



下載國壽海外APP

即時享受升級用戶體驗！輕鬆提交理賠申請及查閱進度。



住院賠償申請表 HOSPITALIZATION CLAIM 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.
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

<input type="text"/>

按索償次序的保單號碼 Policy No. in claim sequence:	保單類別 Type of policy
1. <input type="text"/>	<input type="checkbox"/> 個人保單 Individual policy <input type="checkbox"/> 團體保單 Group policy
2. <input type="text"/>	<input type="checkbox"/> 個人保單 Individual policy <input type="checkbox"/> 團體保單 Group policy
3. <input type="text"/>	<input type="checkbox"/> 個人保單 Individual policy <input type="checkbox"/> 團體保單 Group policy

保險仲介人資料 INSURANCE INTERMEDIARY INFORMATION

保險仲介人姓名 Name of Insurance Intermediary

<input type="text"/>

保險仲介人編號 Insurance Intermediary Code 聯絡電話 Contact No.

<input type="text"/>	<input type="text"/>
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重要須知 IMPORTANT NOTE

- 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.
- 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.
- 本申請表第一部分必須由受保人及保單持有人/索償人填寫，並需於出院後三十日內連同有關之單據、出院證明書及其他證明文件呈交本公司。Part I of this form must be completed by Insured and Policyholder/Claimant and returned to the Company within 30 days (both days inclusive) from the date of discharge along with the original receipts, discharge note and relevant supporting document(s).
- 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.
- 保單持有人之簽署必須與本公司之紀錄相同。The signature of the Policyholder must be the same as the Company's record.
- 保險仲介人或銀行營業員收到本申請表並不代表本公司已收到。Receipt of this form by your Insurance Intermediary or bank officer does not constitute receipt by the Company.
- 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。填妥的表格及所需檔請寄往香港灣仔軒尼詩道 313 號中國人壽大廈 24 字樓 / 中國深圳市福田区福田區福田路 24 號海岸環慶大廈 35 樓。If you have any queries, please feel free to contact your Insurance Intermediary or our Customer Service Hotline at (852) 3999 5519 for details. Completed form(s) and required document(s) should be sent to China Life Insurance (Overseas) Co. Ltd., 24/F, CLI Building, 313 Hennessy Road, Wan Chai, Hong Kong or 35/F, Hai An Huan Qing Building, 24 Futian Road, Futian District, Shenzhen, China.
- 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 form 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，則以客戶偏好為準。If there is any discrepancy or inconsistency between the English version and the Chinese version of this form, customer's preference shall prevail.



4012000702

保單號碼 Policy No.

第一部份 – 索償資料 (由受保人/保單持有人/索償人填寫)

PART I – PARTICULARS OF CLAIM (To be completed by Insured/Policyholder/Claimant)

A. 受保人資料 PARTICULARS OF INSURED

1 受保人年齡及性別 Age and Sex of Insured 聯絡電話 Contact Phone No:

B. 一般資料 GENERAL INFORMATION

1 索償保障類別 Benefit(s) to claim 住院醫療 Hospital Benefit 住院入息 Hospital Income

2 索償申請類別 Type of claim 首次索償 New Claim 再度索償 Further Claim

待決賠案 Pending Claim 重批/覆核 Review / Appeal

3 您有否因同一事故曾/將會向其他保險公司索償? 如是, 請提供詳細資料。
Have you claimed/ will you claim from other insurance company for the same incident? If yes, please provide details. 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

4 是否申請退回收據的核實正本 Request return of certified true copy receipt(s) 是 Yes 否 No

5 受保人現職職位及職責(若多於一種職業, 請列明所有職位及職責) Position and duties of Insured's present occupation (if more than one, please state all)

6 受保人公司或僱主名稱及地址 Name and address of Insured's business or employer

C. 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 上/下午 AM/PM

2 意外發生地點及經過 Location and details of the accident

3 請詳述意外受傷部位及受傷情況 Please describe the part(s) of body injured and the extent of injury in details

4 您有否報警? 如有, 請提供以詳情。 Did you report to the police? If yes, please provide details.

是 Yes 否 No 警署地點 Police Station 檔案編號 Case Reference No.

註: 請附上警察報告/交通意外報告/口供紙/酒精測試報告影印本。
Remarks: Please attach a photocopy of the Police Report / Traffic Accident Report / Police Statement / Alcohol Test Report.

D. 因疾病住院 FOR HOSPITALIZATION DUE TO ILLNESS

1 請描述病徵 Please describe the symptoms

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

保單號碼 Policy No.

