



OUTPATIENT CLAIM FORM 門診索償表格

Outpatient Claim  
 Dental Claim

Please read the instructions at the back 請看背頁指示

Name of Employer: 僱主名稱						
Policy No: 保單編號		Member No. 會員編號				
Name of Employee (in full): 僱員姓名(全名)						
Name of Patient (in full), if other than employee: 病者姓名(僱員毋須填寫)						
Date of Visit (DD/MM/YYYY) 診症日期(日/月/年)	Amount 銀碼	Consultation Type 診症類型			For Office Use Only 此項由保險公司填寫	
		Clinical 門診	Specialist 專科	X-ray / Lab. Test X光/化驗	PL: _____	No: _____
___/___/_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
___/___/_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
___/___/_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
___/___/_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**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](http://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](http://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、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傷患之病歷、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)

## IMPORTANT NOTES:

### 注意事項

1. Please print all answers.  
請用正楷填寫。
2. This form is to be completed by the Insured Employee and separate forms must be used for different patient.  
此索償申請表格須由受保僱員填寫，每份索償表格祇限一位索償申請人(即病者)使用。
3. Original bills and receipts for the claims expenses must be attached showing the date of treatment, patient's name, diagnosis, and the attending physician's stamp and signature.  
須附具詳細門診費用帳單之收據正本，提供治療日期、病者姓名、病症及主治醫生之印鑑及簽署。
4. Claim for specialist consultation, physiotherapy, chiropractor, expenses incurred in buying medicines/drugs and /or claim for undergoing X-ray examination/laboratory tests must be supported by the attending physician's prescription and/or recommendation and the original bills/receipts from the pharmacist and/or laboratory.  
申請索償專科、物理治療、整脊治療、藥物或 X 光/檢驗費用須具主診醫生之處方或介紹信連同認可藥房或化驗室之帳單或收據正本。
5. Claims must be submitted within 90 days after the consultation date.  
索償表格及收據必須於診症後 **90** 日內寄往賠償部。