Manulife 宏利

單一收據金額唔多過港幣3000元嘅索償，可以填好呢張索償表格，上載嚟呢度！
For single receipt not exceeding HK$3000, you can fill in this claim form and upload here!
claimsimple.hk

團體住院及手術索償表格 (本表格適用於住院或門診手術索償)
Group Hospitalization & Surgical Claim Form (This form is applicable to both hospitalization and outpatient surgical claim)

注意事項：

1. 請您填寫此表格前，細閱《有關〈個人資料（私隱）條例〉的客戶通知》(「通知」)。該通知可於宏利人壽保險（國際）有限公司（「宏利」）網址 (www.manulife.com.hk)或向您的宏利顧問（「顧問」）索取。透過填妥及交回此表格，即表示您同意該通知之內容。

Notes:

1. Please read the Notice to Customers relating to the Personal Data (Privacy) Ordinance ("Notice") before you complete this form. The Notice is available on Manulife (International) Limited ("Manulife")'s website (www.manulife.com.hk) or upon request from your Manulife advisor ("Advisor"). By completing and returning to Manulife this form, you are agreeing to the Notice.

按索償次序的保單編號／受保證書編號 Policy No./ Cert No. **in Claim Sequence**:	產品類別 Type of products:		保單持有人／僱員／成員姓名 Name of Policyowner / Employee / Member:
1.	個人 Individual ☐	團體 Group ☐	
2.	個人 Individual ☐	團體 Group ☐	

第一部份PART I - 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（全名） Name of Employee (In Full):	保險證編號 Certificate No.:
病人姓名（全名） Name of Patient (In Full):	身份證/護照號碼 ID Card/Passport No.
職業 Occupation	出生日期 Date of Birth 日DD / 月MM / 年YY　性別 Sex ☐ 男 M ☐ 女 F

與受保僱員關係 Relationship to the Insured Employee ☐ 本人 Self ☐ 配偶 Spouse ☐ 子女 Child

☐ **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.

1 ☐ 此次索償曾於其他保險公司處理，現附上該保險公司的賠償通知書。
This claim was processed by another insurer before, and Payment Advice issued by the earlier insurer(s) is/are attached.

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?
☐ 否 No ☐ 是 (請在下方列出詳情) Yes (Please provide details in below)

保險公司名稱 Name of Insurance Company _____ 保單號碼 Policy No. _____

3 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?
☐ 否 No ☐ 是 (請在下方列出詳情) Yes (Please provide details in below)

現時主診醫生姓名（全名） Current Attending Doctor's Name (in full) _____ 電話 Telephone _____

首次應診醫生姓名（全名） First Attending Doctor's Name (in full) _____ 電話 Telephone _____

首次應診日期 First Consultation Date _____ 日DD / 月MM / 年YY

4 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?
☐ 否 No ☐ 是 (請在下方列出詳情) Yes (Please provide details in below)

意外日期 Date of Accident _____ 日DD / 月MM / 年YY 時間 Time _____ 地點 Place _____

意外經過概述 Brief Description

_____

_____

GC02

For office use only 公司專用： ☐ ID

→ 請參閱續頁 Please turn to next page

聲明及授權書 DECLARATION AND AUTHORIZATION

本人明白，同意並謹此聲明：

1. 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受保家屬的記錄或健康狀況資料，提供予宏利。此授權書是不可撤銷的，即使本人去世，此授權仍然生效。此授權書的影印本將與正本同樣有效。

