招商永隆保險
CMB WING LUNG INSURANCE

招 商 永 隆 保 險 有 限 公 司
CMB Wing Lung Insurance Company Limited
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MEDICAL INSURANCE - HOSPITALIZATION & SURGICAL CLAIM FORM
醫療保險 – 住院及手術索償表格

Please complete and sign this claim form and make sure that the original copy of invoices and receipts are attached. (Please complete in BLOCK LETTER)
請填妥及簽署此賠償申請表並附上所有醫療收據正本（請用正楷填寫）

PART I – To Be Completed by the Patient 甲部 - 由病人填寫

Name of Policyholder / Employer 保單持有人/僱主名稱	Policy No 保單號碼	Certificate No. 証書號碼
Name of Employee (For group account only) 僱員姓名 （只適用於團體合約）	Day Time Contact Tel No. 日間聯絡電話	
Name of Patient 病人姓名	Date of Birth(DD 日/ MM 月/ YY 年) 出生日期	Sex 性別

1. Describe the symptoms and abnormalities which led to the hospitalization 請列出病人因何不適及有何症狀導致是次入院

2. Since when had these symptoms first appeared 病人於何日首次出現上述症狀	3. Date of the first consultation 初診日期

4. Name, address and telephone no. of doctor/hospital the patient first consulted for the illness 初診醫生姓名/醫院名稱、地址及電話

5. Has the patient been treated by other doctor(s) for similar or related illness in the past? 病人曾否因同一或有關之病症而向其他醫生求診？
Yes 是☐ No 否☐ If "yes", please specify 如 "是" ，請詳述
Treatment Date 診治日期 Name & Address of doctor(s) / hospital(s) 醫生姓名 / 醫院名稱及地址

6. Was this hospitalization caused by an accident? 該住院是否因意外引致？ Yes 是☐ No 否☐ If "yes"，如 "是"
Please state when, where and how did it happen 請詳述意外發生的日期、地點及經過

Did the patient report such accident to the Police? 病人有否就這宗意外報警？ Yes 有☐ No 沒有☐ If "yes"，若有
Name/address of police station? 警署名稱/地址 (Please attach a copy of the police report 請提交有關報告副本)

7. Has the patient submitted or does the patient intend to submit a claim to another insurance company(ies) as a result of this hospitalization/surgery?
有關是次索償，病人是否已經或有意向其他保險公司遞交索償申請？ Yes 是☐ No 否☐ If "yes"，如 "是"
Please provide name, address and policy number of the other insurance company(ies).請提供有關保險公司之名稱、地址及保單號碼
Name and Address of Insurance Company 保險公司名稱及地址 Policy Number 保單號碼

8. Please provide name and address of family doctor (or the doctor usually consulted by the patient) 請提供病人之家庭醫生(或經常求診醫生)的姓名及地址

DECLARATION AND AUTHORIZATION 聲明及授權

I/We declare that the above statements and answers made by me/us are true and complete to the best of my/our knowledge. I/We hereby authorize any employer, physician, hospital, insurance company, other organization or person who has any record or knowledge with reference to the accident, or the health and medical history of the patient, to give such information to CMB Wing Lung Insurance Co Ltd or its representative, such authorization to survive me/us in so far as legally possible. A photocopy of this authorization will be as valid as the original.
I/We confirm that I/We have read and understood the *Notice to Customers relating to the Personal Data (Privacy) Ordinance*.

本人/吾等謹此聲明，以上所填報之一切資料，均屬真確完整無訛。 本人/吾等現授權持有有關上述意外事件資料或本人/吾等健康資料或病歷之僱主、醫生、醫院、保險公司、機構或人士，將全部此等有關之資料給予招商永隆保險有限公司或其代表。 如法律上可行，本授權書在本人/吾等身故後仍然有效。此授權書之影印本與正本均具同等效力。
本人/我們確認已閱讀並清楚明白《關於個人資料（私隱）條例致客戶的通知》。

X

Signature of Patient 病人簽署 Name 姓名 Date Signed 簽署日期

(N.B. : If the patient is under 18 years of age, this form should be signed by his/her parent. 注意：如病人是十八歲以下，此表格需由其家長簽署。)

Continued on Part II to be completed by the attending doctor 繼續乙部由主診醫生填寫

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33/F, Infinitus Plaza, 199 Des Voeux Road Central, Hong Kong

