中國太平保險(香港)有限公司
China Taiping Insurance (HK) Company Limited

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

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 I – TO BE COMPLETED BY THE PATIENT
甲 部 – 由病人填寫

Policy No. 保單號碼 ______________________ Policyholder 保單持有人名稱 ______________________

Employee/Member Name 僱員/成員姓名(英文正楷) ______________________ Email Address 電郵地址 ______________________ Contact No. 聯絡電話 ______________

Patient's Name 病人姓名(英文正楷) ______________________ H.K.I.D. No. 香港身份證號碼 ______________ Sex 性別 ________ Date of Birth 出生日期 ______________

Relationship to the Policyholder 與保單持有人關係 ______________ Occupation 職業 ________ Email Address 電郵地址 ______________________ Contact No. 聯絡電話 ______________

Client Code(Member Ref) 客戶編號(員工編號) ______________________ Relationship to the Employee/Member 興成員之關係 ______________ Plan 計劃編號 ________

(1) a. Is condition congenital? 此是否先天性缺陷? ☐ No 否 ☐ Yes 是

b. If confinement is due to childbirth, please indicate the commencement of Pregnancy. 如住院是因生育導致，請提供開始懷孕日期： ______________

c. 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： ______________ Contact No.聯絡電話： ______________ Date(s) 日期： ______________

Address 地址： ______________________________________

(2) Are you making any other insurance claim as a result of this hospitalization/surgery? Please attach the claim statement for another insurance company.
有關此次住院/手術，閣下有否申請其他保險賠償? 若有，請提供其他保險公司的賠償表。

☐ No 沒有 ☐ Yes 有 Name of Insurance Company 保險公司名稱： ______________________

Policy No. 保單號碼： ______________ Policy Type 保單類別 ______________

Return medical receipts or not after claim processing? 賠償辦妥後是否退回醫療收據? ☐ No 否 ☐ Yes 是 (for other claim only 只適用於申請其他賠償)

(Please note we will only return certified true copy, original receipt will be kept by us. 請注意本保險公司只退回核證副本，醫療收據正本由本保險公司保留。)

(3) Was the hospitalization/surgery a result of an accident? 此次住院/手術是否由於一宗意外引致? ☐ No 否 ☐ Yes 是

Date 日期： ______________ Time 時間： ______________ Place 地點： ______________

Brief Description 意外經過及傷勢： ______________________________________

Did the patient report to the police? 傷者有否報警： ☐ No 沒有 ☐ Yes, send us a copy of the police report 有，請提交有關檔案副本一份

PERSONAL INFORMATION COLLECTION STATEMENT 收集個人資料聲明

The information you provide to us is collected to enable us to carry on insurance business and may be used for the purpose of -
- any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or service;
- any claim or investigation or analysis of such claim; and exercising any right of subrogation.

The said information may be transferred to -
- any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claim or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
- any association, federation or similar organization of insurance companies (collectively called "the Federation") 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, and
- any members of the Federation by the Federation for any of the above or related purposes, and
- the Policyholder and/or the Insured Person(s) (if applicable).

Moreover, the Company is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance industry. You have the right to obtain, to access to and to request correction of any personal information concerning yourself held by the Company. Requests for such access can be made in writing to our Manager of the Office of the General Manager at 19/F., China Taiping Tower, 8 Sunning Road, Causeway Bay, Hong Kong.

閣下提供的資料，為本公司提供保險業務所需，並可能使用於下列目的：
- 任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期；
- 任何索償，或該等索償的調查或分析；及本公司行使任何代位權。

上述資料可能移轉予：
- 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；
- 現存或不時成立的任何保險公司協會或聯會或類同組織（統稱為「聯會」），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；及
- 或透過「聯會」移轉予任何「聯會」的會員，以達到任何上述或有關目的；及
- 保單持有人及/或被保險人（如適用）。

此外，在此授權本公司可向「聯會」從保險業內收集的資料中查閱及／或核對 閣下任何資料。閣下有權查閱及要求更正由本公司持有有關 閣下的個人資料。如有需要，請以書面形式向本公司總經理辦公室經理提出，地址為香港銅鑼灣新寧道8號中國太平大廈19字樓。

DECLARATION & AUTHORIZATION 聲明及授權書：

I hereby declare that the statement and answers given above are true and complete to the best of my knowledge and that I have withheld no material fact. I understand that any misrepresentation of the above statement and answers will cause my claim invalid.

I hereby authorize any hospital, physician, clinic, insurance company or other organization or person that has any records or knowledge of me or my health, to furnish to **CHINA TAIPING INSURANCE (HK) COMPANY LIMITED** or its authorized representative any information relevant to this claim. A copy of this authorization shall be as effective and valid as the original.

