宏利
Manulife

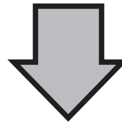
ManuMaster/ManuShine Healthcare Series/Benefit 晉領/ 活亮人生保障系列/ 附加保障

Credit Service for Hospitalization 代繳住院費用服務 – Simple Steps簡易程序

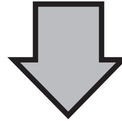
Hong Kong Enquiry Hotline 香港查詢熱線：(852) 2510 3941; China Toll Free 中國免付專線：4008 428 017

Please complete and return Pre-Authorization Request Form to us at least five working days before admission to hospital. 請在入院前最少五個工作日交回已填妥的初步授權申請表。

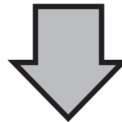
Email電郵地址：*preauth@manulife.com*



When the pre-authorized amount has been confirmed, we will send you a Letter of Confirmation and inform the hospital concerned of the pre-authorized amount. 初步授權金額一經批核，我們會發出「批核確認書」給您並通知有關醫院。



If the Insured is admitted to hospital, please present his/her identification document to the hospital for verification. 入院時，請向醫院出示受保人的身份證明文件以作核實。



At time of discharge, please (a) settle any deductible and/or net balance that exceeded the pre-authorized amount; (b) submit a completed Hospitalization & Surgical Claim Form to us. When our Claims Department receives the invoice from the hospital and completes your claims assessment, we will notify you if there is a shortfall that you need to settle. 出院時，請您(a)向醫院繳付任何自付額及/ 或扣除初步授權金額後的淨額；(b)填妥及交回住院及手術賠償表給我們。當理賠部接獲醫院單據及完成評估後，會通知您有否差額需要您支付。

Note 敬請注意：

1. A final decision regarding the Pre-Authorization Request Form is subject to the discretion of Manulife. 宏利保留初步授權申請表的最後決定權。
2. If hospitalization is due to illness/disability classified under exclusion or other reasons, no pre-authorized amount will be issued. 如因不受保事項或其他原因而引致入住醫院，將不會獲發初步授權金額。
3. You will be required to provide treatment information and authorize Manulife to collect any shortfall including any uncovered items, and so on, from your authorized credit card account. 您須提供治療資料及授權宏利從您授權的信用卡帳戶中收取差額費用，包括任何不受保障項目等。
4. Please fill in and return the completed Hospitalization & Surgical Claim Form. It is a required part of the Credit Service for Hospitalization and may affect future approval on Credit Service if it is not completed. 如要使用代繳住院費用服務，必須填妥並交回住院及手術賠償表，否則有可能影響將來代繳住院費用服務的審批。
5. When using the Credit Service for Hospitalization, ManuMaster/ManuShine will take priority over other medical plans during the medical claims assessment. 如使用代繳住院費用服務，宏利進行醫療理賠評估時，會先從「晉領/ 活亮人生醫療保障」作出賠償。

宏利 Manulife

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ManuMaster/ManuShine Healthcare Series/Benefit 晉領/ 活亮人生醫療保障系列/ 附加保障 Pre-Authorization Request Form 初步授權申請表

Part I – To be completed by Policyowner/Insured 第一部份由保單持有人或受保人填寫

Please complete this form and return to Manulife (International) Limited (“Manulife”) by email (**preauth@manulife.com**) at least 5 working days prior to admission to hospital.
請填妥此表格並於入院前最少五個工作天，以電郵方式**(preauth@manulife.com)**遞交予宏利人壽（國際）有限公司（“宏利”）。

Note: When the Insured is discharged from hospital the hospital will send the invoice to Manulife. However, a completed Hospitalization Claim Form is still required for our claims assessment. If there is any shortfall, a shortfall notification will be sent to the Policyowner. 註：當受保人出院後，醫院會將單據遞交予宏利。但保單持有人或受保人仍須遞交一份已填妥之住院賠償申請表格予宏利以作賠償評估。如有任何差額,差額通知書將會寄予保單持有人。

