中國人壽保險(海外)股份有限公司
China Life Insurance (Overseas) Company Limited
(於中華人民共和國註冊成立之股份有限公司)
(incorporated in the People's Republic of China with limited liability)

中國人壽 CHINA LIFE 海外

CS-CLA20

住院/日間手術醫院直付預批核申請表（只適用於韋予力醫療網絡醫生轉介案例）
Hospitalization / Day Surgery Direct Billing Pre-approval Form
(For Dr.Vio & Partners Panel Doctors referral case)

請保單持有人或受保人填妥此表格第一部份，及主診醫生填妥第二部份，並於入院前最少7個工作天，以傳真2750 4699或電郵claims@chinalife.com.hk方式遞交中國人壽（海外）股份有限公司（以下簡稱“本公司”）理賠部處理。於受保人（病人）符合資格情況下，本公司將委任韋予力醫生醫務所爲受保人簽發「住院付款保證信」。請注意(1)此預先評估並不保證索償申請之批核及(2)索償申請之批核及可索償金額將由最終所提交之索償文件資料及保單條款決定。

Please complete the Part I on the following form by the Policyowner or Insured and Part II by the Attending Physician and send to Claims Department of China Life Insurance Company (Overseas) Ltd (herein called “the Company”). via Fax no.27504699 or Email to claims@chinalife.com.hk at least 7 working days prior to admission to hospital. Subject to the eligibility of the Insured (Patient) a “Letter of Guarantee” will be issued by Dr.Vio & Partners appointed by the Company. Please note that (1) this pre-approval is not meant to guarantee approval of claim application and (2) approval of claim application and the reimbursable amount will be subject to provision of claim documents and according to policy provisions.

第一部份 由保單持有人或受保人填寫
PART I TO BE COMPLETED BY POLICYOWNER/INSURED

甲) 受保人資料 A) Particulars of Insured

保單號碼 Policy No.	受保人姓名 Name of Insured	受保人年齡 及性別 Age and Sex of Insured	受保人身份證/ 護照號碼 I.D. Card / Passport No.of Insured

聯絡電話 Contact phone no:	☐ 首次申请預先批核 New Pre-approval ☐ 再度申请預先批核 Further Pre-approval
電郵 Email Address	郵寄地址 Mailing Address

閣下是否在其他保險公司及本公司投保類似的保障? 若有，請提供詳細資料。 ☐ 是 Yes ☐ 否 No

Are you insured with other insurance company and our company for similar benefits? If yes, please give details.

保險公司 Name of Insurance Company　　保單號碼 Policy No.　　保障類別及保障金額 Type & Amount of benefit

乙)如因疾病入院請填寫1-3及7-8項。B) Please complete Questions 1 to 3 and 7 to 8 if hospitalization was due to illness.

1. 病症名稱 Name of illness	
2. 請描述症狀 Please describe symptoms	
3. 症狀何時開始出現? When did these symptoms first appear?	_____ 年/月/ 日 YY/MM/DD

如因意外入院請填寫4-8項。Please complete Questions 4 to 8 if hospitalization was due to accident.

4. 意外發生時間 Date and Time of the accident	At _____ on _____ 於 上午/下午 AM/PM 在 年/月/日 YY/MM/DD
5. 意外發生地點 Place of accident occured	
6. 意外發生之起因及受傷詳情 Please describe the reason of accident and details of injury	
7. 初診醫生/醫院的資料: The physician/hospital first consulted for this injury or illness.	求診日期 Date of consultation: _____ 年/月/ 日 YY/MM/DD 醫生/醫院名稱及地址 Name & Address of Physician/Hospital
8. 其他曾診治此症或過往類似病況的醫生/醫院資料: Other physicians/hospital consulted for this or similar conditions:	求診日期 Date of consultation: _____ 年/月/ 日 YY/MM/DD 醫生/醫院名稱及地址 Name & Address of Physician/Hospital

丙）聲明及授權 C) Declaration and Authorization

聲　明

本人謹此聲明及同意(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，均爲事實之全部並確實無訛； 本人明白倘有任何未知是否屬於重要事項的資料均須透露；(2)本人對任何人所作出之任何聲明，如沒有在此申請表上填寫或印出，貴公司不須受其約束。若相關人士不能提供任何此申請表所需的資料，貴公司可能因此不能審核及處理此預先批核申請。

DECLARATION

I HEREBY DECLARE and AGREE 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 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 may have made to any person if not written or printed here. If any relevant persons fail to provide any information requested in this application form, it may result in the Company's inability to process and deal with this per-approval application.

