Group Hospitalization & Surgical Insurance Claim Form
團體住院及手術保險賠償申請書

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Sun Life Financial 永明金融

INSTRUCTIONS 說明

1. Part A of this form must be completed by the employee and signed by the patient and Part B by the employer (Policy Owner) and then submitted within **60** days of incurring such expenses. 此申請書之甲部必須由僱員填寫及病人簽署，而乙部則須由僱主(保單持有人)填寫，並於付款後六十天內遞交。
2. If a surgical procedure or operation has been performed during the hospitalization, Part C must be completed by the surgeon. If no surgical procedure or operation is involved, Part C must be completed by the attending physician. 如住院期間曾施行外科手術，丙部須由外科醫生填寫。如無需施行外科手術，丙部則由主診醫生填寫。
3. All invoices, bills and receipts from the physician, surgeon or hospital must be original copies and submitted together with this claim form. 所有連同本申請書遞交之發票、帳單或收據必須為正本，並由有關主診醫生、外科醫生或院方發出。
4. Return all original receipts after claim processing? 賠償辦妥後需退回所有收據正本? ☐ Yes 是 ☐ No 否

Part A – To be completed by employee 甲部 － 由僱員填寫

1. Name of Employee 僱員姓名	H.K.I.D.Card No./Membership No. 香港身份證號碼/會員號碼	Sex 性別	Age 年齡

2. Name of Patient (if other than employee) 病人姓名 (如非僱員)	Relationship 與僱員關係	Age 年齡

3. Name of Hospital 醫院名稱	Date admitted to Hospital 入院日期

4. Complete either (a) or (b) 填寫甲部或乙部

(a) Sickness (甲) 病症： Type of sickness 病症種類		(b) Injury (乙) 損傷： Type of injury 損傷類型	Date occurred 事發日期
Date began 發生日期	Date first treated 首次接受治療日期	Describe how accident occurred 詳述意外發生時之過程	
Is Patient now pregnant? 病人是否現正懷孕? ☐ Yes 是 ☐ No 否 If "Yes", state approximate date of commencement of pregnancy 若「是」，請提供大約受孕日期			

5. Has the patient received medical treatment or advice or been hospitalized for the same or an interrelated cause in the last three (3) months?
If "Yes", please specify date of treatment/advice, name of attending physician, period of hospitalization and name of hospital.
病人曾否於過往三個月內因同一或有關病患而接受治療或住院? 若「是」，請提供接受治療、住院日期、醫生及醫院名稱。

6. Are benefits available for this sickness or injury covered under any other Group Plan? If "Yes", please specify name of Insurer and Policy Number.
此病症或受傷是否獲得其它保險計劃保障? 若「是」，請提供保險公司名稱及保單號碼。

DECLARATION AND AUTHORIZATION 聲明及授權

The claimant (I/We) hereby declare, agree and understand, as the case may be, as evidenced by my/our signature(s) hereunder, that:
索償人（本人/吾等）聲明、同意及明白以下各項（視乎情況適用而定），並在此賠償申請書簽署作實：

