



INDIVIDUAL HOSPITALIZATION CLAIM FORM  
住院賠償申請書

PART I 第一部份

In order to help us process your claim promptly, this form must be completed by Insured/Claimant and returned to the Company within 30 days from the date of discharge with original receipts and discharge note.

為使此賠償能盡速辦理，此申請表必須由被保人/申請人填寫，並需於出院後三十天內連同有關之單據及出院證明書之正本呈交本公司。

**Insured's Particulars 被保人資料**

To be completed by Insured. If the insured is under 18 years of age, this form should be completed by the owner.

本表格需由被保人填寫，如被保人為十八歲以下，應由保單持有人填寫此申請表。

Policy No. 保單編號	Name of Insured 被保人姓名	Age/Sex 年歲/性別	I. D. Number 身份證編號
Claimed Benefit(s) (please tick) 索償保障類別 (請劃上別號) <input type="checkbox"/> 住院醫療保險 <input type="checkbox"/> 附加額外重症保障 <input type="checkbox"/> 住院入息保險 <input type="checkbox"/> 康健保住院醫療保險		Case Type 賠償個案類別： <input type="checkbox"/> New Claim 首次索償 <input type="checkbox"/> Further Claim 再度索償	
Mailing Address : 通訊地址		Contact Phone No. : 日間聯絡電話	
Are you making a claim under any insurance policy for the same accident ? If yes, please state : name of the insurance company and policy number 閣下是否因同一次意外向其他保險公司索償？ 如是，請詳述該保險公司名稱及保單編號		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否  Please specify : 請註明	

**Hospitalization Reason(s) 住院原因**

(a) For hospitalization due to Accident, please complete questions 1-3 below. (甲)若因意外住院者，請填寫以下1-3題

1. When and where did the accident occur ? 意外在何時及何地發生	1. At _____ on _____ 於 _____ AM/PM 上午/下午      YY/MM/DD 年/月/日 Place _____ 地點
2. How did the accident occur ? Please describe in detail. 意外之起因及經過詳情	2.
3. (a) Which part of body was injured ? 受傷的身體部位 (b) Type of injury ? 傷勢類別	3. (a)  (b)

(b) For hospitalization due to Sickness, please complete questions 4-6 below. (乙)若因患病住院者，請填寫以下4-6題

4. Describe the symptoms and abnormalities which led to the hospitalization. 病者因何不適或有何徵狀導致是次住院	4.
5. How long had he/she been experiencing these symptoms prior to first consultation ? 被保人在首次就診前該等病徵已存在多久	5.
6. What was the final diagnosis ? 確診後之病症是什麼	6.

**Consultation History 診治詳情**

7. The physician first consulted for this injury or illness. 初診醫生的資料	7. At _____ on _____ 於 _____ AM/PM 上午/下午      YY/MM/DD 年/月/日 Names & Addresses of Physician(s)/Hospital(s) 醫生/醫院名稱及地址 _____ _____
8. The physician who referred the Insured to hospital 建議轉介被保人入院的醫生資料	8.
9. All other physicians consulted during this injury or illness. 曾診治該次受傷或病症的其他醫生資料	9.
10. Physicians who were seen for the same/any similar or interrelated condition in the past. 過往曾就診此相同/類同或有關的狀況所就診的醫生資料	10.

## Details of hospitalization 住院資料

11. Name of hospital 醫院名稱	11.
12. Date of admission & discharge 入院及出院日期	12. Date admitted on _____ 入院日期於 YY/MM/DD 年/月/日 Date discharged on _____ 出院日期於 YY/MM/DD 年/月/日
13. Name of attending doctor 主診醫生	13.
14. Patient's medical reference no. or follow up card no. 病人檔案號碼/覆診咭號碼	14.

