

團體醫療索償表格

Group Medical Claim Form

門診索償 OUTPATIENT CLAIM

牙科索償 DENTAL CLAIM

由受保人填寫 To be completed by Insured Member

僱主名稱 Employer Name: _____	團體保單編號 Group Policy No.: _____
僱員英文姓名 Employee English Name (In Full): _____	保險証編號 Certificate No.: _____
病人英文姓名 Patient English Name (In Full): _____	家屬編號 (如適用) Dependent No. (If applicable): _____

正本收據將不獲發還。如需取回收據的核實副本，請於方格內加上"✓"。
Original receipt will not be returned. Please "✓" this box for return of certified true copy of receipt.

A. 門診索償 OUTPATIENT CLAIM

診症 / 治療日期 Date(s) of Consultation / Treatment (日 / 月 / 年) (DD / MM / YY)	費用 Amount Charged	診症類別 (必須已列於保單的保障範圍內) Type of Treatment (Should be covered under the policy) * 請圈出合適類別 Please circle the appropriate type	病人自行聲明病症 Self Declaration of Diagnosis 只適用於醫管局轄下的醫院門診部或政府門診 For Claims Incurred at Outpatient Dept. under Hospital Authority / Government Clinics Only
1.		* GP / SP / CMP / Others: _____	病症 Diagnosis
2.		* GP / SP / CMP / Others: _____	病症 Diagnosis
3.		* GP / SP / CMP / Others: _____	病症 Diagnosis
4.		* GP / SP / CMP / Others: _____	病症 Diagnosis

* GP = 普通科 General Practitioner SP = 專科 Specialist CMP = 中醫 Chinese Medical Practitioner
其他 Others = 物理治療 Physiotherapist / 脊醫 Chiropractor / X光 X-ray / 化驗 Lab tests / 例行檢查 Routine Checkup / 住院前之診症 Pre-hospitalisation consultation / 住院後之診症 Post-hospitalisation consultation / 等 etc

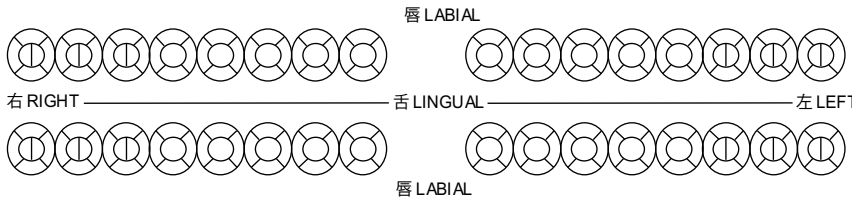
B. 牙科索償 DENTAL CLAIM

遞交牙科索償前，請確保閣下之保單有提供牙科保障。 Please ensure you are covered under the dental benefit before submitting dental claims.

須由應診牙醫填寫。 To be completed by your attending dentist.

日期 Date	治療項目 Particulars	費用 Amount Charged
1. _____	_____	_____
2. _____	_____	_____

請於下圖註明病人接受治療的牙齒或口腔位置。 Please mark teeth treated or area of oral treatment on the following chart.