1. All the foregoing statements and answers in this claim form together with those in any required medical examination, questionnaire, amendment or other document signed by me/us in connection with this claim application are full, complete and true. I/We also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. Sun Life Hong Kong Limited (including its successors or assigns, the Company) may be unable to process this claim application if I/we fail to provide any information required to this application.
此賠償申請書上所載的聲明及答案，以及經本人/吾等簽署之所需的體格檢驗、問卷、修改書及其他文件，均屬真確無訛，詳細完整，並構成賠償申請的依據及其中部份。本人/吾等明白倘有任何未知是否屬於重要事項的資料均須在此透露。倘本人/吾等未能提供此賠償申請所需資料，可導致香港永明金融有限公司 (包括繼承人或承讓人，公司) 未能處理此賠償申請。
2. I/We fully understand that the Company is not bound by any statement which I/we may have made to any person if not written or printed here.
本人/吾等完全明白公司不受一些本人/吾等沒有在此賠償申請書上提及或刊印向任何人士定立的聲明所約束。
3. The personal information of employees, members and dependents held by or on behalf of the Company (whether contained herein or otherwise obtained and including personal information obtained after the date of this Application) may be held, used, disclosed, released and transferred by the Company to the parties and for the purposes mentioned in the Personal Information Collection Statement below:
由公司所持有及由本人/吾等提供有關僱員、成員及配偶或子女的個人資料，公司（不論是否從此申請書或其他途徑，包括在此申請後所得）可持有、使用、發放或轉交予有關人等作以下《個人資料收集聲明》中提及的用途：
Personal Information Collection Statement
Any personal information collected or held by or on behalf of the Company (whether contained in this Application or otherwise obtained) may be held, used, disclosed and transferred by the Company to individuals, companies or organizations associated with the Company or any selected third parties that the Company may consider necessary or advisable, including those carrying on financial services, insurance or related businesses (within or outside of Hong Kong, including reinsurance and claims investigation companies, professional advisors, intermediaries, industry associations/federations, medical services providers, facilities and other services providers relevant to insurance business), for the purposes of (i) processing this Application, (ii) providing insurance and related services, and after-sale services for other financial products and services, (iii) direct marketing and/or data matching for promotional purposes with or without monetary gains and (iv) carrying out regulatory functions and communicating with me/us for such purposes and all other directly related purposes. The Company is hereby authorized to obtain access to and/or to verify any of my/our data with the information collected from the insurance industry by any association, federation or similar organization of insurance companies. I/We understand that the information I/we give is on a voluntary basis. However, failure to supply information may result in the Company being unable to process my/our Application. In accordance with the terms of the Personal Data (Privacy) Ordinance, the Company has the right to charge a reasonable fee for the processing of any data access request. I/We have the right to obtain access to and to request correction of any personal information concerning me/us held by the Company. Request for such access can be made in writing and addressed to: Group Insurance Administration, 8/F, Sun Life Tower, The Gateway, 15 Canton Road, Kowloon.
《個人資料收集聲明》
任何貴公司收集或持有（無論此申報表格所載或由其他途徑所獲取）之任何個人資料並可由貴公司持有、使用、披露及轉移予與貴公司有關之個人、公司或機構或任何貴公司認為必須或合適之指定第三者，包括金融服務、保險或相關業務的經營者（不論在本港或海外，包括再保險及索償調查公司、專業顧問、中介人、同業協會或聯會、醫療服務供應商、醫療機構及有關保險業務之服務供應商），以用作(i)處理此申請 (ii)提供相關保險服務及其他金融產品及服務之售後服務、(iii)直銷推廣及/或作推廣用途的數據配對，不論是否涉及金錢得益，及(iv)執行監管職能及因此等用途與本人/吾等聯絡或其他直接有關之用途。本人/吾等在此授權貴公司索取及/或核實由任何保險業協會或聯會或從事與保險業務有關之公司所提供關於本人/吾等的資料。本人/吾等明白本人/吾等所提供之資料均屬自願，惟若不能提供該等資料有機會導致貴公司無法處理本人/吾等之申請。根據個人資料（私隱）條例，貴公司可能就任何資料查詢要求收取合理費用。本人/吾等有權查閱及要求更正貴公司持有有關本人/吾等的個人資料，有關要求可以書面形式郵寄香港九龍廣東道15號港威大廈永明金融大樓8樓香港永明金融有限公司團體保險行政部。
❑ Please tick (✔) if you do not want your data to be used for the purpose identified in item (iii) above. 如閣下不願意將其個人資料被用於上述第 (iii) 項之用途，請在方格內填上(✔)號。
4. I/We further authorized: (a) any doctor, hospital, clinic, insurance company, government office or any organization or person who has any record, knowledge or information of me/the Insured (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to this Application; and (b) the Company or any of its appointed medical/paramedical examiners or laboratories to perform necessary medical assessments and tests to evaluate the health status of me/the Insured in relation to this Application. This authorization shall bind the successors and assignees of me/the Insured and shall remain valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original.
本人/吾等同時授權：(甲) 任何擁有任何本人/受保人之記錄、詳情或資料（醫療或其他資料）之醫生、醫院、診所、保險公司、政府部門、機構或人士就此賠償申請向公司或其代表披露、透露或轉移此等記錄、詳情或資料；及(乙) 公司或公司指定之醫生/醫護人員或化驗所進行必要之健康評估及檢驗，以評估與此賠償申請之本人/受保人的健康情況。此授權書對本人/受保人之繼承人及受讓人有約束力，並於本人/受保人身故後或喪失能力後仍然有效。此授權書的正本及影印本同屬有效。

Date 日期: Signature of Patient 病人簽署 (*):
(*) In the event of the patient whose age is less than 18, this part should be signed by the insured employee. 倘若病人之年齡在十八歲以下，本申請書須由受保僱員簽署。

