Blue Cross 藍十字
Member of BEA Group 東亞銀行集團成員

29/F, BEA Tower, Millennium City 5, 418 Kwun Tong Road,
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香港九龍觀塘道418號創紀之城 5 期東亞銀行中心29樓
Tel 電話: 3608 2888 Fax傳真: 3608 2938
www.bluecross.com.hk

OUTPATIENT CLAIMS SUBMISSION SLIP 門診索償申請表

Please fill in all details and attach this slip to your claims with the following information and return to Medical Claims Department
(Each slip per person/per family)
請填妥下列所需資料並附上索償文件寄回醫療保險理賠部（每表只限一人/家庭）

No. of bill(s) / statement(s) / receipt(s) for claims purposes
索償用之門診帳單 / 結單 / 收據數目

Policy Number 保單號碼	Staff Number or H.K.I.D. Card Number (If applicable) 職員編號或香港身份證號碼(如適用者)

Name of Policyholder
保單持有人名稱

Name of Insured (Patient)
被保人姓名（病人）

Insured Number (This number appears on your certificate of insurance or schedules 3, Schedule of Insureds in front of your name)
被保人號碼(此編號可見於閣下保險証明書或保單附表三受保人名單閣下姓名之前)

Note: Please submit ORIGINAL bill(s) / statement(s) / receipt(s) in which name of patient, diagnosis, date of consultation, charges breakdown should be stated. Please attach written referral and / or prescription if necessary.

註:請附上門診賬單 / 結單 / 收據正本連同病人姓名、診症結果、診症日期、醫療費用。如有需要，請附上醫生介紹信及藥物處方。

Declaration and Authorization 聲明及授權書

I/We hereby declare, understand and agree that:

(1) I/We have obtained all necessary authorization from my/our dependents to supply their information to Blue Cross (Asia-Pacific) Insurance Limited ("the Company") if my/our dependents are to be covered. I/We also understand that the information requested in this form is required in order for the Company to process this claims.

(2) The information provided herein together with any subsequent alterations or supplements of it is collected or held to enable the Company to carry on insurance business and may be used, stored, disclosed and transferred (whether within or outside Hong Kong) to any individuals/organizations associated with the Company or any selected third party as the Company may consider necessary including any other company carrying on insurance or reinsurance related business, any intermediary, claims investigator, medical facilities, other service provider providing services relevant to insurance business, professional advisor, government authority, industry association/federation or in the event of default, to debt collection agencies for the purpose of any scope of insurance coverage, claim processing/investigation or any analysis/data verification of it within the insurance industry by way of matching procedures or otherwise, promotion of financial products and services by the Company and its affiliated companies, and communication with me/us or any relevant organization/person as the Company may consider necessary. I/We have the right to obtain the "Privacy Policy Statement", access to and to request correction of any personal information concerning ourselves held by the Company. Such request can be made in writing to the Company's Corporate Data Protection Officer.

(3) I/We certify that all the foregoing statements and answers in this claim form, including any attachments herein, are accurate, true, full, complete and given to the best of my/our knowledge and belief. I/We understand that in event of doubt whether a fact is material, it should be disclosed here.

(4) I/We understand that the Company may be unable to process this claim if I/we fail to provide any information required related to this application.

I/We further authorize any hospital, physician, medical practitioner, clinic or other medically related facility, insurance company, or any individual or organization/institution that has any records or knowledge of my/our or the insured's health and medical history or any treatment or advice that has been or may hereafter be consulted to disclose to the Company or its authorized representative such information. This authorization shall bind the successors and assignees of me/us and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as effective and valid as the original.

本人 / 我們謹此聲明，清楚明白及同意以下各項：

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Date 日期	Signature of Insured 被保人簽署

Blue Cross 藍十字
Member of BEA Group 東亞銀行集團成員

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Date
日期

Signature of Insured
被保人簽署

Blue Cross (Asia-Pacific) Insurance Limited
藍十字（亞太）保險有限公司
MC037/05.2005