牙醫簽署及診所印章
Signature of Dentist and
Clinic Chop

簽署日期
Date Signed

C. 聲明及授權書 DECLARATION & AUTHORIZATION

<p>本人明白，同意並謹此聲明：</p> <p>1 本人謹此證明，本人於本表格所提供的一切資料為本人所知的全部及為真確無誤。</p> <p>2 本人授權任何醫生、醫學界執業人士、醫院、診所或其他與醫療有關的機構、保險公司或其他組織、機關或人士，將其所有關於本人及家屬的記錄或健康狀況資料，提供予宏利。此項授權書的影印本與正本同樣有效。</p> <p>3 本人於本表格內提供之資料及日後作出之任何修訂或補充(「資料」)，旨在確保宏利的保險或金融業務得以順利運作，而該等資料可供</p> <p>i) 宏利作以下用途：(a) 批核及管理本保單，或其後進行任何修訂、取消保單或續保事宜；(b) 核保、分析及處理賠償申請；(c) 供宏利、聯營公司或保險/金融業作統計或精算研究用途；(d) 透過保險中介人或直接推廣方式向本人提供/推廣宏利或聯營公司之保險或金融產品資料；及/或</p> <p>ii) 轉交予(a)任何有關連公司；其他從事與保險或再保險有關業務之公司；或保險業中介人、提供理賠、調查或其他保險業相關服務之供應商或現時已存在或日後組成之保險公司聯會或組織；(b)任何人士/機構以作上述用途及/或以配對或其他方法核實資料。</p> <p>4 本人已向所有受保家屬取得授權(如適用)，可向宏利提供其個人資料。本人亦明白本表內提供的資料是讓宏利作處理本人索償之用。</p> <p>5 本人有權以書面通知宏利的僱員福利部，要求索閱及更改個人資料(如需要)。本人亦可致函要求宏利不要向本人寄發宣傳推廣資料。</p> <p>6 本人明白並同意宏利有權要求受保人，因資料不確而退回已賠償之金額。</p> <p>7 本人已經細讀及明白此「團體醫療索償表格」之所有資料及內容；包括背頁所提供之索償指引及一般不受保項目。</p>	<p>I hereby DECLARED, UNDERSTOOD and AGREED that:</p> <p>1 All information provided by me in this form is complete and true to the best of my knowledge and belief.</p> <p>2 I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my Dependent to provide to Manulife any such information. A photocopy of this authorization shall be as valid as the original.</p> <p>3 Information provided herein together with any subsequent alterations or supplements of it ("data") are collected to enable Manulife to carry on its insurance/financial business and may be:</p> <p>i) used by Manulife or its associated companies for the purpose of (a) approving and administering the policy or any alterations, cancellation or renewal of it; (b) underwriting and any claims or analysis of it; (c) statistical or actuarial research of Manulife, Manulife's associated companies or the insurance/financial industry; (d) providing/promoting the insurance or financial related products or services to me through insurance intermediaries or direct marketing; and/or</p> <p>ii) transferred to (a) any related company or other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business or any association or federation of insurance companies that exists or is formed from time to time; (b) any person/organization to fulfill any of the above purposes and/or for the purpose of data verification by way of matching procedures or otherwise.</p> <p>4 I have obtained the necessary authorization from my Dependent to supply their information to Manulife if my Dependent is to be covered. I also understand that the information requested in this form is required in order for Manulife to process this claims.</p> <p>5 By writing to Manulife - Employee Benefits, I can request access to and correction of my personal data (if appropriate), I also understand that consent to the use of my personal information to offer me products and services is optional and if I wish to discontinue such use I may write to Manulife at the address shown at the back of this form.</p> <p>6 Manulife has the right to reverse / claim back any incorrect payment caused by incorrect information provided by me.</p> <p>7 I have read and understood the information and content provided in this entire "Group Medical Claim Form", including the Claims Instructions and General Exclusions provided overleaf.</p>
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病人/受保僱員簽署 (如病者不足18歲，則須受保僱員簽署)
Patient's/Insured Employee's Signature (For patient whose age is below 18, insured employee's signature is required)

日期 (日 / 月 / 年)
Date (DD / MM / YY)



索償指引：

- 1 請填妥及簽署此表格，並交回貴公司人事部或有關負責人。
- 2 附上正本醫療收據並清晰列明以下資料：
 - 病者姓名（請按照香港身份證或認可身份證明文件之姓名填寫）
 - 病症名稱
 - 診症 / 治療日期
 - 收費分類（如診金、藥費、化驗費等）
 - 醫生印鑑與簽署
- 3 如有關申索涉及化驗或X光檢查（請附上化驗資料以作參考）、物理治療、專科治療或醫生處方西藥，請附上醫生轉介書。化驗或X光檢查轉介書有效期為發信期內六個月，並只能使用一次。其他項目之轉介書於發信期內六個月有效。
- 4 索償表及收據必須於診症日後三個月內寄回團體保險理賠部。逾期提出申請或所需資料不全，索償申請將不受理。
- 5 如需索償，所有醫療服務必須由持有香港執業或當地認可資格及執業牌照之人員如醫生、牙醫、專科醫生、中醫師、脊醫及物理治療師等提供。
- 6 正本收據將不獲發還。而發還收據核實副本的申請必須於遞交此表格的三十日內交與宏利，否則該收據將會予以銷毀。
- 7 任何因索取醫療報告而需繳付的費用均不包括在保單的賠償範圍內。
- 8 索償牙科保障，須由應診牙醫填寫B部份。