Part B – To be completed by employer (Policy Owner) 乙部 － 由僱主填寫

1. Name of Employer 僱主名稱(保單持有人)		Policy No. 保單號碼

2. Name of Employee 僱員姓名	Date employed 受僱日期	Effective date of employee's coverage 僱員受保日期

3. Complete either (a) or (b) 填寫甲部或乙部

(a) If employee is the patient (甲) 如病人是僱員: Date last worked 最後上班日期	Date expected to return to work 預計返回工作日期	(b) If employee's dependent is the patient (乙) 如病人是僱員之家屬:
Period of hospitalization 住院時期		Is the dependent covered under this Policy? 家屬是否受保? ☐ Yes 是 ☐ No 否 If "Yes", state effective date of such dependent's coverage. 若「是」，請提供家屬受保日期。

For and on behalf of the Employer 茲代表僱主

Name of Signatory 簽署人姓名： _____

Job Title 職位： _____

Date 日期： _____ Authorized Signature 授權人簽署

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Part C – To be completed by surgeon or attending physician at the claimant's own expense 丙部－由外科醫生或主診醫生填寫，所需費用由索償人承擔

(1) PARTICULARS OF THE PATIENT 病人資料

Name of Patient 病人姓名 _____ H.K.I.D.Card No. 香港身份證號碼 _____ Age 年齡 _____

(2) DETAILS OF HOSPITALIZATION AND TREATMENT 住院詳情及治療

Name of Hospital 醫院名稱 _____

Date of Admission 入院日期 _____ Date of Discharge 出院日期 _____

Level of hospital ward 病房類別 ☐ Private 私家病房 ☐ Semi-private 二等病房 ☐ Ward 普通病房 ☐ Clinical Surgery 門診手術

Nature of the Surgical Procedure 手術名稱 _____ Date of Operation 手術日期 _____

(3) DIAGNOSIS AND MEDICAL HISTORY 診斷及病歷記錄

a) Chief complaints / symptoms of the patient relating to this hospitalization/surgery 此次住院/手術的主要原因 / 病徵 _____

_____

b) Date of the accident or when symptoms first appeared 首次出現病徵或意外發生日期 _____

c) Date on which the patient first consulted you for this condition or related illness 病人首次求診日期 _____

d) To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? If yes, please state dates and give details. 據閣下所知，病人以前曾否患有同類或類似情況？如果答案是“有”，請說明何時及當時病況

_____

e) Final Diagnosis 最後診斷 _____

f) Was condition due to or associated with the following? (Please tick the appropriate boxes) 此病症是否與下列情況有關？(請選擇適合方格)

- ☐ the influence of drugs or alcohol 受藥物或酒精影響
- ☐ infertility or sterilization 不育或絕育
- ☐ cosmetic or plastic surgery 美容或整形手術
- ☐ mental or nervous disorder 精神病或神經錯亂
- ☐ congenital deformities or anomalies 先天性畸形或異常
- ☐ correction of eye sight 視力矯正
- ☐ AIDs, venereal disease, sexually transmitted disease 愛滋病、性病或性接觸傳染病
- ☐ Pregnancy 懷孕 (Date of commencement of pregnancy 受孕日期 _____)
- ☐ accidental bodily injury 意外受傷
- ☐ contraception 避孕
- ☐ self-inflicted injury 自我傷害
- ☐ developmental condition 發育不全
- ☐ hereditary condition 遺傳性疾病
- ☐ general check-up 一般身體檢查
- ☐ vaccination 預防疫苗

g) Brief discharge summary (including treatments, investigation procedures, results, and/or any complications and follow up plan)
出院撮要: (治療及以後治療計劃，包括診查辦法、結果，併發症及跟進計劃)

_____

h) Please provide reason(s) for hospitalization if this type of cases can be managed on day case / outpatient basis.
如類似個案可以在門診處理，請提供人入院之理由

_____

i) If the patient has consulted other physician during this hospitalization, please provide the following details:
如病人在是此住院曾經其他醫生診斷，請提供以下詳細資料：

Name of Physician consulted 醫生姓名 _____ Reason 理由 _____

What treatment had the physician performed? 此醫生提供什麼治療計劃？ _____

j) If the patient was referred by another physician, please give the name and address of the referring physician.
如病人是經其他醫生轉介，請提供該醫生之姓名及地址

_____

k) Are you the patient's usual physician? 你是否病人常見之醫生？ ☐ Yes 是 ☐ No 否

I hereby certify that all information given above is accurate and true to the best of my knowledge 本人特此證明據本人所知，上述所有資料是準確和真實

Name of Physician/Surgeon: _____
主診醫生或外科醫生姓名

Signature of Physician/Surgeon with Official Chop
主診醫生或外科醫生簽署及蓋章

Qualifications: _____
資歷

Address: _____
地址

Telephone: _____
聯絡電話

_____
Date 日期:

若本申請書內之中文譯本與英文原文有任何差異或不連貫時，一切文意以英文為準。