4012000501

住院賠償申請表
HOSPITALIZATION CLAIM FORM

CSM-CLA02

第一部份 PART I

爲使此賠償能盡速辦理，此申請表必須由受保人/保單持有人填寫，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。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 date of discharge with original receipts and discharge note.

受保人資料 Insured's Particulars

本表格需由受保人填寫，如受保人爲十八歲以下，應由受保人之家長或合法監護人填寫此申請表。
To be completed by Insured. If the insured is under age 18, this form should be completed by the insured's parent/ legal guardian.

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

索償保障類別 (請劃上剔號) Claimed Benefit(s) (please tick) ☐ 住院醫療 Hospital Benefit ☐ 住院入息 Hospital Income	☐ 首次索償 New Claim ☐ 再度索償 Further Claim
通訊地址 Mailing Address :	
聯絡電話 Contact Phone No. :	
閣下是否因同一事故向其他保險公司索償？ 如是, 請提供該保險公司名稱及保單號碼 Are you making a claim against any other insurance company for the same incident? If yes, please indicate the name of insurance company and policy number.	☐ 是Yes ☐ 否 No 保險公司名稱 Name of Insurance Company： 保單編號 Policy number：

因意外住院 For hospitalization due to Accident

1. 意外發生時間/日期 Date/Time of the accident At _____ on _____ 上午/下午 AM/PM 年/月/ 日 YYYY/MM/DD	2. 意外發生地點 Location of accident:
3. 請詳述意外發生經過及受傷情況 Please describe the occurrence of the accident and the circumstances of injury in details.	

因疾病住院 For hospitalization due to Illness

4. 請描述病徵/ 病狀 Please describe the symptoms	5. 首次就診前該等病徵已存在多久? How long has the insured been experiencing these symptoms prior to first consultation?

治療詳情 Treatment Details

6. 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 YYYY/MM/DD _____ 醫生/醫院名稱及地址 Name & Address of Physician/Hospital	7. 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 YYYY/MM/DD _____ 醫生/醫院名稱及地址 Name & Address of Physician/Hospital
8(a). 請提供入院及出院日期 Please give the date of admission and the date of discharge. 入院日期 _____ Date of Admission: 年/月/日 YYYY/MM/DD 出院日期 _____ Date of Discharge: 年/月/日 YYYY/MM/DD	8(b). 閣下有否於住院期間請假外出? Have you taken any home leave during the hospital confinement? ☐ 沒有No ☐ 有Yes 如有，請列明外出及返回之日期及時間 If yes, please state the starting and ending date and time of your home leave.

聲明及授權Declaration and Authorization

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，可就此賠償申請替本人/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, or other organization, institution or person, that has any records or knowledge of me/the insured to disclose, release and transfer such information to China 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 claim. 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.

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，如沒有在此申請書上填寫或印出，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。

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 claim form, it may result in the Company's inability to process and deal with this claim.

_____	_____	_____	_____
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 (YYYY/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 insured's 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) _____
Name of insured (in block letter)

與受保人/保單持有人關係_____
Relationship with Insured/ Policyholder .

收集個人資料聲明 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 Signature of Insured/Policyholder	日期 (年/月/日) Date (YYYY/MM/DD)

建議索償文件/參考事項 Suggested Checklist

1. ☐ 保單合同正本
   Original Policy
2. ☐ 由主診醫生填寫之住院賠償申請書第二部份
   Individual Hospitalization Claim Form Part II by Attending Physician
3. ☐ 公立醫院發出之出院紙/ 醫生證明書 (需載有明確診斷)
   Discharge Summary/ Medical Certificate (with exact diagnosis) issued by public hospital
4. ☐ 住院收據及有關費用明細或收費單之正本 (索賠金額 澳門幣/港元/ 人民幣_____)
   Original Hospital Statement and Official Receipt (claim amount: MOPHKD/ RMB_____)
5. ☐ 住院收據及有關費用明細或收費單之副本 (只適用於索償住院入息)
   Photocopy of Hospital Statement and Receipt (for hospital income insurance ONLY)
6. ☐ 化驗/ X光/ 電腦掃描/ 磁力共震/ 病理檢驗報告
   Laboratory/ Xray/ CT Scan/ MRI/ Pathological Reports
7. ☐ 其他保險公司或機構之賠付清單明細 (適用於餘額索償)
   Settlement breakdown from other Insurer/ Party (For balance claim)
8. ☐ 其他
   Others .

