安盛保險有限公司
AXA General Insurance Hong Kong Limited
30/F PCCW Tower Taikoo Place
979 King's Road Quarry Bay Hong Kong
Tel 2523 3061 Fax 2810 0706
Email axahk@axa-insurance.com.hk
Website www.axa-insurance.com.hk

保險公司填寫 For AXA Use
Claim No.
Received Date

門診賠償申請表
OUT-PATIENT CLAIM FORM

索償手續 CLAIM PROCEDURE

1 此申請表須填寫有關資料及簽署，並於接受治療後*90日內連同收據**正本**交回安盛保險有限公司理賠部。(*個人保險須按保單條款為準)
Claim Form should be completed & signed before submitted to Claims Team of AXA General Insurance Hong Kong Limited together with **original** bill(s)/receipt(s) within*90 days from date of loss. (*Individual policy should be referred to policy provision)

2 須附詳細醫療費用賬單暨收據**正本**，提供治療日期，病者姓名，病症名稱及主診醫生之印鑑及簽署。
Original bill(s) and receipt(s) for the claimed expenses must be attached showing the date of treatment, patient's name, diagnosis, and the attending registered medical practitioner's stamp and signature.

3 索償專科診治，X-光/醫學檢驗，脊醫或物理治療等費用，須附主診醫生之處方或介紹信。
Claim for expenses incurred in specialist consultation , X-ray examination/laboratory tests, chiropractor or physiotherapy must be supported by attending registered medical practitioner's prescription or referral letter.

僱主或保單持有人名稱
Name of employer/policyholder _____

保單號碼
Policy no. _____

僱員/成員姓名
Name of employee/member _____ 僱員或成員編號 Staff or Member no. _____

家屬姓名（如病人乃成員家屬）
Name of dependent (complete only if patient is dependent) _____

與受保僱員/成員之關係
Relationship to insured employee/member _____ 性別 Sex _____ 成員編號 Member no. _____

閣下會否就是次醫療事項申請其他保險賠償？ 不會☐ 會☐
Will you making any other insurance claims as a result of this medical treatment ? No Yes

如選擇會，請列明：保單號碼 Policy no. _____ 保險公司名稱 Name of insurance co. _____
保單類別 Policy type _____ 要否退回醫療收據 Return medical receipt or not 不要☐ 要☐ No Yes

聲明及授權書

本人/我們聲明此表格內填報的資料，就本人/我們所知所信全部正確無訛，並無任何保留。本人/我們同意如為處理有關本索償事宜，安盛保險有限公司可使用所收集及持有關於我/我們/受保人的個人資料(包括在此索償表格內或其他地方之資料)或將該等資料給予有關之人士或機構(包括在香港境內或境外之再保公司、賠償調查公司、保險業協會/聯會及其他提供保險業有關服務之公司等)。

本人/我們並授權持有任何關於本人/我們/受保人的健康或醫療記錄或資料之人士或機構，向安盛保險有限公司或其代理人，提供與本索償事宜或與保險公司的追償權有關之記錄或資料。即使我/我們/受保人死亡或在法律上失去能力，對我/我們/受保人的繼承人及受託人而言，本授權將繼續生效。本授權書之影印本將與正本具有同等效力。

DECLARATION AND AUTHORIZATION

I/We hereby declare that to the best of my/our knowledge and belief the above statement and particulars contained herein are in all respects true and complete and are made without reservation of any kind. I/We agree that any of my/our/the Insured's personal information collected or held by AXA General Insurance Hong Kong Limited (whether contained in this claim form or otherwise obtained) is provided and may be held, used and disclosed by the Company to individuals/organization associated with the Company or any selected third party (within or outside Hong Kong, including reinsurance and claim investigation companies and industry associations/federations and other service provider providing services relevant to insurance business) for the purpose of processing this claim.

I/We further authorize any organization, institute or individual that has any records or knowledge or my/our/the Insured's health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to AXA General Insurance Hong Kong Limited on its authorized representatives such information which is/are relevant to the settling of this claim and/or the Insurer's rights of recovery. This authorization shall bind my/our/the Insured's successors and assigns and remain valid notwithstanding my/our/the Insured's death or incapacity in so far as legally possible. A photostat of this authorization shall be considered as effective and valid as the original.

病者（十八歲以上）簽署
Signature of Patient (18 years of age and over)

受保僱員/成員簽署
Signature of Insured Employee / Member

簽署日期
Date signed

此項由保險公司填寫 For AXA Use

CONSU. DATE	DIAGNOSIS	TYPE	INCURRED AMT.	PAID AMT.	REMARKS
EXCHANGE RATE:			INPUT BY:		

C-CF-OP-0703