本人現聲明上述所填報的資料均屬正確無訛且並無缺漏。本人清楚明白如上述資料有誤或不實，可能導致本人的賠償申請無效。

本人茲授權持任何知道本人健康情況及持有此等記錄之醫院、醫生、診所、保險公司或其他機構或人士，均可向中國太平保險(香港)有限公司或其授權之代表提供有關本人的資料。本授權書之影印本與正本有同等效力。

______________________________ ______________________________
Signature of Patient 病人簽署 **Date 日期**

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

Name of Patient 病人姓名 : ______________________ Name of Hospital 醫院名稱 : ______________________

Date & Time of Admission 入院日期及時間 : ______________ Date & Time of Discharge 出院日期及時間 : ______________

Level of Hospital Ward 病房級別 : ☐ Deluxe 豪華 ☐ Private 私家 ☐ Semi-private 半私家 ☐ Ward 普通 ☐ Clinical Surgery 診所外科手術

A. Clinical History 診所病歷

1.. Date on which the patient first consulted you related to this illness/injury 此疾病/受傷之首次求診日期 : ______________

2.. Chief Symptom(s)/complaint(s) of the patient relating to this hospitalization/treatment/investigation/surgery 此次住院/治療/檢驗/手術的主要病徵/病狀 :

____

3.. How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前已患有此症狀多久? ______________

B. Hospitalization Details 住院詳情

1.. Final Diagnosis of conditions 診斷結果 : ____

____

2.. Date of operation 手術日期 : ______________ Nature/Classification 性質/級別 : ______________

Name of the procedure(s) 手術名稱 : ____

3.. Please give a brief discharge summary (including onset and duration of signs and symptoms/disease, etiology, types and results of major examinations, treatments, complications and follow up plan.) 請提供出院撮要 (包括病徵及病狀/疾病徵兆開始及持續期、病理學、主要檢查種類及結果、治療、併發症及跟進計劃)

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____

4.. Has the patient taken any home leave during this hospitalization? 於住院期間，病人有否請假外出? ☐ No 否 ☐ Yes 是

Please state the date, time and reason 請列明日期、時間及原因 : ____

5.5 Please provide reason(s) for hospitalization if this type of cases can be managed on day care/out-patient basis.
若此治療/檢查可於日間護理/診所進行，請提供住院原因。

____

6.6 Has the patient consulted other physician during this Hospitalization? If "Yes", please provide the following: ☐ No 否 ☐ Yes 是
病人有否於住院期間曾接受其他醫生診治？如答案 "是"，請提供以下資料 :

Name of physician consulted 醫生姓名 : ______________ Reason 原因 : ______________

What treatment had the physician performed 治療詳情 : ____

C. Professional Comment 專業意見

1.1 To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? If "Yes", please state dates and describe. 據閣下所知，病人以前曾否患有同類病況？如答案"是"，請說明何時及當時情況。 ☐ No 否 ☐ Yes 是

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2.2 In your opinion, was the patient hospitalised as a result of recurrent episode or a chronic illness or related to a previous complaint / diagnosis. If "yes", please provide date of the first episode and details. 據閣下意見，病人是次住院治療是否因繼發性或慢性疾病或以往的症狀/疾病而引致的。若答案"是"，請提供第 1 次發病日期及詳情。 ☐ No 否 ☐ Yes 是

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3.. Was the condition due to or associated with the following?(Please tick the appropriate boxes) 健康狀況是由於以下問題引致？(請在適當空格)

- ☐ Accidental bodily injury 意外身體受傷
- ☐ Self-inflicted injury 自我傷害
- ☐ Abuse of drugs or alcohol 濫用藥物或酒精
- ☐ Mental or nervous disorder 精神或神經紊亂
- ☐ Refractive error 視力屈光不正
- ☐ Pregnancy 懷孕
- ☐ Infertility or sterilization 不育或絕育
- ☐ Contraception 避孕
- ☐ Treatment for cosmetic purpose 美容性質的治療
- ☐ Vaccination 疫苗接種
- ☐ Congenital condition 先天性疾病 / 異常
- ☐ Developmental condition 發育問題
- ☐ Hereditary condition 遺傳性問題
- ☐ General check-up 一般身體檢查
- ☐ Venereal disease, sexually transmitted disease or AIDS / HIV related illness 性病，性傳播疾病或愛滋病/愛滋病毒有關的疾病

Please use any separate paper with the physician's signature and chop on it if more space is needed. 若需另頁填寫，每張紙都須有醫生的簽署及蓋章作實。

D. Others 其他

1.. Was the patient referred by another doctor? 病人是否經其他醫生轉介? ☐ No 否 ☐ Yes 是

Name and address of the referral doctor 轉介醫生的姓名及地址 : ____

2. Are you the patient's usual physician? 閣下是否病人慣常醫生? ☐ No 否 ☐ Yes 是

3. In-hospital Doctor Visits Fee charged 住院期內醫生巡房費用 : ________ day 日 @ ________ / day 每日費用 Total Fee 總數 : ________

Specialist Consultation Fee charged 專科醫生診症費用 : ________ Each Surgical Fee charged 各項手術費用 : ________

I hereby certify that all information given above is accurate and true to the best of my knowledge. 本人特此證明，就本人所知上述所有資料準確無誤。

____ ______________________
Signature and Chop of Attending Physician/Surgeon 主診醫生/外科醫生簽署及蓋章 Address and Telephone No.地址及電話號碼

____ ______________________
Name of Attending Physician/Surgeon & Qualifications 主診醫生/外科醫生姓名及資歷 Date 日期 (DD 日 / MM 月 / YY 年)