YFLife 萬通保險

GROUP HOSPITALIZATION AND SURGICAL CLAIM FORM
團體住院及手術索償申請表

EMPLOYEE BENEFITS 僱員福利

Please read the following instructions before completing this claim form:- 在填寫此索償申請表前，請細閱下列各項說明：

1. To avoid return of claim due to incomplete information, please answer all questions. 為免因資料不全而被退回索償申請，請回答所有問題。
2. If you need us to return the original receipts after processing, please state your request on the top of this form with your signature. Please note that those claims receipts will not be returned after 3 months from the submission date. 如您需要本公司於索償處理後退回收據正本，請於此申請表上方列明並在旁簽署。請注意，於索償文件遞交日起計三個月後，本公司概不退回收據或索償文件。
3. If a surgical procedure or operation has been performed during the hospitalization, Part II must be completed by the surgeon. If no surgical procedure or operation is involved, Part II must be completed by the attending doctor. 如病者在住院期間曾施行外科手術，第二部份須由外科醫生填寫。如無需施行外科手術，第二部份需由應診醫生填寫。
4. All receipts and bills from the doctor, surgeon and hospital must be the original, and must be submitted together with this claim form within 90 days of the date discharged from hospital. Otherwise claim will be declined 請將所有應診醫生、外科醫生及醫院帳單及收據之正本，連同此申請表在出院後九十天內交回本公司。否則索償申請將不獲處理。

Name of Employer : _____ Policy No. : _____
僱主名稱 保單號碼

Part I - To be completed by the Insured Member 此部份由受保成員填寫 (If the Insured Member is a child under 18 years of age, please fill in and sign this form by the Employee concerned.) 若受保成員是僱員子女而少於十八歲，此申請表須由僱員代為填寫及簽署

1a. Name of Employee 僱員姓名 : _____

b. ID Card No./Certificate No. : _____ Date of Employment : _____ MM 月 DD 日 YY 年
身份證號碼/證書號碼 受僱日期

c. Residential Address 住址 : _____

2a. Name of Patient (if other than Employee) 病者姓名（若病者非僱員） : _____

b. Relationship with Employee 病者與僱員關係 : SELF

3a. Did the patient receive treatment for the same sickness by another doctor? 病者曾否因同樣病症接受其他醫生之治療？ ☐ Yes 有 ☐ No 無

b. If yes, please give details. 如曾接受其他醫生之治療，請提供該醫生的資料。

Date 日期: _____ Name of the Doctor 醫生姓名 : _____

Address of the Doctor 醫生地址 : _____

4. As a result of this hospitalization, will the Insured claim or receive any form of compensation from other insurance companies? If yes, please give details.
就是次住院，閣下會否申請或接受其他同類型之保險索償？若有，請詳述。

☐ No 無 ☐ Yes 有 Name of Insurance Company : _____ Policy No. : _____
保險公司名稱 保單號碼

Declaration and Authorization 聲明及授權

I declare that I am the insured member of the above mentioned policy and all the information supplied by me on this form is complete and true to the best of my knowledge and belief. I also declare that I have read and understood the Personal Information Collection Statement stated below. I authorize any medical attendant, hospital, clinic, insurance company or other organization, institution or person, who has any records or knowledge of me or my health to divulge to YF Life Insurance International Ltd. ("YF Life") any information required for the purpose of evaluating the claims application. A photocopy of this authorization shall be as valid as the original. I also confirm that the claims information regarding myself may be released to my Employer or related parties from YF Life. I also declare that there is no change to my record provided by the Employer upon my enrollment, and if there are any changes to my record, I shall forthwith provide documentary proofs of such changes satisfactory to YF Life, and I authorize YF Life to obtain from and verify my personal information with my Employer for the purpose of conducting due diligence under the relevant laws and regulations.
現聲明本人乃上述保單之受保成員，就本人所知及所信以上所填報之資料均正確無訛。本人亦聲明已閱讀及明白下列個人資料收集聲明。 本人茲授權持有本人健康或任何資料之註冊西醫、醫院、診所、保險公司、機構、協會或人仕，可以將有關資料提供予萬通保險國際有限公司（"萬通保險"），作為索償申請之參考。此授權書之副本與正本有同等效力。本人亦同意萬通保險可向本人之僱主或相關人士提供有關本人之索償資料。本人亦聲明由僱主於登記時所提供有關本人的資料並沒有任何更改，如有關的資料有任何更改，本人會立刻向萬通保險提供與更改有關的及符合萬通保險要求之證明文件。本人亦授權萬通保險向本人之僱主索取及核實本人的個人資料，作為於有關法例及規例下進行盡職審查之用。

