

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

Branch code _____
Location _____
Advisor code _____
Advisor's name _____

PART I – TO BE COMPLETED BY THE PATIENT
第一部份 – 由病人填寫

Name of Policyowner 保單持有人名稱： _____	
Name of Employee/ Member 僱員/ 成員姓名： (for group insurance policy only 只適用於團體保險保單)	Policy No. 保單編號： _____
Insured No./ Certificate No. (if applicable) 保戶編號 / 受保証書編號 (如適用)： _____	

Name of Patient 病人姓名： _____	HKID/ Passport No. 香港身分證 / 護照號碼： _____	
Occupation 職業： _____	Date of Birth 出生日期： (DD / MM / YYYY 日/月/年)	Sex 性別： <input type="checkbox"/> M 男 <input type="checkbox"/> F 女
Relationship to Policyowner 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 of Staff/ Member 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 否 <input type="checkbox"/> YES 是 <input type="checkbox"/>	Doctor's Name 醫生姓名： _____	
	Address 地址： _____	
	Treatment Date 診治日期： _____	
(2) Are you making any other insurance claim as a result of this hospitalization/ surgery? 有關是次住院 / 手術，閣下有否申請其他保險賠償？		
NO 沒有 <input type="checkbox"/> YES 有 <input type="checkbox"/>	Name of Insurance Company 保險公司名稱： _____	
	Policy No. 保單編號： _____	
(3) Was the hospitalization/ surgery a result of an accident? 是次住院 / 手術是否由於一宗意外引致？		
NO 否 <input type="checkbox"/> YES 是 <input type="checkbox"/>	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 Manulife (International) Limited 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予宏利人壽保險(國際)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 (DD / MM / YYYY) 日期 (日/月/年) _____

X

Signature of Patient (if Aged 18 or Above) * 病人簽署 (如十八歲或以上) *

* For patient aged below 18, signature of the policyowner should be provided for the claim. 十八歲以下病人之索償申請必須由保單持有人簽署。

X

Signature of Policyowner 保單持有人簽署 _____

Note: All personal data collected under this form is collected for the purpose of processing the claim under the relevant insurance policy. It is compulsory for the patient(s) to complete the form to claim for the relevant benefit(s) available under the policy. Appropriate correction and access to the personal data under this form is allowed with the approval of Manulife (International) Limited. Request may be made by writing to the Home Office (at the Customer Relations Department, Manulife (International) Limited, 31/F., Manulife Tower, 169 Electric Road, North Point, Hong Kong). The personal data of this form may be transferred to any related companies or any service providers for adjudicating the claim and may be transferred to any insurance regulatory bodies to enable them to carry out their regulatory functions. 註：本表格所收集之任何個人資料乃用以處理有關保單之賠償申請，病人必須完成本表格以索取保單所列之賠償。病人於宏利人壽保險(國際)有限公司同意下可提出修改及取得本表格之個人資料，有關要求可向宏利之客戶服務部提出(地址：香港北角電氣道169號宏利保險中心31樓宏利人壽保險(國際)有限公司)。本表格之個人資料可轉移予任何相關公司，其他服務供應商作處理賠償申請用途，並供保險業監管機構執行監管職權。

The Chinese version of this claim form is for reference only. In the event of conflicts between the Chinese and English versions, the English version shall prevail. 此索償表格之中文譯本只供參考之用，若與英文有異，一概以英文為準。

PART II – TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT'S OWN EXPENSES
第二部份 – 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 Procedure 手術名稱： _____ Nature 性質： _____ _____	
(4) Chief symptoms, complaints and etiology of the patient relating to this hospitalization/ surgery 是次住院 / 手術的主要徵狀、申訴及病因：	
(5) Diagnosis of Conditions 診斷：	
(6) Brief Discharge Summary: (including treatments and after treatments, investigation procedures, results, 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 病人就此病況或有關疾病之首次求診日期：	
(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 請說明日期及當時情況) _____ _____	
(10) Is the patient referred by another doctor? 病人是否經其他醫生轉介？ NO 否 <input type="checkbox"/> YES 是 <input type="checkbox"/> (Please provide name, address and contact no. of the referral doctor 請提供轉介醫生的姓名、地址及聯絡電話) _____ _____	
_____ Name of Attending Physician/ Specialist (with qualifications) 主診 / 專科醫生姓名 (資歷)	_____ Address 地址
X	_____ Contact No. 聯絡電話
_____ Signature of Attending Physician/ Specialist (with stamp) 主診 / 專科醫生簽署 (連印章)	_____ Date (DD / MM / YYYY) 日期 (日/月/年)

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