



Outpatient Claims Submission Slip

門診索償申請表

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, Claims Department**, 10/F East Asia Aetna Tower, 308 Des Voeux Road Central, Hong Kong. Tel: 2850 3060 Fax: 2850 3099 (Each slip per person/per family)

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 - 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 (每表只限一人/家庭)

No. of bill(s)/statement(s)/receipt(s) for claims purposes
索償用之門診帳單 / 結單 / 收據數目

Policy Number
保單號碼

Policyholder's Name
保單持有人名稱

Name of Insured (Patient)
受保人姓名(病人)

Insured Number (This number appears on your certificate of insurance or scheduls 3, Schedule of Insureds in front of your name)
受保人號碼 (此編號可見於閣下保險證明書或保單附表三受保人名單閣下姓名之前)

H.K.I.D. Card Number (If available)
香港身份證號碼 (如適用者)

Note: Please submit ORIGINAL bill(s)/statement(s)/receipt(s) in which name of patient, diagnosis, date of consultation, charges breakdown should be stated. Please attach written referral and/or prescription if necessary.

註: 請附上門診帳單 / 結單 / 收據正本連同病人姓名、診症結果、診症日期、醫療費用。如有需要, 請附上醫生介紹信及藥物處方。

Declaration and Authorization 聲明及授權

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 Healthcare Division at 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 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出的。

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 / 我們有權向藍十字索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。

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

Insured's Signature
被保人簽署