中銀集團保險有限公司
BANK OF CHINA GROUP INSURANCE COMPANY LIMITED

索償編號 (公司專用)
Claim No. (for office use)

香港中環德輔道中 71 號永安集團大廈九樓 9/F., Wing On House, 71 Des Voeux Road Central, Hong Kong. 客戶服務熱線 Customer Service Hotline：3187 5100 傳真 Fax：3906 9906

HOSPITALISATION & SURGICAL CLAIM FORM 住院及手術索賠申請書

Please complete and sign this claim form and make sure the original copies of invoices and receipts are attached 請填妥本申請書及簽署後連同有關單據正本一併遞交。

Note : Original documents submitted would be retained by our company. You are advised to keep a copy for reference.注意：所遞交之正本文件將會存留於本公司，請自備副本參考。

PART I – CLAIMANT'S STATEMENT (IN BLOCK LETTER) 第一部份 – 索償人資料 (請用正楷填寫)

Individual Policy No. 個人保單號碼	Policyholder Name 投保人姓名

Claimant Must Complete The Following 以下部份，必須填寫

Patient Name (in full) 病人姓名	Patient's Age 病人年齡
Patient's HKID / Passport No. (個人保單適用 for individual only) 病人香港身分證/護照號碼	Patient's Insured No. 受保病人編號

1. Has the claimant been treated by other doctor(s) for similar or related illness in the past?
病人曾否因同一或有關之病症向其他醫生求診? ☐ No 否

☐ Yes, please specify: treatment date 有，請註明：接受治療日期	Name & address of the doctor(s)/Hospital(s) 診治醫生姓名及地址/醫院名稱

2. If Hospitalization was due to Accident, 若住院原因屬意外引致,

a) Please state when, where, and how did it happen 請提供意外發生之時間、地點及經過

b) Did the claimant report to the Police? If "yes", please advise the name and address of the police station and their reference number and attach a copy of the police report to claims submission. 索償人有否報警要求協助? 若"有"，請提供警局名稱，地址及檔案副本

3. Has the claimant submitted or does the claimant intend to submit this case to any other insurance company(s)? If yes, please provide name of insurance company(s) & Policy number.
索償人有否或將會是次住院申請向其他保險公司提出索償? 若"有"，請提供該保險公司名稱及保單編號。
☐ 無 No ☐ 有 Yes,_____
"✓" the box for return of certified true copy ("CTC") of original receipt(s) after claim processing. ☐ Please note Certified True Copy will not be returned if the claims are fully reimbursed.
如欲索回醫生的發票和收據正式認證副本，請在方格內填上「✓」號。☐ 請注意 如申請已獲全數賠償，正式認證副本將不獲退回。
If you would like to claim the same loss under another policy with us (when applicable), please also provide the policy number or tick the box.
☐若索償人在我司也有其他保單並且要求一併索償，請提供該保單編號或者在下方空格內畫上 "√"。

4. Please provide name and address of family doctor 請提供閣下家庭醫生之姓名及診所之地址

5. Please provide bank autopay account number and email address for claim settlement purpose. Unless otherwise specify, the designated account number and email address shall be applied to all future claim settlements.
請提供銀行自動轉帳戶口號碼及電郵地址作理賠賠款之用。指定之銀行自動轉帳戶口號碼及電郵地址將適用於以後的理賠，特別註明除外。

戶口持有人 Bank Account Holder	銀行及分行編號 Bank and Branch Code								自動轉帳戶口號碼 Bank Autopay Account Number								電郵地址 Email Address
投保人 Policyholder				--				--									

Authorization

I act on behalf of myself and my dependents hereby authorize any medical practitioner, hospital, clinic, insurance company to disclose to the ***Bank of China Group Insurance Co., Ltd.*** *all information concerning the above disability and any prior medical history for the purpose of proceeding the medical claim. A photostat of this authorization shall be as valid as the original.*

Declaration

1. I hereby declare that the above statement and answers are true and correct. I understand that any misrepresentation of the above statement and answers will cause my/our claim invalid.
2. I understand that the information provided by me to Bank of China Group Insurance Company Limited ("BOCG Insurance") is collected to enable BOCG Insurance to carry on insurance business and may be used for the purpose of:
(i) processing and evaluating my insurance application and any future insurance application I may make; (ii) administering my insurance policy and providing services in relation to my insurance policy; (iii) analysis or investigating, processing and paying claims made under my insurance policy; (iv) invoicing and collecting premiums and outstanding amounts from me; (v) any alterations, variations, cancellation or renewal of any insurance related product or service; (vi) contacting me for any of the above purposes; (vii) exercising any right of subrogation by BOCG Insurance; (viii) other ancillary purposes which are directly related to the above purposes; and (ix) complying with applicable laws, regulations or any industry codes or guidelines.