Personal Information Collection Statement 個人資料收集聲明

Your personal information (including a record of your image or voice by whatever means and your health information) collected by or held by YF Life Insurance International Ltd. ("YF Life") may be used for the purposes of: (1) approving, evaluating or processing your insurance application / policy service request; (2) administering, maintaining or reinsuring your policies; (3) adjudicating your claims, or conducting any investigation or analysis of your claims; (4) data matching; (5) investigation or prevention of crime; or (6) fulfilling legal or regulatory requirements. Please note that failure to provide any information requested by YF Life may result in YF Life not being able to process your insurance application / policy service request. Your personal information collected by or held by YF Life may be transferred or disclosed by YF Life to any of the following persons (whether within or outside Hong Kong) for the purposes as specified above or to governmental / regulatory bodies (whether within or outside Hong Kong) for them to carry out their governmental / regulatory functions: (1) YF Life group companies and their associated / affiliated companies; (2) financial institutions, insurance companies, intermediaries and reinsurers; (3) claims investigation companies or any companies / persons necessary for claims assessment / investigation; (4) industry associations / federations and their members; (5) governmental / regulatory bodies and law enforcement agencies; (6) crime prevention organisations and their members/participants ; and (7) service providers and selected persons which are under a duty of confidentiality to YF Life. You have the right to access to, and to correct, any of your personal information held by YF Life by writing to our Employee Benefits Personal Data Protection Officer. (Address: 27/F, YF Life Tower, 33 Lockhart Road, Wanchai, Hong Kong). YF Life may charge a reasonable fee for the processing of such request.
萬通保險國際有限公司（下稱「萬通保險」）所收集或持有的閣下的個人資料(包括任何形式的肖像、聲音及與健康有關的資料)可能會被用於下列目的：(1) 批核、評審及處理閣下之投保計劃申請 / 保單服務要求；(2) 就閣下之保單提供行政、持續或再保險的服務；(3) 評核閣下索償，或就閣下之索償進行調查或分析；(4) 資料核對；(5) 偵測或防止罪行；或 (6) 符合法律或合規要求。請注意，閣下必須提供萬通保險所需的個人資料，否則，萬通保險將不能處理閣下之投保申請或就閣下之保單提供服務。萬通保險可能為達到上述目的或讓政府 / 監管機構 （不論在香港或海外）執行其職務而向以下任何一方（不論在香港或海外）轉移或透露由萬通保險收集或持有屬於閣下的個人資料：(1) 萬通保險集團成員公司及其關聯或相關公司；(2) 金融機構、保險公司、中介人或再保險公司；(3) 賠償調查公司及所需有關評核索償之公司及 / 或人士；(4) 行業組織 / 聯會及其成員；(5) 政府部門或監管機構和執法機構；(6) 防犯罪組織及其會員 / 參與者；及 (7) 與萬通保險有保密協議的服務提供者及其他人士。閣下有權查閱和更改任何由萬通保險持有屬於閣下的個人資料。如有需要，閣下可與萬通保險的僱員福利資料保護主任提出有關要求、並以書面方式呈交至香港灣仔駱克道33號萬通保險大廈27樓。處理上述要求時，萬通保險可能會收取合理費用。

Signature of Patient (18 years of age or over) 病者簽署(如超過十八歲) _____ Signature of Employee 僱員簽署 _____ Date : (MM / DD / YY) 日期 （月 / 日 / 年） _____

PART II (overleaf) must be completed by the Patient's Surgeon or Attending Doctor. 第二部份（背頁）必須由診治病者之外科醫生或應診醫生填寫。

YF Life Insurance International Ltd. 萬通保險國際有限公司

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Part II - To be completed by the Surgeon or Attending Doctor 此部份由外科醫生或應診醫生填寫

Name of Patient : _____ Age : _____ Admission date from : _____ to _____
病者姓名 年齡 住院日期由 至