## Declaration and Authorization 聲明及授權

**DECLARATION**

I/WE HEREBY DECLARE AND AGREE on behalf of myself/the insured and all Covered Person(s) and other Persons referred to in this claim form ("Relevant Persons") that (1) all the foregoing 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; I/we also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. (2) The Company is not bound by any statement which I/we may have made to any person if not written or printed here. (3) any personal data of the Relevant Persons collected or held by the Company (whether contained herein or otherwise obtained), 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 held, used, stored, disclosed, released and transferred (whether within or outside Hong Kong) to such persons as the Company may consider necessary including without limitation any of its affiliated companies, or any other company carrying on insurance or reinsurance related business or any intermediary or claims investigator or other service provider providing services relevant to insurance business or professional advisor or any association or government authority or federation of insurance companies that exists or is formed from time to time or any individual/organization associated with the Company or any selected party as the Company may consider necessary whether local or overseas for the purpose of (i) any insurance or financial related product or service or any addition, alteration, variation, cancellation, renewal or reinstatement of them (ii) any scope of insurance coverage, claim processing and analysis of it (iii) process and deal with this claim and/or underwrite and evaluate any other existing policies and/or application for insurance (iv) provide all services related to this claim and underwrite and evaluate any other existing policies and/or application for insurance and promote, improve and further promotion of services by the Company and its affiliated companies (v) direct marketing and data matching (vi) 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/WE declare and agree that I/we have the full authority from and consent of the Relevant Persons to make the above declarations and agreements.

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 Claims Department of China Life Insurance Co. Ltd. (Hong Kong Branch) at 21/F., China Life Insurance Building, No.313 Hennessy Road, Wan Chai, Hong Kong. I/we further understand that a reasonable fee may be charged for such request.

**聲明**

本人/吾等謹此代表本人/被保人、所有受保人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; 本人/吾等明白倘有任何未知是否屬於重要事項的資料均須透露; (2) 本人/吾等對任何人所作出之任何聲明, 如沒有在此申請書上填寫或印出, 貴公司不須受其約束; (3) 貴公司可以在任何情況下(不論是可否打算對相關人士採取不利行動)核對貴公司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其他途徑所取得)給貴公司認為有需要之人士, 不受限制地包括貴公司之任何關聯公司, 進行保險或再保險業務之公司, 中間人, 賠償調查員, 其他提供有關保險服務者, 專業顧問, 各團體, 政府機關, 保險業聯合(現有或將來成立), 與貴公司有聯繫之個人或團體, 或任何貴公司確認為有需要之有關人等(不論本地或外地)作以下用途: i) 有關保險或財務之產品或服務, 或該等產品或服務之增加、更改、轉變、取消、更新或復效; ii) 任何保險範圍、賠償申請, 或有關分析; iii) 審核及處理賠償申請書及/或審核及評估任何其他保單及/或投保申請; iv) 提供所有關於此賠償申請及/或審核及評估任何其他保單或投保申請之服務及推廣、改善及進一步推廣關於貴公司及其關聯公司所提供之服務; v) 直接銷售、資料核對; vi) 用於與相關人士作任何其他目的之溝通及/或遵守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, 貴公司可能因此不能審核及處理此賠償申請。

本人/吾等聲明及同意已獲得相關人士授權及同意本人/吾等作出上述聲明及協議。

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貴公司持有關於相關人士之個人資料, 他們可以以書面向中國人壽保險股份有限公司(香港分公司)理賠部之主管提出要求(地址: 香港灣仔軒尼詩道313號中國人壽保險大廈21/F)。本人/吾等同時明白貴公司可就有關要求酌量收費。

**AUTHORIZATION**

I/WE HEREBY AUTHORIZE on behalf of myself/the insured and all Covered Person(s) (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of me/the insured or any of the Covered Person(s) and who has attended or may hereafter attend myself/the insured and any of the Covered Person(s) to disclose, release and transfer such information to China Life Insurance Company Ltd.; (2) China Life Insurance Company Ltd or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/the insured or any Covered Person(s) in relation to this claim. This authorization shall bind the successors and assignees of me/the insured and remains valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original.

I/WE declare and agree that I/we have the full authority from and consent of the insured and all Covered Persons to make the above authorization.