保險中介人專用 For Insurance Intermediary Use Only

本人認爲上述之答案全屬正確無訛。

I believe that the answers given above are true and to the best of my knowledge.

_____	_____	_____	_____
保險中介人簽署 Signature of Insurance Intermediary	保險中介人姓名 (正楷填寫) Name of Insurance Intermediary (in block letter)	保險中介人代碼(如適用者) Insurance Intermediary Code (if any)	日期 (年/月/日) Date (YYYY/MM/DD)

應診醫生報告書 ATTENDING PHYSICIAN STATEMENT

第二部份 PART II

由主診醫生填寫，所有費用由索償人自行承擔
To be completed by the attending physician at the claimant's own expenses.

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.

A. 門診病史 CLINICAL HISTORY

1. 病人之醫療記錄可追溯至 We can trace the medical record of patient back to _____
(年/月/日 YYYY/MM/DD)

2. 首次出現病徵日期或意外發生日期 Date of the accident occurred or symptoms first appeared _____
(年/月/日 YYYY/MM/DD)

3. 病人首次有關此病症之求診日期 Date of first consultation for this condition or related illness _____
(年/月/日 YYYY/MM/DD)

4. 請詳細說明首次會診時之徵狀和病症 Please describe the symptoms and complaints at first consultation.

_____

5. 病人是否由其他醫生轉介？如是，請提供該醫生之姓名及地址。
Is the patient referred by other physician? If yes, please give the name and address of the referring doctor.

_____

6. 診斷 Diagnosis

B. 住院病史 HOSPITALIZATION HISTORY

1. 住院資料 Hospitalization Details

醫院名稱 Name of Hospital _____

入院日期 Date of Admission _____ 出院日期 Date of Discharge _____

2. 手術資料 Surgical Procedure Details

手術日期 Date of Surgical Procedure _____ (年/月/日 YYYY/MM/DD)

手術名稱 Name of the Surgical Procedure _____

手術性質 Nature of the Surgical Procedure_____

☐複雜型 ☐ 大型 ☐中型 ☐小型 (注意:手術類型只供本保險公司作參考用途)

C. 出院撮要 BRIEF DISCHARGE SUMMARY
住院期間之治療、檢查及其結果、有否任何併發症及出院後之覆診或跟進計劃
(including treatments, investigation procedures, results, and/or any complications and follow up plan)

D. 閣下之專業意見 PROFESSIONAL COMMENT

1. 是次病症或受傷是否(1)復發個案，或(2)任何慢性疾病/ 嚴重疾病之併發症，或(3)與過往其他病況有關？如是，請提供有關診治日期及治療詳情。
   Is the condition (1) a recurrent episode or (2) complication of any chronic illness/ major disease or (3) related to any previous conditions? If yes, please provide details of the diagnosis and treatments.

   ☐ 是Yes ☐ 否No
   診治日期 Date of diagnosis/treatments (年/月/日 YYYY/MM/DD)
   詳情(包括診斷/治療/檢查及結果) Details(including diagnosis/ treatments/ investigations and results)

2. 是項疾病之根本主因 What is the underlying cause of such illness?

   _____

3. 病情預測及復發之可能 The prognosis of the condition. What is the chance of having a relapse?

   _____

4. 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:

E. 其他醫療病史 OTHER MEDICAL HISTORY

1. 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

2. 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。Had the patient previously been treated or hospitalized for the above disease or other major disease? If so, please give 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

3. 請提供飲酒/吸煙習慣詳情 Please provide details of Drinking & Smoking habit.

   習慣始自 Drinking/ Smoking start date since _____ (年/月/日 YYYY/MM/DD)

   每日用量 Daily consumption _____ (支/包/樽/罐 piece/ pack/ bottle/ can)

_____ _____
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 日期 (年/月/日)
Signature & Stamp of Attending Physician/ Hospital Date (YYYY/MM/DD)