一般不受保項目：

本公司將不會對下列各項開支作出任何賠償，於保障表內特別註明則除外：

- 1 與受保人因疾病或受傷而須接受之治療或診斷無關之定期身體健康檢查或檢驗，或並非必須之醫療服務。
- 2 先天性異常、有關不育之治療、絕育手術。
- 3 牙科護理及治療。惟保單有提供牙科保障除外。
- 4 整容手術、視力糾正及助聽器，及有關處方。受保人於受保期間因意外受傷而必須接受之治療則除外。
- 5 分娩（包括剖腹產子或因懷孕引致的狀況）。
- 6 直接或間接由於不論宣戰與否之任何戰爭、與戰爭有關之行動、暴動、叛亂或民眾騷動導致之受傷或疾病。
- 7 預防疫苗注射。
- 8 藥物及酒精治療。
- 9 精神障礙或心理治療。
- 10 受保人自殺、試圖自殺或蓄意自我傷害而招致之任何費用。
- 11 後天免疫力缺乏症（愛滋病）及與後天免疫力缺乏症有關之併發症。
- 12 受保前已存在之狀況。
- 13 勞工保償、保險公司或其他醫療保障計劃，已獲得賠償之醫療費用。

以上各項並未全數列出所有不受保項目，詳情請參閱有關保障條款。

請使用宏利客戶號碼及私人密碼，登入網址 www.manulife.com.hk，查詢各索償事項的狀況。

Claims Instructions:

- 1 Send this completed and signed form to your Human Resource Department or plan administrator.
- 2 Attach all original medical receipts (not bill or invoice) with clear information provided as follows:
 - Full name of the patient (must be identical with HKID card or other recognized personal identification)
 - Diagnosis of condition
 - Date of consultation / Treatment Date
 - Breakdown of charges (consultation fee, medication, laboratory fee etc.)
 - The attending Doctor's signature and chop.
- 3 Attach Doctor's referral letter for the diagnostic laboratory test or X-ray (attach details of laboratory tests taken for reference), physiotherapy treatment, Specialist consultation or Prescribed Medication from outside Clinic. The referral letter for laboratory tests or x-ray is valid once within 6 months from the date of issuance. Referral letter for other services is valid for 6 months from the date of issuance.
- 4 Claim(s) must be submitted to Group Claims Department within 3 months from the date of consultation / treatment. No reimbursement will be made for claims submitted late or with insufficient information.
- 5 All medical services must be rendered by a person who has professional qualifications pursuant to the relevant Registration Ordinance of Hong Kong or equivalent, and being authorized and registered in the geographical area of his practice and as a qualified medical practitioner, dentist, Specialist, Chinese medicine practitioner, chiropractor, physiotherapist etc.
- 6 Original receipt will not be returned. Written request of certified true copy of receipt should be submitted within 30 days after submission of this claim to Manulife. Otherwise, the medical receipts will be disposed.
- 7 Medical report fee will not be covered under the medical policy.
- 8 For dental claim, please have your attending dentist to complete Part B.

General Exclusions:

The Company shall not reimburse expenses incurred as a result of the following unless specified in the valid Benefit Schedule:

- 1 Routine physical examinations, health check-ups or tests not incidental to treatment or diagnosis of an insured sickness or injury or any treatment which is not medically necessary unless otherwise provided for in the Clinical Benefits Schedule.
- 2 Congenital anomalies, infertility, sterilization.
- 3 Dental care and treatment unless otherwise provided for in the Dental Benefit Schedule.
- 4 Cosmetic surgery, treatment on refractive errors or hearing aids except as necessitated by injuries wholly occurring during the period of insurance.
- 5 Childbirth (including surgical delivery or pregnancy related).
- 6 Injury or sickness arising directly or indirectly from war or any act of war, declared or undeclared, riots, insurrection, or civil commotion.
- 7 Vaccination and immunization injections.
- 8 Drug addiction or alcoholic treatment.
- 9 Treatment of functional disorders of the mind and psychological treatment.
- 10 Suicide, attempted suicide or intentionally self-inflicted injury, whether sane or insane.
- 11 Treatment of Human Immunodeficiency Virus (AIDS) or ARC (AIDS-related Complex).
- 12 Pre-Existing Conditions.
- 13 Expenses that have been recoverable from Employees' Compensation Law, any government or public programmes of medical benefits', other group or individual insurance.

This is not a comprehensive list of Exclusions, please refer to the specific Benefit Provision for details.

Please use your Manulife Customer Number (MCN) & PIN to check the claim status by login at website www.manulife.com.hk.