Bupa Hospital Claim Form 保柏住院賠償申請表 Only completed original claim form is accepted 只接受已填妥之賠償申請表正本

Sun Flower Insura	nce Brokers Limit
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PART I – To be Completed by Member 第一部份 由會員填寫		
Name of Subscriber / Employer :	賠償申請表編號	
投保人/僱主名稱		
Name of Employee (For group contract only) :	Day Time Contact Tel No. :	
僱員姓名 (只適用於團體合約)	日間聯絡電話	
Name of Patient (if other than Subscriber/Employee) :	Date of Hospitalisation / Day Case Surgery : From to	
病人姓名 (如非投保人或僱員)	住院/日症手術日期 由 DD日/MM月/YY年 至 DD日/MM月/YY年	
Membership No. of Patient 病人會員編號 (16 digits位)	Email Address :	
Must be completed 必須填寫	電郵地址	
If hospitalisation was due to illness 若因疾病而住院	If hospitalisation was due to accident 若因意外而住院	
1. Describe the symptoms and abnormalities which led to the hospitalisation 請列出病人因何不適及有何異常導致是次入院	1. When did it happen? 意外發生日期?	
时为国际人员员生逐次自己共享大人人员	Date 日期 Time 時間	
	2. Where and how did it happen? 意外發生的地點及經過?	
2. Name , address and tel. no of doctor / hospital the patient first consulted for the illness 初影醫生姓名/醫院名稱、地址及電話號碼		
3. Date of the first consultation 初診日期	3. Injured area, type and severity of the injury,受傷部位、類別及傷勢。	
	3. Injured area, type and seventy of the injury. 文極即位 - 無刑及國务 ·	
4. When did these symptoms first appear? 病人於何日首次出現上述症狀?		
	4. Did the patient report to the police? 病人有否報警?	
5. Has the patient received any treatment for similar or related illness by other doctor(s) or been admitted to	Yes Send us a copy of the police report No	
hospital in the past? 病人曾否因同一或有關之病症而向其他醫生求診或入院?	有 〇 請提交有關檔案副本一份	
Yes 有 O No 無 O If Yes, please specify 如有,請詳述	 Was there any concurrent / predisposing illness at the time of the accident? 意外發生時,是否有其他已存在之疾病? 	
ites 有	态开放工时,是自有关他心理性之类物!	
Treatment Date 診治日期		
Name and address of the doctor(s) / hospital(s) 醫生姓名 / 醫院名稱及地址	6. Other information 其他資料	
	Did you submit a claim for workmen's compensation? If yes, please specify the result,	
	有關是次索償閣下有否申請勞工賠償,如有,請詳述結果?	
Other information 其他資料		
Have you ever made or will you make any claim request for compensation from any organisation as a result of this treatment? 就有關治療,您曾否或將會向任何機構要求賠償? 〇 Yes 有		
If Yes, please specify the name of the insurance company / organisation : Policy No. / Membership No. :		
如有,請列明保險公司 / 機構名稱 保單或會員編號 Return all original receipts after claim processing 賠償辦妥後需退回所有收據正本 〇 Yes 是		
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Declaration and Authorisation 聲明及授權書
Hereby declare that the above information given is true and correct.

lalso authorise any medical practitioner, hospital, clinic, by whom or where I / the Member have / has been observed or treated or any insurance company or organisation that has any records or health information concerning me and / or the Member for any reason, to give full particulars thereof including prior medical history to Bupa. A copy of this authorisation shall be considered as effective and valid as the original.

lunderstand that if I and / or the Member fail to provide any information requested in this claim form, it may result in the inability of Bupa to accept or process this claims.

本人達比聲明・以上所填報之一切資料・均屬真確無証。

本人班已授權任何為本人 / 貪農觀察或治療的醫生、醫院、診所・或持有本人及 / 或會員健康或任何資料之保險公司或機構將本人及 / 或會員之全部資料(包括病歷)呈交予保柏・本授權書之副本與正本具同等效力。

本人明白、如本人及 / 或會員未能就本階值申請表所需提供足夠資料可能會導致保柏不能接受或處理本階值申請。

Personal Information Collection Statement

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Purposes: I understand and agree that all personal information relating to me / the Member collected or held by Bupa, whether contained in this application, or obtained in any claim processing procedure or otherwise from time to time, may be used by Bupa for the purposes of (1) processing this application and providing subsequent services: (2) processing any claims analysis and/or medical or other insurance-related checks; (3) provision and design of products and services of Bupa or any of its goup companies (but not other persons or organisations), (5) data matching, statistics and research; (6) communication with me / the Member in relation to any of the purposes set out in this statement; and (7) satisfying any applicable legal or regulatory requirements.

