滙豐保險 HSBC Life

For Hang Seng Bank Customers Only
只適用於恒生銀行客戶

HSBCMIN

Voluntary Health Insurance Scheme – Medical Claim Form (For Vital Care VHIS Flexi Plan and HSBC VHIS Standard Plan)
自願醫保計劃－醫療索償表(適用於「愛 • 護航」自願醫保靈活計劃及滙豐自願醫保標準計劃)

HSBC Life (International) Limited, incorporated in Bermuda with limited liability (the "Company" or "HSBC Life")
滙豐人壽保險(國際)有限公司(註冊成立於百慕達之有限公司)(「本公司」或「滙豐保險」)

PLEASE SUBMIT THE FORM AND RELEVANT DOCUMENTS TO ONE OF THE AVAILABLE CHANNELS BELOW. 請將表格和相關文件用以下其中一種方式遞交。

- Mail to 18/F, Tower 1, HSBC Centre, 1 Sham Mong Road, Kowloon, Hong Kong 郵寄至香港九龍深旺道1號滙豐中心1座18樓；OR 或
- Submit to any **Hang Seng Bank Branch** 於任何**恒生銀行分行**遞交

WHAT HAPPENS NEXT 下一步
The process after we receive your claim form
我們收到此表格後的流程

1. We'll let you know the outcome of this claim within 7 business days upon the receipt of all required documents. 我們將在收妥一切所需文件後7個工作日內通知您此索償的結果。
2. If you have any questions about your claim, please call HSBC Life Claims Hotline (852) 3128 0122. 如果您對索償有任何疑問，請致電滙豐保險索償熱線 (852) 3128 0122。

CLAIMS DOCUMENT CHECKLIST 索償文件清單

- ☐ Part I is fully completed & signed by the Policyholder/Claimant/Life Insured 索償表甲部經由保單持有人／索償人／受保人填寫並簽署
- ☐ Part II is fully completed & signed by the Attending Physician/Surgeon with chop 索償表乙部經由主診醫生／外科醫生填寫，簽署並蓋印
- ☐ Original receipt(s) of the medical expenses (including but not limited to deposit receipt) 醫療費用收據正本(包括但不限於按金收據)
- ☐ Copies of statement for breakdown of hospital expenses (including but not limited to daily charges, meal charges and surgical package charges) (if applicable) 醫院收費詳情(包括但不限於每日醫療、膳食、手術套餐收費)(如適用)
- ☐ Copy of settlement advice from other insurer (if applicable) 其他保險公司之賠償結算通知副本(如適用)
- ☐ Copy of Histopathology, Laboratory Test Report, Endoscopic, Ultrasonogram, X-Ray, CT Scan, MRI, Diagnostic Written Report(s) and Operating theatre summary (if applicable) 病理學、化驗報告、內窺鏡、超聲波、X-光、電腦掃描、磁力共震、手術室摘要及診斷之書面報告副本(如適用)
- ☐ Copy of Policyholder & Insured's Identity Card 保單持有人及受保人之身份證明文件副本
- ☐ Copy of Bank Account Proof (applicable for Policyholder's sole or joint name bank account other than Policyholder's premium deduction account) 銀行戶口證明文件副本(適用於保單持有人之個人或聯名非保費轉賬戶口)

Please ensure completion of the above checklist to avoid unnecessary delay in claim process.請確保完成以上各項以免延緩索償進程。

Notes 註：
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 after the date on which the Insured Person is discharged from the Hospital, or (where there is no Confinement) the date on which the relevant Medical Service is performed and completed. 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，並須於出院或接受相關治療後的90天內提出索償。
2. We will inform you if we require additional information from you or we consider that your claim has to be assessed from third parties (such as doctor, hospital, etc.). As the time required for obtaining the information is variable, the processing time of your claim will likely be lengthened. 若我們有需要就審核是次索償申請而向您或其他人士(如醫生、醫院等)索取額外資料，我們會盡快通知您。因索取有關資料需時，索償申請的審核時間會較長。

PART I – TO BE COMPLETED BY THE INSURED PERSON OR CLAIMANT IN ENGLISH OR CHINESE
甲部 – 由受保人或索償人以英文或中文填寫

DETAILS OF INSURED 受保人資料

Policy No. 保單號碼	Name of Insured Person 受保人姓名	I.D. Card/Passport No. 身份證／護照號碼

Contact Number 聯絡電話	Email Address 電郵地址

Correspondence Address 通訊地址

DETAILS OF PRE- AND POST-CONFINEMENT/DAY CASE PROCEDURE OUTPATIENT CARE 入院前或出院後／日間手術前後的門診護理詳情

