



Liberty
International™
Member of Liberty Mutual Group

Liberty International Insurance Limited

利寶國際保險有限公司

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Outpatient Medical Claim Form
門診醫療賠償申請表

TO BE COMPLETED BY EMPLOYEE (本欄由僱員填寫)

| | | | | | | | | |
|--|---------------------------|---|------------------------------|------------------------------------|--------------------------------------|--|-------------|-----------|
| Policy No. 保單編號 | | Name of Policyholder 保單持有人名稱 | | | | | | |
| Certificate No. 會員編號 | | Name of Employee 僱員姓名 | | | | | | |
| Relationship to employee 與僱員之關係 Spouse 配偶 <input type="checkbox"/> Child 子女 <input type="checkbox"/> | | Name of Patient (if other than employee) 病者姓名(如非僱員本人) | | | | | | |
| | Date of Consultation 診症日期 | General Consultation 普通門診 | Specialist Consultation 專科門診 | Laboratory Testing & X-ray 化驗及 X 光 | Chinese Herbalist & Bonesetter 中醫及跌打 | Physiotherapy & Chiropractic Treatment 物理治療及脊椎治療 | Medicine 藥物 | Others 其他 |
| 1. | | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| 2. | | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| 3. | | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| 4. | | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| 5. | | \$ | \$ | \$ | \$ | \$ | \$ | \$ |

Total Receipt(s) Amount 索償總金額 \$ _____

Total No. of Receipt(s) 收據總數 _____

Return original Receipts 需退回收據正本

Yes 是

No 否

Note 附註

- Please submit **ORIGINAL** receipt(s) which must clearly indicate name of patient (must be identical with ID Card), diagnosis, date of consultation, charges breakdown with the attending physician's chop and signature.
請附上各單據**正本**，單據上必須清楚列明病人姓名(必需按照身份証之姓名)、診症結果、診症日期、各醫療收費項目，並附有主診醫生印鑑及簽署
- All Claim(s) must be submitted after 90 days from the date of consultation
所有索償申請必須於診症後 90 內遞交
- Attach referral letter provided by your General Practitioner for the claim of Specialist Consultant, Diagnostic X-ray and Laboratory Tests or Prescribed Medication. The referral letter is valid for same or related disability for a period of three months from the date of issuance. Treatment received for a new or unrelated disability will require another referral letter.
如申請專科、X 光檢驗及化驗或處方西藥之賠償，必須附上普通科醫生的轉介信，轉介信在發出日起計三個月內診治與該信內提及有關之病症均為有效。當診治病症被診斷為一新症，或診治與該轉介信無關之病症則須提交其他有效轉介信。
- Separate claim form should be used for each patient.
每一病者，請個別呈交申請理賠表格。

Declaration and Authorization 聲明及授權書

I declare that the above statements and answers made by me are true and complete to the best of my knowledge.

本人聲明上述一切陳述及問題所提供之答案均為本人所知所信事實之全部，並確實無訛。

I HEREBY AUTHORISE any employer, physician, hospital, insurance company or other organization or person who has any record or knowledge with reference to the accident, or the health and medical history of the patient, to give such information to Liberty International Insurance Limited. A photocopy of this authorization will be as valid as the original.

本人謹此授權任何僱主、註冊西醫、醫院、保險公司、或其他組織、機構或人士，凡知道或持有任何有關與病者相關的意外、或/及健康及醫療紀錄者，均可將該等資料提供給利寶國際保險有限公司。本授權書的影印本與正本均有同等效力。

By signing below, I, for the purpose of the Personal Data (Privacy) Ordinance, consent that the personal information collected or held by Liberty International Insurance Limited (whether contained in this form or otherwise obtained) may be used by or disclosed to any individual or organization within or outside Hong Kong for the purposes of insurance or reinsurance related business including claim processing, investigation, account collection and litigation.

根據個人資料(私隱)條例，本人現簽署同意利寶國際保險有限公司所收集或保留之任何有關資料(在此申請書所載或從其他途徑取得)，可交予公司選定的有關人士或本港或海外機構用作處理其保險或再保險之相關業務，包括處理賠償、調查、戶口收集及訴訟。

Date 日期 _____

Employee's Signature 僱員簽名 _____