NOTE: No claim will be admitted unless the form below is duly completed by a registered medical practitioner. YF Life Insurance International Ltd. will not be responsible for any fee required for the completion of this report or any follow up cost thereafter.
本部份必須由註冊之執業醫生填寫，否則該索償將不予受理。此外，本公司概不負責任何有關填寫此申請表之費用。

1a. Please give chief complaint for this hospitalization.
請提供主要陳訴病情。

b. Please provide the diagnosis for this hospitalization.
請提供是次住院診斷。

c. Describe the type of treatment/surgical procedure given to the patient.
闡述各項治療 / 外科手術。

2. When were the symptoms first presented before the first consultation or when did the accident happen?
症狀首次於何時出現？如屬意外，何時發生？

MM 月 DD 日 YY 年

3a. When was the first consultation for this treatment/sickness?
首次接受診治日期：

MM 月 DD 日 YY 年

b. Has the patient received continuous treatment related to this sickness since then?
病者是否因相同或相關的疾病繼續接受治療？

4. If hospitalization was due to accident, please state how occurred. Did the patient report to police?
如該住院由意外導致，請詳述意外發生之過程。病者曾否向警方報案？

5a. Was the patient referred to you by another doctor? If YES, please give name and address of the doctor(s).
病者是否經其他醫生轉介？如是，請提供醫生姓名及地址。

☐ No 否 ☐ Yes 是

b. Do you know whether this patient has been treated by other doctor(s) for the same diseases/disorders? If YES, please give name/address of the doctor(s).
病者曾否因相同或相關的疾病經其他醫生診治？如是，請提供醫生姓名及地址。

☐ No 否 ☐ Yes 是

6a. How long have you known this patient? How do you know this patient?
閣下於何時及怎樣認識病者？

b. Have you treated the above patient for this or a related sickness before?
病者曾否因相同或相關之疾病接受閣下治療？

☐ No 否 ☐ Yes 是, please give details 請詳述 _____

c. Was the condition a recurrent episode or a chronic disease? If YES, when was the date of first attack?
此病症是否屬再次復發或慢性疾病？如是，請提供首次病發之日期。

☐ No 否 ☐ Yes 是, it was a 這是 _____

The date of first attack was on _____
初次病發日期為

7. Was the condition caused by or in any way associated with the conditions mentioned below?
此病症是否由以下情況引致或有關連？

	Yes	No
a. the influence of drugs or alcohol intake? 毒癮、酗酒	☐	☐
b. AIDS, venereal disease or sexually transmitted disease? 後天免疫力缺乏症、性病	☐	☐
c. infertility or sterilization? 不育或節育	☐	☐
d. cosmetic or plastic surgery? 美容或整形手術	☐	☐
e. mental or nervous disorder? 精神病或神經錯亂	☐	☐
f. congenital deformities or anomalies? 先天性畸形或異常	☐	☐
g. suicide, insanity or self-infliction? 自殺、自殘身體	☐	☐
h. correction of eye sight? 視力矯正	☐	☐

8. If the treatment is due to pregnancy, please give the date of conception.
如治療與妊娠有關，請提供受孕日期？

_____ MM 月 _____ DD 日 _____ YY 年

9a. Is the hospitalization/treatment medically necessary?
此次住院/治療是否在醫療上是必須的？

☐ No 否 ☐ Yes 是, please give details 請詳述 _____

b. For the average patient, what is the usual duration of hospitalization for this sickness?
一般患上此病的病人需要住院多久？

c. Is it possible to provide this treatment/investigation(s) on an outpatient basis?
此治療 / 檢查可否於門診進行？

☐ No 否 ☐ Yes 是, please give details 請詳述 _____

10. Did any complications arise during hospitalization?
病者曾否於住院期間發生併發症？

☐ No 否 ☐ Yes 是, please give details 請詳述 _____

11. Did the patient have home leave during hospitalization?
病者曾否於住院期間外出返家？

☐ No 否 ☐ Yes 是, please give date(s) 請提供日期 _____

This report is a matter of importance to the Insured, please complete and return it without delay. Thank you very much.
此報告對辦理索償程序非常重要，請盡快填妥並寄回本公司以便辦理索償手續。多謝合作。

Signature & Stamp
醫生簽署 & 蓋章

Name and Qualifications of Surgeon/Attending Doctor : _____
主診醫生姓名及專業資格：

Date : _____ MM 月 DD 日 YY 年
日期

YF Life Insurance International Ltd. 萬通保險國際有限公司
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