



OUTPATIENT MEDICAL CLAIM FORM
門診醫療賠償申請表格

Please "✓" if original receipts should be returned 如欲退回正本收據, 請填 "✓"

CLAIM INSTRUCTIONS 申請賠償指示

- This form is applicable to clinical consultations only. For minor operation and other medical expenses, please use "Hospitalization and Surgical Claim Form".
此表格只限於門診賠償。小手術及其他醫療費用賠償, 請用「住院及手術賠償申請表格」。
- In case of accidental injury, please also complete the part of "Accident Particulars". 如因意外受傷, 請填寫“意外細節”部分。
- If the claimant is a Dependant of an Insured Member, this Form should be completed and signed by the Insured Member. 如索償人為受保人家屬, 應由受保人填寫及簽署此表格。
- Original receipt of each claim bearing the following information must be attached: (a) Date of Treatment; (b) Name of Patient; (c) Amount of Charge (itemized if more than one "Benefit Claimed"); (d) Diagnosis; (e) Attending Physician's signature and official stamp and (f) Name of the Clinic / Laboratory / Hospital.
每項賠償申請之收據必須為正本, 並列明以下資料: (a) 診症日期; (b) 病者姓名; (c) 收費 (如多於一個賠償項目, 應列明各項目收費); (d) 診斷病因; (e) 主診醫生簽署及蓋章; (f) 診所、化驗所或醫院之名稱。
- For claims in respect of Laboratory Test, Specialist Consultation or Prescribed Medicines, original written referral from the Attending Physician must be attached to this Form.
所有化驗、專科門診或處方藥物之賠償申請, 均需一併遞交主診醫生之轉介信正本。
- This Form must be submitted within 90 days of incurring such expenses. Otherwise, claims will not be processed. 請於支出費用後 90 日內遞交此表格, 否則賠償申請將不獲受理。
- This Form must be fully completed and signed, and the information supplied on all receipts should be clearly stated. Otherwise, documents submitted will be returned for verification or other necessary actions. 此表格必須詳盡填寫並由受保人簽署, 收據所載資料必須清楚明確, 否則所遞交之文件將被退回。

CLAIM INFORMATION 賠償資料

Policy No. 保單編號		Policyholder 保單持有人名稱			Member No. 受保人編號		Surname 姓		Other Name 名	
No. 編號	Name of Claimant 索償人姓名	Relationship (if an Insured member's Dependant) 關係 (如屬受保人家屬)	Visit Date (in chronological order) 求診日期 (按日期次序排列) (D 日/M 月/Y 年)	Expenses Incurred 費用	Benefit Claimed (Please '✓') 申請賠償項目 (請用 '✓')					
					General Consultation 普通科門診	Specialist Consultation 專科門診	Lab. Test 化驗	Prescribed Medicines 處方藥物	Others (please state) 其他(請說明)	
Amount reimbursed by other insurance or compensation 其他保險賠償或補償										
Total (less Amount reimbursed by other insurance or compensation) 總數 (減去其他保險賠償或補償)										

Accident Particulars (Please complete the following in case of Accidental Injury) 意外細節 (如因意外受傷, 請填寫以下部分)

Name of Injured 傷者姓名	Place of Accident 意外發生地點		
Date of Accident 意外日期	Part of body injured 受傷部位		
How Accident happened 意外發生經過	Have you had prior treatment for this accident? 以前有否因同一意外接受治療?	Yes / No	If yes, date of prior treatment 若曾經接受治療, 何時?

DECLARATION and AUTHORIZATION 聲明及授權書:

I/We hereby declare that to the best of my/our knowledge and belief, the above statement and particulars contained are true and complete in every respect and are made without reservation of any kind. I also authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish to The Tokio Marine and Fire Insurance Company (Hong Kong) Limited ("the Company") 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. The information provided by me/us to the Company is collected to enable the Company to carry on insurance business and may be used for the purpose of (i) any insurance or financial related product or service or any alterations, variations, cancellation or renewal of the said products or services; (ii) any claim or investigation or analysis of such claim; and (iii) exercising any right of subrogation; and may be transferred to (iv) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; (v) any association, federation or similar organization of insurance companies ("Federation") that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation; and (vi) any members of the Federation by the Federation for any of the above or related purposes.

本人/我們現聲明上述所填報的一切資料均屬正確無訛, 並無任何保留。本人更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東京海上火災保險(香港)有限公司(「貴公司」)或其代理人。本人/我們明白本人/我們提供的資料為 貴公司提供保險業務所需, 並可能使用於下列目的: (i) 任何與保險或財務有關的產品或服務, 或該等產品或服務的任何更改、變更、取消或續期; (ii) 任何索償, 或該等索償的調查或分析; 及 (iii) 行使任何代位權; 並可能轉移予: (iv) 任何有關的公司, 或任何其他從事與保險或再保險業務有關的公司, 或與保險業務有關的中介人或索償或調查或其他服務提供者, 以達到任何上述或有關目的; (v) 現存或不時成立的任何保險公司協會或類同組織(「聯會」), 以達到任何上述或有關目的, 或以便聯會執行其監管職能, 或其他基於保險業或任何聯會會員的利益而不時在合理要求下賦予聯會的職能; 及 (vi) 或透過聯會轉移予任何聯會的會員, 以達到任何上述或有關目的。

Moreover, the Company is hereby authorized to obtain access to and/or to verify any data provided by me/us with the information collected by the Federation from the insurance industry. I/We understand that I/we have the right to obtain access to and to request correction of any personal information concerning myself/ourselves held by the Company. Requests for such access can be made in writing to the Compliance Officer, 27th Floor, United Centre, 95 Queensway, Hong Kong. A photostat copy of this authorization shall be considered as effective and valid as the original.

此外, 本人/我們授權 貴公司向聯會從保險業內收集的資料中查閱及核對本人/我們任何資料。本人/我們明白本人/我們有權查閱及要求更正由 貴公司持有有關本人/我們的個人資料。如有需要查閱, 本人/我們可用書面寄香港金鐘道 95 號統一中心 27 樓, 向 貴公司條例主任提出。此授權書之影印本具同等效力。

Date 日期

Signature of Insured Member 受保人簽署