



CLAIM FORM 索償表格

Group Life Scheme - Hospital Cash Benefit 團體人壽計劃 - 住院現金保障

Claims for hospital cash benefits. To be filled in by both the employee or patient and doctor, any expense incurred will be borne by the employee or patient. 住院現金索償。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:

RV MAII

Employee Benefits Claims, HSBC Life, 18/F, Tower 1, HSBC Centre, 1 Sham Mong Road, Kowloon, Hong Kong

涯豐保險僱員福利索償部 — 香港九龍深旺道1號涯豐中心1座18樓

IMPORTANT NOTES 重要事項

- Claim must be submitted within 90 days from incurring such expenses. Otherwise, the claims will be declined for reimbursement. 索償應於90日內申請,否則該索償會被拒絕接受辦理。
 - 条度燃水50g内中的 自对欧条度自以汇配及文册在·
- 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申請結果。
- If you have any questions about your claim, please call (852) 3128 0153 如果然對索償有任何疑問,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。

- □ Copy of receipt(s) of the medical expenses (including deposit receipt) 醫療費用收據副本 (包括按金收據)
- □ 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 Referral letter(s) from any specialists 任何專科轉介信副本
- - 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例如適用)
- Copy of employee / patient's proof of identity such as ID Card, Passport or Birth Certificate etc.
- 僱員 / 病人的身份證明副本,例如身份證,護照或出生證明等
 □ Copy of document with the employee / patient's name and bank account details (if applicable)
 - 僱員 / 病人之個人本地銀行戶口證明文件副本(如適用)

SECTION 1: CLAIM INFORMATION 甲部 – 索價資料 To be completed in BLOCK LETTERS by the employee or patient 由僱員或病人以正楷填寫									
1. GROUP LIFE SCHEME INFORMA	1. GROUP LIFE SCHEME INFORMATION 團體人壽計劃資料								
1A. EMPLOYER DETAILS 僱主資料									
Group life 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・否則素償將不予處理									
English Full Name 英文姓名		Contact no. 聯絡電話號碼			Email 電郵				
1C. PATIENT DETAILS 病人資料									
English Name of Patient (if different 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	患病而家價 								
Duration of symptoms 症狀持續時間	Description of illnes 症狀之描述	Description of illness symptoms 症狀之描述							
	I								

						EB21		
2. MEDICAL SERVICE DETAILS FOR	RYOUR	CLAIM (CONTINUED) 醫療服務詳情(續)						
2A. CLAIMING FOR AN ILLNESS (C	CONTIN	UED) 因患病而素償(續)						
ATTENDING DOCTOR'S INFORMAT (If this doctor is a different from your								
Have you had any previous treatme this illness or a related condition? If please provide details.					Date of Consultation 求診日期			
您是否曾經接受任何此類或相關疾病的如'是',請提供詳情。	的治療?							
□ Yes 是 □ No 不是						·		
2B. CLAIMING FOR AN ACCIDENT	因意外而	京索償			DDH WWY)	11111		
	Location 意外地點	n of accident តំ		Please provide details of how your inju 請詳細説明您是如何在事故中受傷	uries were caused by the	accident		
3. PAYMENT INSTRUCTIONS 付款指	旨示							
支票 - 以支票支付僱員 · 並將支票 Via transfer to bank account (The Please fill in the detail below.	票寄往其 e employ	ne employee and will be sent by mail to empl 通訊地址。 yee must hold or jointly hold the bank accoun 名銀行戶口,否則付款將以支票形式寄予僱員	t. Oth	erwise a cheque made payable to the e	mployee will be sent by I	mail to their address.)		
Account no. 戶口號碼				ount holder name 持有人姓名				
cheque payable to the employee and	mailed	ee's full name and bank account details attac to the employee's correspondence address. ·顯示僱員全名和銀行戶口詳細信息作為索償的				,		
4. EMPLOYEE'S / PATIENT'S DECL	LARATIO	ON AND AUTHORISATION 僱員 / 病人的聲明	月及授	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 OR code on the right, or else I can request a copy by visiting my local HSBC Branch or 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 information for the insurance industry to analyse and check information provided against existing information in the pro								
5. PATIENT'S SIGNATURE 病人簽署	要 首							