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PART II – To Be Completed by 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

Patient Name (in full) 病人姓名(全名) : _____

Date of Admission 入院日期 (DD 日/ MM 月/ YY 年)_____ Date of Discharge 出院日期 (DD 日/ MM 月/ YY 年)_____

Name of Hospital 醫院名稱 _____

Level of hospital ward 病房級別: ☐Private 頭等房 ☐Semi-private 二等房 ☐Ward 三等房 ☐Clinical Surgery 門診小手術

1. Clinical History 求診記錄

a) Date on which the patient first consulted you related to this illness/injury 病人就此疾病/受傷後，首次向閣下求診的日期(DD 日/MM 月/YY 年)_____

b) Symptoms / complaint(s) of the patient relating to this hospitalization /treatment /investigation 病人就此次住院/治療/檢驗所出現的相關症狀及主訴

_____

_____

c) How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前已患有此症狀多久? _____

2. Hospitalization Details 住院詳情

a) Final Diagnosis 最後的診斷 _____ Date of Operation 手術日期(DD 日/ MM 月/ YY 年) _____

b) Operation procedure(s) performed 手術的名稱 _____

c) If the patient has consulted other physician during this hospitalization, please provide the following 如病人於住院期間曾向其他醫生求診，請提供以下資料：

Name of physician consulted 醫生姓名 _____ Reason 原因 _____

What treatment had the physician performed 治療詳情 _____

d) Please give a brief discharge summary (including onset and duration of signs and symptoms/disease, etiology, types and results of major examinations, treatments, complications and follow up plan)請提供出院撮要(包括開始時及持續出現的徵兆/症狀、病因、主要檢查的種類及結果、治療、併發症及覆診詳情)

_____

e) Please provide reason(s) for hospitalisation if this type of cases can be managed on day care / out-patient basis.
若此次病症能在日間護理/診所內進行治療，請提供住院原因。

_____

3. Professional Comment 專業意見

a) In your opinion, was the patient hospitalised as a result of recurrent episode or a chronic illness or related to a previous complaint / diagnosis.
If "yes", please provide date of the first episode and details.
就閣下意見，病人是次住院治療是否因繼發性或慢性疾病引致或與以往的主訴/診斷有關？若答案為"是"，請提供首次發病日期及詳情。

_____

b) Was the condition due to or associated with the following?(Please tick the appropriate boxes) 上述情況是否出於或與以下問題關連? 請在適當空格填上 √ 號）

☐ Accidental bodily injury 意外身體受傷
☐ Self-inflicted injury 自我傷害
☐ Abuse of drugs or alcohol 濫用藥物或酒精
☐ Mental disorder 精神紊亂
☐ Refractive error 屈光不正
☐ Pregnancy 懷孕
☐ Infertility or sterilization 不育或絕育
☐ Contraception 避孕
☐ Treatment for cosmetic purpose 美容性質的治療
☐ Vaccination 疫苗接種
☐ Congenital condition 先天性疾病/異常
☐ Developmental condition 發育問題
☐ Hereditary condition 遺傳性問題
☐ General check-up一般身體檢查
☐ Venereal disease , sexually transmitted disease or AIDS / HIV related illness 性病，性傳播疾病或愛滋病/愛滋病毒有關的疾病

_____

Others 其他

a) If the patient was referred by another doctor, please provide the referring doctor's name and address.如病人由其他醫生轉介，請提供轉介醫生的姓名和地址。

_____

b) Are you the patient's usual physician? 閣下是否該病人的慣常醫生? ☐Yes 是 / ☐No 否

I hereby certify that all information given above is accurate and true to the best of my knowledge.
本人特此聲明，就本人所知，上述所有資料均準確無誤。

X

_____ _____
Signature & Chop of attending physician / Surgeon 主診醫生/外科醫生簽名及蓋章 Address and Telephone No. 地址及電話號碼

_____ _____
Name of attending physician/Surgeon & qualifications 主診醫生姓名/外科醫生姓名及資歷 Date 日期 (DD 日/MM 月/YY 年)

Part II of this claim form is endorsed by the Hong Kong Medical Association and Medical Insurance Association of The Hong Kong Federation of Insurers.
本索償表格乙部已獲香港醫學會及香港保險業聯會屬下醫療保險協會認可。

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