

HOSPITALIZATION & SURGICAL CLAIM FORM 住院及手術賠償表格

(29082011)

Important Notes 重要事項：

- (i) Original itemized bills and receipts and this Claim Form must be submitted within 90 days from the date of hospital admission.
 請於入院日起計 90 日內將正本詳列之賬單及收據連同賠償表格一起遞交。
- (ii) Please attach copies of hospital discharge summary, laboratory tests report, pathology report, physician's statement and any other related information.
 請同時附上出院紙、化驗報告、病理報告、醫生報告及其他相關資料之副本。

Part 1 - To be completed by the Claimant 第一部份 - 由索償人填寫

| | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|----------------------------------------------------|----------------------------------------|--|------------------------------------------------|--|---------------------------------------|--|
| 1a. Policy No. 保單號碼 | | b. Policyholder 保單持有人名稱 | | | | | | | |
| 2. (Applicable to Group Insurance Only. 只適用於團體醫療保險。) Name of Employee 僱員姓名 Surname 姓 Other name 名 | | | | | | | | | |
| 3a. Ref. No. 參照號碼 | | b. Name of Claimant 索償人姓名 Surname 姓 Other name 名 | | c. ID Card/Passport No. 身份證/護照號碼 | | | | | |
| 4. Claimant's relationship to the Policyholder 索償人與保單持有人關係 <input type="checkbox"/> Employee 僱員 <input type="checkbox"/> Employee's Dependant 僱員家屬 <input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Child 子女 | | | | | | | | | |
| 5. Describe the symptoms and abnormalities leading to this hospitalization. 請描述因何不適及有何異常引致是次入院。 | | | | | | | | | |
| 6. Name, Address & Telephone No. of doctor / hospital first consulted for the illness. 首次求診之醫生姓名 / 醫院名稱、地址及電話號碼。 | | | | | | | | | |
| 7a. Date of the first consultation 首次求診日期 | | | b. When did these symptoms first appear? 病徵何時首次出現? | | | | | | |
| 8. If hospitalization was the result of an accident, please describe when, where and how the accident happened? 如因意外入院, 請敘述時間、地點及發生過程。 | | | | | | | | | |
| 9. Has the Claimant taken any home leave during this hospitalization? 索償人曾否在住院期間請假離院? <input type="checkbox"/> Yes 有 Period 日期: From 由 _____ to 至 _____ <input type="checkbox"/> No 無 | | | | | | | | | |
| 10. Has the Claimant had any prior treatment for the same or closely interrelated cause? If yes, please complete: 索償人以前曾否接受過同樣或相關原因之治療? 如「有」, 請填此欄: | | | | | | | | | |
| Date admitted / Treated 入院 / 治療日期 | | Date discharged 出院日期 | | Cause 原因 | | Name & Address of Doctor 醫生姓名及地址 | | Name & Address of Hospital 醫院名稱及地址 | |
| 11a. Are the Claimant making any other insurance or compensation claim as a result of this hospitalization? If yes, please provide reimbursement breakdown. 索償人曾否因這次入院而申請其他保險賠償或補償? 如「有」, 請提供賠償明細表。 <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 無 | | | | b. Name of Insurance Company 保險公司名稱 | | c. Type of Insurance / Compensation 保障或補償類別 | | | |

1) I hereby declare that the foregoing statements, including any statement attached, are true, correct and complete to the best of my knowledge and belief.

2) **Personal Information Collection Statement**
 The information you provide to **Falcon Insurance Company (Hong Kong) Ltd.** 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 such product or service; (ii) any claim or investigation or analysis of such claim; and (iii) exercising any right of subrogation. The information may be transferred to (i) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claim or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; (ii) 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 (iii) any members of the "Federation" by the "Federation" for any of the above or related purposes. Moreover, **Falcon Insurance Company (Hong Kong) Ltd.** is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance industry. You have the right to obtain access to and to request correction of any personal information concerning yourself held by **Falcon Insurance Company (Hong Kong) Ltd.** Requests for such access can be made to our compliance officer (6/F., DCH Commercial Centre, No.25 Westlands Road, Quarry Bay, Hong Kong. Tel: 2232 2888 Fax: 2232 2799).

