Manulife 宏利

This is a fillable form. You can fill it in and print it for signature.

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

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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. 提交之
   ✓ 索償表格 ✓ 正本單據 ✓ 收條 ✓ 出院撮要
   需列明治療日期、病者姓名、病症連同主診醫生蓋章及簽署。以上文件必須於治療後三個月內遞交。
2. 背頁之醫生聲明須由主診醫生完整填妥。
3. 如在海外求醫，請提交各項收費服務、病症、手術名稱等之中文 / 英文翻譯本。
4. 如住院收據費用是HK$3,000或以下，索償一旦經由網站https://www.claimsimple.hk提交後，除非收到宏利通知，不需要提交該索償文件之正本。

Notes:

1. Submit
   ✓ Claim Form ✓ ORIGINAL Receipt ✓ Bills ✓ Discharge Summary showing date of treatment, patient's name, diagnosis with attending physician's stamp and signature within 3 months from date of treatment.
2. Doctor statement at the back page must be duly completed.
3. For overseas hospitalization/surgical treatment, please provide translation to English/Chinese on each item, diagnosis, operation name, etc.
4. For hospitalization's receipt amount at HKD3,000 or below, once the claim submitted via https://www.claimsimple.hk, there is no need to submit hardcopy document unless notice from Manulife.

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

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）；而收據核實副本將於完成處理索償後發還。正本收據將不獲發還。
Yes (Please provide details in 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 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 _____

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. 從本人收集及關於本人及/或受保家屬的資料（包括但不限於以往申索紀錄），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
   i) 宏利或其聯營公司作以下用途：(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)處理本人的申請、調查和結清申索、及偵測和防止欺詐行為（無論是否與就此申請而發出的保單有關）；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監管機構、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；與及安排再保險；(c)醫護專業人士、醫院、會計師、法律顧問、僱主；(d)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）、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）。

   所有資料處理過程或會涉及資料移轉至香港特別行政區/澳門特別行政區及以外地區。
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. 本人有權以書面通知宏利僱員福利部之個人資料主任，要求索閱及更改個人資料（如需要）。
6. 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。假如本人未有細閱該通知/聲明（如適用），本人可從本人的宏利中介人或透過宏利網址www.manulife.com.hk取得該通知/聲明（如適用）。
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 collected from me and in respect of me and/or my dependent (including but not limited to claims history) can enable Manulife to carry on its insurance/financial business and may be:
   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) processing my application, investigating and settling claims and detecting and preventing fraud (whether or not relating to the policy issued in respect of this application); 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 regulatory 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), the police 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. By writing to the Privacy Officer of Manulife - Employee Benefits, I can request access to and correction of my personal data (if appropriate).
6. 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). In case I have not read the Notice / Statement (where applicable) before, I can obtain such Notice / Statement (where applicable) from my Manulife's intermediary or through Manulife's website at www.manulife.com.hk.
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)

For office use only 公司專用： ☐ ID

→ 請參閱續頁 Please turn to next page

Please download the latest version at Manulife website 請在宏利網站下載最新版本 https://www.manulife.com

Manulife (International) Limited *(Incorporated in Bermuda with limited liability)*
宏利人壽保險（國際）有限公司 *（於百慕達註冊成立之有限責任公司）*

ISO 9001
Certified to Manulife Employee Benefits

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)

Please return the completed form and original receipts to 請將填妥的表格連同收據正本交：
For Hong Kong policy - Employee Benefits, 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.
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)有限公司僱員福利部 。
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。