

# Dental Claims Form

## 牙科賠償申請表

BLUE CROSS

Please fill in all details and attach this slip to your claims with the following information and return to **Blue Cross (Asia-Pacific) Insurance Limited, Medical Claims, Healthcare Division, 10/F East Asia Aetna Tower, 308 Des Voeux Road Central, Hong Kong.** Tel: 2850 3060 Fax: 2850 3099

請填妥下列所需資料並附上索償文件寄回藍十字(亞太)保險有限公司 - 醫療理賠部, 香港中環德輔道中308號東亞安泰中心10樓 電話: 2850 3060 圖文傳真: 2850 3099

**To be filled with original accounting statements and other relevant documents. 請附交賬項聲明及其他有關文件。**

**To Be Completed by the Insured (or Parent If Insured Is a Minor) 由被保人填寫 (若被保人為小童, 可由家長填寫)。**

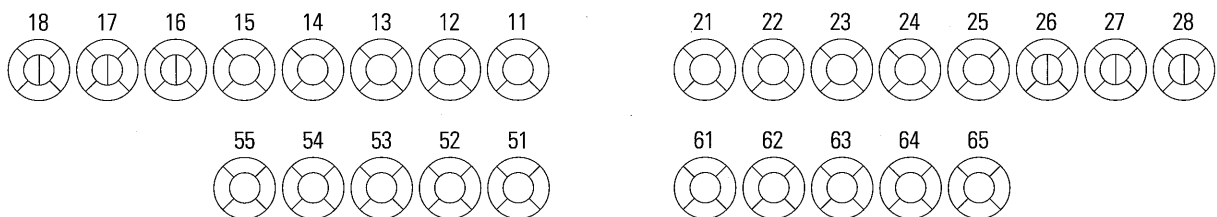
Employer/Policyholder 僱主 / 保單持有人		Policy No. 保單編號
Insured Name 被保人姓名		Insured's HKID No. or Insured No. 被保人身份證號碼或被保人號碼
Name and HKID No. of parent (If Insured is a minor) 若被保人為小童, 請註明家長之姓名。		
Dentist's Name 牙科醫生姓名	Dentist's Address 牙科醫生地址	

**To Be Completed by the Dentist Providing Treatment. 由負責治療之牙科醫生填寫。**

Date 日期	Particulars 詳情	Charges 收費
1.		
2.		
3.		
4.		
5.		
6.		

Please mark teeth treated or area of oral treatment on the following chart.  
請在下圖顯示接受治療之牙齒或口腔治療範圍。

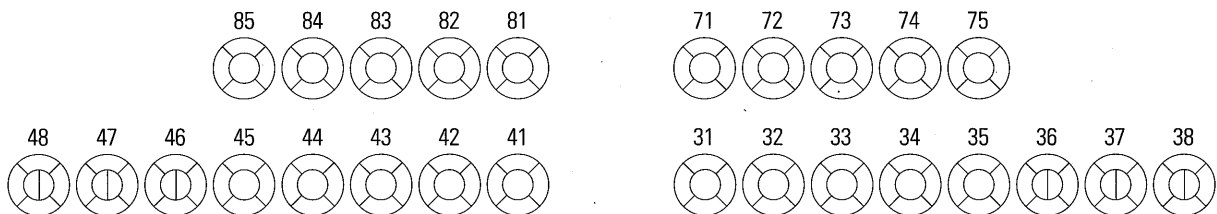
### LABIAL 唇部



### RIGHT 右

### LINGUAL 舌部

### LEFT 左



### LABIAL 唇部

Remarks 備註	
Date 日期	Signature of Dentist 牙科醫生簽署

## To Be Completed by the Insured (or Parent If Insured Is a Minor) 由被保人填寫 (若被保人為小童, 可由家長填寫)。

If any of the dental treatments or services were necessitated as a result of an accident please give brief descriptions of the accident.  
若任何牙醫治療或服務是因意外造成, 請簡述意外經過。

Where did the accident take place?  
意外發生地點?

When did the accident take place?  
意外發生日期?

Was the accident of a nature requiring report to the police?  
意外是否需要向警方報告?

