



GROUP MEDICAL HOSPITALIZATION & SURGICAL CLAIM FORM 團體保險住院手術賠償申請表

Please complete this form and attach copy of all diagnostic/tests reports, original itemized invoices and receipts within 90 days from the day of discharge/operation.

請填寫此表格並附上所有診斷和檢驗報告副本及全部賬單和收據正本於住院/手術後90天內遞交。

PART 1 – TO BE COMPLETED BY THE PATIENT 甲部 – 由病人填寫

Name of Policy Holder 保單持有人名稱:		
Policy No. 保單編號:	Member No. 會員編號:	Name of Member (in full) 會員姓名(全名):

Name of Patient (in full) 病人姓名(全名):	H.K.I.D Card No. 香港身份證號碼:	Occupation 職業:
Relationship to the Member 與會員關係:	Date of Birth 出生日期:	Sex 性別: <input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女

(1) Describe the symptoms and anomalies which led to the hospitalization 請列明病者因何不適或有何徵狀導致是次入院:

(2) Have you had any prior consultation / treatment for this or the related condition? If yes, please give details as below:
閣下是否曾經因同一病況而求診/接受治療? 如有, 請列出有關資料如下: No 沒有 Yes 有

Date of Visit 求診/治療日期	Name of Doctor 醫生姓名	Address of Doctor 醫生地址
_____	_____	_____
_____	_____	_____

(3) Name and address of your family / usual doctor 閣下的家庭/慣常醫生姓名及地址:

(4) Was the hospitalization / surgery caused by accident? 此次住院/手術是否由於意外事故所引致? No 不是 Yes 是

Date, time and place of accident 意外事故發生的日期、時間及地點: _____

Account of accident 意外事故發生的經過: _____

Name and address of witness 目擊者的姓名及地址: _____

(5) Do you have any medical / accident / hospital cash insurance policies with other insurance companies? If yes, please give details as below:
閣下有否在其他保險公司享有醫療/意外/住院現金保險保障? 如有, 請列出有關資料如下: No 沒有 Yes 有

Name of Insurance Company 保險公司名稱	Policy No. 保單號碼	Effective Date 生效日期	Name of Insured 受保人姓名
_____	_____	_____	_____
_____	_____	_____	_____

If yes, please indicate whether return of original receipt(s) is required? 如有, 請列明是否需要退回收據正本? No 否 Yes 是

DECLARATION & AUTHORIZATION 聲明及授權書:

I hereby declare that all the information given is true and correct and no relevant information has been omitted.
I agree that your Personal Data Policy, a copy of which is available upon request or from www.hl-insurance.com, shall apply. I agree that all my personal data will be subject to such Policy (as may be amended from time to time). I authorize you to provide to and collect information about me (and my dependents if any) in connection with this Claim Form from any other member of the Hong Leong group or any other organization, institution or person relevant to your business, including other insurance companies, credit agencies, financial institutions, healthcare related entities etc., and to compare such information with my personal data, and to use the results for taking of any actions that may be adverse to my interests. I understand that I am entitled to request access to and the correction of my personal data so held by you. Such request shall be made to your Data Protection Officer. A reasonable fee may be charged by you for processing such request.
I authorize any hospital, clinic, physician, insurance company, service provider or other person or organization that has any records or knowledge of me or my health, insurance or claim history to furnish to your company or your authorized representative, any and all personal data and other information with respect to any illness or injury, medical history, insurance or claim history, consultation prescriptions or treatment and copies of all hospital, medical or other records concerning me. A photostat copy of this authorization shall be considered as effective and valid as the original. Your issue of this claim form does not signify your acceptance of any claim.

本人現聲明上述所填報的資料正確無訛, 並沒有遺漏。
本人同意貴公司之「個人資料政策」會被引用。本人可以向貴公司索取或從網址 www.hl-insurance.com 下載有關政策。本人同意該政策(按不時之修正)適用於本人所有個人資料。本人現授權貴公司向/從任何豐隆集團成員或其他公司、機構、業務有關人士包括保險公司、信貸機構、金融機構、醫療保健相關機構等提供、收集並比較本人(及本人的家屬, 如適用)於本賠償申請表的個人資料, 並利用比較結果採取任何行動, 其可能不符合本人利益。本人理解本人有權要求查閱及更正貴公司持有有關本人之個人資料。此等查詢應向貴公司之資料保安主任提出。貴公司有權收取處理該查詢的合理費用。
本人茲授權持有本人健康、投保資料、索償記錄或任何有關資料之醫院、診所、醫生、保險公司、提供服務者或其他人士/機構, 可以將部份或全部有關本人之傷患病歷、投保資料、索償記錄、求診藥方或治療記錄及所有住院、醫療或其他記錄給予貴公司或其代理人。此授權書之影印本與正本具同等效力。發出此索償申請表並不代表貴公司接受本人之索償。

