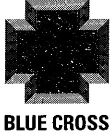

BLUE CROSS

MEDICAL INSURANCE - HOSPITALIZATION & SURGICAL CLAIM FORM
醫療保險 - 住院及手術賠償表

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

Name of Policyholder 保單持有人名稱：

Name of Employee/Member 僱員 / 成員姓名
(For group insurance policy only)

Policy No. 保單編號

Insured No./Certificate No. 保戶編號 / 受保証書編號 (If applicable 倘適用)

Name of Patient 病人姓名

Occupation 職業

Date of Birth 出生日期

Sex 性別 : ☐ M 男 ☐ F 女

Relationship to the Policy Holder 與保單持有人關係 ☐ Self 本人 ☐ Spouse 配偶 ☐ Child 子女 ☐ Staff/Member 僱員 / 成員 ☐ Dependent 僱員 / 成員家屬

(1) 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 ____________

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 ☐ Yes 有 ☐ 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 沒有 ☐ Yes 有 ☐ Date 日期 ________ Time 時間 ________ Place 地點 ________

Brief Description 經過 ____________

____

Declaration & Authorization 聲明及授權書

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 purposes.
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 Medical Claims Department at 22/F, Cosco Tower, 183 Queen's 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 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.

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仕 / 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香港中環皇后大道中 183 號中遠大廈 22 樓之醫療理賠部辦理。
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曾為或將為本人 / 被保人診治之機構、組織或人仕，向藍十字透露有關資料。此授權書之正本與副本同屬有效。

____________ Date 日期

____________ Signature of Patient 病人簽署

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 of Admission 入院日期 ____________________ Date of Discharge 出院日期 ____________________

(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) Brief discharge summary: (including treatments, investigation procedures, results; and/or any complications and follow up plan.)

出院撮要：(治療及以後治療計劃，包括診查、結果、拼發症及跟進計劃)

(7) Date of the accident occurred or symptom first appeared. 首次出現病徵日期或意外發生日期。

(8) Date of first consultation for this condition or related illness 病人首次求診日期

(9) 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 ☐ Yes 有 ☐ Please state dates and describe ____________________

請説明何時及當時情況 ____________________

(10). Is the patient referred by another doctor? 病人是否經其他醫生轉介？

No 沒有 ☐ Yes 有 ☐ Name and address of the referral doctor ____________________

轉介醫生的姓名和地址 ____________________

____

Name of Attending Physician / Specialist (with qualifications)

主診 / 專科醫生的姓名(資歷)

____

Address

地址

____

Telephone

電話

____

Signature of Attending Physician/Specialist

主診 / 專科醫生簽名

____

Date

日期

This claim form is endorsed by the Hong Kong Medical Association and the Medical Insurance Association of the Hong Kong Federation of Insurers.