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)	scotion or tr	1011111. 明外正相类	10 JE 14 JE		RMMLE	/6 G G /U/H A .	工 酉 70 之 日		1月17日之
1. PATIENT DETAILS 病人資料									
English Full Name Date of bi 英文姓名 出生日期				《/Macau ID card no. 港/澳門身份證號碼		processed)	Patient's membership no. (required for the processed) 病人成員編號(此欄必須填寫否則索償申請將		
		 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 imaging test(s)/other diagnostic test(s) the patien during their hospitalisation. 建議之化驗/影像檢查/其他診斷性檢查及接受該等核	t required								
3. HOSPITAL AND SERVICES INFORMATION (上院詳情								
Admission type 醫院/日間手術護理中心/醫療診所類型				Accommodation t 住院級別	type				
□ Inpatient □ Hospital Outpa 住院 □ Department 醫院門診部	tient	Day Case Procedu Center 日間中心	re	□ Private 私家房		□ Semi-priv 半私家房	ate	□ Ward 大房	
□ Medical clinic 診所				☐ Hospital day 醫院日症	ward	□ Medical c 醫療診所	linic		
Please provide details of treatment, treatment se 請提供是次住院詳情,包括相關治療、檢查、測詞			g treatme	ent and recovery pl	lan below				
Date of treatment / admission and discharge 治療日期	Code	osis / ICD-10 f/國際疾病分類代碼		surgery or nt administered 台療名稱	at any p	patient leave the pint during their pn? 管曾在住院期間離		Please provide reasons f length of the hospital sta including the reason for number of days as an inp 請提供是次持續留院日數	ly, the patient
Date of treatment / admission 治療/入院日期					☐ Yes	E	No 不是		
DD日 MM月 YYYY年						please fill in the 。 請填寫日期	date		
Date of discharge 出院日期									
DD日 MM月 YYYY年					DD∄	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?	(s)/Surgeon(s) during this ation?			w. 是,請在下方填	寫資料。				
Name of Physician(s)/Surgeon(s) 醫生姓名		Reason 原因				Treatment perfo 所提供的治療	rmed		

4. CANCER TREATMENT 癌症/腫瘤相關治療									
Type of treatment administered 治療種類									
□ Surgical 外科治療	□ Chemothera 化療	ру	☐ Hormonal Therapy 荷爾蒙治療		□ Targ 標鞘	get Therapy 『治療	□ Radiotherapy 電療		
Immunotherapy 免疫療法	nmunotherapy Others 投療法 其他								
		1		1					
Name of drug administered 藥物名稱	Dosage 藥物劑量	Frequer dosage 治療頻 ²		Duration of treatment 持續治療的時間		please provide details.	ny complications during treatment, 出現併發症,請提供詳情。		
5. MEDICAL DIAGNOSIS	AND ADVICE 診斷詳情								
Can medical tests and proc		If 'vos'	plassa provida dat	:ails for the reason. 若'可以'	,善当阳》	床, 住院的原因。			
outpatient basis / at a Day 該檢查及手術是否可以在門	Case Procedure Centre?			n for the hospital stay. 若'不					
☐ Yes 是	□ No 不是								
Was it an emergency hosp 這是否緊急個案?	italisation or procedure?	lf 'yes', please provide details. 如'是',請提供詳情。							
☐ Yes 是 ☐ No 不是									
Was the current condition (上述情況是否與以下問題有	due to one of the following 關?	?							
□ Accidental bodily injury □ Self-inflicted 意外身體受傷 □ 自我傷害		l injury Abu 濫月		use of drugs or alcohol 月藥物或酒精	☐ Infertility or sterilisation 不育或絕育		□ Contraception 避孕		
Treatment for cosmeti purpose 美容性質的治療	ic □ Vaccination 疫苗接種	□ Pre. 懷容		egnancy ☐ (ngenital condition 5性疾病異常	☐ Mental disorder 精神紊亂		
天台に見り/7/京 Refractive error Development				reditary condition		neral check-up			
屈光不正	₩ 發育問題			專性問題	— — — 彤	设身體檢查 			
In your opinion, was the ho	ospitalisation a result of a re	ecurring /	☐ Vas nlease n	rovide details below. 是,請	在下方提(世细節。			
chronic illness or related to 您認為是次住院是因為複發	o a previous condition? ﴿性/長期疾病或之前的疾病?		□ No 不是	Tovide details below. AE TH	E I // JÆ I	V (마타 도)			
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目 M	IM月 YYYY年								
Is everything being claimec 是次檢查的治療及住院日數	d on this form medically ne				gnosis?				
□ Yes 是 □ No 不是									

6. MEDICAL HISTORY 病歷紀	 禒								
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 doo 醫生姓名	otor	Patient's symptoms 病徵	condition		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)			
7. DOCTOR INFORMATION 醫	生資料								
7A. REGULAR DOCTOR'S INF	ORMATION 1	貫常醫生資	資料						
1 1 2 / 1 2 1 1 2 1 2 2 2 2 2 2 2 2 2 2			please proceed to section 7년 請跳至7B。		ease provide pati 請提供病人的慣	ent's regular doctor's information below. 常醫生的資料。			
Full name Address 姓名 地址			:				Contact no. 電話號碼		
7B. REFERRED DOCTOR'S INI	ORMATION	轉介醫生	資料						
Is the patient referred by anoth 病人是否由其他醫生轉介?	please provide the referring ow. 請提供轉介醫生的資料。	doctor's information	□ No 不:	走					
Full name Addre 姓名 地址		Address 地址	ss				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 pro本人謹此聲明及同意上述一切陳	ovided is true 東述及問題的所	and com 有答案	plete to the best of my knowl ,就本人所知所信,均為事實至	edge. È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			S				Contact no. 電話號碼		
DOCTOR'S SIGNATURE 醫生領	簽署	'							
				 DD日 MM月	- 	 F			
Signature and stamp of attending doctor 主診醫生簽名及蓋章				Date signed 簽署日期					