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出院後 30 天內遞交。

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

Name of Policyholder 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 Policyholder 與保單持有人關係 :	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 similar condition? If yes, please give details as below :
閣下是否曾經因此或同類病況而求診 / 接受治療? 如有，請列出有關資料如下: ☐ No 沒有 ☐ Yes 有

Date of Consultation / Treatment 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 :

(1) I/We declare that the above information is in all respects true and correct to the best of my/our knowledge and belief.
(2) I/We acknowledge and agree that you may:
  (a) collect, use and disclose my/our (and my/our dependent's, if applicable) and the claimant's personal information (including but not limited to credit information and claims history) for the purposes necessary to process my/our application, investigate and settle claims and detect and prevent fraud (whether or not relating to the policy issued in respect of this application); and
  (b) transfer my/our personal information to the following persons who may collect and use this information only as reasonably necessary to carry out the purposes described above: including, but not limited to, insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organisations that consolidate claims and underwriting information for the insurance industry; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph); self-regulatory or industry bodies or associations of insurance; claims investigation agencies; the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information (collectively, "Such Persons").
(3) I/We further agree that your Policy on Personal Data ("Data Policy"), a copy of which is available upon request or from www.hl-insurance.com, shall apply and my/our personal information may be used, disclosed and/or transferred in accordance with the Data Policy.
(4) I/We hereby authorize any Such Person or any other person or organization that has any records or knowledge of me/us including without limitation my/our health, insurance or claim history to furnish to your company or your authorized representative, any personal data and other information with respect to any medical history (if applicable), insurance or claim history concerning me/us or to any loss, damage, theft or other events connected with my/our insurance or claim history and copies of all relevant records. 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.
(5) I/We declare and confirm that I am / we are duly authorized by the claimant(s) to submit this claim application to you, all information (including personal data) provided to you in this claim application relating to the claimant(s) is collected by lawful means and with the consent of the claimant(s). I/We further confirm that the claimant(s) agree to be bound by the Data Policy and consent to the use and disclosure of their personal data by you for any of the above-mentioned purposes and in accordance with the Data Policy.
(一) 我/我們現聲明上述所填報的資料在各方面盡我/我們所知及所信均為正確無訛。
(二) 我/我們明白並且同意貴公司可：
  (a) 收集、使用和披露我/我們(及我/我們的家屬，如適用)及索償人的個人資料（包括但不限於信用資料和以往申索紀錄），以用作處理我/我們的申請、調查和結清申索、以及偵測和防止欺詐行為（無論是否與就本申請而發出的保單有關）所需的目的；及
  (b) 把我/我們的個人資料轉移給以下人士，而他們只能在有合理需要履行上述目的之情況下才可收集和使用這些資料：包括但不限於保險理算人、代理和經紀；僱主；醫護專業人士；醫院；會計師；財務顧問；律師；整合保險業申索和承保資料的組織；防欺詐組織；其他保險公司（無論是直接地，或是通過防欺詐組織或本段中指名的其他人士）；自我規管或行業機構或保險業聯會；理賠調查機構；警察；和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊（及其運營者）(合稱「該等人士」)。
(三) 我/我們並同意貴公司之「個人資料政策」(「該資料政策」)會被引用，貴公司可按照該資料政策使用、披露及/或轉移我/我們的個人資料。我/我們可以向貴公司索取或從網址 www.hl-insurance.com 下載該資料政策。
(四) 我/我們茲授權該等人士或任何持有我/我們記錄或資料(包括但不限於健康、投保資料、索償記錄)之人士／機構，可以將任何有關我/我們的個人資料及其他有關我/我們之病歷(如適用)、投保資料、索償記錄或有關我/我們保險、索償記錄所涉及之損失、損毀、盜竊或其他事故等資料及所有有關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我/我們之任何索償。
(五) 我/我們聲明及確認，我/我們獲索償人適當授權向貴公司遞交本索償申請，且我/我們就本索償申請向貴公司提供的所有有關索償人的資料包括個人資料均以合法途徑收集並獲索償人同意。我/我們進一步確認索償人同意受貴公司之「個人該資料政策」所約束並且同意貴公司按照以上列明之任何用途及貴公司之「個人該資料政策」使用及披露其個人資料。

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 similar condition 閣下首次替病人就此或同類病況診治的日期 :

(9) The date on which the patient first received consultation for this or similar condition 病人首次就此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復發或是與其 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