滙豐保險 HSBC Life

EB21

CLAIM FORM 索償表格

Group Medical Scheme - Hospitalisation And Surgical 團體醫療計劃 - 住院和手術

Claim for hospitalisation and/or surgical procedure. To be filled in by both the employee or patient and doctor, any expense incurred will be borne by the employee or patient. 住院及/或外科手術索償。由僱員或病人和醫生共同填寫，所產生的費用由僱員或病人承擔。

HOW TO SUBMIT THIS FORM 如何提交此表格

After completing the form please send back to us:
填妥表格後，請寄送給我們：

BY MAIL
Employee Benefits Claims, HSBC Life, 18/F, Tower 1, HSBC Centre, 1 Sham Mong Road, Kowloon, Hong Kong
郵寄
滙豐保險僱員福利索償部 — 香港九龍深旺道1號滙豐中心1座18樓

IMPORTANT NOTES 重要事項

1. The claim application of confinement and pre-or post-confinement treatment expenses can be submitted together. However, the claim application must be submitted within 90 days from the date of discharge or the date of consultation.
索償申請可連同入院、前或後有關之門診治療費用一併遞交，惟必須於接受傷病治療完結後的 90 天內提出索償。
2. We'll let you know the outcome of this claim within 10 business days.
我們將在 10 個工作日內通知您此索償的結果。
3. If you have any questions about your claim, please call (852) 3128 0153.
如果您對索償有任何疑問，請致電(852) 3128 0153。
4. We'll contact you as soon as possible if we need more information, or if we need to have your claim assessed by a third party such as an impartial doctor or hospital. This could cause a delay to your claim. The employee or patient is responsible for any expenses incurred while the claim is being processed.
如果我們需要更多資料，或者需要讓第三方(例如公正的醫生或醫院)評估您的索償，我們會盡快與您聯絡。這可能會導致您的索償延遲。僱員或病人亦有可能需要支付索償期間產生的相關費用。

CLAIMS DOCUMENT CHECKLIST 索償文件清單

What you need to submit with this claim:
請連同此索償一併提交以下文件：

Note: a discharge summary can replace Section 2 of the form if the hospital stay was in a government hospital (managed by Hospital Authority, ward level).
注意：如果住院是在政府醫院(由醫院管理局管理之普通病房)，則出院總結可以代替表格乙部。

- ☐ Original receipt(s) of the medical expenses (including deposit receipt)
醫療費用收據正本(包括按金收據)
- ☐ Original statement for breakdown of hospital expenses (including daily charges, meal charges and package charges)
醫院收費詳情正本(包括每日醫療、膳食、套餐收費)
- ☐ Copy of settlement advice from other insurance company (if applicable)
其他保險公司之索償結算通知副本(如適用)
- ☐ Copy of hospitalisation surgical package charges breakdown (if applicable)
住院手術套餐費細目副本(如適用)
- ☐ Copy of laboratory test breakdown and amount
化驗詳情及金額副本
- ☐ Copy of drug list (include drug name, dosage, quantity and amount)
藥物詳情副本(包括藥物名稱、劑量、數量及金額)
- ☐ Copy of referral letter(s) from any specialists
任何專科轉介信副本
- ☐ Copy of Histopathology or Laboratory Test Report, Endoscopic, Ultrasonogram, X-Ray, CT Scan, MRI etc., Diagnostic Written Report(s) and Operating theatre summary (if applicable)
病理學或化驗報告，內窺鏡檢查，超聲檢查，X 射線，CT 掃描，磁力共振等診斷之書面報告及手術室摘要副本(如適用)

SECTION 1: CLAIM INFORMATION 甲部 – 索償資料

To be completed in BLOCK LETTERS by the employee or patient 由僱員或病人以正楷填寫

1. GROUP MEDICAL SCHEME INFORMATION 團體醫療計劃資料

1A. EMPLOYER DETAILS 僱主資料

Group medical policy no. 團體保單編號		Employer name 僱主名稱	

1B. EMPLOYEE DETAILS 僱員資料

Mandatory field, otherwise, claim will not be processed 必須填寫，否則索償將不予處理

English Full Name 英文姓名	Contact Number 聯絡電話號碼	Email 電郵

1C. PATIENT DETAILS 病人資料

English Name of Patient (if different from above) 病人英文姓名(如與上述不同)	HK/Macau ID card no. 香港/澳門身份證號碼	Membership no. (Refer to E-medical card/Physical Medical Card) 成員編號(請參閱您的電子醫療卡/實體醫療卡)

