



Outpatient Medical Claim Form

團體門診醫療索償申請表

賠案編號

CLAIM NO.: \_\_\_\_\_

保單編號

POLICY NO.: \_\_\_\_\_

保單持有人名稱

POLICYHOLDER: \_\_\_\_\_

病者中文及英文姓名

PATIENT'S NAME: \_\_\_\_\_ ( )

職員

STAFF

配偶

SPOUSE

子女

CHILD

父母

PARENT

受保人中文及英文姓名

STAFF NAME: \_\_\_\_\_ ( )

受保人香港身份證號碼

STAFF I.D. NO.: \_\_\_\_\_

職員編號

MEMBER NO.: \_\_\_\_\_

| NO. | 診症日期<br>Consultation Date | 普通科門診索償金額<br>Consultation Fee | 專科門診索償金額<br>Specialist Fee | X 光或化驗索償金額<br>Lab/X-ray Fee | 中醫或跌打索償金額<br>Chinese Herbalist/<br>Bonesetter Fee | 牙科索償金額<br>Dentist Fee | 其他(請註明):<br>Others (Please specify) |
|-----|---------------------------|-------------------------------|----------------------------|-----------------------------|---|-----------------------|-------------------------------------|
| 1   |                           |                               |                            |                             |   |                       |                                     |
| 2   |                           |                               |                            |                             |   |                       |                                     |
| 3   |                           |                               |                            |                             |   |                       |                                     |

總收費 Total Amount HK\$ / RMB / US\$ / \_\_\_\_\_ :

- \* 祈請 閣下填寫此索償申請表時, 必須提供表格內之所有資料, 如中英文姓名、香港身份證號碼及索償金額等。
- \* Please complete all the information in this form.
- \* 請檢查 閣下提供之中醫或西醫門診賬單/結單/收據正本內是否清楚註明病人姓名、診症日期、診斷病症、醫療費用及醫生簽署。
- \* Original receipt of each claim submitted must including: Name of Patient/ Date of Consultation/ Diagnosis/ Amount of Charges and Doctor's Signature & Chop.
- \* 若申請專科、X 光化驗、物理治療及脊椎治療索償, 請提供有關之醫生推薦書。
- \* The Attending Physician's referral for Specialist, Lab, Test, X-ray, Physiotherapy and Chiropractic (where appropriate) claims must be attached.
- \* 此表格必須由受保人在診症後九十天內填報及寄回本保險公司, 逾期申請均不獲處理。
- \* This Claim Form must be completed and returned to the Insurance Company by the claimant within 90 days after incurring such expenses, otherwise claim will not be approved.
- \*  如需退回收據請於方格內劃✓號。
- \*  If need to return the original receipt, please tick.

**聲明及授權書:** 本人/我們現聲明並同意, 貴公司可保留、使用或透露貴公司所收集或保留之任何有關本人/我們的個人資料(在此申請書所載或從其他途徑取得), 給予與貴公司有關的人士/機構或任何被選定的機構(在本港或海外的, 包括再保險及賠償調查公司, 及有關的行業協會/聯會), 用作處理本申請及提供其稍後的服務, 及資料核對等用途, 及因此等用途與本人/我們聯絡。本人/我們明白到本人/我們有權向貴公司查閱及申請改正所有與本人/我們(及本人/我們的受贍養者, 如適用)的個人資料。有關的申請可於貴公司的理賠部辦理。  
本人聲明上述所填報之資料完全真實無訛。本人授權曾給予本人治療之醫生、醫院、診所提供有關此賠償申請所須之資料。  
本授權書之副本與正本有同等效力。

**Declaration & Authorization:** I/we hereby declare and agree that any personal information collected or held by the Company (whether contained in this application or otherwise obtained) is provided and may be held, used, and disclosed by the Company to individuals/organizations associated with the Company or any selected third party (within or outside of Hong Kong, including reinsurance and claims investigation companies and industry associations/federations) for the purposes of processing this application and providing subsequent services, and data matching, and to communicate with me/us for such purposes. I/we understand that I/we have the right to obtain access to and to request correction of any personal information held by the Company concerning me/us (and my/our dependents, if any). Such request can be made to the Company's Claims Department.

I hereby declare that the above statement and answers are complete and true, I hereby authorize any physician, medical practitioner, hospital or clinic from whom I received medical treatment to release any information pertaining to my claim. Photocopy of this authorization shall be as valid as original.

\_\_\_\_\_ Date 日期

\_\_\_\_\_ Signature of Claimant 申請索償者簽署