redefining / standards

Medical Insurance - Hospitalisation & Surgical Claim Form 醫療保險－住院及手術賠償表

This form is applicable to both Inpatient and Outpatient surgical claims

本表格適用於住院或門診手術賠償

Part 1 - To Be Completed by the Patient 甲部－由病人填寫

Provide the meal breakdown record.
請提供所有膳食記錄

Name of Employer 僱主名稱:

Name of Employee 僱員姓名:
(For Group Insurance Policy only)

Policy No 保單號碼: | Certificate No. 保險證號碼:

Name of the Patient 病者姓名: | HKID Card No 身份証號碼:

Occupation 職業: | Date of Birth 出生日期:

Relationship with Employee 病者與僱員關係: ❑ Spouse 配偶 ❑ Child 子女

1) Have you had any prior treatment for this or related conditions? ❑ No 不是 ❑ Yes是
閣下是否曾經因同一病況而接受治療？

Doctor's Name 醫生姓名: ______

Address 地址: ______

______

Date(s) 日期: ______

2) Are you making any other insurance claim as a result of this hospitalisation/surgery? ❑ No 不是 ❑ Yes是
有關此次住院 / 手術，閣下有否申請其他保險賠償？

Name of Insurance Company 保險公司名稱: ______

Policy No 保單號碼: ______

3) Was the hospitalisation/surgery a result of an accident? ❑ No 不是 ❑ Yes是
此次住院 / 手術是否由於一宗意外引致？

Date 日期: ______ Time 時間: ______ Place 地點: ______

Brief Description 經過: ______

______

Declaration & Authorisation

I HEREBY DECLARE AND AGREE on behalf of myself and the Patient referred to in this claim form ("Relevant Persons") that (1) all statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true; (2) any personal data of the Relevant Persons collected or held by AXA China Region Insurance Company Limited ("the Company") (whether contained in this claim form or otherwise), may be used in connection with matching for whatever purpose (whether or not with a view to taking any adverse action against the Relevant Persons) with such other personal data and/or may be used, stored, disclosed, transferred (whether within or outside Hong Kong) to such persons as the Company may consider necessary including without limitation any of its affiliated companies, reinsurers or any individuals/organisations associated with the Company to (i) process and deal with this claim and underwrite and evaluate any other existing policies and/or application for insurance; (ii) provide all services (whether related to this claim or not) and promote, improve and further promotion of services by the Company and its affiliated companies; (iii) communicate with the Relevant Persons for any other purpose and/or comply with the laws of any applicable jurisdiction.

If the Relevant Persons fail to provide any information requested in this claim form, it may result in the Company's inability to process and deal with this claim.

I DECLARE AND AGREE that I have the full authority from and consent of the Patient to make the declarations, agreements, and authorisations in this claim form.

The Relevant Persons have the right under the Personal Data (Privacy) Ordinance to request access to and correct any of the personal data held by the Company concerning the Relevant Persons. Any request may be made in writing and addressed to the head of the Employee Benefits Services at 19/F AXA Centre 151 Gloucester Road Wanchai Hong Kong.

I HEREBY AUTHORISE on behalf of the Patient (1) any employer, medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of the Patient and/or who has attended or may hereafter attend to the Patient to disclose such information to the Company; (2) the Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessments and tests to evaluate the health status of the Patient in relation to this claim. This authorisation shall bind the Patient's successors and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.

聲明及授權

本人謹此代表本人／病者及其他在此賠償申請表提及之人士（"相關人士"）聲明及同意（1）上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所信，均為事實之全部並確實無訛；（2）安盛金融可以在任何情況下（不論是否打算對相關人士採取不利行動）核對安盛金融所收集或持有之任何相關人士的個人資料（不論是否此賠償申請表所載或從其他途徑所取得）及／或可以使用、儲存、透露、轉移（不論在本港或海外）任何安盛金融所收集或持有之任何相關人士的個人資料（不論是否此賠償申請表所載或從其他途徑所取得）給安盛金融認為有需要之人士，不受限制地包括安盛金融之任何關聯公司、再保公司或任何與安盛金融有關之人士／組織，以（i）審核及處理此賠償申請及／或審核及評估任何其他保單或投保申請；（ii）提供所有服務（不論與此賠償申請相關與否）及推廣、改善及進一步推廣關於安盛金融及其關聯公司所提供之服務；（iii）用於與相關人士作任何其他目的之溝通及／或遵從任何適用之司法區域之法律。