**授權**

本人/吾等謹此代表本人/被保人及所有受保人授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、或其他機構、組織或人士、凡知道或持有任何有關本人/被保人或任何一位受保人之紀錄者, 及/或曾診驗或可能將會診驗本人/被保人或任何一位受保人者, 均可將該等資料提供、發放及轉交給中國人壽保險; (2) 中國人壽保險或任何其指定之醫生或化驗所, 可就此賠償申請書本人/被保人及任何受保人進行所需之醫療評估及測試, 作為審核本人/被保人及任何受保人之健康狀況。此授權對本人/被保人之繼承人及授權人具有約束力; 即使本人/被保人死亡或無行為能力時, 此授權書仍具效力。此授權書的影印本與正本均有同等效力。

本人/吾等聲明及同意已獲得被保人及所有受保人授權及同意本人/吾等作出上述授權。

Dated at \_\_\_\_\_ on \_\_\_\_\_

簽署於 \_\_\_\_\_ 在 \_\_\_\_\_ 地方 \_\_\_\_\_ 年/月/日

Signature of Agent/Witness  
營業員/見證人簽署

Signature of Insured  
被保人簽署

Signature of Owner/Claimant (if other than insured)  
保單權益人/申請人簽署 (如非被保人)

Remarks: This declaration and authorization must be signed by the insured. If the insured is a minor, the insured's parent/legal guardian can sign on his/her behalf.  
備註: 此聲明及授權書必須由被保人簽署, 若被保人為小童, 則可由其家長/合法監護人簽署。  
In the event of the Insured is physically incapacitated and prevent from signing, PART I may be signed by a close relative or other representative authorized by the Insured.  
如受保人因傷殘不能書寫, 其家屬或代理人可代為填寫此申請書及簽字。

Name of insured (in block letter) 被保人正楷姓名	Please complete if the signature is not given by the Insured. 若簽署者非被保人, 請填寫此欄 Name (in block letter) _____ Relationship with Insured: _____ 姓名 (正楷書寫) _____ 與被保人關係 _____
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## Suggested Checklist 建議參考事項

1. <input type="checkbox"/> Please write down the correct insured name & policy number. 請填上正確被保人姓名及保單編號;
2. <input type="checkbox"/> Please complete all the questions in Part I. 此表格上所有問題都必須作答;
3. <input type="checkbox"/> Please ensure Part II to be completed by a registered doctor. 請確保填寫表格第二部份之醫生是註冊西醫;
4. <input type="checkbox"/> Please attach the original hospital receipts. If need to return, please tick "YES" 請附上住院單據正本, 請於"是"劃上剔號; <input type="checkbox"/> YES 是
5. <input type="checkbox"/> Please make sure the signature of the insured / owner is consistent with that in policy application. 請確保以上之簽名與保單申請書之簽名一致。

## For Agent's / Witness's Use only 營業員/見證人專用

I believe that the answers given above are true to the best of my knowledge. 我認為上述之答案全屬正確無訛

Documents attached with this claim form 與申請表一起呈遞之文件

1.  Original Hospital receipt(s). 住院正式單據

2.  Other(s) 其他: \_\_\_\_\_

Signature of Agent/Witness 營業員/見證人簽署	Name of Agent/Witness (in block letter) 營業員/見證人姓名 (正楷書寫)	Agent Code & Region (if any) 營業員編號及區域(如適用者)	Date (YY/MM/DD) 日期 (年/月/日)
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# ATTENDING PHYSICIAN'S STATEMENT 應診醫生報告書

## PART II 第二部份

To be completed by the attending physician / surgeon at the claimant's own expenses.