2. MEDICAL SERVICE DETAILS FOR YOUR CLAIM 醫療服務詳情

2A. CLAIMING FOR AN ILLNESS 因患病而索償

Duration of symptoms 症狀持續時間	Description of illness symptoms 症狀之描述

2. MEDICAL SERVICE DETAILS FOR YOUR CLAIM (CONTINUED) 醫療服務詳情（續）

2A. CLAIMING FOR AN ILLNESS (CONTINUED) 因患病而索償（續）

ATTENDING DOCTOR'S INFORMATION 主診醫生資料

(If this doctor is different from your regular doctor 如非您的慣常醫生)

Have you had any previous treatment for this illness or a related condition? If 'yes', please provide details. 您是否曾經接受任何此類或相關疾病的治療?如'是'，請提供詳情。	Name 醫生姓名	Address 醫生地址	Date of Consultation 求診日期
☐ Yes 是 ☐ No 不是			____ - ____ - ________ DD日 MM月 YYYY年

2B. CLAIMING FOR AN ACCIDENT 因意外而索償

Date and time of accident 意外日期及時間	Location of accident 意外地點	Please provide details of how your injuries were caused by the accident 請詳細說明您是如何在事故中受傷
____ - ____ - ________ DD日 MM月 YYYY年 ____ : ____ ☐ A.M 上午 ☐ P.M 下午 HR時 MIN分		

3. CLAIMS SUBMITTED TO OTHER INSURER(S) 已向其他保險公司索償

Have you submitted a claim to another insurance company for medical services received? 您是否已就接受的醫療服務向另一家保險公司提交索償?	☐ Yes, please provide information below and attach all related settlement forms or documents. 是，請提供下列資料並附上所有相關賠償表或文件。 ☐ No 不是
Name of insurance company 保險公司名稱	**Policy no.** 保單號碼

4. SUBMITTING CLAIMS TO OTHER INSURER(S) OR TO HSBC LIFE TO COVER THE REMAINING BALANCE 向其他保險公司或滙豐保險索償餘額

If you plan to submit a claim to other insurers to cover the remaining balance:
如您有意向其他保險公司索償餘額:

Do you require Certified True Copies of the original invoice(s) and receipt(s) after your claim is processed? 在處理索償後，您是否需要賬單和收據的認證副本文件? Note: Please note that the Certified True Copies of the original invoice(s) and receipt(s) will not be issued or returned if the claims are fully reimbursed. The receipts will only be retained for 3 months from the claim process date. 備註：如索償已獲全數賠償，認證副本和賬單將不獲發出。賬單和收據從索償完成日期起保留3個月。	☐ Yes 是 ☐ No 不是

If you plan to submit a claim to HSBC Life to cover the remaining balance:
如您有意向滙豐保險索償餘額:

Would you like to claim for the balance payment of the medical expense under another HSBC Life policy? Please note that any missing policy information will affect the internal transfer of claim. 您想使用另一份滙豐人壽保單去索償剩餘的醫療費用嗎？請在空格內填上✓號並於右格填上保單號碼，有關資料將會被轉移至相關部門進行進一步索償處理。請注意，遺漏任何重要資料將會影響索償之內部轉移。 ☐ Yes 是 ☐ No 不是	HSBC Life policy no. 滙豐保險保單號碼

5. EMPLOYEE'S / PATIENT'S DECLARATION AND AUTHORISATION 僱員/病人聲明和授權

I/We hereby certify that the answers and statement given above are true and complete to the best of my/our knowledge and that I/We have withheld no material fact. I/We authorise any physician, hospital, clinic, insurance company or other individual organisation or government office that has any records or knowledge of my/our health, to disclose to HSBC Life (International) Limited or its representative any information relevant to this claim. This authority shall remain valid notwithstanding my death or incapacity and a copy of this authorisation shall be as effective and valid as the original. By signing below, I/we confirm the above application and agree that the Company may use and disclose all personal data about me/us that the Company currently or subsequently hold for the purposes as set out in the Notice relating to the Personal Data (Privacy) Ordinance (which may otherwise be referred to as 'Personal Information Collection Statement'). I understand I can view such notice by scanning the QR code on the right, or I can request a copy by calling the Life Insurance Service Hotline: (852) 2583 8000. The Company will collect, use, disclose and transfer my/our and/or beneficiary's personal information, for the purposes necessary to detect and prevent fraud (whether or not relating to the policy mentioned in this form) to the following persons who may collect and use this information only as reasonably necessary to carry out the purposes described above: organisations that consolidate claims and underwriting information for the insurance industry; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information.

