



Hospitalization Claim Form

團體住院醫療索償申請表

賠案編號
CLAIM NO.: _____

保單編號
Policy No.: _____

病者姓名
Patient's Name: _____

職員姓名
Staff Name: _____

入院日期
Date of Admitted: _____

原因/病症
Cause/Diagnosis: _____

醫生姓名及地址
Name & Address of Physician: _____

醫院姓名及地址
Name & Address of Hospital: _____

僱主名稱
Policyholder: _____

職員 配偶 子女 父母
Staff Spouse Child Parent

職員身份證號碼 職員編號
Staff I.D. No.: _____ Staff No.: _____

出院日期
Date of Discharge: _____

如住院是由於意外導致，請詳述意外發生時間，地點及過程

If hospitalization was the result of an accident, please describe when, where and how the accident happened.

有關此住院有否在其他保單中申請賠償。請詳述

Is there any other insurance or compensation claim as a result of this hospitalization? Please specify.

保險公司名稱

Name of Insurance Company: _____

賠償金額

Reimbursement Amount: _____

請附上賠償清單

Please submit the claim settlement sheet

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(在本澳或海外的，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。

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 Macau, including reinsurance and claims investigation companies and industry associations/federations) for the purpose 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.

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。

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.

Remarks附註: Please return original receipt(s) 請退回收據正本

Date 日期

Signature of Claimant 申請索償者簽署

CLAIM PROCEDURE 賠償手續

1. 每表只限一位索償申請人使用。

One form for each claimant.

2. 此表格必須由申請賠償者在出院後三十天內填報連同收據正本寄回保險公司，逾期申請均不獲處理。

This Claim Form must be completed and returned with all the original receipts to the Insurance Company by the claimant within 30 days after the discharged date otherwise claim will not be approved.

3. 所有保單內列明之“非承保範圍”均不予受理。

Payment of items and conditions listed under “EXCLUSIONS” on the Policy shall not be reimbursed.

4. 請填妥申請表所有資料。

Complete the form.

CHINA LIFE INSURANCE (OVERSEAS) CO. LTD.

Macau Branch

中國人壽保險(海外)股份有限公司

澳門分公司

Hospitalisation Insurance Attending Physician's Statement

住院醫療保險主診醫生證明書

Note: This statement should be fully completed and signed by Attending Physician. The expense must be paid by insured if necessary.

注意:本表須由被保人交予主診之註冊醫生填寫,並且保戶必須負責該表填寫費用。

| | | | | |
|---|---|--|--------------------------------------|-------------------|
| 1. Name of Patient: 病人姓名 | I.D.#: 身份証號碼 | Age: 年齡 | Sex: 性別 | |
| 2. Date of admitted: 入住日期 Period of Hospitalisation 住院天數 | Date of discharge: 出院日期 Hospital's #: 醫院檔案編號 | | | |
| 3. Was the patient referred to your hospital by a general practitioner? If yes, please indicate his/her name and address. 病人是否由註冊醫生推薦入院接受治療? 若是,請註明醫生姓名及地址。 | | | | |
| 4. a. When did the patient first receive medical attention for his sickness? 病人首次接受治療日期? b. Of what symptoms did the patient complain when he/she first saw you for this sickness? 當該病人首次接受治療時,所患疾病之病徵怎樣? | | | | |
| 5. a. According to the patient, how long had he/she been experiencing these symptoms? 根據該病人透露,他患此病徵有多久? b. How long do you feel the symptoms had lasted? Is it a congenital disease? 你認為該病人患此病徵已有多久? 是否與先天性疾病有關? | | | | |
| 6. Had the patient previously seen any other doctor on account of these symptoms? If yes, please indicate his/her name and address. 該病人曾否接受由其他醫生診治該疾病? 若有,請註明該醫生姓名及地址。 | | | | |
| 7. a. What was your final diagnosis? 出院診斷 b. Did you inform the patient of your final diagnosis? If yes, please state the time. 你有否將出院診斷告訴給該病人知道? 若有,何時透露? | | | | |
| 8. Kind of medical treatment give: 接受何種治療 Kind of operation performed: 接受何種手術 Date of performed 接受手術日期 | | | | Surgeon 外科醫生姓名 |
| 9. Any possibility of having a relapse? 該疾病是否有復發之可能? | | | | |
| 10. Has the patient previously been treated or hospitalized in this or any other hospital for this or any other serious disorder? If yes, please state. 病人曾否因患上述疾病及其他嚴重疾病接受醫生或入住醫院醫療? 有,請列明。 | | | | |
| Date 日期 | Disease 疾病 | Details of treatment/ hospitalization 接受何種藥物/住院治療 | Doctor/ Hospital's Name 醫生姓名/醫院名稱 | |
| a. | | | | |
| b. | | | | |
| c. | | | | |
| 11. For female only 只適用女性病人 Was the patient pregnancy at the time of hospitalization? If yes, for how many months? 是次住院治療,是否因懷孕引致? 若是,已懷孕多少月? | | | | |
| 12. Name of Hospital: 醫院名稱 Name of Attending Physician: 主診醫生姓名 Date: 日期 | | | | |
| Signature of Attending Physician | | | Hospital Stamp | |