ING

ING General Insurance Company Limited

MEDICAL INSURANCE - HOSPITALISATION & 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 1 - TO BE COMPLETED BY THE PATIENT

甲部 – 由病人填寫

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

Name of Patient 病人姓名 :	I.D. Card No. 身份證號碼 :	
Occupation 職業 :	Date of Birth 出生日期 :	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?
閣下是否曾經因同一病況而接受治療?

NO 沒有 ☐ YES 有 ☐ Doctor's Name 醫生姓名 : _____

Address 地址 : _____

_____

Date(s) 日期 : _____

(2) Are you making any other insurance claim as a result of this hospitalisation / surgery?
有關此次住院 / 手術，閣下有否申請其他保險賠償?

NO 沒有 ☐ YES 有 ☐ Name of Insurance Company 保險公司名稱 : _____

Policy No. 保單號碼 : _____

(3) Was the hospitalisation / surgery a result of an accident?
此次住院 / 手術是否由於一宗意外引致?

NO 不是 ☐ YES 是 ☐ Date 日期 : _____ Time 時間 : _____ Place 地點 : _____

Brief Description 經過 : _____

_____

DECLARATION & AUTHORISATION 聲明及授權 :

I hereby declare that the above information given is true and correct.

I further authorise any hospital, physician, insurance company or organisation that has any records or knowledge of me or my health, to furnish to ING General Insurance Company Limited or its authorised representative, any and all information with respect to any illness or injury, medical history, consultation prescriptions or treatment and copies of all hospital or medical records. A Photostat copy of this authorisation shall be considered as effective and valid as the original.

本人現聲明上述所填報的資料正確無訛。

本人茲授權持有本人健康或任何資料之醫生、醫院、保險公司或機構，可以將部份或全部有關本人傷患之病歷，診斷報告及藥方等資料給與 ING General Insurance Company Limited 或其代理人。此授權書之影印本與正本具同等效力。

_____ _____

Date 日期 Signature of Patient 病人簽署

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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) Hospitalisation

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 the procedure 手術名稱 : _____

Nature 性質 : _____

_____

(4) Chief complaints of the patient relating to this hospitalisation / 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，包括診查辦法、結果、併發症及跟進計劃）

(7) Date of the 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 沒有 ☐ YES 有 ☐ 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 沒有 ☐ YES 有 ☐ Name and address of the referral doctor _____

轉介醫生的姓名和地址 _____

_____
Name of Attending Physician / Specialist (with qualifications)
主診 / 專科醫生的姓名（資歷）

_____
Address
地址

_____
Telephone
電話

_____
Signature of Attending Physician / Specialist
主診 / 專科醫生簽署

_____
Date
日期

This claim form is endorsed by the Hong Kong Medical Association and the Medical Insurance Association of the Hong Kong Federation of Insurers