授　權

本人謹此授權 (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/受保人之紀錄者，均可將該等資料提供、發放及轉交給中國人壽保險(海外)股份有限公司（以下簡稱「貴公司」）； (2) 貴公司或任何其指定之醫生或化驗所，可就此預先批核申請替本人/受保人進行所需之醫療評估及測試，作爲審核本人/受保人之健康狀況。此授權對本人/受保人之繼承人及授讓人具有約束力；即使本人/受保人死亡或無行爲能力時，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。

AUTHORIZATION

I HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, orother organization, institution or person, that has any records or knowledge of me/the Insured to disclose, release and transfer such information toChina Life Insurance (Overseas) Company Limited (hereinafter called "the Company"); (2) the Company 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 in relation to this pre-approval application. This authorization shall bind the successors and assignees of me/the Insured and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

受保人/保單持有人簽署 Signature of Insured/Policyholder	受保人/保單持有人姓名 Name of Insured/Policyholder	身份證/護照號碼 I.D.Card / Passport No.	日期(年/月/日) Date (YY/MM/DD)
_____	_____	_____	_____

備註: 此聲明及授權書必須由受保人簽署，若受保人爲小童，則可由其家長/合法監護人簽署。
Remarks: This declaration and authorization must be signed by the insured. If the insured is a minor, the insureds parent/legal guardian can sign on his/her behalf.
如受保人因傷殘不能書寫，其家屬或代理人可代爲填寫此申請書及簽字。.
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.

若簽署者非受保人，請填寫此欄 Please complete if the signature is not given by the Insured.

受保人姓名 (正楷書寫)_____ 與受保人/保單持有人關係_____
Name of insured (in block letter) Relationship with Insured/ Policyholder

丁) 收集個人資料聲明 E) PERSONAL INFORMATION COLLECTION STATEMENT

本人確認已閱讀及明白中國人壽（海外）股份有限公司的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於www.chinalife.com.hk下載或向中國人壽（海外）股份有限公司索取。

I confirm that I have read and understood the personal information collection statement of China Life Insurance (Overseas) Company Limited. For the latest version of the personal information collection statement, it can be downloaded from www.chinalife.com.hk or is made available upon request.

_____	_____
受保人/保單持有人簽署	日期(年/月/日)

戊)收取自付額及差額費用之信用卡授權書 E) Credit Card Authorization Form for Deductible Amount and Shortfall Collection(此部份必須填寫）

如中國人壽（海外）股份有限公司（以下簡稱"本公司"）直接向醫院支付的費用超出合資格索償的應支付賠償額，或有關費用不屬於保障範圍，此授權書將授權本公司從以下信用卡戶口收取有關差額或費用。信用卡持卡人必須爲此保單之保單持有人或受保人，或與保單持有人及受保人有直接關係，如配偶及父母(需填寫「第三者付款指示表格」)。本公司將於以下信用卡扣取港幣3,000元作爲按金，直至整個理賠程序完結。本公司已扣取之按金可視作爲已繳付之部份賠償差額，如最終理賠後賠償差額低於港幣3,000元，將退回相關餘額。如最終不能成功收取有關差額，本公司將不會退回按金並有權拒絕閣下日後之預批核申請及從保單獲利的金額（如紅利、分期領款、身故保障等）扣除有關費用。本公司將於扣取有關差額或費用十四天前發出「差額繳付通知書」以通知保單持有人有關賠償詳情。

If the expense which China Life Insurance (Overseas) Company Limited (hereinafter called "the Company") paid directly to the hospital exceeds the eligible amount of qualified claim the relevant expense is not included in the benefit coverage, this authorization will authorize the Company to debit the relevant shortfall amount or expense from the below credit card account. The credit card holder must be the Policyowner or the Insured person of this policy, or have direct relationship with the Policyowner or the Insured person (Such as spouse and parents)(「Third Party Payment Instruction Form」is required to be completed). The Company will debit HKD3,000 as deposit , until entire claim process is completed. The deposit of HKD3,000 can be regarded as part of claims shortfall and if the relevant shortfall amount is below HKD3,000, the Company will refund the balance. If the Company could not successfully receive due shortfall payment, the deposit will not be refunded. The Company reserve the right to reject the pre-approval application afterwards and debit the shortfall amount from policy benefits (such as dividend, bonus, death benefit etc). The Company will issue a "Shortfall Payment Notice" with settlement