E. 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 建議入院的醫生資料/其他曾診治此病或過往同類病況的醫生資料

The doctor who referred the insured to hospital / other doctors seen for this or similar past condition

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

3 請提供慣常求診之醫生或醫院資料。 Please provide details of usual Physician(s) / Hospital(s)

醫生/醫院名稱 Name of physician/hospital

診所/醫院地址 Address of clinic/ hospital

4 入院日期 Date of admission

出院日期 Date of discharge

年 Year 月 Month 日 Day 年 Year 月 Month 日 Day

5 受保人有否於住院期間請假外出？如有，請列明外出及返回之日期及時間。

Has the Insured taken any home leave during the hospital confinement? If yes, please state the starting and ending 有 Yes 沒有 No date and time.

外出日期及時間 Starting date and time 年 Year 月 Month 日 Day 時 Hour 分 Minute 上午/下午 AM/PM

返回日期及時間 Ending Date and Time 年 Year 月 Month 日 Day 時 Hour 分 Minute 上午/下午 AM/PM

6 若就診之註冊醫生/醫療服務提供者與受保人/保單持有人/索償人/保險仲介人有任何關係，請列明。

Is there any relationship between the Registered Medical Practitioner / Medical Services Provider and the Insured /Policyholder /Claimant / Insurance Intermediary? If so, please state the relationship.

F. 賠款方式 PAYMENT METHODS

請就每宗理賠申請選擇一項理賠支付方式。如未有註明指示，理賠將以港元劃線支票進行支付，並經由保險仲介人轉遞。 Please select one settlement option for each claim submission. For any unspecified instruction, the payment will be issued by crossed cheque in HKD and delivered via Insurance Intermediary.

賠款幣種選擇 PAYMENT CURRENCY OPTION (如無註明，賠款將以港幣發放。 If not specified, payment will be issued in HKD.)

保單貨幣 Policy Currency 港幣 Hong Kong Dollar

1 自動入賬 DIRECT CREDIT

轉賬至本公司已登記之預設收款賬戶 TRANSFER TO DEFAULT PAYMENT ACCOUNT REGISTERED IN OUR COMPANY

保單號碼 Policy No.

F. 賠款方式(續) PAYMENT METHODS (Continued)

轉賬至本地銀行之賬戶 TRANSFER TO ACCOUNT IN LOCAL BANK

銀行名稱 Name of bank 銀行編號 Bank Code 分行編號 Branch Code 戶口號碼 Account No.

賬戶持有人姓名(中文) (必須為保單持有人)

Name of bank account holder (Chinese) (Policyholder Only)

賬戶持有人姓名(英文) (必須為保單持有人)

Name of bank account holder (English) (Policyholder Only)

轉數快 FPS (請勾選以下一項識別代號 Please select one of the proxy IDs below)

電郵地址 Email Address:

轉數快識別號碼 FPS ID:

手機號碼 Mobile Number: (國際電話區 Country Code)

(手機號碼 Mobile Number)

備註 :

- 銀行或轉數快賬戶持有人必須為保單持有人。 Bank or FPS Account Holder must be the Policyholder.
- 倘未有足夠資料顯示銀行賬戶持有人為保單持有人或因故未能成功自動入賬，有關款項將以劃線支票形式發出。 If there is insufficient information to identify the ownership of bank account belonging to the Policyholder or direct credit has failed for any reason, the payment will be issued in the form of a crossed cheque.
- 如選擇以「轉數快」方式領款 If you choose to receive the payment by "FPS",
 - 「轉數快」只適用於實付貨幣為港元或人民幣的申請，每筆交易金額上限為港元或人民幣 5,000,000。 "FPS" is only applicable for payment in HKD or CNY. The maximum payment amount of each transaction is HKD/CNY 5,000,000.
 - 請注意人民幣幣種僅適用於人民幣保單。 Please note that CNY currency is only applicable for CNY policy.
- 如選擇以「轉賬至本地銀行之賬戶」方式領款 If you choose to receive the payment by "Transfer to account in local bank",
 - 需提供賬戶證明檔，如印有賬戶持有人姓名/名稱及賬戶號碼的銀行卡/月結單/存摺。 Proof of bank account document(s), such as bank card/monthly statement/ passbook with account holder name and account no. is required.
 - 如賠款為港元或人民幣以外幣種，銀行所收取的代付手續費及匯率損失將由保單持有人自行承擔 (如適用)。 If the payment is not in HKD or CNY, bank charge and losses caused by exchange rate associated with the transaction would be borne by the recipient (if applicable).
 - 如轉賬不成功，相關手續費用及匯率損益將於給付款項中自動扣除 (如適用)。 Administration fees and losses caused by exchange rate would be deducted from the payment amount in case of remittance failure (if applicable).

