

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

香港銅鑼灣新寧道8號民安廣場19字樓
19/F, Ming An Plaza, 8 Sunning Road, Causeway Bay, Hong Kong.
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住院及手術賠償申請表
HOSPITALIZATION & SURGICAL CLAIM FORM

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

Name of Policyholder 保單持有人名稱：	
Policy No. 保單編號：	Plan No. 計劃組別：
Name of Employee/Member 僱員/成員姓名： (For Insured Employee/Member who is covered under Group Medical Insurance policy only) (只適用受保於團體醫療保險計劃之僱員或成員)	
Member Reference. 員工編號 (if applicable 倘適用)：	

Name of Patient 病人姓名：	I.D. Card No. 身份證號碼：	
Occupation 職業：	Date of Birth 出生日期：	Sex 性別： <input type="checkbox"/> M 男 <input type="checkbox"/> F 女
Relationship to the Policyholder 與保單持有人關係：	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Staff/Member 僱員/成員	<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dependant 僱員/成員家屬 <input type="checkbox"/> Child 子女
(1) a. Is condition congenital? 此是否先天性缺陷? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否		
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 <input type="checkbox"/> Yes 有 <input type="checkbox"/> Doctor's Name 醫生姓名：_____		
Address 地址：_____		
Date(s) 日期：_____		
(2) Are you making any other insurance claim as a result of this hospitalization/surgery? 有關此次住院/手術，閣下有否申請其他保險賠償? No 沒有 <input type="checkbox"/> Yes 有 <input type="checkbox"/> Name of Insurance Company 保險公司名稱：_____		
Policy No. 保單號碼：_____		
(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 不是 <input type="checkbox"/> Yes 是 <input type="checkbox"/> Date 日期：_____ Time 時間：_____ Place 地點：_____		
Brief Description 經過：_____		

收集個人資料聲明 Personal Information Collection Statement

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：
The information you provide to us is collected to enable us to carry on insurance business and may be used for the purpose of:

- 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；
any insurance or financial related product or service or any alterations, variations, cancellations or renewals of them;
- 任何索償或索償分析；及可能轉移予：
any claim or analysis of it, and may be transferred to:
現存或不時成立之任何有關的公司，或任何其他從事與保險或再保險有關的公司，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，或任何保險公司的協會或聯會。
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 or any association or federation of insurance companies that exists or is formed from time to time.

閣下有權查閱及要求更正本公司持有有關閣下的個人資料。如有任何要求或查詢，請來函或聯絡本公司總經理辦公室經理。
You have the right to obtain access to and to request correction of any personal information concerning yourself held by us. Should you have any requests or enquiries, please contact or write to our Manager of the Office of the General Manager.

DECLARATION & AUTHORIZATION 聲明及授權書：

I hereby declare that the above information given is true and correct.
I further authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish to CHINA TAIPING INSURANCE (HK) COMPANY LIMITED or its authorized representative, and any all information with respect to any illness or injury, medical history, consultation prescriptions or treatment and copies of all hospital or medical records. A photostat copy of this authorization shall be considered as effective and valid as the original.

本人現聲明上述所填報的資料正確無訛。
本人茲授權持有本人健康或任何資料之醫院、醫生、保險公司或機構，可以將部份或全部有關本人傷病之病歷，診斷報告及藥方等資料給於中國太平保險(香港)有限公司或其代理人。此授權書之影印本與正本具同等效力。

Date 日期

Signature of Patient 病人簽署

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PART II – TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT’S OWN EXPENSES

乙 部 – 由主診醫生填寫，所需費用由索償人自行承擔

(1)	Name of Patient 病人姓名 : _____						
(2)	Hospitalization 住院 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 : _____						
(3)	Surgical procedure 手術 Date of operation 手術日期 : _____ Name of the procedure 手術名稱 : _____ Nature 性質 : _____						
(4)	Chief complaints of the patient relating to this hospitalization/surgery 此次住院 / 手術的主要病因 : _____						
(5)	Diagnosis of conditions 診斷 : _____						
(6)	Is this pre-existing disease? 此是否原有之傷病? No 否 <input type="checkbox"/> Yes 有 <input type="checkbox"/> How Long? 已存在多久? _____						
(7)	Is condition congenital? 此是否先天性缺陷? No 否 <input type="checkbox"/> Yes 是 <input type="checkbox"/>						
(8)	Brief discharge summary : (Including treatments, investigation procedures, results, and/or any complications and follow up plan.) 出院摘要 : (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)						
(9)	Date of the accident occurred or symptom first appeared. 首次出現病徵日期或意外發生日期						
(10)	Date of first consultation for this condition or related illness 病人首次求診日期						
(11)	To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? 據閣下所知, 病人以前曾否患有同類病況? No 沒有 <input type="checkbox"/> Yes 有 <input type="checkbox"/> Please state dates and describe 請說明何時及當時情況 : _____						
(12)	Is the patient referred by another doctor? 病人是否經其他醫生轉介? No 否 <input type="checkbox"/> Yes 是 <input type="checkbox"/> Name and address of the referral doctor 轉介醫生的姓名及地址 : _____						
(13)	Have you recommended and secured the opinion or services of a specialist? No 否 <input type="checkbox"/> Yes 是 <input type="checkbox"/> If “Yes”, please answer: 閣下是否推薦病人要接受專科醫生意見及診治? 如答案“是”, 請解答: a. Name of Specialist 專科醫生姓名 : _____ b. Reason 原因 : _____						
(14)	a. In-hospital Doctor Visits Fee charge 住院期內醫生巡房費用 _____ day 日 @ _____ / day 每日費用 Total Fee 總數 : _____ b. Specialist Consultation charged 專科醫生診症費用 : _____ c. Each Surgical Fee charged 各項手術費用 : _____						
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> _____ Name of Attending Physician/Specialist (with qualifications) 主診/專科醫生姓名 (資 歷) </td> <td style="width: 50%; border: none;"> _____ Address 地 址 </td> </tr> <tr> <td style="border: none;"> _____ Signature of Attending Physician/Specialist 主診/專科醫生簽署 </td> <td style="border: none;"> _____ Telephone 電 話 </td> </tr> <tr> <td style="border: none;"> _____ </td> <td style="border: none;"> _____ Date 日 期 </td> </tr> </table>		_____ Name of Attending Physician/Specialist (with qualifications) 主診/專科醫生姓名 (資 歷)	_____ Address 地 址	_____ Signature of Attending Physician/Specialist 主診/專科醫生簽署	_____ Telephone 電 話	_____ 	_____ Date 日 期
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_____ 	_____ Date 日 期						