

團體醫療 - 住院及手術索償表格
Group Medical - Hospitalization & Surgical Claim Form

注意事項

- 1 請用正楷填寫本表格，並於適當空格內加✓號。如須作出任何更改，請於刪改之位置旁簽署。
- 2 提交之索償表格必須為正本。宏利將不接受以傳真遞交之索償表格。
- 3 必須附上正本單據及收條，單據及收條須包括診症日期、病者姓名、診斷以及主診醫生蓋章及簽署。
- 4 住院/診所手術費用賠償申請，必須於出院後三個月內遞交。
- 5 所有正本單據及收條俱不會發還，請自行影印副本。
- 6 父母必須替子女填寫及簽署本表格。
- 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。

Notes

- 1 Please complete this form in BLOCK LETTERS and check the boxes where appropriate. Please initial any corrections you make on this form.
- 2 Original claim form must be submitted. Claim form received by fax will not be accepted by Manulife.
- 3 Original bills and receipts for the claimed expenses must be attached showing the date of treatment, patient's name, diagnosis and the Attending Physician's stamp and signature.
- 4 Claim for hospitalization and surgical expenses must be submitted within 3 months from the date of discharge from hospital.
- 5 Original bills or receipts will not be returned. Please make copies as necessary.
- 6 Parents must complete and sign this form on behalf of their children.
- 7 Medical report fee will not be covered under the medical policy.

A. 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.: _____	
病人姓名 Patient's Name _____		香港身份証/護照號碼 HKID Card/Passport No. _____	
職業 Occupation _____		出生日期 Date of Birth _____ DD / MM / YY	性別 Sex <input type="checkbox"/> 男 M <input type="checkbox"/> 女 F
與保單持有人關係 Relationship to the Policyholder <input type="checkbox"/> 僱員/本人 Employee/Self <input type="checkbox"/> 配偶 Spouse <input type="checkbox"/> 子女 Child			
1 閣下是否曾經因同一病況而接受治療? Have you had any prior treatment for this or related conditions? <input type="checkbox"/> 否 No <input type="checkbox"/> 是 (請在下方列出詳情) Yes (Please provide details at below) 應診醫生姓名 Attending Doctor's Name _____ 地址 Address _____ 電話 Telephone _____ 應診日期 Consultation Date _____ DD / MM / YY			
2 有關此次住院/手術，閣下有否申請其他保險賠償? Are you making any other insurance claim as a result of this hospitalization/surgery? <input type="checkbox"/> 否 No <input type="checkbox"/> 是 (請在下方列出詳情)；而收據核實副本將於理賠處理完成後發還。正本收據將不獲發還。 Yes (Please provide details at below). A certified true copy of receipt will be returned after claim is processed. Original receipt will not be returned. 保險公司名稱 Name of Insurance Company _____ 保單號碼 Policy No. _____			
3 此次住院/手術是否由於一宗意外引致? Was the hospitalization/surgery a result of an accident? <input type="checkbox"/> 否 No <input type="checkbox"/> 是 (請在下方列出詳情) Yes (Please provide details at below) 意外日期 Date of Accident _____ 時間 Time _____ 地點 Place _____ DD / MM / YY 意外經過概述 Brief Description _____			

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.

B. 聲明與授權 DECLARATION AND AUTHORIZATION

<p>本人明白，同意並謹此聲明：</p> <ol style="list-style-type: none"> 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。 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。 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 <ol style="list-style-type: none"> 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 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。 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。 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。 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。 7 本人已經細讀及明白此「團體醫療 - 住院及手術索償表格」之所有資料及內容。 	<p>I hereby DECLARED, UNDERSTOOD and AGREED that:</p> <ol style="list-style-type: none"> 1 All information provided by me in this form is complete and true to the best of my knowledge and belief. 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. 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: <ol style="list-style-type: none"> 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 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. 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 claim. 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. 6 Manulife has the right to reverse / claim back any incorrect payment caused by incorrect information provided by me. 7 I have read and understood the information and content provided in this entire "Group Medical - Hospitalization & Surgical Claim Form".
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病者/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)



C. 由主診醫生填寫(所需費用由索償人自行承擔)**TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON (AT THE CLAIMANT'S OWN EXPENSES)**

1 病人姓名 Name of Patient _____

2 住院 Hospitalization

醫院名稱 Name of hospital _____

入院日期 Date of admission _____ 出院日期 Date of discharge _____

3 手術 Surgical operation

手術日期 Date of operation _____ 手術名稱 Name of operation _____

性質 Nature _____

4 此次住院/手術的主要病因 Chief complaints of the patient relating to this hospitalization/surgery

5 診斷 Diagnosis of conditions

6 出院撮要 (治療及以後治療計劃, 包括診查辦法、結果、併發症及跟進計劃)

Brief discharge summary (including treatments, investigation procedures, results, and/or any complications and follow up plan)

7 意外發生日期或首次出現病徵日期 Date of the accident occurred or symptom first appeared

8 病人首次求診日期 Date of first consultation for this condition or related illness

9 據閣下所知, 病人以前曾否患有同類病況?

To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto?

 否
No 是 (請在下方列出詳情)
Yes (Please provide details at below)日期和當時情況 _____
Dates and Details _____

10 病人是否經其他醫生轉介? Is the patient referred by another doctor?

 否
No 是 (請在下方列出詳情)
Yes (Please provide details at below)轉介醫生的姓名和地址 _____
Name and address of the referral doctor _____主診/專科醫生的姓名 (資歷)
Name of Attending Physician/Specialist (with qualifications)地址
Address電話
Telephone主診/專科醫生簽名及印鑑
Signature & Stamp of Attending Physician/Specialist日期
Date請把填妥的表格寄交九龍中央郵政局郵政信箱70302號宏利人壽保險(國際)有限公司。
Please return the completed form to Manulife (International) Limited, P.O. Box 70302, Kowloon Central Post Office.本表格之中文譯本只供參考用途, 若與英文版本有異, 一概以英文版本為準。
The Chinese version of this form is for reference only. In the event of discrepancies between the Chinese and English versions, the English version shall prevail.