



CLAIM FORM 索償表格

Group Life Scheme - Simplified Critical Illness 團體人壽計劃 - 簡易危疾

Claim for simplified critical illness including a) Kidney failure; b) Paralysis and c) Coma. To be filled in by the employee or patient and the consulting doctor, any expense incurred will be borne by the employee or patient.

精簡危疾的索償,包括: a) 賢功能衰竭; b) 癱瘓 和 c) 昏迷。由僱員或病人和諮詢醫生填寫,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

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

- All claims must be submitted within 90 days of completion of treatment 所有索償必須在治療完成後90天內提交。
- 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。
- 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.

加里我們需要再多姿料,或老需要讓第二方(例加公正的醫生或醫院)誣什你的委僧,

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

- Copy of Sick leave certificate with diagnosis and/or proof of consultation 列有診斷證明之病假證明書及/或治療詳情副本
- Copy of Physiotherapy and/or occupational therapy reports (if applicable) 物理治療/職業治療報告副本(如適用)
- Copy of Drug list (include drug name, dosage, quantity and amount) 藥物詳情副本(包括藥物名稱、劑量及數量)
- Copy of Referral letter(s) from any medical 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)
- Copy of Police Report (if applicable) 警察事故報告副本(如適用)
- Copy of Employee/Patient's Identity Proof such as ID Card, Passport or Birth Certificate etc.
 - 僱員/病人之身份證明文件副本例如身分證、護照或出生證明書等
- 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)

我們會盡快與您聯絡。這可能會導致價期間產生的相關費用。		□ Copy of the latest employment pay slip as proof for the sum assured issued by Policyholder 由保單持有人發出之最近入息證明副本以作保額計算用途				
SECTION 1: CLAIM INFORMATION F		nt 由受保僱員或病人以正楷	填寫			
1. GROUP LIFE SCHEME INFORMATI	ION 團體人壽保險資料					
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 n	not be processed 必須填緊	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 fro 病人英文姓名(如與上述不同)	om above)	HK/Macau ID card no 香港/澳門身份證號碼			(Refer to E-medical card/Physical Medical Card) 您的電子醫療卡/實體醫療卡)	
2. MEDICAL SERVICE DETAILS FOR	YOUR CLAIM 醫療服務部	样情				
2A. CLAIMING FOR AN ILLNESS 因患	景病而索償					
Description of illness and its symptom 疾病症狀之描述	S				Duration of symptoms 症狀持續時間	
Is this a chronic or recurring illness? 此疾病是否慢性 / 復發疾病?				illness 復發	☐ Others 其他	

