安盛保險有限公司
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保險公司填寫 For AXA Use
Claim No.
Received Date

住院及手術賠償申請表
HOSPITALIZATION & SURGICAL CLAIM FORM

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

甲部 - 由病人填寫
PART I - TO BE COMPLETED BY THE PATIENT

請附上有關醫院及醫生收據的正本並連同此申請表一併寄回
Original bills and receipts for the claimed expenses must be attached with the Claim Form

僱主或保單持有人名稱
Name of Employer/Policyholder _____

保單編號
Policy No _____

受保僱員 / 成員姓名
Name of Insured Employee/Member _____

病人姓名
Name of Patient _____

身份証號碼
I.D. Card No. _____

受保成員編號
Member No _____

性別
Sex 女 Female ☐ 男 Male ☐

與保單持有人關係
Relationship to the Policyholder
本人 Self ☐ 配偶 Spouse ☐ 子女 Child ☐

出生日期
Date of Birth _____ (日 / 月 / 年 dd/mm/yyyy)

職業
Occupation _____

僱員 / 成員 Staff/Member ☐ 僱員 / 成員家屬 Dependent ☐

(1) 閣下有否曾經因同一病況而接受治療?
Have you had any prior treatment for this or related conditions ?
沒有 No ☐ 有 Yes ☐

醫生姓名
Doctor's Name _____

地址
Address _____

診症日期
Consultation Date _____ (日 / 月 / 年 dd/mm/yyyy)

(2) 閣下會否就是次醫療事項申請其他保險賠償?
Will you making any other insurance claims as a result of this medical treatment ?
不會 No ☐ 會 Yes ☐

如選擇"會"，請列明 : 保單號碼
If "Yes", please state : Policy No _____

保險公司名稱
Name of Insurance Company _____

保單類別
Policy Type _____

要否退回醫療收據
Return medical receipt or not
不要 No ☐ 要 Yes ☐

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

日期
Date _____ (日 / 月 / 年 dd/mm/yyyy)

簡述意外經過
Brief Description _____

時間
Time _____

地點
Place _____

聲明及授權書

本人 / 我們聲明此表格內填報的資料，就本人 / 我們所知所信全部正確無訛，並無任何保留。本人 / 我們同意如為處理有關本索償事宜，安盛保險有限公司可使用所收集及持有關於我 / 我們 / 受保人的個人資料 (包括在此索償表格內或其他地方的資料) 或將該等資料給予有關的人士或機構 (包括在香港境內或境外的再保公司、賠償調查公司、保險業協會 / 聯會及其他提供保險業有關服務的公司等) 。

本人 / 我們並授權持有任何關於本人 / 我們 / 受保人的健康或醫療記錄或資料的人士或機構，向安盛保險有限公司或其代理人，提供與本索償事宜或與保險公司的追償權有關的記錄或資料。即使我 / 我們 / 受保人死亡或在法律上失去能力，對我 / 我們 / 受保人的繼承人及受託人而言，本授權將繼續生效。本授權書的影印本將與正本具有同等效力。

DECLARATION AND AUTHORIZATION

I/We hereby declare that to the best of my/our knowledge and belief the above statement and particulars contained herein are in all respects true and complete and are made without reservation of any kind. I/We agree that any of my/our/the Insured's personal information collected or held by AXA General Insurance Hong Kong Limited (whether contained in this claim form or otherwise obtained) is provided and may be held, used and disclosed by the Company to individuals/organization associated with the Company or any selected third party (within or outside Hong Kong, including reinsurance and claim investigation companies and industry associations/federations and other service provider providing services relevant to insurance business) for the purpose of processing this claim.

I/We further authorize any organization, institute or individual that has any records or knowledge or my/our/the Insured's health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to AXA General Insurance Hong Kong Limited on its authorized representatives such information which is/are relevant to the settling of this claim and/or the Insurer's rights of recovery. This authorization shall bind my/our/the Insured's successors and assigns and remain valid notwithstanding my/our/the Insured's death or incapacity in so far as legally possible. A photostat of this authorization shall be considered as effective and valid as the original.

成員家屬（十八歲以上）簽署
Signature of Dependent (18 years of age and over)

受保僱員 / 成員簽署
Signature of Insured Employee /Member

簽署日期(日 / 月 / 年)
Date Signed(dd/mm/yyyy)

(請轉下頁 Please turn over)

乙部 - 由主診醫生填寫，所需費用由索償人自行承擔
PART II - TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT'S OWN EXPENSES

(1) 病人姓名
Name of Patient _____

(2) 住院 Hospitalization
醫院名稱
Name of Hospital _____
入院日期
Date of Admission _____ (日 / 月 / 年 dd/mm/yyyy)
出院日期
Date of Discharge _____ (日 / 月 / 年 dd/mm/yyyy)

(3) 治療 Treatment
治療詳情
Nature of medical treatment given _____
手術名稱
Name of Procedure _____
手術日期
Date of Procedure _____ (日 / 月 / 年 dd/mm/yyyy)
外科手術醫生
Surgeon _____

(4) 此次住院 / 手術的主要申訴或徵狀
Major complaint(s)/symptom(s) of the patient relating to this hospitalization/surgery

_____

_____

(5) 診斷
Diagnosis of Conditions _____

(6) 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）
Brief Discharge Summary (including treatments, investigation procedures, results, and/or any complication and follow up plan)

_____

_____

_____

(7) 首次出現病徵日期或意外發生日期 (日 / 月 / 年)
Date of the accident occurred or symptom first appeared (dd/mm/yyyy) _____