本人（等）在此聲明以上所提供的資料均屬正確無訛且並無缺漏。本人謹此聲明，本人已細閱並完全明白以上內容及本表格後頁的個人資料收集聲明。本人（等）授權任何知道本人健康情況及據知任何紀錄之醫生，醫院，診所，保險公司或其他私人，政府機構向滙豐人壽保險（國際）有限公司或其代表提供本人（等）之有關資料。此授權書於本人（等）死亡或喪失能力後依然生效。本授權書之影印本亦屬有效。本人（等）在下方簽署即確認上述申請，並同意 貴公司可跟據本表格內有關個人資料（私隱）條例的通知書（也可稱為「個人資料收集聲明」）內列出的用途，使用及披露現時或其後持有有關本人（等）的所有個人資料。本人明白可以透過掃描右方的二維碼瀏覽該通知書，或致電滙豐人壽保險服務熱線：(852) 2583 8000索取該通知書的副本。本人（等）及／或受益人的個人資料給以下人士，以用作偵測和防止欺詐行為（無論是否與就本表格而發出的保單有關）所需的目的，而他們只能在有合理需要履行上述目的之情況下才可收集和使用這些資料：整合保險業申索和承保資料的組織；防欺詐組織；其他保險公司（無論是直接地，或是通過防欺詐組織或本段中指名的其他人士）；和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊（及其運營者）。

Personal Information Collection Statement (English)

個人資料收集聲明（中文）

6. PATIENT'S SIGNATURE 病人簽署

Signature of Patient/Parent or Legal Guardian (if Patient below 18 years of age) 病人簽署/家長或合法監護人簽署（適用於十八歲以下之病人）	Full name (in BLOCK letters) 姓名（請以正階英文書寫）	HK/Macau ID card no. 香港/澳門身份證號碼	Date signed 簽署日期 ____ - ____ - ________ DD日 MM月 YYYY年

SECTION 2: DOCTOR SECTION 乙部 – 由醫生填寫

To be completed in BLOCK LETTERS and signed by the consulting doctor. If the patient is confined in a government hospital (managed by Hospital Authority, ward level), discharge summary would replace the completion of this section of the form. 請以正楷填寫並由主診醫生簽署（若索償人入住香港醫管局轄下公立醫院之普通病房，出院摘要可替代索償表格之乙部）

1. PATIENT DETAILS 病人資料

English Full Name 英文姓名	Date of birth 出生日期	HK/Macau ID card no. 香港/澳門身份證號碼	Patient's membership no. (required for the claim to be processed) 病人成員編號（此欄必須填寫否則索償申請將不獲辦理）
	____-____-______ DD日 MM月 YYYY年		

2. CLINICAL HISTORY 求診記錄

Date of first consultation 首次看診日期	Description of patient's symptoms 病徵	How long has the patient shown these symptoms? 病人在首次求診前該病徵持續了多久?
____-____-______ DD日 MM月 YYYY年		

Please list and provide reasons for any laboratory test(s)/ imaging test(s)/other diagnostic test(s) the patient required during their hospitalisation. 建議之化驗/影像檢查/其他診斷性檢查及接受該等檢查的原因。	

3. HOSPITAL AND SERVICES INFORMATION 住院詳情

Admission type
醫院/日間手術護理中心/醫療診所類型

- ☐ Inpatient 住院
- ☐ Hospital Outpatient Department 醫院門診部
- ☐ Day Case Procedure Center 日間中心
- ☐ Medical clinic 診所

Accommodation type
住院級別

- ☐ Private 私家房
- ☐ Semi-private 半私家房
- ☐ Ward 大房
- ☐ Hospital day ward 醫院日症
- ☐ Medical clinic 醫療診所

Please provide details of treatment, treatment sessions, tests conducted, on-going treatment and recovery plan below.
請提供是次住院詳情，包括相關治療、檢查、測試結果、持續治療及康復計劃。

Date of treatment / admission and discharge 治療日期	Final diagnosis / ICD-10 Code 最後的診斷/國際疾病分類代碼	Type of surgery or treatment administered 手術或治療名稱	Did the patient leave the hospital at any point during their admission? 病人是否曾在住院期間離院?	Please provide reasons for the length of the hospital stay, including the reason for the number of days as an inpatient 請提供是次持續留院日數及其原因
Date of treatment / admission 治療/入院日期 ____-____-______ DD日 MM月 YYYY年			☐ Yes 是 ☐ No 不是	
Date of discharge 出院日期 ____-____-______ DD日 MM月 YYYY年			If 'yes', please fill in the date 如'是'，請填寫日期 ____-____-______ DD日 MM月 YYYY年	

Has the patient been consulted by other Physician(s)/Surgeon(s) during this hospitalisation? 病人是否曾在住院期間向其他醫生求診?	☐ Yes, please provide information below. 是，請在下方填寫資料。 ☐ No 不是