3. 從本人／吾等／本人的家屬、保單持有人及擬受保人所收集的資料（包括但不限於個人資料、健康資料及索償記錄），可供宏利用於經營保險／金融業務之用，並可供：

   i) 宏利、其關聯公司、僱員、第三方供應商／服務供應商、再保險公司及／或分銷商使用於以下目的：(a) 處理本人申請，包括但不限於釐定資格及批核申請；(b) 核保；(c) 處理索償，包括但不限於管理、評估、裁決、調查、徵求外部專業意見、支付款項、差額管理、代位申索、分析及匯報事宜；(d) 付款請求及／或信貸服務；(e) 管理保單或有關保單的任何變更、取消或續期事宜；(f) 偵查及防範欺詐（無論是否與本申請書所簽發的保單有關）；(g) 提供客戶服務，包括但不限於跟進相關查詢，以及／或與閣下及／或閣下代表之間的通訊事宜；(h) 宏利、宏利的關聯公司或保險／金融行業所開展的統計或精算研究工作；(i) 基於自動化／人工智能的決策或分析；(j) 遵守適用法律、法規及其他相關目的。

   ii) 轉移至(a)任何相關公司或其他從事保險或再保險相關業務的公司、中介人、提供保險相關服務的索償、調查或其他機構，或任何現存或不時成立的監管／法定機構、協會或保險公司聯會；(b)以實現上述任何一項目的及／或以核對程序或其他方式進行數據核實、以及／或進行保單再保險事宜的任何個人／組織；(c) 醫護專業人員、醫院、會計師、法律顧問、僱主；(d) 為保險業整合索償及核保資料的機構、防範欺詐機構、其他保險公司（無論是直接轉移至或透過防範欺詐機構或本段所述之其他人士作出轉移）、執法機構 、可供保險業界根據現有資料進行資料分析和核實的數據庫或登記冊（及其營運者）。

   所有資料處理程序可能涉及將資料轉移至香港特別行政區或澳門特別行政區境內外的地方。

4. 本人同意宏利將有關由本人提供的所有資料傳回給保單持有人（即僱主）／受保僱員（如適用）。本人已向所有受保家屬取得授權（如適用），可(a) 向宏利提供其資料；及(b) 將所有其提供的資料傳回給保單持有人（即僱主）和本人。本人亦明白本表格內提供的資料是讓宏利作處理本人索償之用。

5. 宏利可按於《有關〈個人資料（私隱）條例〉的客戶通知》（「通知」）（適用於香港保單）／《宏利個人資料收集聲明（「聲明」）（適用於澳門保單）（如適用）所述，處理有關資料。

6. (只適用於索償申請文件為電子收據)本人特此聲明，附上之索償申請文件為電子收據，並同意在需要時按要求提供付款證明。倘若本人曾經就上述理賠個案向其他保險公司作出賠償申請，本人確認已經附上該保險公司的賠償通知書副本，以作餘額索償申請之用(如適用)。本人明白，倘若有其他保險公司曾就上述理賠個案作出賠償，宏利保留撤銷／取回已賠償之金額的所有權利。本人確認上述理賠個案在其他保險公司沒有正在進行的賠償申請。本人確認，作出以上聲明並不代表宏利保險（國際）有限公司（「 宏利 」）必須就任何有關索償負上理賠責任。

7. 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。

8. 本人已經細讀及明白此「團體住院及手術索償表格」之所有資料及內容。

I hereby DECLARED, UNDERSTOOD and AGREED that:

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. Such authorization shall survive me and shall be irrevocable. A photocopy of this authorization shall be as valid as the original.

3. Information (including but not limited to personal data and health information and claims history) collected from me/us/my dependent, the policyowner/policyholder and the proposed insured, can enable Manulife to carry on its insurance/financial business and may be:

   i) used by Manulife, its associated companies, employees, third-party vendors/service providers, reinsurers and/or distributors for the purpose of (a) processing my application, including, but not limited to, determining eligibility and approval; (b) underwriting; (c) handling claim(s) including, but not limited to, administering, assessing, adjudicating, investigating, seeking external professional advice, disbursing payment, shortfall management, subrogation, analysis and reporting; (d) requests for payment and/or credit services; (e) administering the policy or any alterations, cancellation or renewal of it; (f) detecting and preventing fraud (whether or not relating to the policy issued in respect of this application); (g) providing customer service, including but not limited to, any follow up on related enquiry and/or communication with you and/or your representative(s); (h) statistical or actuarial research of Manulife, Manulife's associated companies or the insurance/financial industry; (i) automated/ artificial intelligence decision making or profiling; (j) complying with applicable laws, regulations and other related purposes;

   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 regulatory/statutory bodies, 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; and/or reinsurance of the policy; (c) health care professionals, hospitals, accountants, legal advisors, employers; (d) 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), law enforcement agencies and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information.