Policy Number 保單號碼：	Name of Policyowner 保單持有人姓名：
Name of Insured 受保人姓名：	Insured I.D. Card/Passport Number 受保人身份證/ 護照號碼：
Advisor's Name 保險顧問姓名：	Advisor's Code 保險顧問編號：
Branch Code 分行編號：	Location 地點：
Advisor's Contact No. 保險顧問聯絡電話號碼：	

FOR HOSPITALIZATION DUE TO ACCIDENT, PLEASE COMPLETE QUESTIONS 1 TO 5 因意外受傷入院請填寫問題1至5
1. Date of accident 意外日期DD日/MM月/YYYY年
2. Where and how did the accident happen 意外地點及經過：
3. Part of body injured and type of injury 受傷部位及傷勢：
4. Present occupation (if more than one, state all) and exact nature of occupation duties 現職（若有兼職請列明）職位及職責：
5. Name and address of business or employer 公司或僱主名稱及地址：
FOR HOSPITALIZATION DUE TO ILLNESS, PLEASE COMPLETE QUESTIONS 6 TO 8 因疾病入院請填寫問題6至8
6. Give a brief description of symptoms 描述病徵
7. How long have these symptoms existed prior to the first consultation? 該等病徵在首次求診前已存在多久？
8. Give details of consultations 診治詳情 (a) The doctor first consulted for this illness首次就診的醫生資料(Date 求診日期 DD日/MM月/ YYYY年)： (b) Name and address of clinic/hospital 診所/ 醫院名稱及地址：

Part II – To be completed by the Insured's attending Physician/Surgeon at the Policyowner/Insured's expenses if any.
第二部份由受保人之主診醫生或外科醫生填寫(如有需要,保單持有人或受保人需自行承擔填寫表格費用)

Name of Patient 病人姓名:	Sex 性別: ☐ Male 男 ☐Female 女
Hospital name 醫院名稱:	Room Class 住房級別: ☐ Ward 普通病房 ☐ Semi-prive 半私家 ☐ Private 私家 Room Price (per day) 住房價格(每日):
Planned Date of Admission (DD/MM/YY) 預計入院日期(日/ 月/ 年):	
Planned Number of days of Confinement 預計住院日數:	

Medical Condition醫療詳情

1. Chief complaint of current consultation 是次就診之主訴:

2. Diagnosis and associated signs and symptoms 診斷和相關病狀及病徵:

3. Onset date of first symptoms 首次發病日期(DD日/ MM月/ YY年):

4. First consultation date of first symptoms 首次發病求診日期 (DD日/ MM月/ YY年):

5 Is the condition recurrent/chronic? 此情況是否為復發性/ 慢性?
☐ Yes 是 ☐ No 否
If "Yes", onset date of the first episode 如"是",首次病發日期(DD日/ MM月/ YY年):

6. Is the hospitalization/treatment medically necessary? 是次入院/ 治療是否醫療所需?
☐ Yes 是 ☐ No 否
If "Yes", please give details. 如是,請詳述之。

7 Given the condition of the patient, is it possible to provide this treatment on an outpatient basis? 根根據你的評估及意見,病人就是次的病況,是否可以單從門診設施中接受是次治療?
☐ Yes 是 ☐ No 否
If "No", please explain 如"不可以",請提供原因:

8. Is illness/injury related to the following condition 此疾病/ 受傷是否由以下情況引起:

a) Congenital/Hereditary anomaly 先天性異常	☐ Yes 是	☐ No 否
b) Psychiatric condition 精神病	☐ Yes 是	☐ No 否
c) Influence of alcohol ,drug or intoxicant 酒精,藥物或麻醉劑影響	☐ Yes 是	☐ No 否
d) Obesity, weight control 肥胖,體重控制	☐ Yes 是	☐ No 否
e) Pregnancy, childbirth, abortion 懷孕、分娩、流產	☐ Yes 是	☐ No 否

