中國人壽 CHINA LIFE 海外

「國壽海外」尊尚醫療醫院直付預先批核申請表
MASTERCARE MEDICAL PLAN DIRECT BILLING PRE-APPROVAL APPLICATION FORM

保單持有人姓名 Name of Policyholder	受保人姓名 Name of Insured	保單號碼 Policy No.

受保人身份證/ 護照號碼 I.D. / Passport No. of Insured

保險仲介人資料 INSURANCE INTERMEDIARY INFORMATION

保險仲介人姓名 Name of Insurance Intermediary

保險仲介人編號 Insurance Intermediary Code

聯絡電話 Contact No.

重要須知 IMPORTANT NOTE

- 本申請表中所用之「本公司」或「貴公司」之表述指中國人壽保險(海外)股份有限公司。The expressions "the Company" or "our Company" used in this form refers to China Life Insurance (Overseas) Company Limited.
- 請以正楷填寫本申請表。任何資料如有更改，受保人及保單持有人/索償人必須在更改的位置簽署作實。Please complete this form in BLOCK LETTERS. All amendments should be endorsed by the Insured & Policyholder / Claimant in full signature.
- 請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（適用於香港、澳門或中國內地住院）或 14 個工作天（適用於海外住院），透過國壽海外 APP 或以電郵 claimspa@chinalife.com.hk 方式遞交至理賠管理部。如有任何緊急查詢，請致電「國壽海外」尊尚醫療客戶專線(852) 3999 5501 與客戶服務員聯絡。Please complete Part 1 on the following form by the Insured and Part 2 by the Attending Physician and send to Claims Department via OneService App or email to claimspa@chinalife.com.hk at least 7 working days (applicable for hospitalization in Hong Kong, Macau or Mainland China) or 14 working days (applicable for hospitalization in overseas). For urgent enquiries/assistance, please call our Hotline at (852)3999 5501.
- 在審核受保人符合本預先批核申請的情況下，本公司將為受保人簽發「住院付款保證信」。請注意(1)本預先批核申請之結果並不構成或保證日後正式索償申請之批核及(2)日後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。Subject to the approval of this pre-approval application, the Company will issue a "Letter of Guarantee" to the Insured. Please note that (1) the result of this pre-approval application does not constitute or guarantee an approval of the subsequent claims application and (2) approval of the subsequent claims application and the reimbursable amount shall be subject to the provision of claims documents and according to the policy provisions.
- 此預先批核服務由協力廠商供應商提供，並非保障條款內容。本公司有權隨時撤銷此項服務而無須另行通知，並保留絕對決定權。This pre-approval service is provided by third party service provider, and not a contractual service. Our company reserves the right to terminate this service at any time at its sole and absolute discretion without giving prior notice.
- 如受保人為十八歲或以上，受保人及保單持有人必須親自填寫及簽署本申請表，如受保人為十八歲以下，本申請表應由保單持有人及受保人之合法監護人填寫及簽署。如受保人/保單持有人因傷殘不能書寫，其直系親屬可代為填寫本申請表及簽字，並提供關係證明及醫生證明。If the insured is at or above age 18, the Insured and policyholder must complete and sign this form by his or her good self. If the insured is under age 18, this form should be completed and signed by policyholder and the insured's legal guardian. In the event that the Insured/ policyholder is physically incapacitated and prevented from signing, this form may be completed and signed by an immediate family member with relevant relationship proof and physician's statement provided.
- 受保人/保單持有人/索償人之簽署必須與本公司之紀錄相同。The signature of the Insured / Policyholder / Claimant must be the same as the Company's record.
- 如有任何查詢，請與您的保險仲介人聯絡或致電本公司客戶服務熱線(852) 3999 5519 查詢。If you have any queries, please feel free to contact your insurance intermediary or our Customer Service Hotline at (852) 3999 5519 for details.
- 本公司有權隨時更新此申請表，並拒絕未符合本公司要求的申請表。請登入本公司網站 www.chinalife.com.hk 瀏覽及下載最新版本。The Company has the right to update this form from time to time and reject the pre-approval application if the Company's requirements are not fulfilled. Please visit our website www.chinalife.com.hk to view and download the latest version of the form.
- 如中英文版本有任何抵觸或不符之處，一概以中文版本為準。If there is any discrepancy or inconsistency between the English version and the Chinese version, the Chinese version shall prevail.