Date of Outpatient 門診日期	Period of hospitalisation or date of surgery 住院期間或手術日期
	to 至

DETAILS OF BODY CHECK UP (APPLICABLE TO GOLD LEVEL AND DIAMOND LEVEL ONLY) 身體檢查詳情(只適用於金級及鑽級)

Date of body check-up 身體檢查日期	Type of check-up 檢查類別

Name and address of hospital and/or health care provider 醫院及／或醫療服務提供者之名稱及地址

DETAILS OF HOSPITLISATION AND SURGERY 住院及手術詳情

Hospitalisation/surgery due to 住院／手術原因

☐ Illness 疾病 (Please fill in section I 請填寫I部)　☐ Accident 意外 (Please fill in section II 請填寫II部)

(I) HOSPITALISATION/SURGERY DUE TO ILLNESS 因疾病住院／手術

Description of symptoms 請詳述病徵	Duration of symptoms 病徵已存在多久

Name of hospital/outpatient center and address in respect of hospitalisation/surgery relating to the current claim 就有關此索償，住院／手術之醫院／日間手術中心名稱及地址

Have you had any prior treatment for this or related condition? 您是否曾經接受任何此類或相關疾病的治療?

☐ Yes 是　☐ No 否

If yes, please provide details at the right hand side.
如是，請在右方提供資料

Name of attending physician/surgeon 主診醫生／外科醫生姓名

Consultation Date 求診日期

(II) HOSPITALISATION/SURGERY DUE TO ACCIDENT 因意外住院／手術

Date and time of accident 意外日期及時間	Location of accident 意外地點

Brief description of the accident, part of body injured and type of injury 意外經過、受傷部位及傷勢

CLAIMS WITH OTHER INSURANCE COMPANY(IES) 向其他保險公司索償

Are you making claims to any other insurance company as a result of the treatment? 有關是次治療，您有否向其他保險公司申請索償？

☐ Yes 是 ☐ No 否

If yes, please provide details below and a copy of the settlement advice from the other insurers 如有，請提供以下資料及提供其他保險公司之賠償結算通知副本

(a) Name of insurance company 保險公司名稱 _____

(b) Policy Number 保單號碼 _____

REQUEST FOR DOCUMENT RETURN 退還文件要求

☐ Please "✓" this box if you wish to obtain Certified True Copy(ies) of original invoice(s) and receipt(s). 如您欲索取醫生的發票和收據核證副本，請在空格內填上「✓」號。

Note 注意：

(1) Certified True Copy will not be issued if the claims are fully reimbursed. 如索償已獲全數賠償，核證副本將不獲發出。

(2) The originals will not be returned and will only be retained for 3 months from the claim processed date. 正本文件將不獲退還，並將只從索賠處理完成日期起計保留3個月。

NO CLAIM DISCOUNT (NCD) 無索償折扣 (ONLY APPLICABLE TO Vital Care VHIS Flexi Plan) (只適用於「愛 • 護航」自願醫保靈活計劃)

Important Note 重要通知

If after a no claim discount has been deducted, a claim incurred in respect of previous five (5) Policy Years becomes payable under This Plan, the no claim discount shall be re-calculated by taking into account the relevant claim payable, and the Policyholder shall return to the Company immediately the difference between the recalculated amount (in respect of no claim discount) and the no claim discount actually offered to the Policyholder. 在扣除無索償折扣後，若本公司須就前五(5)個保單年度內產生的索償按本計劃支付賠償，則無索償折扣應根據有關賠償額而重新計算，及保單持有人須立即向本公司交回實際提供予保單持有人的無索償折扣與重新計算的無索償折扣金額之間的差額。

PAYMENT INSTRUCTION 付款指示

☐ By Bank Account 經銀行戶口

☐ Transfer to the policyholder's premium deduction account (not applicable if the bank account is held by someone other than the policyholder's sole or joint name) 轉賬至保單持有人之保費轉帳戶口(不適用於非保單持有人之個人或聯名銀行戶口)

☐ Transfer to the Policyholder's sole or joint name bank account below 轉賬至以下保單持有人之個人或聯名銀行戶口

Bank Name and Branch 銀行及分行之名稱	Bank No. 銀行編號	Branch No. 分行編號	Account No. 賬戶號碼

Notes 註:

Please also submit adequate proof showing the full name and the bank account number of Policyholder's sole or joint name bank account (such as copy of bank book, ATM card, bank statement, etc.) to the company. If we do not receive the copy of the required document(s), the payment will be made by cheque payable to the Policyholder and mailed to the Policyholder's correspondence address. 請同時提交印保單持有人之個人或聯名戶口全名及銀行戶口號碼之充足證明(如銀行存摺或自動櫃員機卡或月結單副本等)。若您沒有提供上述所需文件，款項將以支票形式寄予保單持有人之通訊地址。

☐ By Cheque 以支票形式

Mail the cheque to the Policyholder's correspondence address 寄往保單持有人之通訊地址

For your attention 請注意：

1. If policy has outstanding levy, The Company will deduct all of the outstanding levy from the claim payment. 如保單有逾期保費徵費，本公司會從賠償金額中扣除有關保單的保費徵費。
2. If the benefit payments are settled in currencies other than the policy currencies/currency of levy cap i.e. HKD as provided by the Insurance Authority, the benefit payments would be subject to the change according to the prevailing exchange rate of policy currencies/HKD to payment currencies to be determined by the Company from time to time. The fluctuation in exchange rates may have impact on the amount of payments. By choosing the payment currency(ies) other than policy currency, you are subject to the exchange rate risks. Exchange rate fluctuates from time to time. You may suffer a loss of your benefit values as a result of the exchange rate fluctuations. 如利益支付款項的貨幣不是以保單貨幣或保險業監管局訂定徵費上限的貨幣(即港幣)支付，該利益支付款項將會受本公司不時釐定的保單貨幣對支付貨幣／港幣的匯率而改變。匯率之波動會對款額構成影響。選擇非保單貨幣結算支付款項，您須承受匯率風險。匯率會不時波動，您可能因匯率之波動而損失部分的利益價值。
3. If the receiving bank account is a non-HSBC bank account, bank charges may incur which will be deducted from the amount payable by the said receiving bank and/or HSBC, if applicable. If you provide a bank account in currency different from the payment currency, the amount payable is subject to exchange rates difference. The Company will not be liable for any charges or loss due to payment settled via non-HSBC bank, currency exchange or rejection of transaction by the receiving bank as a result of incorrect bank account details. 如收款戶口非滙豐銀行之戶口，該銀行及／或滙豐銀行可於款項中收取服務費用，如適用。如您提供與利益支付款項的貨幣不同貨幣的戶口，請留意匯率的兑換差價。本公司將不會承擔任何因不同銀行或貨幣而導致被收取之費用或損失或因銀行戶口資料不乎而被拒絕轉賬之責任。
4. Unless otherwise specified, claim payment will be made according to the current payment instruction (if any) registered with the Company. 如無明確指示，賠償會按本公司的現有記錄轉賬(如有)。

DECLARATION AND AUTHORISATION 聲明及授權

I/we hereby certify that all the answers and statements given above are true and complete and that I/we have not withheld any 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。

I/we authorise any physician, hospital, clinic, insurance company or other individual organisation or government office that has any records or knowledge of me/us or 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. 本人(等)授權任何知道本人(等)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。

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 hand side or I can request a copy by calling the Life Insurance Service Hotline: (852) 2583 8000. 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。

Personal Information Collection Statement (English)

個人資料收集聲明(中文)

SIGNATURE 簽署

Signature of Life Insured 受保人簽署	Signature of Policyholder 保單持有人簽署
Name 姓名	Name 姓名
I.D. Card/Passport No. 身份證／護照號碼	I.D. Card/Passport No. 身份證／護照號碼
Date 日期	Date 日期

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PART II – TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT'S OWN EXPENSES IN ENGLISH OR CHINESE
乙部 – 由主診醫生／外科醫生以英文或中文填寫，所需費用由索償人自行承擔

A. Details of Insured Person (Patient) 受保人（病人）資料

1. Name of Insured Person (Patient) 受保人（病人）姓名

2. ID card/Passport no.
身份證／護照號碼

B. Clinical History 臨床病歷

3. (a) Date of first consultation 首次求診日期（DD 日／MM 月／YYYY 年）

(b) Symptom(s) 病徵

(c) Symptom(s) presented onset date 出現病徵日期（DD 日／MM 月／YYYY 年）

4. How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前該病徵已存在多久？

5. Diagnosis of condition (ICD10 WHO version 國際疾病分類代碼) 病情診斷

C. About Hospitalisation/Day Case Procedure/Advanced Diagnostic Imaging Test 有關住院／日間手術／先進影像診斷檢查

6. (a) Name of hospital/day case procedure centre/medical clinic 醫院／日間手術護理中心／醫療診所名稱

