HOSPITALIZATION / SURGICAL CLAIM FORM

住院 / 手術賠償申請表

PART A – Member Information – (to be completed by the insured employee)

甲項 – 會員資料(由受保僱員填寫)

Policy No. 保單號碼	Policy Holder / Company Name 保單持有人/公司名稱	Patient Name (for Dependent) 病者姓名	Patient's HealthCard No. (if applicable) 病者保健咭號碼 (如適用)
Employee/Cert No. 僱員號碼	Employee Name 僱員姓名	Patient Name (for Dependent) 病者姓名	Patient's Date of Birth (DD/MM/YY) 病者出生日期 (日/月/年)

Are you also filing any other insurance or compensation claim as a result of this hospitalization/surgery?
此次住院/手術是否獲得其他保險金或補償金

☐ No 否 ☐ Yes, Name of Insurance Company/Type of Compensation: 是, 保險公司名稱/補償金類別: _____

Has the patient had any prior treatment for this condition?
病者曾否在同一病況下就醫或治療?

☐ No 否 ☐ Yes, Please state date: 是, 請填寫日期 _____

If hospitalization was the result of an accident, please give date and a brief description of the accident:
如因意外受傷而入院, 請略述其發生之日期 、地點及情況:

☐ Work related 與工作有關 ☐ Non-work related 與工作無關

Notes for filing a claim:

1. Part A should be completed by the insured employee/member while Part B by Attending Physician.
2. Original bills and receipts must be attached showing the date of treatment, patient's name, diagnosis and the Attending Physician's stamp and signature.
3. Referral must be attached for specialist consultation.
4. For hospital claim, claim form must be sent to Claims Department within 90 days after discharge.
5. Original bills or receipts will not be returned (unless clearly stated). Please make copy as required.
6. If the hospitalization was made outside HKSAR, please specify the name of country and provide claim supporting document in English or Chinese

申請賠償須知:

1. 此表格之甲項須由僱員/會員填報,而乙項則須由主診醫生填報。
2. 必須附上正本單據及收條,單據及收條須包括診治日期,病者姓名, 診斷以及主 診醫生蓋章及簽署。
3. 專科賠償, 必須附上轉介推薦書。
4. 住院賠償申請必須在出院後 90 日內交回賠償部。
5. 所有正本單據及收條俱不會發還(除非清楚註明), 請自行影印副本.
6. 如入住海外醫院, 請提供國家名稱及英文或中文版本之賠償文件.。

A photocopy of this authorization shall be as valid as the original.
此授權書之正本與副本同屬有效。

聲明 **DECLARATION**

本人 / 吾等聲明，本人 / 吾等已填報一切必要的資料，絕對正確，並無隱瞞或保留。本人 / 吾等明白本人 / 吾等提供的資料為泰山保險顧問有限公司提供保險業務所需，並可能使用於下列目的：i) 任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期；ii) 任何索償，或該等索償的調查或分析；iii) 行使任何代位權；及可能移轉予任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的。

I / We declare that the Statements and particulars given in this application are true and that I / We have not withheld any material information. The information provided by me / ourselves to Taishan Insurance Brokers Ltd. is collected to enable Taishan Insurance Brokers Ltd. to carry on insurance business and may be used for the purpose of: i) any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or service; ii) any claim or investigation or analysis of such claim; and iii) exercising any right of subrogation; and may be transferred to any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes.

支付經紀佣金 **PAYMENT OF BROKER COMMISSION**

泰山保險顧問有限公司（「該公司」）藉向保險公司收取的佣金，作為其所提供服務的酬金。 閣下同意進行是項保險交易，即構成閣下同意該公司收 取佣金。

Taishan Insurance Brokers Limited is remunerated for its services by the receipt of commission paid by insurers. Your agreement to proceed with this insurance transaction shall constitute your consent to the receipt of commission by the Company.

本人 / 投保人亦明白泰山保險顧問有限公司必須取得本人 / 投保人以上的同意，才可以處理本人 / 投保人之保險申請。

I / Proposed insured further understand that the above agreement is necessary for Taishan Insurance Brokers Limited to proceed with the application.

Signature of Employee 僱員簽署	Signature of Patient (Age 18 or above) 病者 (18 歲或以上) 簽署	Date signed 簽署日期

PART B – To be completed by the Attending Physician, for Hospitalization & Surgical Claim

Name of Patient :

Date of Admission :

Accommodation Level:

☐ Ward ☐ Semi Private ☐ Private ☐ Hospital Outpatient Division

Chief Complaints of the patient relating to this hospitalization /surgery:

Pathology & brief history of disability:

Diagnosis of the Conditions:

Have you recommended for the opinion of a specialist, other than the surgeon?

☐ No ☐ Yes, please give the name of specialist and the reason for his opinion or services.

If Surgical Operation was involved, please specify the type of the Operation:

Date of the accident occurred or symptom first appeared:

To the best of your knowledge, 1) Is condition congenital?

☐ No ☐ Yes, please give details: _____

2) Has the patient ever had the same or similar conditions or symptoms relating thereto?

☐ No ☐ Yes, please state date of consultation: _____

Diagnosis: _____ Treatment type: _____

Is the patient referred by another doctor?

☐ No ☐ Yes, Please state name & address of the referring doctor:

If the condition is due to pregnancy, please give approximate date of commencement of pregnancy: _____ (DD/MM/YYYY)

Period of Confinement in Hospital:

From: _____ to _____

(DD/MM/YYYY) (DD/MM/YYYY)

Name and address of hospital:

Physician's Name: _____

Physician's Signature : _____

Clinic Address and Tel No.:

OUTPATIENT CLAIM FORM
門診賠償申請表

Policy No. 保單號碼	Policy Holder / Company Name 保單持有人/公司名稱	Patient's HealthCard No. (if applicable) 病者保健咭號碼 (如適用)
Employee/Cert No. 僱員號碼	Employee Name 僱員姓名	Patient Name (for Dependent) 病者姓名

Treatment Date [1] (DD/MM/YY) 診治日期(日/月/年)	Claim Type [2] 申請賠償類別	Receipt Amount [3] 收據金額
	☐GP ☐SP* ☐Lab* ☐Dental ☐Others 其他:_____	$
	☐GP ☐SP* ☐Lab* ☐D Dental ☐Others 其他:	$
	☐GP ☐SP* ☐Lab* ☐Dental ☐Others 其他:_____	$
	☐GP ☐SP* ☐Lab* ☐Dental ☐Others 其他:_____	$
	☐GP ☐SP* ☐Lab* ☐Dental ☐Others 其他:_____	$
	☐GP ☐SP* ☐Lab* ☐Dental ☐Others 其他:_____	$

NOTES

1. Claim must be submitted and received by the Claims Department within 90 days of treatment.
2. Claim Type
   GP – Outpatient Doctor's Consultation
   SP* – Outpatient Specialist Consultation
   Lab* – Diagnostic Laboratory Tests Dental – Dental Services
   *Doctor's Referral is required
3. Original bills and receipts must be attached showing the date of treatment, patient's name, diagnosis and the Attending Physician's stamp and signature.

申請賠償須知

1. 賠償申請必須在診治日期後 90 日內交回賠償部
2. 賠償類別
   GP - 普通科醫生　　SP* - 專科醫生
   Lab* - 診斷化驗測試　　Dental - 牙科
   * 須附醫生轉介推薦書
3. 必須附上正本單據及收條,單據及收條須包括診治日期,病者姓名, 診斷以及主診醫生蓋章及簽署。

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Date signed 簽署日期　　Signature of Employee 僱員簽署