Name of Physician(s)/Surgeon(s) 醫生姓名	Reason 原因	Treatment performed 所提供的治療

4. CANCER TREATMENT 癌症/腫瘤相關治療

Type of treatment administered
治療種類

☐ Surgical 外科治療
☐ Chemotherapy 化療
☐ Hormonal Therapy 荷爾蒙治療
☐ Target Therapy 標靶治療
☐ Radiotherapy 電療
☐ Immunotherapy 免疫療法
☐ Others 其他 ______________________

Name of drug administered 藥物名稱	Dosage 藥物劑量	Frequency of dosage 治療頻率	Duration of treatment 持續治療的時間	If the patient suffered any complications during treatment, please provide details. 如病人在接受治療期間出現併發症，請提供詳情。

5. MEDICAL DIAGNOSIS AND ADVICE 診斷詳情

Can medical tests and procedures be done on an outpatient basis / at a Day Case Procedure Centre?
該檢查及手術是否可以在門診/日間手術中心進行?

☐ Yes 是 ☐ No 不是

If 'yes', please provide details for the reason. 若'可以'，請說明病人住院的原因。
If 'no', please give a reason for the hospital stay. 若'不可以'，請提供原因。

Was it an emergency hospitalisation or procedure?
這是否緊急個案？

☐ Yes 是 ☐ No 不是

If 'yes', please provide details.
如'是'，請提供詳情。

Was the current condition due to one of the following?
上述情況是否與以下問題有關?

☐ 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
☐ Infertility or sterilisation 不育或絕育
☐ Contraception 避孕
☐ Treatment for cosmetic purpose 美容性質的治療
☐ Vaccination 疫苗接種
☐ Pregnancy 懷孕
☐ Congenital condition 先天性疾病異常
☐ Mental disorder 精神紊亂
☐ Refractive error 屈光不正
☐ Developmental condition 發育問題
☐ Hereditary condition 遺傳性問題
☐ General check-up 一般身體檢查

In your opinion, was the hospitalisation a result of a recurring / chronic illness or related to a previous condition?
您認為是次住院是因為複發性/長期疾病或之前的疾病?

☐ Yes, please provide details below. 是，請在下方提供細節。
☐ No 不是

Date 日期	Details on the recurring / chronic illness or previous condition. 請就複發性/長期疾病或之前的疾病請提供詳情
_____ - _____ - __________ DD日 MM月 YYYY年	

Is everything being claimed on this form medically necessary and recommended for the patient's current diagnosis?
是次檢查的治療及住院日數(如有)是否和上述診斷有直接關係而且是醫療所需及由醫生建議?

☐ Yes 是 ☐ No 不是

6. MEDICAL HISTORY 病歷紀錄

Has the patient previously suffered from related conditions to this illness? 病人是否曾出現與此疾病相關的徵狀?	☐ Yes, please provide details below. 是，請在下方提供細節。 ☐ No 不是

Date of doctor's consultation or hospital admission 醫生就診或住院日期	Name of doctor 醫生姓名	Patient's symptoms 病徵	Doctor's diagnosis of patient's condition 診斷	Name of treatments administered (Add details of any past or upcoming surgical procedure/s) 所提供的治療(請列明已接受或將會進行的手術名稱)
____-____-________ DD日 MM月 YYYY年				

7. DOCTOR INFORMATION 醫生資料

7A. REGULAR DOCTOR'S INFORMATION 慣常醫生資料

Are you the patient's regular doctor? 您是否該病人的慣常醫生?	☐ Yes, please proceed to section 7B. 是，請跳至7B。	☐ No, please provide patient's regular doctor's information below. 不是，請提供病人的慣常醫生的資料。

Full name 姓名	Address 地址	Contact no. 電話號碼

7B. REFERRING DOCTOR'S INFORMATION 轉介醫生資料

Is the patient referred by another doctor? 病人是否由其他醫生轉介?	☐ Yes, please provide the referring doctor's information below. 是，請提供轉介醫生的資料。	☐ No 不是

Full name 姓名	Address 地址	Contact no. 電話號碼

8. DOCTOR'S DECLARATION AND AUTHORISATION 醫生聲明及授權書

I declare that all information provided is true and complete to the best of my knowledge.
本人謹此聲明及同意上述一切陳述及問題的所有答案 ，就本人所知所信，均為事實全部並確實無訛。

Name of attending doctor (Please add your qualifications) 主診醫生姓名(請提供您的專業資格)	Address 地址	Contact no. 電話號碼

DOCTOR'S SIGNATURE 醫生簽署

____-____-________
DD日 MM月 YYYY年

Signature and stamp of attending doctor
主診醫生簽名及蓋章

Date signed
簽署日期