Classes of data transferees: I further agree that such personal information may be transferred for the purposes as specified above to any of the following parties (within or outside Hong Kong): any group company of Bupa, any insurance intermediary as authorised by myself, any reinsurance company, any claims investigation company, any service provider providing services to Bupa, any association or federation relating to the insurance industry or any person or organisation as required by law.

Consequences of non-provision of personal information: I understand that Bupa may be unable to process this application if I fail to provide any information requested in this application or otherwise by Bupa.

My rights in respect of my personal information: I further understand that (1) under the Personal Data (Privacy) Ordinance, I / the Member shall have the right to request access to and correction of any personal information concerning me / the Member provided to Bupa; and that all such requests can be made in writing and addressed to the Personal Data Privacy Officer of Bupa at 18/F, DCH Commercial Centre. 25 Westlands Road, Quarry Bay, Hong to ther means as Bupa may notify me from time to time; and (2) I / the Member ca

個人員1774 米 年 77 用途: 本人明白及同意保拍透過此申請、任何索償程序或其他途徑不時收集或持有之所有有關本人/會員的個人資料,可供保柏作以下用途 (1)處理此申請及提供售後服務: (2)處理任何索償分析及/或與醫療或其他保險有關的查核: (3)提供及設計保柏或其集團機構的產品及服務:(4)推廣保柏或其集團機構的產品及服務 (但不會包括其他人士或機構):(5)資料核對、統計及研究:(6)就任何本聲明中所述的用途與本人/會員聯絡:及(7)遵守法律或監管要求。 資料承讓人的類別:本人亦同意該等個人資料可因上述用途提供予以下機構(在香港境內或境外):任何保柏的集團機構、本人委任的保險中介人、再保險公司、賠償調查公司,為保柏提供服務的供應商機構,保險業協會或聯會、或 法律要求的任何人士或團體。

未能提供個人資料的後果:本人明白若本人不能提供此申請或保柏要求的其他資料,保柏不能處理此申請。

有關個人資料的權利:本人明白(1)根據個人資料(私隱)條例·本人/會員有權查閱及修正保柏所持有關於本人/會員的任何個人資料。有關要求請致函保柏個人資料私隱主任收·地址為香港**科**魚涌華蘭路25號大昌行商業中心18樓·或按保柏不時通知本人的其他途徑遞交:及(2)本人/會員如對個人資料收集聲明有任何查詢·可致電保柏的客戶服務專線2517 5333 (個人計劃會員)/ 2517 5388 (團體計劃會員)/。

Date 日期

To help us to process your claim promptly, please check that you have:

- fully completed and signed the claim form
- requested your attending doctor to answer all questions in Part II, sign and stamp the form
- attached all original payment receipts, doctors slips and hospital bills showing:
 - treatment date
- name of patient
- breakdown of charges
- attached pre-authorisation confirmation, if applicable
- attached referral letters for any specialist consultations or SRN nursing

Note: No reimbursement shall be made for claims submitted after 90 days from date of discharge.

Signature of Member 會員簽署

為了使我們能儘速處理閣下之索償申請,請您檢查是否已:

- 填妥及簽署此申請表
- 請您的主診醫生填妥第二部份,簽署及蓋章
- 附上所有醫療賬單收據及醫生收費單之正本,並列明:
 - 診治日期
- 病人姓名
- 病症
- 各收費項目
- 附上初步保障審核確認(如適用)
- 附上專科診治及私家看護之醫生轉介信

註:索償申請於出院90天後遞交,恕不獲辦理。

Please send this completed claim form with attachment(s) to :填妥之賠償申請表及附帶文件請交回:

Bupa (Asia) Limited - Claims Dept. 保柏 (亞洲) 有限公司 — 理賠部收 18/F. DCH Commercial Centre, 25 Westlands Road. Quarry Bay, Hong Kong 香港劇魚涌華蘭路 25 號大昌行商業中心 18 樓

- Customer Care helpdesk 客戶服務專線:
 Individual members 個人計劃會員 (852) 2517 5333

- Group members 團體計劃會員 (852) 2517 5388 - Bupa Gold members 保柏尊貴寶會員 (852) 2517 5383 Facsimile 傳真: (852) 2548 1848