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保單號碼 Policy No.										

第一部份 – 索償資料
PART I – PARTICULARS OF CLAIM

A. 一般資料 GENERAL INFORMATION

1 手提電話 Mobile No. _____

2 電郵 Email _____

3 職業 (必須填寫) Occupation (Compulsory) _____

4 行業(必須填寫) Business (Compulsory) _____

5 您有否因同一事故曾/將會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。 Did/Will you make a claim against any other insurance company for the same incident? If yes, please indicate the name of insurance company and policy no.. ☐ 是 Yes ☐ 否 No

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

B. 因意外住院 FOR HOSPITALIZATION DUE TO ACCIDENT

1 意外發生日期及時間 Date and time of the accident 年 Year ____ 月 Month ____ 日 Day ____ 時 Hour ____ 分 Minute ____ AM/PM ____

2 意外發生地點 Place of accident occurred 請描述症狀 Please describe symptoms

_____

_____

_____

3 意外發生之起因及受傷詳情 Please describe the reason of accident and details of injury

_____

_____

_____

C. 因疾病住院 FOR HOSPITALIZATION DUE TO ILLNESS

1 病症名稱 Name of illness

_____

_____

_____

2 請描述病徵 Please describe symptoms

_____

_____

_____

3 首次出現病徵日期 Date of symptoms first appeared 年 Year ____ 月 Month ____ 日 Day ____

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D. 治療詳情 TREATMENT DETAILS

1 首次求診之醫生姓名/醫院 Name of physician/hospital first consulted for the above condition

首次求診日期 Date of first consultation: 年 Year ____ 月 Month ____ 日 Day ____

醫生/醫院名稱及地址 Name & Address of Physician/Hospital

2 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 Year ____ 月 Month ____ 日 Day ____

醫生/醫院名稱及地址 Name & Address of Physician/Hospital

E. 收取差額費用之信用卡授權書（此部份必須填寫） CREDIT CARD AUTHORIZATION FORM FOR SHORTFALL COLLECTION (THIS SECTION IS MANDATORY)

如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，或有關差額或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。信用卡持卡人必須為相關保單之保單持有人或受保人。本公司將於發出「差額付款通知書」的十四天後扣取有關差額及費用。如最終不能成功收取有關差額，我們將保留採取適當措施(包括但不限於展開法律程式)或於下次理賠金額中扣除上述款項的權利，同時拒絕閣下日後之住院直付預批核申請。If the expenses which the Company paid directly to the hospital exceeds the eligible amount of qualified claim or the relevant shortfall or expenses is not included in the benefit coverage, this authorization form will authorize the Company to debit the relevant shortfall or expenses from the credit card account below. The credit card holder must be the Policyholder or the Insured of the Policy. The Company will debit the outstanding shortfall or expenses from the credit card account below 14 days after the issuance of "Shortfall Payment Notice". If we could not successfully receive the shortfall payment, we will reserve the right to take appropriate actions (including but not limited to commencing legal proceedings) or deduct the above shortfall amount from future claims, and reject the hospitalization direct billing pre-approval application afterwards.

持卡人姓名： Cardholder's Name:		**持卡人簽署: Cardholder's Signature:**		
持卡人身份證/護照號碼: Cardholder I.D. Card/Passport No.:				
信用卡戶口號碼: Credit Card Account No.:				
信用卡到期日: Credit Card Expiry Date:				
信用卡類別: Credit Card Type:	☐ Visa ☐ Mastercard 萬事達卡 ☐ UnionPay 銀聯卡	**年Year**	**月Month**	**日Day**
持卡人聯絡電話: Cardholder's Contact Phone No.:				

持卡人與病者關係: Relationship between cardholder and patient: 請在適當格內加上剔號 (Please tick the appropriate box)	☐ **保單持有人 Policyholder** ☐ **病者本人 Patient**

本人/我們，受保人/保單持有人/索償人，謹聲明上述提供之信用卡資料均為事實之全部並確實無訛，並同意授權及指示貴公司從本人以上信用卡戶口扣除有關差額或費用（如適用）。I/We, the Insured/Policyholder/Claimant, hereby declare that above credit card information provided is complete and true, and agree to authorize and instruct the Company to debit the outstanding shortfall or expenses (if applicable) from my above credit card account.