若相關人士不能提供任何此賠償申請表所需的資料，安盛金融可能因此不能審核及處理此賠償申請。本人聲明及同意已獲相關人士授權及同意本人作出在此賠償申請表的聲明、協議及授權。

所有相關人士有權依據個人資料（私隱）條例要求查閱及更正任何安盛金融持有關於相關人士之個人資料，所有要求均可以以書面向僱員福利部之主管提出（地址：香港灣仔告士打道151號安盛中心19字樓）。

本人謹此代表病者授權（1）任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、或其他組織、機構或人士、凡知道或持有任何有關病者之紀錄者，及／或診驗或可能將會診驗病者，均可將該等資料提供給安盛金融。（2）安盛金融或任何其指定之醫生或化驗所，可就此賠償申請替病者進行所需之醫療評估及測試，作為審核病者之健康狀況，此授權對病者之繼承人具有約束力，即使死亡或無行為能力時，此授權仍具效力。本授權書的影印本與正本均有同等效力。

Patient's Signature (Aged 18 and above) 病者簽名（十八歲或以上）	Employee's Signature 僱員簽名	Date 日期

Part II - To Be Completed by the Attending Physician/Surgeon at the Claimant's Own Expenses
乙部－由主診醫生填寫，所需費用由索償人自行承擔

Patient Name (in full) 病人姓名 (全名): ______

Date of Admission 入院日期 (DD日/MM月/YY年) ______ Date of Discharge 出院日期 (DD日/MM月/YY年) ______

Name of Hospital 醫院名稱: ______

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

1. Clinical History 求診記錄:

a) Date on which the patient first consulted you related to this illness / injury 病人就此疾病/受傷後, 首次向閣下求診的日期 (DD日/MM月/YY年) ______

b) Symptom(s) / complaint(s) of the patient relating to this hospitalisation / treatment / investigation 病人就此次住院/治療/檢驗所出現的相關症狀及主訴

______

______

c) How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前已患有此症狀多久? ______

2. Hospitalisation Details 住院詳情:

a) Final Diagnosis 最後的診斷 ______ Date of Operation 手術日期 (DD日/MM月/YY年) ______

b) Operation procedure(s) performed 手術的名稱 ______

c) If the patient has consulted other physician during this hospitalisation, please provide the following 如病人於住院期間曾向其他醫生求診，請提供以下資料:

Name of physician consulted 醫生姓名 ______ Reason 原因 ______

What treatment had the physician performed 治療詳情 ______

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

______

______

e) Please provide reason(s) for hospitalisation if this type of cases can be managed on day care / out-patient basis.
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。

______

______

3. Professional Comment 專業意見:

a) In your opinion, was the patient hospitalised as a result of recurrent episode or a chronic illness or related to a previous complaint / diagnosis.
If "yes", please provide date of the first episode and details.
就閣下意見，病人是次住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？ 若答案為 "是"，請提供首次發病日期及詳情。

______

______

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

- ❏ Accidental bodily injury 意外身體受傷
- ❏ Self-inflicted injury 自我傷害
- ❏ Abuse of drugs or alcohol 濫用藥物或酒精
- ❏ Mental disorder 精神紊亂
- ❏ Refractive error 屈光不正
- ❏ Pregnancy 懷孕
- ❏ Infertility or sterilization 不育或絕育
- ❏ Contraception 避孕
- ❏ Treatment for cosmetic purpose 美容性質的治療
- ❏ Vaccination 疫苗接種
- ❏ Congenital condition 先天性疾病 / 異常
- ❏ Developmental condition 發育問題
- ❏ Hereditary condition 遺傳性問題
- ❏ General check-up 一般身體檢查
- ❏ Venereal disease , sexually transmitted disease or AIDS / HIV related illness 性病，性傳播疾病或愛滋病/愛滋病毒有關的疾病

4. Others 其它:

a) If the patient was referred by another doctor, please provide the referring doctor's name and address. 如病人由其他醫生轉介，請提供轉介醫生的姓名和地址。

______

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

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

______ ______

Signature and chop of attending physician/Surgeon 主診醫生/外科醫生簽名及蓋章 | Address and Telephone No. 地址及電話號碼

______ ______

Name of attending physician/Surgeon & qualifications 主診醫生姓名/外科醫生姓名及資歷 | Date 日期 (DD日/MM月/YY年)

Part II of this claim form is endorsed by the Hong Kong Medical Association and Medical Insurance Association of The Hong Kong Federation of Insurers.
本索償表格乙部已獲香港醫學會及香港保險業聯會屬下醫療保險協會認可。

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