豐隆保險(亞洲)有限公司
HongLeong Insurance (Asia) Ltd.

MEDICAL / HOSPITAL CASH CLAIM FORM 醫療 / 住院現金保險索償申請表

Please complete this form and attach copy of all diagnostic/tests reports, original itemized invoices and receipts within 30 days from the day of discharge.
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後 30 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.: 保單號碼:	
Address: 住址:	Contact Telephone No.: 聯絡電話:	Email Address: 電郵地址:

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 : ☐ Male 男 ☐ 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 understand that: (a) you may use my personal data contained in this form or collected or held by you by any means from time to time for the purposes of the daily operation of the provision of insurance services, direct marketing, researching, designing services or products for me, communicating with me and/or fulfilling any obligations as required by law/regulation from time to time; (b) you may disclose my personal data to any member of the Hong Leong Group and/or any third party (in each case whether within or outside Hong Kong), for any of the above purposes and/or for the purposes of providing administrative and/or other services to you in connection with the operation of your business; (c) I have the right 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; (d) if I do not wish you to use my personal data in direct marketing or to receive any marketing materials from you, I will notify you of my opt-out in writing addressed to your Data Protection Officer.
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, claims investigation agencies, 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 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. The 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。本人明白：(a)貴公司可能將本表格所載或貴公司不時從其他途徑所收集或持有有關本人的個人資料用於就提供保險服務所涉及的日常運作、直接促銷、研究、設計服務或產品予本人、聯絡本人及/或滿足法律/規例不時需要之任何責任；(b) 貴公司可能向任何豐隆集團成員及/或任何第三方(不論香港境內或境外)披露本人的個人資料，用作以上列明之任何用途及/或就貴公司業務運作向貴公司提供行政及/或其他服務之用；(c)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；(d) 如本人不希望貴公司把本人的個人資料用於直接促銷或接收任何直銷資料，本人會書面通知貴公司的資料保安主任。
本人現授權貴公司向／從任何豐隆集團成員或與貴公司業務有關的其他公司、機構或人士包括其他保險公司、理賠調查機構、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) 於本索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的個人資料及其他有關本人之傷患、病歷、投保資料、索償記錄、求診藥方或治療記錄等資料及所有住院、醫療或其他記錄之副本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任何索償。

Date 日期 _____

Signature (Patient or Parent if a minor) 簽名(病者如未成年請由父母代簽) _____

豐隆保險(亞洲)有限公司
HongLeong Insurance (Asia) Ltd.

PART 2 – TO BE COMPLETED BY THE ATTENDING PHYSICIAN　乙部 – 由主診醫生填寫

(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 :
出院撮要包括病因、 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 ☐ Yes 是 ☐

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?

(a) Congenital anomalies or deformities 先天異常	No 不是 ☐	Yes 是 ☐
(b) Sterilisation, contraception or treatment relating to birth control 不育、避孕或節育	No 不是 ☐	Yes 是 ☐
(c) Disorders of the mind, psychotic or neurotic 精神錯亂	No 不是 ☐	Yes 是 ☐
(d) Rest cure or sanitary care 休養治療或衛生上的照料	No 不是 ☐	Yes 是 ☐
(e) Drug addiction or alcoholism 酗藥或酗酒	No 不是 ☐	Yes 是 ☐
(f) Cosmetic treatment or plastic surgery 美容或整容手術	No 不是 ☐	Yes 是 ☐
(g) Eye refraction or hearing aids 視力或聽力幫助	No 不是 ☐	Yes 是 ☐
(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 ☐	Yes 是 ☐

If yes, please give details 如是，請詳述:

(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 ☐ Yes 是 ☐

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 ☐ Yes 是 ☐

_____
Name of Attending Physician / Specialist (with qualifications)
主診 / 專科醫生的姓名 (資歷)

_____
Signature of Attending Physician / Specialist
主診 / 專科醫生簽名

_____
Address 地址

_____
Telephone 電話

_____
Date 日期