   All data processes may involve a transfer of information to places either within or outside the Hong Kong Special Administrative Region/Macau Special Administrative Region.

4. I agree Manulife to transfer back all supplied information from me to the policyholder (i.e. the Employer)/ the insured employee (where applicable). I have obtained the necessary authorization from my dependent to (a) supply their information to Manulife; and (b) transfer back all supplied information from them to the policyholder (i.e. the Employer) and me if my dependent (if applicable) is to be covered. I also understand that the information requested in this form is required in order for Manulife to process this claims.

5. All information may be treated by Manulife in the same manner as mentioned in the "Notice to Customers relating to the Personal Data (Privacy) Ordinance" ("Notice") (for Hong Kong policy)/Manulife Personal Information Collection Statement ("Statement") (for Macau policy) (where applicable).

6. (Only applicable when the claim application document(s) is/are digital receipt(s)) I hereby declare that the enclosed claim application document(s) is/are DIGITAL receipt(s), and I agree to provide payment proof upon request if needed. If I have applied to other insurance company(ies) for payment(s) of the abovementioned claim, I confirm that a copy of the payment advice from that insurance company has been enclosed here in support of my/our application for the remaining balance of the claim (if applicable). I understand that Manulife reserves all rights to reverse / claw back any payment made if my claim has been paid by any other insurance company(ies). I confirm that there is no ongoing payment application in relation to the abovementioned claim at any other insurance company. I acknowledge that the making of this declaration shall not in any way determine the liability of Manulife (International) Limited ("Manulife") in any relevant claims settlement.

7. Manulife has the right to reverse/claim back any incorrect payment caused by incorrect information provided by me.

8. I have read and understood the information and content provided in this entire "Group Hospitalization & Surgical Claim Form".

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)

→ 請參閱續頁 Please turn to next page

第二部份 - 由主診醫生/外科醫生/專科醫生填寫(所需費用由索償人自行承擔)
PART II - TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON/SPECIALIST (AT THE CLAIMANT'S OWN EXPENSES)

病人姓名(全名) Name of Patient (in full) _____

醫院名稱 Name of hospital _____

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

病房級別 Level of hospital ward ☐ 頭等房 Private ☐ 二等房 Semi-Private ☐ 三等房 Ward ☐ 門診小手術 Clinical Surgery

1 求診記錄 Clinical Record :

a) 意外發生日期或首次出現相關病徵日期 Date of the accident occurred or symptom first appeared _____ 日 DD/月 MM/年 YY

b) 病人就此病況或有關疾病之首次求診日期 Date of first consultation for this condition or related illness _____ 日 DD/月 MM/年 YY

c) 病人就此次住院/治療/檢查所出現的相關症狀,主訴及病因 Symptoms, complaints and etiology of the patient relating to this hospitalization / treatment / investigation

_____

_____

_____

2 住院或手術詳情 Hospitalization or Surgical Details :

a) 最後診斷 Final Diagnosis _____

b) 手術日期 Date of Operation _____ 日 DD/月 MM/年 YY

手術的名稱 Name of Operation procedure(s) performed : _____

_____

c) 如病人於住院期間曾向其他醫生求診,請提供下列資料 If the patient has consulted other physician during hospitalization, please provide the following

醫生姓名 Name of physician _____ 原因 Reason _____

治療詳情 What treatment had the physician performed _____

d) 請提供出院撮要(包括開始時及持續出現的徵兆/病狀、病因、主要檢查的種類及結果、治療、併發症及覆診詳情) Please give a brief discharge summary (including onset and duration of signs and symptoms/disease, etiology, types and results of major examination, treatments, complications and follow up plan)

_____

_____

e) 若此次病症能在日間護理/診所內進行治療,請提供住院原因 Please provide reason(s) for hospitalization if this type of cases can be managed on day care/out-patient basis.