9. Has the patient ever had the same or similar symptoms/medical conditions before? 病人是否曾經患有同一或相似病徵/ 病況?
☐ Yes 是 ☐ No 否
Please state when and describe details. 請說明何時及描述詳情。

10. Is the patient having any treatments or taking medicines? 病人現在是否接受任何治療或服用藥物?
☐ Yes 是 ☐ No 否
Please provide details (including onset date, consulted doctor's name, diagnosis, name of medicine taking, etc) 請提供詳情(包括病發日期,應診醫生姓名,診斷,藥名等)

Treatment Details 治療詳情

11. Surgery/treatment required 建議之手術/ 治療：

Estimated Surgeon fee charge 預計外科手術費：

12. Anaesthesia 麻醉： ☐ General 全身麻醉 ☐ Local 局部麻醉

Estimated Anaesthesia Fee 預計麻醉費用：

Estimated Operation Theatre Fee 預計手術室費用：

13. Please list out any lab tests/imaging/other diagnostic investigation required for the hospitalization and reasons forhaving those.
建議需要住院之化驗/ 影像檢查/ 其他診斷性檢查及接受該等檢查的原因。

Can the investigations be carried out in the outpatient setting? 是否可以從門診設施中接受該等檢查？

Estimated hospital expenses charges 預計醫院費用：

14. Doctor's Visit Fee 醫生巡房費：__________________/day每日

Specialist Fee 專科醫生費：

15. Estimated total fee for this confinement 預計是次住院總費用：

Doctor's information 醫生資料

Are you related to the patient in any way other than your professional capacity? 除專業身份外，與病人是否有其他關係？

☐ No 否 ☐ Yes, please specify the relationship with patient 是，請註明與病人之關係：

Doctor's name 醫生姓名：	Signature of Doctor and chop 醫生簽署及印章：
Contact no 聯絡號碼：	
Fax no. 傳真號碼：	Date日期：______________________________ (DD日/ MM月/ YY年)

Part III – To be completed by Policyowner/Insured 第三部份由保單持有人或受保人填寫

Credit Card Authorization for Shortfall Collection 收取差額費用之信用卡授權書

If the amount paid by Manulife (International) Limited ("Manulife") to the hospital exceeds the eligible claim payout arising from this hospitalization, this form authorizes Manulife to collect the shortfall amount from the following credit card account. The credit card holder must be the Policyowner or the Insured or has direct relationship with the Policyowner and/or the Insured e.g. spouse, parent, etc. A shortfall notice will be sent to Policyowner 14 days prior to the collection.
如宏利人壽保險(國際)有限公司("宏利")向醫院支付的費用超出是次住院之合資格保障應支付的賠償額,此授權書將授權宏利從以下信用卡户口收取有關差額。信用卡持卡人必須為保單持有人或受保人,或與保單持有人及/或受保人有直接關係,如配偶或父母等。本公司將於收取差額費用14天前發出差額付款通知書予保單持有人。

I hereby authorize and direct Manulife to debit the outstanding shortfall due from my credit card account.
本人特此授權及指示宏利從本人之信用卡户口扣除到期之差額費用。

X ______________________
Name of Cardholder 持卡人姓名

Credit Card No. 信用卡號碼
(Visa or Master Card Only 只適用於Visa or Master Card)