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2. MEDICAL SERVICE DETAILS FOR YOUR	CLAIM (CONTINUED) 醫療服務詳情(續)						
2A. CLAIMING FOR AN ILLNESS (CONTINU	JED) 因患病而索償(續)						
CONSULTING DOCTOR'S INFORMATION	態診醫生資料						
Have you had any previous treatment for this illness or a related condition? If 'yes', please provide more details.	Name 醫生姓名	Address 醫生地址		Date of consultation 首次求診日期			
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。				_	_		
☐ Yes 是 ☐ No 不是				DD日 MM月 YYYY年			
2B. CLAIMING FOR AN ACCIDENT 因意外而] 页索償						
Date and time of accident 意外日期及時間	Location of accident 意外地點		Can you provide detail 您能詳細説明你是如何		es caused by the accident? 勺嗎?		
DD日 MM月 YYYY年							
:							
HR時 MIN分 □ P.M 下午							
2C. CLAIMS SUBMITTED TO OTHER INSUR	L RER(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					
3. PAYMENT INSTRUCTIONS 付款指示							
□ Via Cheque - made cheque payable to the employee and will be sent by mail to employee's address. 支票 - 以支票支付僱員並將支票寄往其通訊地址。 □ Via transfer to bank account (The beneficiary must hold or jointly hold the bank account. Otherwise a cheque made payable to the beneficiary will be sent by mail to their address.) Please fill in the details below. 轉賬至受益人之本地銀行戶口(不適用於非受益人之個人或聯名銀行戶口。若該戶口並非受益人之個人或聯名銀行戶口,付款將以支票形式寄予受益人通訊地址。)請提供下列資料。							
Account no. 戶口號碼		Account holder name 戶口持有人姓名					
	Account Number 戶口號碼						
We require a document that includes the em	ployee's full name and bank account details to	be attached to this claim	im as proof. If you do r	not provide the	bank proof, payment will be		
	d mailed to the employee's correspondence a 顯示僱員全名和銀行戶口詳細信息作為索償的		テ證明,我們將以支票F	形式支付予僱員	並郵寄到僱員的通訊地址。		
4. EMPLOYEE'S / PATIENT'S DECLARATION	ON AND AUTHORISATION 僱員/病人聲明和打	受權					
IWe authorise any physician, hospital, clinic, ihealth, to disclose to HSBC Life (International) death or incapacity and a copy of this authoris the Company may use and disclose all persona the Personal Data (Privacy) Ordinance (which scanning the QR code on the right, or else I ca Company will collect, use, disclose and transfe not relating to the policy mentioned in this for purposes described above; organisations that	ment given above are true and complete to the linsurance company or other individual organisati Limited or its representative any information relation shall be as effective and valid as the origin all data about me/us that the Company currently of may otherwise be referred to as 'Personal Information request a copy by visiting my local HSBC Braner my/our and/or beneficiary's personal information of the following persons who may collect at consolidate claims and underwriting information of the following persons who may collect at consolidate claims and underwriting information of the following persons who may collect at consolidate claims and underwriting information of the following persons who may collect as the consolidate claims and underwriting information of the personal provided against expensive the state of the personal provided against expensive the personal provi	on or government office event to this claim. This all. By signing below, I/wr subsequently hold for the mation Collection Statem or by calling the Life Iron, for the purposes neceind use this information ind use this information in for the insurance in	that has any records or authority shall remain va e confirm the above app ne purposes as set out in ent'). I understand I ca isurance Service Hotline sessary to detect and pre only as reasonably nece idustry; fraud preventio	knowledge of r lid notwithstandi dication and agre in the Notice rela- n view such not : (852) 2583 800 vent fraud (whet issary to carry of n organisations;	ny/our ng my se that ting to ice by 0. The her or ut the other Personal Information Personal Information Collection Statement		
此技權書於本人(等)死亡或喪失能刀後依然生 人私隱)條例的通知書,也可稱為「個人資料收 維碼瀏覽該通知書,或可前往各滙豐分行或致 用作偵測和防止欺詐行為(無論是否與就本表 險業申索和承保資料的組織;防欺詐組織;其 作出分析和檢查的數據庫或登記冊(及其運營者	bugn fraud prevention organisation or other palyse and check information provided against exismits 且並無缺漏。本人達此聲明,本人已細閱述,醫院,診所,保險公司或其他私人,政府機構之效。本授權書之影印本亦屬有效。本人(等)在文集聲明])內別出的用途,使用及披露現時或其紅電豐人壽保險服務熟線:(852) 2583 8000季花格面發出的保單有關)所需的目的,而他們只能在他保險公司(無論是直接地,或是通過防欺詐組皆)。	下方豪者即雌総上娅中前 接持有有關本人(等)的前所 收該通知書的副本。本人 E有合理需要履行上述目 織或本段中指名的其他人	,亚同意 真公可可取計 有個人資料。本人明白 (等)及/或受益人的的 的之情况下才可收集和 (士):和保險業就現有 (土):	家	国人負 方的二 士,以 但 整合保 DE 1970 的資料 個人資料收集聲明 (中文)		
5. PATIENT'S SIGNATURE 病人簽署							
	Full name (in BLOCK letters)	HK/Macau ID card no.		DDE MN Date signed	1月 YYYY年 —————————————————————————————————		
	姓名(請以正階英文書寫)	香港/澳門身份證號碼		簽署日期			

(適用於十八歲以下之病人)

SECTION 2: DOCT To be completed in				ne consulting o	doctor 以正楷填寫並由主診	醫生簽署			
1. PATIENT DETAI	ILS 病人資	料							
English Full Name 英文姓名		Date of birt 出生日期	:h	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)			
				YYYY年					
2. MEDICAL HISTO	ORY 病歷		1011017]	11111					
Date of first consultation 首次看診日期			Description of patient's symptoms at the first consultation 病人首次看診時的病徵 How long has the patie 病人在首次求診前患有					hown these symptoms? 徵有多久?	
					, ,,,,,,,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5. 13 25 (7. 3	2002 7 0
DD日 MM月 YYYY年									
Are you the patient's regular doctor? 您是否該病人的慣常醫生?		□ Yes 是 □ No, please provide patient's regular doctor's information below. 不是,請提供慣常醫生資料							
Full name 姓名				Address 地址					Contact no. 電話號碼
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
Date of diagnosis 診斷日期		What is the diagnosis of the condition? 病情的診斷是什麽?							
DD日 MM月	- <u>YY</u>	 YY年							
How is the conclus 如何得出上述結論					It of any tests performed. 斷。				
Date of test							result 結果		
 DD日 MM月	- <u>Y</u>	YYY年							
 DD日 MM月	- <u>Y</u>	 YYY年							
	- <u>Y</u>	 YYY年							
	- <u>Y</u>	YYY年							
 DD日 MM月	- <u>Y</u>	YYY年							
									

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3. TREATMENT 治療							
Please provide a detailed description of type of prescribed treatment, including medication, surgical treatments, chemot or radiotherapy, duration, quantity and frequency. Please use a separate piece paper and attach it if you need more spa 請詳細描述您處方的治療類型,包括藥物,手術治療、化療或電療、週期、數量和持約如果空間不足,您可附上額外紙張。	cherapy of sice. 治療、						
4. SUPPORTING INFORMATION 補充資	4. SUPPORTING INFORMATION 補充資料						
Please provide any further information th 請提供任何進一步的信息,以幫助我們評	nat will assist us in assessing this claim. 估這項索償。						
5. DOCTOR'S DECLARATION AND AU	THORISATION 醫生聲明及授權書						
	is true and complete to the best of my knowl 問題的所有答案,就本人所知所信,均為事實全						
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	or	Date signed					
主診醫生簽名及蓋章		簽署日期					