3) **Consent & Authorization**
 In accordance with the provisions of the Personal Data (Privacy) Ordinance of Hong Kong, I/and on behalf of the Claimant* consent, by signing below, that the personal information of me/the Claimant* provided by me/us* and held by **Falcon Insurance Company (Hong Kong) Ltd.** (whether contained herein or otherwise obtained) may be held, used, disclosed, released and transferred by **Falcon Insurance Company (Hong Kong) Ltd.** to the parties and for the purposes mentioned in the "Personal Information Collection Statement. I hereby authorize/and on behalf of the Claimant hereby authorize* (i) any doctor, hospital, clinic, or insurance company, government office or any organization or persons who has any records/knowledge/information of me/the Claimant* (whether medical or otherwise) to disclose, release or transfer to Falcon Insurance Company (Hong Kong) Ltd. or its representative such record, knowledge or information pertinent to the claim herein and/or the disability resulting from the said claim; (ii) Falcon Insurance Company (Hong Kong) Ltd. or any of its appointed medical/para-medical examiners or laboratories to perform necessary medical assessment and tests to evaluate the health status of me/the Claimant* in relation to (i) above. This authorization shall bind the successors and assignees of me/the Claimant* and remains valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original.
 *delete where appropriate

1) 本人謹在此聲明, 以上所述一切是根據本人所知所信正確填寫, 並為完全和真確。

2) **收集個人資料聲明**
 閣下提供的資料, 為富勤保險(香港)有限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; (iii) 行使任何代位權, 該等資料可能移轉予: (i) 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; (ii) 現存或不時成立的任何保險公司協會或聯會或類同組織〔「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 (iii) 或透過「聯會」移轉予任何「聯會」的會員, 以達到任何上述或有關目的; 此外, 在此授權富勤保險(香港)有限公司由「聯會」從保險業內收集的資料中查閱及/或核對閣下任何資料, 閣下有權查閱及要求更正由富勤保險(香港)有限公司持有有關閣下的個人資料, 如有需要, 可向本公司監察主任(香港鰂魚涌華蘭路 25 號大昌行商業中心 6 樓 電話: 2232 2888 傳真: 2232 2799) 提出。

3) **同意及授權書**
 根據香港個人資料(私隱)條例, 就簽署此賠償表格, 本人同意/謹代表賠償申請人同意富勤保險(香港)有限公司持有或使用任何有關本人賠償申請人之個人資料(不論是否從此賠償表格或其他途徑所得), 或將該等資料透露、發放或轉交予「收集個人資料聲明」內提及之組織、機構或人仕作為有關之用途, 本人謹此授權/謹此代表賠償申請人授權 (i) 任何擁有本人賠償申請人之醫療記錄或資料之醫生、醫院、診所、保險公司、政府部門或其他機構及人仕, 向富勤保險(香港)有限公司或其代表透露及提供關於本人賠償申請人之記錄或資料; (ii) 富勤保險(香港)有限公司或其指定之醫療檢查人員或化驗所對本人賠償申請人進行與(i)有關之身體檢查及化驗, 此授權對本人賠償申請人之繼承人及受讓人均有約束力, 即使在本人賠償申請人身故或喪失行為能力後仍然有效, 此授權書之副本, 與正本同樣有效。

*請將不適用者刪除

Date 日期

 Signature (Claimant/Parent if Claimant aged under 18)
 簽署 (索償人/父母 - 如索償人未滿 18 歲)

Part 2 - To be completed by the Attending Physician (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付)