BOCG Insurance may disclose my and/or the Insured Person(s)'s personal data for the above purposes to the following classes of transferees:
(a) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist BOCG Insurance to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors); (b) in the event of a claim, loss adjudicators, claims investigators and medical advisors; (c) in the event of default, debt collectors and recovery agents; (d) insurance reference bureaus or credit reference bureaus; (e) reinsurers and reinsurance brokers; (f) my insurance broker (if any); (g) BOCG Insurance's legal and professional advisors; (h) BOCG Insurance's related companies (as that term is defined in the Companies Ordinance); (i) any association, federation or similar organization of insurance companies ("Federation") and its members that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation; (j) any member(s) of the "Federation" by the "Federation" for any of the above or related purposes; (k) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; (l) the Insurance Claims Complaints Bureau and similar industry bodies; and (m) government agencies and authorities as required or permitted by law.
BOCG Insurance is hereby authorized to obtain access to and/or to verify any of my and/or the Insured Person(s)'s data with the information collected by the Federation from the insurance industry.
Moreover, BOCG Insurance may also use and disclose my and/or the Insured Person(s)'s personal data otherwise with my consent.
*I have the right to obtain access to and to request correction of any personal information concerning myself and/or the Insured Person(s) held by BOCG Insurance. Requests for such access can be made to BOCG Insurance's Legal and Compliance Department (*Address: 9/F., Wing On House, 71 Des Voeux Road Central, Hong Kong*)*

授權

本人現授權任何西醫、醫院、診所、保險公司及其他人士，均可向**中銀集團保險有限公司**提供本人或本人家屬之健康情況、傷病資料及病歷記錄，作為審核有關醫療保險索賠之用。本授權書之影印本與正本有同等效力。

聲明

1、本人聲明上述所填報之資料均屬真實無訛，本人清楚明白如上述資料有誤或不實，可能導致本人或本人家屬的保障無效。
2、本人明白本人提供予中銀集團保險有限公司("中銀集團保險")的資料，為中銀集團保險提供保險業務所需，並可能使用於下列目的:
(i) 處理及審批本人的保險申請或本人將來提交的保險申請；(ii) 執行本人保單的行政工作及提供與本人保單相關的服務；(iii) 分析或調查、處理及支付本人保單有關的索償；(iv) 發出繳交保費通知及向本人收取保費及欠款；(v) 任何與保險有關的產品或服務的任何更改、變更、取消或續期；(vi) 就以上用途聯絡本人；(vii) 中銀集團保險行使任何代位權；(viii) 其它與上述用途有直接關係的附帶用途；及(ix) 遵循適用法律，條列及業內守則及指引。

中銀集團保險亦可因應上述用途將本人及/或受保人的個人資料移轉予下列各方：
(a) 就上述用途，向中銀集團保險提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問（包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商）；
(b) 處理索賠個案的理賠師、理賠調查員及醫療顧問； (c) 追討欠款的收數公司或索償代理；(d) 保險資料服務公司及信貸資料服務公司；(e) 再保公司及再保經紀；(f) 本人的保險經紀（若有）；(g) 中銀集團保險的法律及專業業務顧問；(h)中銀集團保險的關連公司(以《公司條例》內的定義為準)；(i) 現存或不時成立的任何保險公司協會或聯會或類同組織(「聯會」)及其會員，以達到任何上述或有關目的，或以便「聯會」執行其監管職能，或其他基於保險業或任何「聯會」會員的利益而不時在合理要求下賦予「聯會」的職能；(j) 透過「聯會」移轉予任何「聯會」的會員，以達到任何上述或有關目的；(k) 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；(l) 保險索償投訴局及同類的保險業機構；及(m) 法例要求或許可的政府機關。

本人在此授權中銀集團保險可向「聯會」從保險業內收集的資料中查閱及/或核對本人及/或受保人的任何資料。
此外，經本人同意，中銀集團保險可能會以其它方式使用及披露本人及/或受保人的個人資料。
本人有權查閱及要求更正由中銀集團保險持有有關本人及/或受保人的個人資料。如有需要，可向中銀集團保險法律與合規部提出 (地址: 香港中環德輔道中 71 號永安集團大廈 9 樓)。

Signature (Patient/Parent if patient aged under 18)
病人簽署(十八歲以下請由監護人代簽)

Date (DD/MM/YY) 日期

Name 姓名

Contact No. (If Applicable) 聯絡電話 (如適用)

轉背頁 P.T.O.

