Manulife GROUP INSURANCE
宏利團體保險

HOTLINE: 2510 5797

GROUP DENTAL CLAIM FORM
團體牙科賠償索償表格

Employer Name
僱主名稱：_____

Policy No. 保單編號：_____ – Account No. 分組編號：_____ – _____

Employee Name
僱員姓名：_____

Certificate No.
證書編號：_____

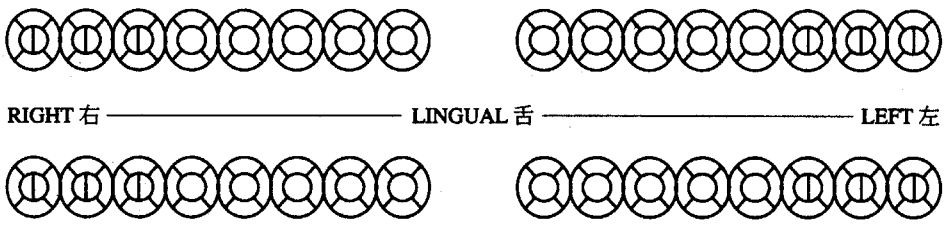
Patient Name
病人姓名: _____

Dependent No.
家屬編號：_____

Please have the following completed by the dentist providing the treatments.
以下資料須由應診牙醫填寫。

Date 日期	Particulars 治療項目	Charges 收費
1.		
2.		
3.		
4.		
5.		

Please make teeth treated or area of oral treatment on following chart.
請於下圖註明病人接受治療的牙齒或口腔位置。



Signature of Dentist
牙醫簽署：_____

Date
日期：_____

I hereby authorize the release of any information pertinent to this claim from any medical personnel as requested by Manulife (International) Limited.
本人謹此授權任何醫護人員，按宏利人壽保險（國際）有限公司的要求，提供與是次索償有關的任何資料。

_____ _____

Signature (Patient; or Parent if a minor)
簽署（病人或未成年病人的父母）

Date Signed
簽署日期

* ALL INVOICES/RECEIPTS AND OTHER RELEVANT DOCUMENTS MUST BE SUBMITTED WITH CLAIM.
* 必須一併遞交所有發票／收據及其他有關文件。
* IF DENTAL TREATMENT IS RESULTING FROM AN ACCIDENT, AN ADDITION DOCTOR REPORT IS REQUIRED.
* 如病人因遇到意外而需接受牙科治療，另須遞交醫生報告。