_____

_____

3 專業意見 Professional Comment :

a) 就閣下意見,病人是次入院治療是否因繼發性或慢性疾病所引致或與以往的主訴/診斷有關? In your opinion, was the patient hospitalized as a result of recurrent episode or a chronic illness or related to a previous complaint/diagnosis.

☐ 否 No ☐ 是 Yes (請提供首次發病日期及詳情 please provide date of the first episode and details)

_____

_____

b) 上述情況是否出於或併發於或與以下問題關連(請在適當空格填上 ✓ 號) Was the condition due to or complicated from or associated with the following? (Please tick the appropriate boxes)

☐ 牙科治療 Dental treatment	☐ 懷孕問題 Pregnancy related condition	☐ 先天性疾病/異常 Congenital condition/Abnormality
☐ 自我傷害 Self-inflicted injury	☐ 不育或絕育 Infertility or sterilization	☐ 發育問題 Developmental condition
☐ 濫用藥物或酒精 Abuse of drugs or alcohol	☐ 避孕 Contraception	☐ 遺傳性問題 Hereditary condition
☐ 精神紊亂 Mental disorder	☐ 美容性質的治療 Treatment for cosmetic purpose	☐ 自殺或企圖自殺 Suicide or attempt suicide
☐ 屈光不正 Refractive error	☐ 疫苗接種 Vaccination	☐ 一般身體檢查 General check up
☐ 愛滋病/愛滋病毒有關疾病 AIDS/HIV related illness	☐ 性病或性傳播疾病 Venereal disease, sexually transmitted disease	☐ 以上全部不適用 None of the above

4 其他 Other :

a) 病人是否由其他醫生轉介 Was the patient referred by another doctor?

☐ 否 No ☐ 是 Yes (請在下方列提供詳情 please provide details in below)

轉介醫生的姓名和地址 Name and address of the referral doctor _____

_____

b) 閣下是否該病人的慣常醫生 Are you the patient's usual physician? ☐ 否 No ☐ 是 Yes

本人特此聲明,就本人所知,上述所有資料均準確無誤 I hereby certify that information given above is accurate and true to the best of my knowledge.

主診醫生/外科醫生/專科醫生姓名及資歷
Name of attending Physician/Surgeon/Specialist & qualifications

地址及電話號碼
Address & Telephone

主診醫生/外科醫生/專科醫生簽署及蓋章
Signature and chop of attending Physician/Surgeon/Specialist

日期 (日 / 月 / 年)
Date (DD / MM / YY)

請將填妥的表格連同收據正本交 Please return the completed form and original receipts to:
適用於香港保單 - 九龍中央郵政局郵政信箱70302號宏利人壽保險(國際)有限公司團體人壽及醫療保險理賠部。
適用於澳門保單 - 澳門新馬路61號永光廣場14樓A宏利人壽保險(國際)有限公司澳門分行行政部。
For Hong Kong policy - GLH Claim, Group Life & Health Insurance, Manulife (International) Limited, P.O. Box 70302, Kowloon Central Post Office.
For Macau policy - Manulife (International) Limited, Macau Administration Office, Avenida De Almeida Ribeiro No. 61, Circle Square, 14 andar A, Macau.

此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 conflicts between the Chinese and English versions, the English version shall prevail.