Credit Card Expiry Date 信用卡到期日

____
Cardholder's Signature 持卡人簽署

____
Signature Date 簽署日期

Part IV – Declaration and Authorization 第四部份 – 聲明及授權

I/We hereby declare that the answers to the above questions are full and true to the best of my/our knowledge. I/We further authorize any physician, hospital, insurance company, claims investigation company, government authority or organization that has any record or knowledge of me/us, my/our health or my/our activities (including records relating to Social Welfare, Workers' Compensation, credit, financial, earnings and employment history) to furnish to Manulife or its authorized representative such information including without limitation all information with respect to any illness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photostatic copy of this authorization shall be as effective and valid as the original. 本人/我們特此聲明填報於本表格內之資料已是本人/我們所知之全部並為真實無訛。本人/我們茲授權任何醫生、醫院、保險公司、賠償調查公司、政府有關部門或其他持有本人/我們個人資料、健康狀況或記錄(包括有關本人/我們所獲之社會福利及勞工賠償、本人/我們之存款、財政狀況、入息及就業記錄)之組織可以將該等資料,包括但不限於所有有關本人/我們之疾病或受傷,傷患之病歷、診斷報告、藥方或治療及所有醫院或醫療記錄副本等資料予宏利或其代理人。此授權書之複製本與正本具同等效力。

I/We hereby authorize that: 本人/我們茲授權:
In the event that Manulife has settled any charges not covered in the policy or exceeds my/our eligible benefit limit, Manulife shall have the right to deduct any of such charges from the credit card as specified in Part III in this Pre-Authorization Request Form. However, if Manulife cannot collect such shortfall due to insufficient credit available in the credit card account or for any other reason whatsoever, Manulife shall have the right to offset the shortfall amounts against the amount due or payable to me/us from this Policy/Benefit and/or any Policy/Benefit issued by Manulife of which I/we am/are the owner(s) or trustee(s) including but not limited to any death benefit (to the extent it is permissible by law), dividends or return of premium (for whatever reason). 若宏利有為本人/我們支付任何不在受保障範圍內的費用,或支付超出合資格保障限額的費用時,宏利將有權從本初步授權申請表第三部份所指定的信用卡中扣除任何相關的金額。若宏利因有關信用卡户口的信用額不足,或不論任何其他原因以至未能收取該筆差額,宏利將有權把應收款項從此保單/保障,及/或任何由宏利簽發並以本人/我們作為保單持有人或信托人的保單/保障所獲支付予本人/我們的金額中抵銷扣除,包括但不限於任何身故賠償(法律允許的範圍內),紅利或保費退還(不論何種原因)。

I/We understand that acceptance of this Pre-Authorization Request Form by Manulife shall not be regarded as admission of liability on the part of Manulife.
本人/我們明白宏利接受此初步授權申請表不能被視為宏利承擔有關賠償責任。

