Liberty International
Member of Liberty Mutual Group

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HOSPITALIZATION/SURGICAL CLAIM FORM 住院/手術醫療索償申請表

Please complete, sign this claim form and attach the original copies of invoices and receipts. 請填妥並簽署本表，連同賬單及收據正本寄交本公司。

PART I – CLAIMANT'S STATEMENT (IN BLOCK LETTER)
第一部份 – 索償人資料

Policyholder Name 保單持有人名稱：_____ Policy No. 保單編號：_____

Employee Name 僱員姓名：_____ HK ID No. 香港身份證號碼：_____
(group policy only 適用於團體保險客戶)

Patient Name (in full) 病人姓名：_____ Insured No./Date of Birth 會員編號/出生日期：_____

1. Has the claimant been treated by other doctor(s) for similar or related illness in the past? 閣下曾否因同一病況接受治療?

   No 否 ❑ Yes 曾 ❑ Please specify 請明確說明： Treatment date 接受診治日期：_____

   Name & address of the doctor(s)/Hospital(s) 醫生姓名/醫院名稱及地址

   Name 姓名/名稱：_____ Address 地址：_____

2. If hospitalization was due to an accident 如因意外引致之住院：

   a. Please state when, where, and how did it happen. 請提供意外發生的日期、地點；並簡述受傷情況及意外之經過。

   _____

   _____

   _____

   b. Did the claimant report to the Police? 閣下有否通知警方?

   No 沒有 ❑ Yes 有 ❑ Please advise the name and address of the police station with their reference number and attach a copy of the police report.
   請提供警署名稱、地址及警方檔案編號，並提交警方報告之副本。

   _____

3. Has the claimant submitted or does the claimant intend to submit this case to any other insurance company(s)?
   閣下有否或會否申請其他保險賠償?

   No 否/不會 ❑ Yes 有/會 ❑ Please provide name of insurance company(s) & policy number on a separate sheet.
   請另加附頁列明保險公司之名稱及保單編號。

4. Please provide name and address of family doctor. 請提供家庭醫生之姓名及診所地址。

   Name 姓名：_____ Address 診所地址：_____

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之全部，並確實無訛。

I hereby authorize 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 of Hong Kong for the purposes of insurance or reinsurance related business including claims 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使用所收集或保留之任何有關個人資料(在此申請書所載或從其他途徑取得)，可交予本港或海外有關人士或機構作處理其保險或再保險之相關業務，包括處理賠償、調查、戶口賬目收款及訴訟。

Signature (Patient/Parent if patient aged under 18) 簽名(病人/家長 – 若病人未滿十八歲)

Date (DD/MM/YY) 日期(日/月/年)

Name 姓名

Contact Telephone Number 聯絡電話

PART II – ATTENDING PHYSICIAN'S STATEMENT (at the claimant's own expenses)
第二部份 – 本欄由主診醫生填寫 (所需費用由索償人自行承擔)

Patient Name (in full) 病人姓名 (全名) : _____

Admission Date (DD/MM/YY) 入院日期 (日/月/年) : _____ Date of Discharge (DD/MM/YY) 出院日期 (日/月/年) : _____

1. CLINICAL HISTORY OF THIS PATIENT 病人之門診病歷

a. Date on which the patient first consulted you regarding this medical condition(s)/injury 閣下首次為病人就上述病況/受傷之診症日期 :

b. Symptoms and complaints for this hospitalization/treatment :
是次住院/接受治療的病徵及申訴 :

c. Underlying cause(s) of this hospitalization 構成是次住院的成因 :

d. According to the medical history given by the patient, how long had he/she been experiencing these symptoms before the 1st consultation and the date of the 1st consultation?
根據病人提供之病歷，他/她首次求診前該傷病已患有多長時間? 並請提供他/她的首次求診日期。

e. How long, in your opinion, has the patient been suffering from this illness?
就閣下意見，病人患有此傷病已多長時間?

