereby give my consent and authorize that any of my personal information (including the past Nursing Incident Record) collected or held by AHKNS, the Broker and the Insurance Company may be used and disclosed to any individuals / organizations for the purpose of processing this insurance and providing related and subsequent services. I understand and agreed that AHKNS's administration will be compensated by handling fee payable by the Broker/Insurance Company and the services of the Broker will be remunerated by the commission payable by the Insurance Company.
本人,現特此聲明此續保通知之資料均為正確及並沒有故意隱瞞事實。所有有關提供之資料均會成為此保險合約生效後之一部份。同時,本人亦明白及答應如在投保人沒有任何資料之改變,此保險之生效日期為保險公司確定之生效日零時零一分開始。本人現同意並授權香港護士協會、安排此保險之保險經紀及承保之保險公司保留、使用或透露所收集或保留本人之任何個人資料(包括過去之護理事故及索償紀錄),給予有關人士或機構用作處理與此保險有關的申請,及提供其相關及稍後的服務。本人明白並同意 AHKNS 的行政管理費用支出將由保險經紀/保險公司以手續費形式作出補償,而保險經紀的服務將由保險公司以佣金支付。

Date 日期 _____ 日 _____ 月 2018 年
Signature of the Insured 受保人簽署 _____