Personal Information Collection Statement 個人資料收集聲明
I/we acknowledge that the personal data provided in this Form will be used by Manulife for the purposes of processing, adjudicating and investigating claims application(s) and request(s) for credit service, approving and underwriting insurance applications, administering and reinsuring policies, complying with applicable laws and other related purposes and for such purposes, may be transferred to such persons or entities (whether within or outside Macao) as: (a) any person in connection with any claims made by or against or otherwise involving customers in respect of any products and/or services; (b) any agent, contractor or third party service provider who provides administrative, telecommunications, computer, information technology, payment, data processing or storage, marketing, mailing, printing, telemarketing, customer satisfaction analysis, or other services to Manulife or any member of Manulife's group of companies in connection with the operation of business, including any custodian, administrator, investment manager, investment advisor or distributor; (c) any credit reference agencies or, in the event of default, any debt collection agencies; (d) any advisor (including his or her employees) or other intermediary (including their employees); (e) reinsurers and medical service providers; (f) employers of the customers; (g) any person which has undertaken to Manulife or any member of Manulife's group of companies to keep such data confidential; (h) any actual or proposed assignee, transferee, participant or sub-participant of the rights or business of Manulife or any member of Manulife's group of companies ; (i) any member of Manulife's group of companies; (j) any person to whom Manulife or any member of Manulife's group of companies is under an obligation or otherwise required to make disclosure under the requirements of any law, rules, regulations, codes of practice, guidelines or guidances binding on or applicable to Manulife or any member of Manulife's group of companies including but not limited to any local or foreign regulators, governmental bodies, or industry recognised bodies; (k) any person to whom Manulife or any member of Manulife's group of companies is under an obligation or otherwise required to make disclosure pursuant to any contractual or other commitment or arrangement with local or foreign regulators, governmental bodies, or industry recognised bodies (whether within or outside Macao) that is assumed by or imposed on Manulife or any member of Manulife's group of companies by reason of its financial, commercial, business or other interests or activities in or related to the jurisdiction of the relevant local or foreign regulators, governmental bodies, industry recognised bodies. I/we understand that I/we am/are not obliged to provide such personal data as requested but if I/we refuse to provide such data, Manulife may not be able to proceed further on my/our application(s) and/or request(s) in this Form. I/we may request access to and correction of my/our personal data held by Manulife, by writing to Privacy Officer at Manulife (International) Limited, Macao Administration Office, Avenida De Almeida Ribeiro No.61, Circle Square, 14 andar A, Macao.
本人/我們確認載於本表格內之個人資料將被宏利用以處理、判定及調查有關之索償及代繳費用服務申請,批核及承保保險申請,管理保單並安排分保,遵守適用法律及其他相關用途並就此等用途,該等個人資料可被轉送到下列人士或機構(無論在澳門境內還是境外)(a)與客戶、針對客戶或涉及客戶就任何產品及/或服務提起的任何索賠相關的任何人士;(b)向宏利或宏利的公司集團任何成員提供與業務經營相關的行政管理、電信通訊、電腦、資訊技術、付款、資料處理或儲存、市場推廣、郵寄、列印、電話行銷、客戶滿意度分析或其他服務的任何代理、承辦商或第三方服務供應商,包括任何託管人,執行人,投資管理人,投資顧問或分銷商;(c)任何信貸資料服務機構或(如出現付款違約)任何債務托收機構;(d)任何顧問(包括其僱員)或其他中介人士/機構(包括其僱員);(e)再保險商和醫療服務供應商;(f)客戶的僱主;(g)已向宏利或宏利的公司集團任何成員承諾將對該等資料保

密的任何人士；(h)宏利或宏利的公司集團任何成員的權利或業務的任何實際或擬議受讓人、承讓人、參與人或次級參與人；(i)宏利的公司集團任何成員；(j)宏利或宏利的公司集團任何成員根據對其有約束力或適用的任何法律、法規、規章、守則、指引或指南的規定有義務或必須向其披露的任何人士，其中包括但不限於任何當地或外國的監管機構、政府機構或公認行業組織；(k)根據由於宏利或宏利的公司集團任何成在相關當地或外國監管機構、政府機構、或公認行業組織（無論在澳門境內還是境外）所在司法管轄區的或涉及該等司法管轄區的財務、商業、業務或其他利益或活動而由宏利或宏利的公司集團任何成員承擔或施加給其的、與該等當地或外國監管機構、政府機構、公認行業組織之間的任何合同、其他承諾或安排，有義務或必須向其披露的任何人士。本人/我們明白本人/我們並無責任提供該等個人資料。但如果本人/我們拒絕提供該等資料，宏利可未能繼續處理本人/我們的申請及/或本表格內之申請.本人/我們可去信個人資料主任於宏利人壽保險(國際)有限公司，澳門分行行政部，澳門新馬路61號永光廣場十四樓A要求查閱及更改本人/我們在宏利之個人資料。

×

Signature of Insured (if Aged 18 or Above) * 受保人簽署（如十八歲或以上）*	Name (In BLOCK LETTERS) & I.D. No. of Insured 受保人姓名（請以正楷書寫）及身份証號碼	Date (DD/MM/YYYY) 日期（日/月/年）

×

Signature of Policyowner 保單持有人簽署	Name (In BLOCK LETTERS) & I.D. No. of Policyowner 保單持有人姓名(請以正楷書寫)及身份証號碼	Date (DD/MM/YYYY) 日期（日/月/年）

* For Insured aged below 18, signature of the policyowner <u>must</u> be provided for the application for Pre-Authorization Request
十八歲以下受保人之初步授權申請必須由保單持有人<u>簽署</u>