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. Name of patient 病者姓名 | 2. Name of Hospital 醫院名稱 | 3a. Date admitted 入院日期 | b. Date discharged 出院日期 |
| 4. Complete diagnosis for hospitalization 住院之診斷 | | 5. Symptoms and onset date 病徵及其何時開始 | |
| 6. Aetiology of the medical condition 病因 | | | |
| 7. When did the patient first consult you for this condition or other related symptoms? 病者何時因這種病症或其他有關病徵向你首次求診? | | 8. Was the patient referred to you by another doctor? (Yes/No) If yes, please state the name of the doctor 病者是否由另一醫生轉介? (是/否) 如「是」, 請提供該醫生之姓名 | |
| 9. Has the patient been treated or hospitalized for the same or closely interrelated condition before? If yes, please complete: 病者以往曾否因同樣或相關之病症而接受治療或住院? 如「有」, 請填寫: | | | |
| a. Date admitted 入院日期: Date discharged 出院日期: Name of Hospital 醫院名稱: | | Cause 入院原因: Treatment 治療: Attending physician/surgeon's name 主診/外科醫生姓名: | |
| b. Date of clinic consultation 門診日期 | | Symptoms/complaints 病徵/不適 | Treatment 治療 |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| 10. Are you the patient's usual physician? 閣下是否病者慣常求診之醫生? | | | |
| a. Yes 是 <input type="checkbox"/> . Please fill in the medical history 請填寫病歷: (Please use additional paper if necessary 如有需要, 請用附加紙張) | | | |
| Date of clinic consultation 門診日期 | | Symptoms/complaints 病徵/不適 | Recommended tests/treatment 檢查/治療 |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| b. No 否 <input type="checkbox"/> . Please give the name(s) of the patient's usual doctor(s) that you know. 請提供閣下知悉之病者慣常求診之醫生姓名 _____ | | | |
| 11. Have you recommended and secured the opinion or services of a specialist? 你會否獲得專科醫生之意見或服務? <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 無 If yes, please give the name of the Specialist and the reason why his opinion or services are required. 如「有」, 請提供該專科醫生之姓名及需要其意見或服務之理由。 | | 12. In-hospital Doctor Visit Fees charged 醫生巡房收費 日數 _____ days 每日 @ _____ Total Fees 費用總額: | |
| 13. If confinement is due to childbirth 如因分娩住院 | | | |
| a. approximate date of commencement of pregnancy 懷孕開始之大概日期 Day 日 Month 月 Year 年 | | b. it should be classified as a 分娩類別 <input type="checkbox"/> Normal Delivery 順產 <input type="checkbox"/> Legal Abortion 合法墮胎 <input type="checkbox"/> Miscarriage 流產 <input type="checkbox"/> Caesarian Birth 剖腹生產 | |
| I hereby declare that I was the Attending Physician of the above-named patient during hospital confinement, and that the answers given by me as above are full, complete and true to the best of my knowledge. 本人謹在此聲明, 本人乃上述住院病者之主診醫生。以上所述一切是根據本人所知正確填寫, 並為完全和真確。 | | | |
| Date 日期 | Name, Qualifications & Address of Attending Physician 主診醫生之姓名、資歷及地址 | | Attending Physician's Signature & Official Stamp 主診醫生簽署及蓋章 |

Part 3 - To be completed by the Surgeon if operation was performed 第三部份 - 如需動手術, 此欄由外科醫生填寫。

| | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------|
| 1. Name of Patient 病者姓名 | 2. Date of Operation 手術日期 | 3. Where performed 手術地點 |
| 4. Brief description of operating procedure performed 請簡略敘述手術進行之步驟 | | |
| 5. Surgical Fees charged 外科手術費用 | 6. Name of Anaesthetist 麻醉師姓名 | 7. Anaesthetist Fees charged 麻醉師費用 |
| I hereby declare that the above patient had a surgical operation done by me, and that the answers given by me as above are complete and true to the best of my knowledge. 本人謹在此聲明, 上述病者曾接受由本人負責之外科手術。以上所述一切是根據本人所知正確填寫, 並為完全和真確。 | | |
| Date 日期 | Name, Qualifications & Address of Surgeon 外科醫生之姓名、資歷及地址 | Surgeon's Signature & Official Stamp 外科醫生簽署及蓋章 |

* 本賠償表格之中文譯本只供參考之用, 如有爭議, 應以英文原義為準。 **EMPLOYEE BENEFITS DIVISION 僱員福利部**