電匯 TELEGRAPHIC TRANSFER

可於 <https://www.chinalife.com.hk/zh-hk/customer-service/forms-download/individual-claim> 下載「理賠匯款服務申請表」。

Please download "Claim Remittance Service Application Form" from <https://www.chinalife.com.hk/zh-hk/customer-service/forms-download/individual-claim>

大灣區廣發銀行跨境匯款服務 GREATER BAY AREA CGB CROSS BORDER REMITTANCE SERVICE

可於 <https://www.chinalife.com.hk/zh-hk/customer-service/forms-download/individual-claim> 下載「理賠跨境匯款服務申請表 (只適用於持有大灣區廣發銀行賬戶客戶)」 Please download "Claim Cross Border Remittance Service Application Form (Only Applicable For Greater Bay Area CGB's Account Holder)" from <https://www.chinalife.com.hk/zh-hk/customer-service/forms-download/individual-claim>

2 本地銀行劃線支票 HK LOCAL CROSSED CHEQUE

親自到灣仔客戶服務中心提取 Collect cheque at Wan Chai Customer Service Centre in person

(如保單是透過網上銷售方式購買，而保單持有人尚未完成身份認證，則賠款須以支票形式支付，並請保單持有人帶同身份證明文件親臨本公司客戶服務中心收取支票。 If the Policyholder purchased the policy online, and has not completed the identity verification, the claim payment will be made by cheque. The Policyholder should collect the cheque at our Customer Service Centre by presenting the identity document.)

授權第三者(代領人)到灣仔客戶服務中心領取 Pick up cheque at Wan Chai Customer Service Centre by authorized person

代領人姓名

Name of authorized person

代領人聯絡電話

Contact no. of authorized person

代領人身份證明文件號碼

I.D. no. of authorized person

郵寄至保單登記的通訊地址 Mail to correspondence address registered in our Company

經保險仲介人轉遞 Deliver via Insurance Intermediary

親自到銀行分行領取 (請指定銀行分行) Collect cheque at branch in person (Please state the branch)

銀行分行 Branch

保單號碼 Policy No.

F. 賠款方式(續) PAYMENT METHODS (Continued)

3 其他 OTHERS

- 資金調配至保單 FUND TRANSFER TO POLICY**
僅適用於同一領款人名下生效之保單，請指定保單號碼。抵付保費時已包括保費徵費。 Only applicable to inforce policy under the same payee, please specify the policy no.. The Premium Levy has been included into the Premium Payment.
- 非劃線支票 / 匯票 UNCROSSED CHEQUE / DEMAND DRAFT**
可於 <https://www.chinalife.com.hk/zh-hk/customer-service/forms-download/individual-claim> 下載「特別領取方式申請表」。 Please download "Special Payment Arrangement Request Form" from <https://www.chinalife.com.hk/zh-hk/customer-service/forms-download/individual-claim>

G. 索償所需文件清單 CLAIM DOCUMENT CHECKLIST

- ✓ 基本文件 Basic Documents ; ● 附加檔 Additional Documents ; ✕ 不適用 Not Applicable

索償所需文件(文件的核實正本可於本公司的客戶服務中心辦理) Claim Document (Documents can be certified at our Company's Customer Service Centres)	住院醫療 Hospital Benefit	住院入息 Hospital Income
<input type="checkbox"/> 由閣下填妥並簽署之本申請表第一部份 Part I of this form completed and signed by your good self	✓	✓
<input type="checkbox"/> 由主診醫生填寫並且簽署及蓋印之本申請表第二部份 Part II of this form completed and signed by attending physician with chop	✓	✓
<input type="checkbox"/> 載有明確診斷之出院紙/病假紙/醫生證明書(適用於香港醫院管理局轄下醫院之住院) Discharge slip/sick leave certificate/medical certificate with clear exact diagnosis (applicable to hospitalization in hospitals of the Hospital Authority of Hong Kong)	✓	✓
<input type="checkbox"/> 住院病案紀錄其中包括：病案首頁、住院病歷、出院小結、門診病歷及住院費用清單 (適用於中國境內之住院) Medical records including: Admission summary, hospitalization records, Discharge summary, outpatient records and statement of account (applicable to hospitalization in Mainland China)	✓	✓
<input type="checkbox"/> 住院醫療收據正本及其帳單明細表 Original hospital receipt and statement of account	✓	✓(只需副本) (Copy required only)
<input type="checkbox"/> 住院期間之診斷測試報告 (如：病理報告、驗血報告、正電子掃描/電腦掃描/磁力共振報告、心電圖報告、超聲波報告及 X 光報告等) Prognostic report and laboratory test report during hospitalization (such as pathological report, blood test report, PET Scan/CT Scan/MRI report, ECG report, ultrasound report and X-ray report etc.)	●	●
<input type="checkbox"/> 其他保險公司之賠償明細表 Settlement advice from other insurers	●	✕
<input type="checkbox"/> 受保人及保單持有人之身份證明文件(核實正本) ID of Insured and Policyholder (Certified True Copy)	✓	✓