PART II – ATTENDING PHYSICIAN'S STATEMENT (Fill by attending physician, at the claimant's own expenses)
第二部份 – 主診醫生證明書 (由主診醫生填寫，所需費用由索償人承擔)

Patient Name (in full) 病人姓名	Date of Admission (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 : 門診病歷

a) Date on which the patient first consulted you related to this medical condition(s) / injury 病人首次就上述病況或有關疾病或受傷之求診日期

Symptoms and complaints for this hospitalization/treatment 病人是次主要因何癥狀或不適入院

b) Underlying cause(s) of this hospitalization 引致是次住院之主要原因

c) According to the medical history given by the patient, how long had he/she been experiencing these symptoms before the 1st consultation 病人初次求診時，該病癥已出現多久？

How long, in your opinion, has the patient been suffering from this illness? 您認為病人患有該疾病多久？

2. Hospitalization History of this patient : 住院病歷

a) Final Diagnosis 診斷結果 | Date of Operation 手術日期

b) Operational procedure(s) performed 手術名稱

If you have consulted other doctor during this hospitalization, please provide the following 於住院期間，如曾將病者轉介往其他醫生，請提供下列有關資料:

Consulted Doctor's Name: 醫生姓名 | Reason : 轉介原因

What treatment had the doctor performed 治療名稱

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

d) Has the patient taken any home leave during this hospitalization ? if "yes", please state the date, time and reason 於住院期間，病者有否請假外出？如 "有" ，請列明日期、時間及原因

e) Please provide reason(s) for hospitalization if this type of cases can be managed on day care / out-patient basis. 如是次住院可在日間病房進行, 請提供住院原因

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. If "yes", please provide date of the first episode and details. 就閣下意見，是次病況是否為復發性病症或慢性病症？如 "是" ，請提供首次復發日期。

b) Has the patient even had the same symptoms before/has the patient been treated or hospitalized for the same symptoms before? 病者以前曾否患有同類病況？
If "yes", please state, to the best of your knowledge, on a separate sheet when and describe details (including a brief summary describing theonset date, duration of signs and symptoms,/disease, etiology types and results of major examinations, treatments, complications and follow-up plan.) 如 "是" ，請說明日期及詳情 (請另頁書寫並簽署作實)

c) Was the condition due to or associated with the following (Please circle the right answers) 上述情況是否因下列問題所致？(請圈出有關項目)
Accidental bodily injury, abuse of drugs or alcohol, AIDS/HIV related illness, venereal disease or sexually transmitted disease, pregnancy, infertility or sterilization, refractive error, cosmetic or plastic surgery, mental or nervous disorder, congenital condition, hereditary condition, developmental condition, self-inflicted injury, general check up or none of the above. 身體意外受傷／濫用藥物或酒精／後天免疫力缺乏症（愛滋病）／與人類免疫力缺乏病毒（HIV）、性病或因性接觸感染之疾病／懷孕、不育或絕育／視力不正常／美容或整容手術／精神病／先天性症狀或疾病／遺傳性症狀或疾病／發育期狀況／自我傷害／一般身體檢查或防疫注射／以上全不適用

d) If the condition is due to pregnancy, please advise the date of the LMP :
如上述情況由懷孕引致，請說明最後經期日期

4. Others : 其他

If you are referred by another doctor, please provide the referring doctor's name and address :
如閣下乃由其他醫生轉介，請提供該醫生姓名及地址：

I hereby certify that all information given above is accurate and true to the best of my knowledge 本人謹此聲明，以上所填報之資料，均屬真實無訛。

Signature of attending doctor/Surgeon with Practice/Hospital Stamp
主診／外科醫生簽署／醫院蓋章

Address and Telephone No.
地址及電話

Name of attending doctor/Surgeon
主診／外科醫生姓名

Date (DD/MM/YY)
日期（日／月／年）