Manulife 宏利

單一收據金額唔多過港幣3000元嘅索償，可以填好呢張索償表格，上載嚟呢度！
For single receipt not exceeding HK$3000, you can fill in this claim form and upload here!
claimsimple.hk

團體住院及手術索償指引
GROUP HOSPITALIZATION & SURGICAL CLAIMS INSTRUCTION

請於**治療／出院後3個月內**將索償表格及所需的索償文件遞交至貴公司人事部或有關負責人或以下宏利地址。
Please submit the requested information **within 3 months from date of treatment/discharge date from Hospital** to your Human Resources Department or plan administrator or Manulife Address :

適用於香港保單 - 九龍中央郵政局郵政信箱70302號宏利人壽保險(國際)有限公司團體人壽及醫療保險理賠部。
For Hong Kong policy - GLH Claims, Group Life & Health Insurance, Manulife (International) Limited, P.O. Box 70302, Kowloon Central Post Office.

適用於澳門保單 - 澳門新馬路61號永光廣場14樓A宏利人壽保險(國際)有限公司澳門分行行政部。
For Macau policy - Manulife (International) Limited, Macau Administration Office, Avenida De Almeida Ribeiro No. 61, Circle Square, 14 andar A, Macau.

索償文件清單 - 基本要求
CLAIMS DOCUMENT CHECKLIST - BASIC REQUIREMENTS

1. 已填妥之「團體住院及手術索償表格」(GC02) 及
   Fully Completed Group Hospitalization & Surgical Claim Form
   - 表格第一部份 (由病者／受保僱員填寫及簽署)
     Part I (To be completed by Patient/Insured Employee with signature)
   - 表格第二部份 (由主診醫生／外科醫生／專科醫生填寫、簽署及蓋章)
     Part II (To be completed by attending physician/surgeon/specialist with signature and chop)
2. 正本醫療收據／醫院收費單及收據
   Original medical receipt/ hospital statement of account & receipt
3. 正本賬單或發票 (如適用)
   Original Bill or Invoice (if applicable)
4. 化驗、檢驗、藥物、膳食和醫療套餐的費用細分 (如適用)
   Breakdown of charges of laboratory, investigation tests, medication, meal and medical package (if applicable)

想知更多有關住院索償，請掃描
To know the hospitalization claims submission, please connect

索償文件清單：附加要求
CLAIMS DOCUMENT CHECKLIST - ADDITIONAL REQUIREMENTS

適用於 Applicable for/When	附加文件 Additional Documents
已獲其他保險公司處理索償 Claim processed by other insurers	提供該保險公司發出之收據的核證副本及賠償通知書 Provide the certified true copy of the receipt and the settlement notice(s) / payment advice(s) issued by the other insurers
海外醫療收據 Overseas Medical Receipt	如果索償文件並非用中文或英文填寫，請要求醫生或醫療機構提供英文翻譯本 If the claim document is in neither Chinese nor English, kindly request an English translation from the doctor or medical facility.
如入住香港政府醫院 (只適用於普通病房) Hospital confinement at Hong Kong Government Hospital (Applicable to Ward Room only)	提供已列明**診斷**的出院紙副本 (在一般情況下，無須填寫團體住院及手術索償表格第二部份之醫生聲明) Provide a copy of the Discharge Summary/Slip with **diagnosis** issued by the hospital is required. (This could replace the Claim Form Part II (Doctor Statement) whenever possible.)
去疣／及良性表皮病變手術 Wart/Benign Skin Lesion Surgery	需提交由主診醫生填妥之「去疣／及良性表皮病變手術理賠 - 附加表格」，以及附上有關文件副本。請瀏覽宏利之網站 https://www.manulife.com.hk 及下載表格 Submit Wart/Benign Skin Lesion Surgery Claim - Supplementary Form completed by the attending doctor and a copy of related documents. Please visit Manulife website https://www.manulife.com.hk and download the Form

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 休養、療養治療。
14 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。

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 Rest cures, treatment in sanatoria.
14 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.

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.