**Blue Cross 藍十字**

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# MEDICAL INSURANCE - HOSPITALIZATION & SURGICAL CLAIM FORM
# 醫療保險-住院及手術賠償表

This form is applicable to both inpatient and outpatient surgical claim 本表格適用於住院或門診手術賠償

## Part I - To be completed by the patient
## 甲部 - 由病人填寫

| Name of Policyholder 保單持有人名稱 | Policy No. 保單號碼 | Insured No./Certificate No. 保戶編號/受保証書編號 (If applicable 倘適用) |
|---|---|---|
| Name of Employee/Member 僱員/成員姓名 (For group insurance policy only) | | |

| Name of Patient 病人姓名 | Occupation 職業 | Date of Birth 出生日期 (DD/MM/YY 日/月/年) | Sex 性別 ☐ M 男 ☐ F 女 |
|---|---|---|---|
| | | | |

Relationship to the Policyholder 與保單持有人關係 ☐ Self 本人 ☐ Spouse 配偶 ☐ Child 子女 ☐ Staff/Member 僱員/成員 ☐ Dependent 僱員/成員家屬

(1) Have you had any prior treatment for this or related conditions? 閣下是否曾因同一病況而接受治療? ☐ No 否 ☐ Yes 是

Date(s) 日期 _____ Name of Doctor 醫生姓名 _____

_____ Address 地址 _____

_____ _____

(2) Are you making any other insurance claim as a result of this hospitalization/surgery? 有關此次住院/手術，閣下有否申請其他保險賠償？ ☐ No 否 ☐ Yes 是

Name of Insurance Company 保險公司名稱 _____

Policy No. 保單號碼 _____

(3) Was the hospitalization/surgery a result of an accident? 此次住院/手術是否由於一宗意外引致？ ☐ No 否 ☐ Yes 是

Date 日期 _____ Time 時間 _____ Place 地點 _____

Brief Description 經過 _____

_____

## 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：**

(1) 本人/我們已向家屬取得一切所需授權(如適用)，可向藍十字(亞太)保險有限公司("貴公司")提供其個人資料。本人/我們亦明白本表內提供的資料是讓貴公司作處理本人/我們索償之用。

(2) 本人/我們明白及同意貴公司可收集或持有本表格內提供的資料(包括日後作出之修訂及補充)用於保險業務之用途，並可將該等資料儲存、使用、透露及轉交(不論在本港或海外)予任何與貴公司有關之人士/機構或任何貴公司認爲有需要之人等或被指定之第三者，包括其他從事與保險或再保險業務有關之公司、中介人、理賠調查員、醫療機構、有關提供保險業務服務之公司、專業顧問、政府機關、或保險業組織或聯會，以用作任何保障範圍，處理理賠/調查及其有關分析或核實資料；任何貴公司及其附屬公司之財務計劃、商品及服務之推廣活動；與本人/我們或貴公司認爲有關之機構/人士溝通。本人/我們有權致函向貴公司之個人資料保護主任索取「私隱政策聲明」，查詢及要求更正貴公司所持有有關之個人資料。

(3) 本人/我們謹此聲明上述所有聲明及答案，包括其他附件，均是無誤、眞實及爲事實之全部，並且是本人/我們所知及所信提供的。本人/我們明白倘有任何未知是否屬於重要事項的資料均須向貴公司透露。

(4) 倘若本人/我們未能提供此申請所需資料，可導致貴公司未能處理此索償。

(5) 茲授權任何醫生、醫學界執業人士、醫院、診所及其他醫療有關的機構、保險公司或任何知悉本人/我們/被保人之健康狀況及病歷或任何治療或諮詢記錄及曾爲或將爲本人/我們/被保人診治之機構組織及人士向貴公司或其代理人透露有關資料。此授權書對本人/我們之繼承人及受讓人均有約束力，即使在本人/我們死亡或喪失行爲能力後仍然有效。此授權書之正本及副本具同等效力。

_____ _____

Date 日期 (DD/MM/YY 日/月/年) Signature of Patient 病人簽署

## Part II - To be completed by the attending Physician/Surgeon at the Claimant's Own Expenses
## 乙部 - 由主診醫生填寫，所需費用由索償人自行承擔

(1) Name of Patient 病人姓名

| (2) Hospitalization 住院 | Name of Hospital 醫院名稱 | Date of Admission 入院日期 | Date of Discharge 出院日期 |
|---|---|---|---|
| | | | |

| (3) Surgical procedure 手術 | Date of Operation 手術日期 | Name of procedure 手術名稱 |
|---|---|---|
| | | |

Nature 性質 _____

_____

(4) Chief complaints of the patient relating to this hospitalization/surgery 此次住院/手術的主要病因

(5) Diagnosis of conditions 診斷

(6) Brief discharge summary: (including treatments, investigation procedures, results; and/or any complications and follow up plan.)
出院撮要：（治療及以後治療計劃，包括診查、結果、併發症及跟進計劃）

(7) Date of accident occurred or symptom first appeared 首次出現病徵日期或意外發生日期

(8) Date of first consultation for this condition or related illness 病人首次求診日期

(9) To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto?
據閣下所知，病人以前曾否患有同類病況？

☐ No 否 ☐ Yes 是 Please state dates and describe 請說明何時及當時情況 _____

_____

(10) Is the patient referred by another doctor? 病人是否經其他醫生轉介？

☐ No 否 ☐ Yes 是 Name and address of the referral doctor 轉介醫生的姓名和地址 _____

_____

| Name of Attending Physician / Specialist (with qualifications)<br>主診/專科醫生的姓名(資歷) | Signature of Attending Physician / Specialist<br>主診/專科醫生簽名 | Date (DD/MM/YY)<br>日期(日/月/年) |
|---|---|---|
| | | |

Address 地址