(8) 病人首次求診日期 (日 / 月 / 年)
Date of first consultation for this condition or related illness (dd/mm/yyyy) _____

(9) 此病可有復發機會?
Any possibility of having a relapse ? _____

(10) 以上情況是否屬先天性異常?
Is this condition arising from congenital anomalies ?
不是 No ☐ 是 Yes ☐

如 "不是" 請簡述致病原因
If "No", please state the cause of the diagnosis _____

(11) 據閣下所知，病人以前曾否患有同類病況?
To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto?
沒有 No ☐ 有 Yes ☐ 請說明何時及當時情況 Please state dates and describe

_____

(12) 病人是否經其他醫生轉介?
Is the patient referred by another doctor?
沒有 No ☐ 有 Yes ☐ 轉介醫生的姓名及地址 Name and address of the referral doctor

_____

(13) 如上述情況由懷孕引致，請說明開始懷孕日期
If condition is due to pregnancy, please give approximate date of commencement

_____

(14) 病人有否在住院期間批予離院外出?
Did the patient take home leave during hospitalization?
沒有 No ☐ 有 Yes ☐ 請說明日期、時間及原因 Please state date(s), time(s) and reason(s)

_____

_____

地址
Address _____

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

_____

電話
Telephone _____ 傳真 Fax _____

_____

主診 / 專科醫生簽名 / 醫院蓋章
Signature of Attending Physician/Specialist/Hospital Stamp

日期 (日 / 月 / 年)
Date (dd/mm/yyyy) _____

In-hospital Credit Arrangement – Application Form

AXA Assistance 24 Hour Hotline 安盛救援中心二十四小時熱線 **: 2861 9285**

UCMG is appointed by AXA Assistance as coordinator for 24-hour In-hospital Credit Arrangement services. 聯康醫療受安盛救援中心之委託爲受保人提供二十四小時之住院信貸服務。

UCMG Hotline 聯康醫療熱線: 2710 8105 Fax No. 傳真: 2710 8289 / 3010 0210 (after office hours from 6:00 pm to 9:00 am)

Name of Insured Member 受保人姓名	Membership No. 受保人編號	Policyholder/Employer 保單持有人/僱主	Policy No. 保單號碼

The following information should be completed by attending doctor 以下資料須由主診醫生填寫:

The above Insured Member is suffered from (diagnosis) :_____

上述會員因患(症狀) _____

Please tick the appropriate box. 請於適當位置填上 '√' 號

☐ **SURGICAL PROCEDURE / DIAGNOSTIC TEST** 外科手術 / 診斷檢驗

Surgical Procedure / Diagnostic Test :_____ Estimated cost : HK$_____
外科手術 / 診斷檢驗之名稱 大約費用 港幣

Place of Treatment : _____ Date of Treatment : _____/_____/_____
手術 / 檢查之診所或醫院名稱 手術 / 診斷檢驗日期 (DD/MM/YYYY)

☐ **HOSPITAL ADMISSION FOR THE ABOVE CONDITION :**
(If admit for surgical procedure / diagnostic test, please also fill in the above information.)
住院（如須進行外科手術或診斷檢驗，請同時填寫上述資料）

Name of Hospital : _____ Attending Doctor's Fee Per Day : HK$_____
醫院名稱 主診醫生每日巡房費用 港幣

Estimated Days of Stay : _____ Room Type / Cost : _____ Date of Admission : _____/_____/_____
大約留院日數 住房類別 /費用 入院日期 DD/MM/YYYY)

☐ **REQUIRED TO BE REFERRED TO SPECIALIST** 須轉介專科醫生治理

Name of Specialist: _____ who is a specialist for _____
專科醫生姓名 專科類別

****

Name of Attending Doctor: _____ Address:_____
主診醫生姓名 地址
Doctor's signature & Date: _____ Telephone: _____ Fax:_____
主診醫生簽署及日期 電話 傳真

Information for Insured Member 受保人須知 **:**

1. This form should be completed by your attending doctor and fax to UCMG . 受保人及其主診醫生須填寫有關資料，然後傳真至聯康醫療。
2. You will receive an In-hospital Credit Arrangement Approval Form by fax from UCMG when this application is approved. 若此申請獲批核，聯康醫療會將批核文件致受保人提供之聯絡傳真號碼。
3. Present the In-hospital Credit Arrangement Approval Form together with Guarantee Letter when you admit to hospital. 入院時需帶同批核文件及保證信以便辦理入院手續。
4. Ask your attending doctor to complete the Hospitalization Claim Form when you discharge from hospital. 出院時受保人及其主診醫生須填寫住院賠償申請表並交回醫院作申請賠償。

Important ** Authorization and Agreement 受權及同意書 :

I hereby authorize my attending doctor to release any information regarding my health, medical history or any treatment that required for the purpose of applying in-hospital credit facility and agree to reimburse the Policyholder or AXA General Insurance Hong Kong Limited for any charges incurred during my hospitalization which are in excess of my benefits entitlement or any ineligible benefits not provided under the Policy.
本人茲授權上述主診醫生可提供本人 / 家屬之健康及治療狀況作爲申請住院信貸服務。本人同意繳付予保單持有人或安盛保險有限公司有關此次入院收費及保險賠償之差額。

Insured Member's signature & Date 受保人簽署及日期 :

_____

Confirmation of approval should be returned to
批核回覆須送遞如下 :
Fax 傳真 : _____

Telephone 電話: _____