H. 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.

I. 電子票據索償聲明 DECLARATION FOR ELECTRONIC RECEIPT

本人/我們，受保人/保單持有人/索償人謹此確認是次遞交之電子票據為唯一收據，相關診所醫院並沒有就是次求診收據曾經或重覆發出書面正本收據。本人/我們，受保人/保單持有人/索償人亦聲明及保證除貴公司外，就該住院或有關求診將獲賠付部份，並沒有向其他保險公司或機構進行重覆索償。本人/我們，受保人/保單持有人/索償人承諾如上述聲明不正確，本人願意退還貴公司就該住院或有關求診之全部賠償，並承擔有關之一切法律責任。 I/We, the Insured/Policyholder/Claimant, confirm that the electronic receipt(s) submitted for this claim application is/are the sole receipt(s). The clinic / hospital of this visit has not ever or repeatedly issued the original paper receipt(s) for the same visit. I/We, the Insured/Policyholder/Claimant, declared and guarantee that apart from our company, I/we have not filed/ will not file the duplicate claims against other insurance companies or institutions concerning the amount to be claimed in your company for the said electronic receipt(s). I/We, the Insured/Policyholder/Claimant, undertake that if the above statement is incorrect, I/we are willing to refund the full claim payment for the said receipt(s) to our company and bear all related legal liabilities.

J. 收取個人壽險保費徵費 COLLECTION OF PREMIUM LEVY ON INDIVIDUAL LIFE INSURANCE POLICIES

本人/我們謹已收悉：貴公司就保險業監管局要求並授權向每位保單持有人所持有的有效保單徵收「保費徵費」(下稱「徵費」)，及將收取的徵費將會全數轉交予該局。保險業監管局亦可以根據相關條例，將有關的欠付款作為民事債項及向相關的保單持有人追討欠款並有機會徵收罰款。有關收取徵費的詳情，請瀏覽中國人壽(海外)股份有限公司的網頁 <https://www.chinalife.com.hk/zh-hk/customer-service/useful-information/premium-levy>。 I/We hereby notified that: China Life Insurance (Overseas) Company Limited, as an authorized insurer, is statutorily required to collect Premium Levy ("Levy") from policyholder on behalf of the Insurance Authority ("IA") and report to IA. IA may take legal proceedings against policyholder in respect of any outstanding Levy as civil debt and may impose pecuniary penalty. For details of the collection of Levy, please refer to the website at <https://www.chinalife.com.hk/customer-service/useful-information/premium-levy>.

K. 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/我們·受保人/保單持有人/索償人·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/我們親手所寫·就本人/我們所知所信·均為事實之全部並確實無訛;本人/我們明白倘未知任何一項是否重要·本人/我們均須將其事實在本申請表上說明;(2)本人/我們對任何人所作出之任何聲明·除在本申請表上填寫或印出及經貴公司發表和批准外·貴公司不須受其約束。若相關人士不能提供任何本申請表所需的資料·貴公司可能因此不能審核及處理本索償申請;(3)如本人/我們提供的資料有任何不實及/或遺漏之處·貴公司有權拒絕本索償申請及/或要求本人/我們退回任何已賠償之金額。(4)本人/我們同意賠償貴公司任何因本人/我們提供之資料為虛報、誤導或不完整所導致的任何損失、索償或法律行動。I/ We, the Insured/Policyholder/Claimant HEREBY DECLARE and AGREE that (1) all the foregoing statements and answers to all questions whether or not written by my/our own hand are to the best of my/our 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 unless it is written or printed here and is presented and approved by the Company. 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; (3) I/We understand that if any information given is untrue and/or has been withheld, the Company reserves the right to decline my claim application and/or request a refund of any claim amount paid. (4) I/We agree to indemnify the Company against any loss, claim and action resulting from any false, misleading or incomplete information provided by me/us.

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

	受保人(年齡 18 歲或以上) Insured (whose age is 18 or above)			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									