5012000301

團體住院賠償申請表
Group Hospitalization Claim Form

CSM-CLA21

保單號碼 Policy No.	保單持有人/僱主名稱 POLICYHOLDER / NAME OF EMPLOYER		
僱員中文及英文姓名 NAME OF EMPLOYEE （中文 ）	身份證/ 護照號碼 I.D. Card / Passport No.	出生日期Date of Birth	國籍 Nationality
現時住址 Current Residential Address :			
永久住址(如與現時住址不同) Permanent Address (if differ to current residential address):			
病者中文及英文姓名(如非僱員) NAME OF PATIENT(if other than employee) （中文 ）	身份證/ 護照號碼 I. D.Card / Passport No.		
病者與受保僱員關係 RELATIONSHIP WITH EMPLOYEE	成員/僱員編號 MEMBER/ EMPLOYEE NO.		

入院日期
Date of admission: _____

出院日期
Date of Discharge: _____

原因/病症
Cause/Disease: _____

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

醫院名稱及地址
Name & Address of Hospital: _____

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 provide circumstances of the accident.

_____

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 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 claim settlement sheet)

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

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。
   Please complete the form with all the required information.

_____
申請索償者簽署
Signature of Claimant
日期 Date

_____
僱主簽署及公司印章
Authorized Signature of Employer and Co. Stamp
日期 Date

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.

僱員簽署 Signature of Employee	僱員姓名 Name of Employee	身份證號碼 I.D. Card	日期(年/月/日) Date (YY/MM/DD)

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.

僱員簽署 Signature of Employee	日期 (年/月/日) Date (YYYY/MM/DD)

主診醫生証明書
ATTENDING PHYSICIAN STATEMENT

注意 :本証明書必須由主診醫生填寫及簽署，而有關費用須由索償人自行承擔。
Note: This statement should be fully completed and signed by attending physician/surgeon at the claimant's own expenses.

1. 病人姓名 Name of Patient: 身份証號碼 I.D. No.: 年齡 Age: 性別 Sex:

2. 入住日期 Date of admission: 出院日期 Date of discharge:

   住院天數No. of days of Hospitalization 醫院檔案編號Hospital's case no:

3. 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。
   Was the patient referred to your hospital by a general practitioner? If yes, please indicate his/her name and address.

4a. 病人首次接受治療日期?
   When did the patient first receive medical attention for his sickness?
   b. 病人首次接受治療時，所患疾病之病徵怎樣?
   Of what symptoms did the patient complain when he/she first consulted you for this sickness?

5a. 根據該病人的資料，他患此病徵有多久?
   According to the patient's record, how long had he/she been experiencing these symptoms?

   b. 你認爲該病人患此病徵已有多久? 是否與先天性疾病有關?
   In your opinion, how long have the symptoms occurred? Is it a congenital disease?

6. 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。
   Had the patient previously seen any other doctor on account of these symptoms? If yes, please indicate his/her name and address.

7a. 出院診斷
   What was the final diagnosis?

   b. 你有否將出院診斷告訴給該病人知道? 若有，何時透露?
   Did you inform the patient of the final diagnosis? If so, please state the time.

8a. 治療詳情
   Treatment details:

   b. 已進行何種手術:
   Operation performed:

   □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)

   已進行手術日期: 外科醫生姓名:
   Date of performed: Name of Surgeon:

9. 該疾病是否有復發之可能?
   Any possibility of having a relapse?

10. 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? 如有，請列明。
    Has the patient previously been treated or hospitalized in this or any other hospital for this or any other serious disorder? If so, please state.

日期 Date	疾病 Disease	接受何種藥物/住院治療 Details of treatment/ hospitalization	醫生姓名/醫院名稱 Doctor/ Hospital's Name

11. 只適用於女性病人 For female patient only
    是次住院治療，是否因懷孕引致? 若是，已懷孕多久?
    Was the admission in relation to pregnancy? If so, please state the gestation period.

醫院名稱
Name of Hospital:

主診醫生姓名/資歷:
Name of Attending Physician / Qualification:

日期
Date:

_____
主診醫生簽署/ 醫院蓋章
Signature & Stamp of Attending Physician/ Hospital