滙豐保險
HSBC Life

EB27

DECLARATION FORM 聲明表格

Group Medical Scheme - Loss of Original Receipt(s) 團體醫療計劃 - 醫療正本收據報失聲明表格

Submit this form to declare that you have lost original receipt(s) relating to a claim. **Limited to once per policy year.**
請提交此表格以聲明您遺失了與索償相關的正本收據。**每保單年度只允許一次。**

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. Your request is usually processed within 10 business days after we've received your completed form.
   當收到您的申請後，我們通常會在10個工作日內處理。
2. If you have any questions about your request please call (852) 3128 0153.
   如果您對申請有任何疑問，請致電(852) 3128 0153。

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：

☐ Copy of the lost original receipt(s).
您所遺失的醫療費用收據之副本

CLAIM INFORMATION 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. INCURRED DATE OF THE RECEIPT(S) 醫療收據的診症日期

I hereby declare that the copy(ies) of the original receipt(s) as attached and incurred on the below stated date has/have been lost in transit of mail.

本人特此聲明，所附副本的正本收據已在寄件途中遺失，診症日期如下：

_____ – _____ – _____

DD日 MM月 YYYY年

3. CLAIMS DECLARATION 索償聲明

Please tick ✓ the appropriate box.
請於適當方格內加上「✓」號

☐ I have not claimed with any other insurance company using these receipts.
本人聲明並沒有向任何保險公司就該筆醫療費用作出索償申請。

☐ I have claimed with another insurance company using these receipts (please provide the name of the insurance company on the line on the right, and attach all related settlement forms or documents).
我已就此收據向另一家保險公司提交索償（請在右邊橫線上提供保險公司的名稱，及附上所有相關賠償表或文件）。 _____

4. EMPLOYEE'S / PATIENT'S DECLARATION AND AUTHORISATION 僱員/病人的聲明及授權

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 QR 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.
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，或可前往各滙豐分行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)

5. PATIENT'S SIGNATURE 病人簽署

_____ – _____ – _____

DD日 MM月 YYYY年

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（請以正楷英文書寫）	HK/Macau ID card no. 香港/澳門身份證號碼	Date signed 簽署日期