

Liberty International Insurance Ltd
利寶國際保險有限公司

Member of Liberty Mutual Group

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 1 - TO BE COMPLETED BY THE PATIENT

甲部－由病人填寫

Name of Policy Holder 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／受保證書編號 (If applicable 倘適用)：	

Name of Patient 病人姓名：	I.D. Card No. 身份証號碼：	
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 Policy Holder 與保單持有人關係：	<input type="checkbox"/> Self 本人	<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Child 子女
	<input type="checkbox"/> Staff/Member 僱員／成員	<input type="checkbox"/> 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 不是 YES 是

Date 日期：_____ Time 時間：_____ Place 地點：_____

Brief Description 經過：_____

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 **Liberty International Insurance Ltd** or its authorized representative, any and 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患之病歷、診斷報告及藥方等資料給與利寶國際保險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

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)	
(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 <input type="checkbox"/> YES 有 <input type="checkbox"/> Please state dates and describe _____ 請說明何時及當時情況 _____	
(10) Is the patient referred by another doctor? 病人是否經其他醫生轉介？ NO 不是 <input type="checkbox"/> YES 是 <input type="checkbox"/> 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