PART II - To be Completed by Surgeon / Attending Physician 第二部份 由主診醫生填寫 Remarks: Please attach copies of histopathology, endoscopic, diagnostic / laboratory tests report, operating theatre summary 備註:請連同病理學、內規鏡、診斷性化驗/檢驗報告、手術室握要副本交回。 Name of Patient 病人姓名:. HKID Card Number 香港身份證號碼: Admission Date 入院日期: Discharge Date 出院日期: _ Clinical History 門診病歷 Date on which the patient first consulted you for the condition or related illness / injury which led to this hospitalisation / treatment / diagnostic tests? 病人首次就上述病況或有關疾病或受傷,而導致是次住院/治療/診斷性化驗之求診日期? What were the patient's chief symptom(s) / complaint(s) for this hospitalisation / treatment / diagnostic tests? 病人是次主要因何微狀或申訴入院、接受治療或診斷性化驗? How long had the patient been experiencing these symptoms before the first consultation? 在病人首次求診前,該傷病已患有多長時間? Hospitalisation History 住院病歷 Final diagnosis 病症結果: _ When was it made? 您是何時對病人作出診斷? Operation performed 手術名稱: Date of Operation 手術日期: . Surgeon / Assistant Surgeon name 外科醫生 / 助理外科醫生姓名:_ Recommended treatment, diagnostic tests and the reason for the treatment 轉介之治療,診斷性化驗名稱及原因 If you have referred other doctor to the patient during the hospitalisation, please provide the following relevant information. 於住院期間,如開下已將病人轉介往其他醫生,請提供下列有關資料。 Referral reason 轉介原因 Brief discharge summary (including onset and duration of sign and symptoms / disease, etiology, types and results of major examination, treatment, complication and follow-up plan). 出院撮要: (請列出有關疾病及病徵的病發日期、病因、檢驗性質與結果、有關治療、併發症及跟進計劃。) Has the patient taken any home leave during this hospitalisation? 於住院期間,病人有否請假外出? Please state the date, time and reason 請列明日期、時間及原因 If hospitalisation has been arranged for scans, diagnostic testing or a procedure that is normally carried out as a day case, please explain the reason. 如此次住院是因為進行診斷掃描、檢驗或一般日症手術,請説明安排病人住院之原因。 Professional Comment 專業意見 In your opinion, was the hospitalised illness a recurrent episode or a chronic disease? If so, when would be the first episode? 就閣下意見,是次病況是否為復發性病症或慢性病症?如是,何時為首次病發日期? Has the patient ever had the same or similar symptoms(s) before? 病人以前曾否患有同類病況? Yes 有 O Please state when and describe details 請説明日期及詳情 No 無 ○ Was the condition due to or associated with the following (circle the right answers) 上述情況是否因以下問題所致?(請圈出正確答案) accidental bodily injury \ the abuse of drugs or alcohol \ AIDS / HIV related illness, veneral disease or sexually transmitted disease \ pregnancy, infertility or sterilisation \ refractive error \ treatment for cosmetic purpose \ mental or nervous disorder \ congenital condition \ hereditary condition \ developmental condition \ self inflicted injury \ general check-up or vaccination \ NONE OF THE ABOVE 身體意外受傷\濫用藥物或酒精\後天免疫力缺乏症(愛滋病)/與人類免疫力缺損病毒(HIV)、性病或因性接觸感染之疾病\懷孕、不育或絕育\視力不正常\美容治療\精神或神經病\先天性症狀\遺傳性疾病\ 發育異常 \ 自我傷害 \ 一般身體檢查或防疫注射 \ 以上全部不對 Had the patient been previously treated or hospitalised for this or any other disorders? If so, please give a brief summary (including onset and duration of sign and symptoms / disease; etiology; type and results of major examination; treatment and follow-up results)病人過去曾否就此疾病或其他病症而需接受診治或入院接受治療?如是者,請說明撮要(請列出有關病況及病徵的病發及痊愈日期、病因、檢驗性質與結果、有 關治療、併發症及跟進計劃。) Disease / Disorder / Complaint 疾病 / 失調 / 申訴 Dates 日期 Details of treatment / hospitalisation 治療 / 住院的詳情 Name of doctor / hospital 西醫姓名/醫院名稱 (Please use any separate paper with the doctor's signature on it if more space is needed) 若需另頁填寫,每張紙都須有醫生的簽署作實 Others 其他 Are you the patient's usual physician? 閣下是否病人的長期醫生? 1. Yes 〇, please fill in question 2 是,請填寫問題 2 No \bigcirc , Does the patient have any other usual/family doctor(s)? if Yes, please give us the name(s) and telephone no. 不是,病人是否有其他的長期/家庭醫生?如是者,請提供姓名及電話號碼

Please fill in the date of consultation and the symptoms and complaints of the patient for each consultation 請填寫診治日期及每次診治的病徵及申訴 Consultation date 診治日期 Symptoms / Complaints 病微 / 申訴 Recommended tests / treatment 已轉介的檢查或治療

If you are referred by other doctor, please provide the doctor name, contact number and address. 如閣下乃其他醫生轉介,請提供該醫生的姓名、聯絡電話及地址。

Name of Doctor 醫生姓名: __ ______ Telephone 電話: _ ____ Email Address 電郵地址:_

Signature and Chop of Surgeon / Attending Physician

主診醫生簽署及蓋章

Authorised Signature and Chop of Hospital 醫院授權簽署及蓋章



Date: 日期