F. 個人資料收集聲明 PERSONAL INFORMATION COLLECTION STATEMENT

本人/我們確認已閱讀及明白「中國人壽保險（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 https://www.chinalife.com.hk/zh-hk/privacy-policy/personal-information-collection-statement-clio 下載或向中國人壽保險（海外）股份有限公司索取。I/We confirm that I/we have read and understood the Personal Information Collection Statement ("PICS") of China Life Insurance (Overseas) Company Limited. For the latest version of the PICS, it can be downloaded from https://www.chinalife.com.hk/zh-hk/privacy-policy/personal-information-collection-statement-clio or is made available upon request.

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G. 聲明及授權 DECLARATION AND AUTHORIZATION

授權 Authorization

本人/我們，受保人/保單持有人/索償人，代表本人/我們/尚未成年之受保人（如有）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、政府部門，或凡可能知道或具有任何有關本人/我們/尚未成年之受保人之紀錄、認識或資料的其他機構、組織或人士，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療/輔助醫療檢查員或化驗所，可就本索償申請替本人/我們/尚未成年之受保人進行所需之醫療評估及測試，作為審核本人/我們/尚未成年之受保人之健康狀況。此授權對本人/我們之繼承人及授讓人具有約束力。此授權書的影印本與正本均有同等效力。I/We, the Insured/Policyholder/Claimant, represent me/ us/ the Insured under 18 years old (if any) HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, government department, or other organization, institution or person that may be aware of or has any records, knowledge or information of me/us/ the Insured under 18 years old to disclose, release and transfer such information to China Life Insurance (Overseas) Co. Ltd ("the Company"); (2) the Company or any of its designated medical / para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ ourselves/ the Insured under 18 years old in relation to this claim application. This authorization shall bind the successors and assignees of me/us. A photocopy of this authorization shall be as valid as the original.

聲明 Declaration

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，均為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；(3)遞交本申請或由貴公司發出的「住院付款保證信」並不構成貴公司承擔其責任的一部份；(4) 如貴公司已支付保單中不在受保障範圍的任何費用或超出我/我們/受保人的合資格保障限額，貴公司有權根據本申請表 E 部份指定的信用卡中扣除此類費用。如貴公司因信用卡可用信用額不足或任何其他原因而致無法收取該等差額，貴公司有權從本保單及/或由貴公司繕發的任何保單（由我/我們/受保人為保單持有人或信託人）之應付或可賠付予我/我們/受保人的賠款抵銷相關差額，包括但不限於任何身故賠償（在法律許可的範圍內）、紅利或退回之保費（無論出於何種原因）。 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 pre-approval application; (3) neither submission of this application nor the issuance of the "Letter of Guarantee" by the Company shall be construed as admission of liability on the part of the Company; (4) in the event that the Company has settled any charges not covered in the policy or exceeds my/our /the Insured's eligible benefit limit, the Company shall have the right to deduct any of such charges from the credit card as specified in part E of this form. However, if the Company cannot collect such shortfall due to insufficient credit available in the credit card account or for any other reason whatsoever, the Company shall have the right to set-off the shortfall amounts against the amount due or payable to me/us/ the Insured from this Policy and/or any policy issued by the Company of which I/we/the Insured am/are/is the Policyholders or trustee(s) including but not limited to any death benefit (to the extent it is permissible by law), dividends or return of premium (for whatever reason).

H. 簽署(請勿在空白表格上簽署) SIGNATURE (Please DO NOT sign on BLANK form)

	受保人 Insured			保單持有人 / 索償人* Policyholder / Claimant*			見證人 Witness		
簽署 Signature									
姓名 Name									
身份證/護照號碼 I.D. Card / Passport No.									
日期 Date	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day
*索償人與受保人/保單持有人關係 *Relationship with Insured/Policyholder									