Date 日期	Signature (Patient or Parent if a minor) 簽名(病者如未成年請由父母代簽)
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(1) Name of Patient (in full) 病人姓名(全名):	H.K.I.D. Card No. 香港身份證號碼:																								
(2) Name of Hospital 醫院名稱: Date of Admission 入院日期: _____ Date of Discharge 出院日期: _____																									
(3) Chief complaints of the patient relating to this hospitalization / surgery 此次住院 / 手術的主要病因:																									
(4) Diagnostic investigations / procedures performed 診斷性檢驗 / 程序名稱: Final Diagnosis 診斷結果:																									
(5) Surgical operation performed 手術名稱: Date of Operation 手術日期:																									
(6) Brief discharge summary including etiology, treatment, prognosis and any complications and / or follow up plan : 出院摘要包括病因、治療法、預後情況、任何併發症與及跟進治療方案:																									
(7) The date on which the signs and symptoms first appeared or the accident occurred 有關症狀首次出現或意外發生的日期: Please state the signs and symptoms 請詳述有關症狀:																									
(8) The date on which you first attended to the patient for this or the related condition 閣下首次替病人就這或同類病況診治的日期:																									
(9) The date on which the patient first received consultation for this or the related condition 病人首次就這或同類病況求診的日期:																									
(10) Was this condition a recurrent episode or in anyway associated with a similar condition that the patient had before? If yes, please give details as below: 病人之病況是否再次覆發或是與其過往曾患有的同類病況有關連? 如是, 請列出有關資料如下: No 不是 <input type="checkbox"/> Yes 是 <input type="checkbox"/> Date of Onset 首次病發日期 Name of Attending Doctor 主診醫生姓名 Symptoms and Diagnosis 症狀及診斷結果																									
(11) Was the patient's condition caused by or in anyway associated with the conditions mentioned below? 病人之病情是否由下列情況所導致或有關連? <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">(a) Congenital anomalies or deformities 先天異常</td> <td style="width: 15%;">No 不是 <input type="checkbox"/></td> <td style="width: 15%;">Yes 是 <input type="checkbox"/></td> </tr> <tr> <td>(b) Sterilisation, contraception or treatment relating to birth control 不育、避孕或節育</td> <td>No 不是 <input type="checkbox"/></td> <td>Yes 是 <input type="checkbox"/></td> </tr> <tr> <td>(c) Disorders of the mind, psychotic or neurotic 精神錯亂</td> <td>No 不是 <input type="checkbox"/></td> <td>Yes 是 <input type="checkbox"/></td> </tr> <tr> <td>(d) Rest cure or sanitary care 休養治療或衛生上的照料</td> <td>No 不是 <input type="checkbox"/></td> <td>Yes 是 <input type="checkbox"/></td> </tr> <tr> <td>(e) Drug addiction or alcoholism 酗酒或酗酒</td> <td>No 不是 <input type="checkbox"/></td> <td>Yes 是 <input type="checkbox"/></td> </tr> <tr> <td>(f) Cosmetic treatment or plastic surgery 美容或整容手術</td> <td>No 不是 <input type="checkbox"/></td> <td>Yes 是 <input type="checkbox"/></td> </tr> <tr> <td>(g) Eye refraction or hearing aids 視力或聽力幫助</td> <td>No 不是 <input type="checkbox"/></td> <td>Yes 是 <input type="checkbox"/></td> </tr> <tr> <td>(h) AIDS related, venereal disease or sexually transmitted disease 愛滋病, 性病或由性接觸而傳染的疾病</td> <td>No 不是 <input type="checkbox"/></td> <td>Yes 是 <input type="checkbox"/></td> </tr> </table> If yes, please give details 如是, 請詳述:		(a) Congenital anomalies or deformities 先天異常	No 不是 <input type="checkbox"/>	Yes 是 <input type="checkbox"/>	(b) Sterilisation, contraception or treatment relating to birth control 不育、避孕或節育	No 不是 <input type="checkbox"/>	Yes 是 <input type="checkbox"/>	(c) Disorders of the mind, psychotic or neurotic 精神錯亂	No 不是 <input type="checkbox"/>	Yes 是 <input type="checkbox"/>	(d) Rest cure or sanitary care 休養治療或衛生上的照料	No 不是 <input type="checkbox"/>	Yes 是 <input type="checkbox"/>	(e) Drug addiction or alcoholism 酗酒或酗酒	No 不是 <input type="checkbox"/>	Yes 是 <input type="checkbox"/>	(f) Cosmetic treatment or plastic surgery 美容或整容手術	No 不是 <input type="checkbox"/>	Yes 是 <input type="checkbox"/>	(g) Eye refraction or hearing aids 視力或聽力幫助	No 不是 <input type="checkbox"/>	Yes 是 <input type="checkbox"/>	(h) AIDS related, venereal disease or sexually transmitted disease 愛滋病, 性病或由性接觸而傳染的疾病	No 不是 <input type="checkbox"/>	Yes 是 <input type="checkbox"/>
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(12) Was the patient referred by another doctor? If yes, please give details as below: 病人是否經其他醫生轉介? 如是, 請列出有關資料如下: No 不是 <input type="checkbox"/> Yes 是 <input type="checkbox"/> Date of Referral 轉介日期 Name of Referral Doctor 轉介醫生姓名 Address of Referral Doctor 轉介醫生地址																									
(13) Was the hospitalization medically necessary? If yes, please give reasons as below : 是次入院是否醫療所需? 如是, 請詳述原因如下: No 不是 <input type="checkbox"/> Yes 是 <input type="checkbox"/>																									
Name of Attending Physician / Specialist (with qualifications) 主診 / 專科醫生的姓名 (資歷)	Address 地址																								
Signature of Attending Physician / Specialist 主診 / 專科醫生簽名	Telephone 電話																								
	Date 日期																								