details to Policyowner in 14 days before debiting the claim shortfall or expense from the credit card account.	
持卡人姓名： Cardholder's Name	持卡人身份證/護照號碼: Cardholder I.D. Card/Passport Number
信用卡戶口號碼: Credit Card Account No.：	信用卡到期日: Credit Card Expiry Date 信用卡到期日:
本人授權及指示中國人壽（海外）股份有限公司從本人以上信用卡戶口扣除自付額、有關差額或欠繳費用（如適用）。本人明白自付額、有關差額或欠繳費用（如適用）將根據保單條款而轉變。 I hereby authorise and instruct China Life Insurance (Overseas) Company Limited to debit the Deductible Amount, the relevant Shortfall or expense due (if applicable) from my above credit card account. I understand that the Deductible Amount, the relevant Shortfall or expense due (if applicable) is in accordance with the provisions of the policy. 本人確認已閱讀及明白中國人壽（海外）股份有限公司的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於www.chinalife.com.hk下載或向中國人壽（海外）股份有限公司索取。 I confirm that I have read and understood the personal information collection statement of China Life Insurance (Overseas) Company Limited. For the latest version of the personal information collection statement, it can be downloaded from www.chinalife.com.hk or is made available upon request.	
持卡人簽署: Cardholder's Signature:	日期(月/日/年): Date (MM/DD/YY):

第二部份 由主診醫生填寫
PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

該部份表格填寫所需費用由索償人自行承擔
To be completed by the attending physician at the claimant's own expenses.

甲) 病人資料 A) Particulars of Patient		
病人姓名 Name of Patient	年齡 及性別 Age and Sex	身份證/ 護照號碼 I.D. Card / Passport No.
醫院名稱 Name of Hospital	主診醫生姓名及電話 Name and Telephone of Attending Physician	

乙) 疾病/受傷詳情及有關資料 B) Illness/injury details and related information	
1. 診斷和相關病徵 Diagnosis and associated signs and symptoms	
2. 發病日期 Onset date of the symptoms/conditions	_____ 年/月/ 日 YY/MM/DD
3. 此情況是否爲復發性/慢性? Is the condition recurrent/chronic? □是 Yes □ 否 No 如"是", 首次發病日爲 (月/日/年) If "Yes", onset date of the first episode: / / (MM/DD/YY)	4. 病人就是次的病況，是否可以單從門診設施中接受適當的治療？ Given the condition of the patient, is it possible to provide this treatment on an outpatient basis? □是Yes □ 否 No 如 "否" ，請提供原因: If "No", please explain：_____

5. 請圈出與是項疾病有關之狀況：
Is the illness associated with the following? Please circle the appropriate：

先天性疾病Congenital condition / 發育異常Developmental abnormality / 遺傳性疾病Hereditary condition / 精神紊亂Mental disorder / 濫藥或酗酒Abuse of drugs or alcohol / 性病Venereal disease/ 不育或絕育Infertility or sterilization/愛滋病或人體免疫缺損病毒感染AIDS or HIV related illness / 整容或整形治療Cosmetic or plastic surgery / 懷孕(請說明預產期)Pregnancy (please provide expected date of delivery) /自殘Self-inflicted injury / 以上皆否 None of the above
請說明詳情 Please state details:

6. 請圈出病人過往有否以下病症/習慣：
Does the patient have any medical history or habit as indicated below? Please circle the appropriate：

哮喘 Asthma /心臟病 Cardiac problem /糖尿病 Diabetes Mellitus / 乙型肝炎 Hepatitis B / 高血壓 Hypertension / 曾接受手術 Previous operation /濫藥 Drug abuse /飲酒習慣 Drinking /吸煙習慣 Smoking /其他疾病，請說明 Other disease, please specify _____/ 以上皆沒有 None
如有者，請說明詳情 If yes, Please state details:

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

丙）治療詳情及預計費用 C) Treatment details and cost estimation		
入院日期Date of Admission	預計留院日數 Estimated length of stay	住院級別 Bed Class ☐ 私家 Private ☐ 半私家 Semi-Private ☐ 大房 Ward
治療計劃或手術名稱Treatment plan or Surgical procedure name	麻醉 Anesthesia ☐全身麻醉 G.A. ☐ 局部麻醉L.A.	醫院或日症中心 ☐ 住院 In-patient ☐ 診所Clinic ☐ 醫院門診部 Hospital OPD ☐ 日症 Day case

住房及膳食費Room and board	HK$ Per day
醫生巡房費用Daily Visit	HK$ Per day
外科醫生費用Surgeon's Fee	HK$
麻醉師費用Anaesthetist's Fee	HK$
手術室費用Operating Theatre Fee	HK$
醫院雜項費用Miscellaneous Expenses	HK$
入院前及出院後之門診護理Pre and post hospitalization outpatient follow up	HK$

丁）主診醫生資料 D) Attending Physician's information

_____ _____
主診醫生姓名 Name of Attending Physician　　資歷 Qualification

_____ _____
地址 Address　　聯絡電話 Contact Phone No.

_____ _____
主診醫生簽署/ 醫院蓋章
Signature & Stamp of Attending Physician/ Hospital　　日期（年/月/日）
Date (YY/MM/DD)