☐ Inpatient 住院 ☐ Hospital OPD 醫院門診 ☐ Day Centre 日間中心 ☐ Medical Clinic 醫療診所

(b) Ward class 住院級別

☐ Private 私家房 ☐ Semi-private 半私家房 ☐ Ward 大房 ☐ Hospital day ward 醫院日症
☐ Day case procedure centre 日間手術護理中心／Medical clinic 醫療診所

(c) Date of admission/treatment 入院／治療日期（DD 日／MM 月／YYYY 年）

(d) Date of discharge 出院日期（DD 日／MM 月／YYYY 年）

7. Final diagnosis at the time of discharge 出院時最後的診斷

8. Name of surgery/treatment 手術或治療名稱

9. Has the patient been consulted by other Physician/Surgeon(s) during this hospitalisation? ☐ Yes 是 ☐ No 否
病人曾否於住院期間向其他醫生／外科醫生求診？

(a) Name of Physician/Surgeon 醫生／外科醫生姓名

(b) Reason 原因

(c) Treatment Performed 治療詳情

10. Please provide details of the hospitalisation, including treatment, investigations, tests conducted, on-going treatment and recovery plan. 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。

11. Please provide details of the period of hospitalisation including reasons for number of days as in-patient. 請提供是次持續留院日數及其原因。

12. Can the treatments/investigations of the patient be managed on an out-patient basis? 病人的治療／檢查是否可在門診進行？

☐ Yes, please provide reason(s) for this hospitalisation 是，請提供是次必須留院接受治療之原因

☐ No, please provide reason(s) 否，請提供原因

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D. PROFESSIONAL OPINION 專業意見

13. In your opinion, was the hospitalisation a result of recurrent episode/chronic illness or related to a previous condition? 您認為是次住院是因為復發性／長期疾病或之前的疾病／意外？ ☐ Yes 是 ☐ No 否

If yes, please provide date of the first episode and details. 如是，請提供首次發病日期及詳情。

14. Was the condition due to or associated with 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
☐ Mental disorder 精神紊亂 ☐ Refractive error 屈光不正 ☐ Developmental condition 發育問題
☐ 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 ☐ Pregnancy 懷孕 ☐ Congenital condition 先天性疾病／異常

E. CANCER/TUMOUR-RELATED TREATMENT 癌症／腫瘤相關疾病

15. 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
☐ Other 其他

16. Date of treatment 治療日期(DD日／MM月／YYYY年)

17. Please provide details of the treatment including drug name, dosage, frequency and duration of treatment, all other types of treatment and any complications. 請提供治療細節如藥物名稱，藥物劑量，治療頻率，持續治療的時間及其他治療類別和其併發症。

F. ABOUT THE HEALTH HISTORY 有關診治記錄

18. Has the patient previously suffered from related conditions of this illness? If yes, please provide the details below. 病人曾否出現與此疾病相關的徵狀？如有，請提供以下詳情。 ☐ Yes 是 ☐ No 否

Name of physician/ surgeon/hospital 醫生／外科醫生姓名或醫院名稱	Date of consultation/ hospitalisation 就診／住院日期	Symptoms 病徵	Diagnosis 診斷
Treatments given (please state name of surgical procedure if performed or to be performed) 所提供的治療(請列明已接受或將會進行的手術名稱)			

G. OTHER 其它

19. (a) Are you the patient's usual physician/surgeon? 您是否該病人的慣常醫生／外科醫生？ ☐ Yes 是 ☐ No 否

(b) Referring physician's/surgeon's name (if applicable) 轉介醫生／外科醫生的姓名(如適用)

(i) Name of physician/surgeon 醫生／外科醫生姓名

(ii) Telephone 電話號碼

H. DECLARATION AND AUTHORISATION 聲明及授權

I hereby declare and agree that all statements and answers to all questions are complete and true to the best of my knowledge and belief. 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 physician/ surgeon (with qualifications) 主診／外科醫生姓名(資歷)	Address 地址	Contact Telephone No. 聯絡電話號碼

Signature and name chop of attending physician/surgeon
主診／外科醫生簽名及蓋章

Date 日期
(DD日／MM月／YYYY年)

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