由主診醫生填寫，所有費用由索償人自行承擔

Full name of Patient 病人姓名	Age/Sex 年歲/性別	I. D. Number 身份證號碼
<p><b>A. CLINICAL HISTORY 就診病史</b></p> <p>1. Date on which the patient first consulted you for the hospitalized illness or injury. 有關此次患病或受傷住院，閣下於何時首次會診該病人 _____ (YY/MM/DD 年/月/日)</p> <p>2. Please describe the symptoms and complaints of the patient during first consultation. 請詳細註明該病人於首次會診時之徵狀和病症 _____</p> <p>3. According to medical history given by the patient, 根據該病人透露之過往就診病史</p> <p>a. how long had the patient been experiencing these symptoms before the first consultation. 該病人於首次求診時患此病徵已存在有多久 Since on 自 _____ (YY/MM/DD 年/月/日) OR accident date 或意外日期 _____ (YY/MM/DD 年/月/日)</p> <p>b. how long do you feel the symptoms had lasted before this first consultation. 閣下認為該病人於首次會診前之病徵已存在多久 _____</p> <p>c. had the patient previously consulted any other physician on account of these symptoms? If so, please give name and address of physician and other details. 該病人曾否接受由其他醫生診治上述該疾病? 若有，請註明該醫生之姓名、地址和有關資料 _____</p> <p>4. a. What was your clinical diagnosis? 於會診後，閣下確診該病人之病症是什麼 _____</p> <p>b. When was it made? 於何時確診 _____</p>		
<p><b>B. HOSPITALIZATION HISTORY 住院病史</b></p> <p>5. a. Hospitalization 住院資料</p> <p>Name of Hospital 醫院名稱 _____</p> <p>Date of Admission 入院日期 _____ Date of Discharge 出院日期 _____</p> <p>Final diagnosis 住院診斷 _____</p> <p>Medical treatment given and test(s) performed 需接受何種治療及化驗檢查 _____</p> <p>b. Surgical Procedure 手術資料</p> <p>Date of Operation 手術日期 _____ Name of the procedure 手術名稱 _____</p> <p>Surgeon 外科手術醫生姓名 _____ Anaesthetist 麻醉師姓名 _____</p> <p>Nature 性質 _____</p>		
<p><b>C. BRIEF DISCHARGE SUMMARY 出院撮要</b> (including treatments, investigation procedures, results, and/or any complications and follow up plan) 治療及以後治療計劃，包括診查辦法、結果、併發症及覆診跟進計劃</p>		

D. PROFESSIONAL COMMENT 閣下之專業意見

1. Was it the first attack of this illness or injury? If not, please provide the first occurrence date and past treatment details.

是次病症或受傷是否第一次發作? 如否者, 請提供該病人上述第一次發作之日期及過往治療資料

Yes 是  No 否

please state 請註明 \_\_\_\_\_

2. Was it secondary to some major illness(es)? If yes, please give details.

是否由其他嚴重疾病併發造成? 如是者, 請述詳情

Yes 是  No 否

please state 請註明 \_\_\_\_\_

3. The prognosis of the condition.

病症之預斷

\_\_\_\_\_

4. What is the chance of having a relapse?

是否有復發之可能

\_\_\_\_\_

5. To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto?

根據閣下所知, 該病人以前有否患有同類或類似病況

Yes 是  No 否

please state date and describe 請註明日期及當時病況 \_\_\_\_\_

\_\_\_\_\_

E. FOR FEMALE ONLY 只適用於女性病人

Was the patient pregnancy at the time of hospitalization? If yes, please state how many months & confinement date.

該病人此次住院, 是否因懷孕導致而成? 如是者, 請註明懷孕多久及預產日期

Yes 是  No 否

please state 請註明 \_\_\_\_\_

F. OTHERS 其他

1. Is the patient referred by another doctor? 該病人是否經其他醫生轉介

Yes 是  No 否

Name and address of the referral doctor 轉介醫生之姓名和地址 \_\_\_\_\_

\_\_\_\_\_

2. Had the patient previously been treated or hospitalized for this or any other serious disorder? If so, please give details.

該病人曾否因患上述疾病或其他嚴重疾病接受醫生或醫院治療? 如是者, 請述詳情

<u>Dates</u>	<u>Disease/Disorder</u>	<u>Details or treatment/hospitalization</u>	<u>Name of Physician/Hospital</u>
日期	疾病	治療/住院詳情	醫生姓名/醫院名稱

\_\_\_\_\_  
Name of Attending physician / Specialist (with qualification)  
主診 / 專科醫生的姓名 (資歷)

\_\_\_\_\_  
Address  
地址

\_\_\_\_\_  
Telephone  
電話

\_\_\_\_\_  
Signature of Attending physician / Specialist  
主診 / 專科醫生簽名

\_\_\_\_\_  
Date  
日期

\_\_\_\_\_  
Hospital Stamp  
醫院蓋章

\_\_\_\_\_  
Name of Hospital  
醫院名稱

\_\_\_\_\_  
Address (if outside of Hong Kong)  
地址 (如非在香港)