Yes  
是  No  
否

If so, was the accident reported? (copy of documents to be enclosed)  
若是, 是否已向警方報告? (請附交有關文件)

Yes  
是  No  
否

Date reported and where? (copy of documents to be enclosed)  
報警日期及地址? (請附交有關文件)

## Declaration and Authorization 聲明及授權

I/We hereby declare and agree that any personal data concerning myself/ourselves collected and held by **Blue Cross (Asia-Pacific) Insurance Limited** "The Company" (whether contained in this application or otherwise obtained) may be used, stored, disclosed and transferred (whether within or outside Hong Kong) to such individuals/organizations associated with the Company as the Company may consider necessary or any selected third party including reinsurers, claims investigators, medical facilities and industry associations/federations for the purposes of processing this application and providing subsequent service, and to communicate with me/us for such purpose.

I/We understand that I/We have the right to request access to and, to request correction of any personal information concerning myself/ourselves held by the Company. Such request can be made to the Company's HealthCare Division.

Address: 10/F, East Asia Aetna Tower, 308 Des Voeux Road Central, Hong Kong.

I/We also hereby authorize any organization or individual that has any record or knowledge of my/the Insured(s)'s health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to the Company such information. A photocopy of this authorization shall be as valid as the original.

I/We hereby declare that the answers to all the above questions are accurate, true and complete and are given to the best of my/our knowledge and belief.

I/We hereby declare and agree that any personal data concerning myself/ourselves collected and held by Blue Cross (Asia-Pacific) Insurance Limited ("the Company") (whether contained in this application or otherwise obtained) may be used, stored, disclosed and transferred (whether within or outside Hong Kong) to such individuals/organizations associated with the Company as the Company may consider necessary or any selected third party including reinsurers, claims investigators, medical facilities and industry associations/federations for the purposes of processing this application and providing subsequent service, and to communicate with me/us for such purpose.

I/We understand that if I/we and/or the Insured(s) fail to provide any information requested in this application, it may result in the inability of the Company to accept or process this application.

I/We understand that I/We have the right to request access to and, to request correction of any personal information concerning myself/ourselves held by the Company. Such request can be made to the Company's HealthCare Division at 10/F, East Asia Aetna Tower, 308 Des Voeux Road Central, Hong Kong.

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本人/我們現聲明並同意, 貴公司可保留、使用或透露藍十字(亞太)保險有限公司(貴公司)所收集或保留之有關本人/我們的個人資料(在此申請書所載或從其他途徑取得), 給予貴公司有關的人士/機構或任何被選定的機構(在本港或海外), 包括再保險及賠償調查公司、醫療機構, 及有關的行業協會/聯會, 用作處理本申請及提供其稍後的服務, 及資料核對等用途, 及因此等用途與本人/我們聯絡。本人/我們明白到本人/我們有權向貴公司查閱及申請改正所有與本人/我們的個人資料。有關的申請可於貴公司的醫療保健部辦理。

地址: 香港中環德輔道中 308 號東亞安泰中心 10 樓

本人/我們茲授權任何知悉或擁有本人/被保人之健康狀況及病歷或任何治療或諮詢記錄及會為或將為本人/被保人診治之機構、組織或人士, 向貴公司透露有關資料。此授權書之正本與副本同屬有效。

本人/我們謹此聲明上述所有問題的答案均是準確無誤, 真實及為事實的全部, 並且是盡本人/我們所知及所信而作答的。

本人/我們謹此聲明並同意, 藍十字(亞太)保險有限公司("藍十字")可保留、使用及透露藍十字所收集或保留之有關本人/我們的個人資料(在此申請書所載或從其他途徑取得), 給予藍十字有關的人士/機構或任何被選定的機構(在本港或海外), 包括再保公司、賠償調查員、醫療機構, 及保險業協會/聯盟, 用作處理本申請及提供其稍後的服務, 及資料核對等用途, 及因此等用途與本人/我們聯絡。

本人/我們明白, 如本人/我們及/或被保人未能就本申請所需提供足夠資料將或會導致藍十字不能接受或處理本申請。

本人/我們明白到本人/我們有權向藍十字查閱及申請改正所有與本人/我們的個人資料。有關的申請可於藍十字位於中環德輔道中 308 號, 東亞安泰中心 10 樓之醫療保健部辦理。

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Date  
日期

Signature of Insured (or Parent if Insured is a Minor)  
被保人(或家長)簽署