2. HOSPITALIZATION HISTORY OF THIS PATIENT 病人之住院病歷

a. Final Diagnosis 病症結果 : _____

Date of Operation 手術日期 : _____

Operational procedure(s) performed 手術名稱 :

b. If you have consulted other doctor(s) during this hospitalization, please provide the following 若閣下曾於是次住院中徵詢其他醫生的意見，請提供以下資料 :

i) Consulted Doctor's Name 醫生姓名 : _____

ii) Reason 原因 : _____

iii) What treatment had the doctor(s) performed 所作的診治 :

c. Brief discharge summary (including onset and duration of signs & symptoms/disease, etiology, types & results of major examinations, treatment, complications and follow up plan) 出院撮要 (請列出有關病及病徵的病發日期、病因、檢驗性質與結果、有關治療、併發症及跟進計劃) :

d. Has the patient taken any home leave during this hospitalization?
病人在住院其間有否請假外出? No 沒有 ❑ Yes 有 ❑
If yes, please state the date, time and reason 如有，請說明日期、時間及原因 :

e. Please provide reason(s) for hospitalization if the type of cases can be managed by day care. 若病情能以日間護理處理，請提供住院理由。

Remarks : Please attach copies of histopathology, endoscopic, diagnostic/laboratory tests report, operating theatre summary.
備註 : 請連同病理學、內視鏡、診斷性化驗/檢驗報告、手術室撮要交回。

3. PROFESSIONAL COMMENT 專業意見

a. In your opinion, was the hospitalized illness a recurrent episode or a chronic illness or related to previous complaint/diagnosis?
就閣下意見，是次病況是否為復發性病症、慢性病症或與以往的病因/診斷有關 ?

No 否 ❑ Yes 是 ❑ Please provide date of the first episode and details. 請詳述首次發病的日期及細節。

b. Has the patient ever had the same symptoms before/has the patient been treated or hospitalized for the same symptoms before?
病人以往曾否患有同類病況/病人以往曾否因同類病況而接受治療或住院 ?

No 否 ❑ Yes 曾 ❑ If yes, please state details, to the best of your knowledge (including a brief summary describing the onset date, duration of signs and symptoms/disease, etiology, types and results of major examinations, treatments, complications and follow-up plan). 據閣下所知，請另加附頁，說明何時及詳細描述 (請列出過往有關病及病徵的病發日期、病因、檢驗性質與結果、有關治療、併發症及跟進計劃) 。

c. Was the condition due to or associated with the following? If yes, please circle the condition. 上述病況是因以下問題所致? 如有，請圈出所屬情況。

Accidental bodily injury 身體意外受傷 / Abuse of drugs or alcohol 濫用毒品或酒精 / Refractive error 屈光不正 / Hereditary condition 遺傳性疾病 / AIDS/HIV related illness 後天免疫力缺乏症 (愛滋病) / 人體免疫缺損病毒有關之疾病 / Developmental condition 發育異常 / Self-inflicted injury 自我傷害 / Venereal disease or sexually transmitted disease 性病或因性接觸傳染之疾病 / General check-up or Vaccination 一般身體檢查或防疫注射 / Cosmetic or Plastic surgery 美容或整容手術 / Pregnancy, Infertility or Sterilization 懷孕、不育或絕育 / Mental or Nervous disorder 精神或神經病 / Congenital condition 先天性症狀

Yes 是 ❑ ❑ None of the above 以上無一合適

d. If the condition is due to pregnancy, please advise the date of the LMP 若狀況與懷孕有關，請提供上次月經週期首天的日期 : _____

4. OTHERS 其他

Please give the name and address of the referring physician (if any) 請提供轉介醫生之姓名及診所地址 (若適用) :

Name 姓名 : _____ Address 診所地址 : _____

I hereby certify that all information given above is accurate and true 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之全部，並確實無訛。

Name of Doctor 醫生姓名

Signature of Attending Doctor/Surgeon with Hospital Stamp 主診醫生簽名及蓋章

Address and Telephone Number/Fax Number 地址及電話號碼/傳真