滙豐保險
HSBC Life

EB22

CLAIM FORM 索償表格

Group Medical Scheme - Outpatient Benefit 團體醫療計劃 - 門診福利

Claim for outpatient benefits. To be filled in by the employee or the patient. 申請門診福利索償。由僱員或病人填寫。

We highly encourage all members to submit claims via Mobile App instead of paper submission. You can enjoy electronic claim submission without any amount limits, faster claim process and experience. You will also be able to track your claims status anytime anywhere. 我們鼓勵所有成員通過手機應用程式提交索償以減少紙張用量。電子索償讓您享受更快索償流程而沒有索償金額限制。您亦能夠隨時隨地跟進您的索償進度。

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. Claim must be submitted within 90 days from incurring such expenses. Otherwise, the claims will be declined for reimbursement.
   索償必須於90日內申請，否則該索償將不予處理。
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：

- ☐ Original receipt(s) of the medical expenses (including deposit receipt)
  醫療費用收據正本(包括按金收據)
- ☐ Copy of referral letter(s) for any specialists and/or laboratory test breakdown and amount.
  任何專科轉介信及/或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 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)

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 fields, 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 no. 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. OUTPATIENT BENEFITS 門診福利

2A. CLAIMING OUTPATIENT BENEFITS 門診福利

Consultation date 診症日期	Claim amount ($) (please specify currency) 申請索償金額 (請註明幣值)	Consultation Type 診症類別		
_____ – _____ – _____ DD日 MM月 YYYY年	☐ HKD ☐ _____	☐ General Medical Practitioner Consultation 普通科醫生 ☐ Diagnostic X-ray, Laboratory Test and Imaging X光診斷，化驗及影像	☐ Specialist Consultation 專科醫生 ☐ Physiotherapy/Occupational Therapy/Dental Treatment 物理治療/職業治療/牙科治療	☐ Prescribed Medication 醫生處方之藥物 ☐ Consultation or treatment by Chinese Medicine Practitioner 中醫諮詢服務或治療服務
_____ – _____ – _____ DD日 MM月 YYYY年	☐ HKD ☐ _____	☐ General Medical Practitioner Consultation 普通科醫生 ☐ Diagnostic X-ray, Laboratory Test and Imaging X光診斷，化驗及影像	☐ Specialist Consultation 專科醫生 ☐ Physiotherapy/Occupational Therapy/Dental Treatment 物理治療/職業治療/牙科治療	☐ Prescribed Medication 醫生處方之藥物 ☐ Consultation or treatment by Chinese Medicine Practitioner 中醫諮詢服務或治療服務

2. OUTPATIENT BENEFITS 門診福利(續)

2B. GOVERNMENT HOSPITAL OUTPATIENT BENEFIT 政府醫院門診福利

Consultation date 診症日期	Claim amount ($) (please add currency) 申請索償金額 (請註明幣值)	Consultation Type 診症類別	
_____ – _____ – _____ DD日 MM月 YYYY年	☐ HKD ☐ _____	☐ HK Hospital Authority/Hospital Conde S. Januario in Macau 香港醫院管理局/澳門山頂醫院 ☐ Specialist Outpatient Department 專科門診	☐ General Outpatient Department 普通科門診 ☐ Others 其他 _____

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(請以正楷英文書寫)	HK/Macau ID card no. 香港/澳門身份證號碼	_____ – _____ – _____ DD日 MM月 YYYY年 Date signed 簽署日期