聯豐亨人壽
Luen Fung Hang Life

住院保障索償申請書
Hospitalization Benefit Claim Form

營業員姓名 Agent Name		營業員號碼 Agent Code		聯絡電話 Contact Tel. No.	

索償類別 Coverage claiming for	☐ 『身』心醫療保障計劃 SMP	☐ 住院及手術保障 HS	☐ 住院入息保障 HI	☐ 其他 Others	

附上文件 Documents attached	☐ 醫院帳單正本 Original Hospital Bills	☐ 出院報告 Discharge Summary	☐ 病假證明書 Sick Leave Certificate	☐ 其他 Others	

填表須知 Instructions	
	1. 發出此申請書並不表示本公司已接納是次索償申請。在此索償過程中，索償人無需支付任何性質之手續費予本公司之僱員或營業員。 The issue of this form is in no way an admission of liability. No fee, commission or charge of whatever nature is required to pay to the employees or agents of the company with respect to this claim. 2. 請回答申請書第一部份所有問題。申請書第二部份必須由主診醫生填寫並由索償人支付有關費用。 Please answer ALL the questions in Part I of this claim form. Part II of this claim form MUST be completed and signed by the attending physician. The completion of this part is at claimant's own expenses. 3. 請附上有關報告或文件，例如詳細列明每項費用之醫院帳單正本、醫院發出的出院報告並列明實際病因、病假紙、醫療報告等以方便審核。 Please attach other reports or relevant documents, such as original hospital bills with breakdown details, discharge summary issued by hospital containing the exact diagnosis, sick leave certificate, medical report, etc. to enable us to assess your claim. 4. 請確保索償人在此申請書的簽署必須和投保書簽署一致。 Please make sure the signature of claimant on this claim form is in consistent with that appearing on the policy application form.

第一部份 - 索償人聲明(由索償人/被保人填寫)
PART I - CLAIMANT'S STATEMENT (to be completed by Claimant/Insured)

☐ New Claim 首次索償 ☐ Further Claim 再度索償 ☐ Review/Appeal 重批/覆核

保單號碼 Policy No.		被保人姓名 Name of Insured	英文 in English		中文 in Chinese	
身份證號碼 ID Card No.		出生日期 Date of Birth	年 YY / 月 MM / 日 DD	年齡 Age		性別 Sex ☐ 男 Male ☐ 女 Female
聯絡地址 Mailing address				聯絡電話 Contact Tel. No.		

就業詳情 Employment Details

1. 僱主名稱及地址 Name and Address of employer		聯絡電話 Contact Tel. No.	
如僱主與投保時不同，請說明何時轉工 If the employer is different from the one stated in the application, please state when it was changed	年 YY / 月 MM / 日 DD		
現時職業及職務(倘有兼職請列明) Present occupation & job duties (if more than one, state all)			

如住院因意外引致，請填報第 2 項 Complete item 2 if Hospitalization was due to Accident

2. a. 意外發生日期、時間和地點 Date, Time and Place of accident	日期 Date 年 YY / 月 MM / 日 DD	時間 Time ☐ 上午 a.m. ☐ 下午 p.m.	地點 Place
b. 意外發生經過? How did the accident happen? (請附上新聞剪報，如有) (attach newspaper clippings, if any)			
c. 受傷部位? Which part(s) of body injured?			
d. 受傷程度? What is the extent of the injury?			
e. 是否有報警? Had reported to police?	☐ 是， Yes, 報案警署名稱 Police station	檔案編號(請附上副本，如有) Police reference number (submit photocopy if any)	☐ 否 No

如住院因疾病引致，請填報第 3 項 Complete item 3 if Hospitalization was due to Illness

3. a. 請敘述住院前所患疾病及其病徵 Describe the nature of illness and the symptoms before hospitalization	
b. 何時首次因相關疾病向醫生求診? When did you first consult doctor for the related illness?	年 YY / 月 MM / 日 DD
c. 在首次求診前，病徵何時開始出現? Since when did you have these symptoms before the first consultation?	年 YY / 月 MM / 日 DD

診治詳情 Consultation Details

4. 就此傷病求診之醫生資料 Details of consultation for the illness or injury	求診日期(年/月/日) Consultation Date (YY/MM/DD)	原因/病因 Reason/Diagnosis	醫生姓名及地址(請附上病歷咭，如有) Name and Address of doctor (please attach patient card copy if available)
a. 首次求診的醫生 Doctor first consulted			
b. 建議入院的醫生 Doctor referred to hospital			
c. 過往就同類或有關類似病症曾求診的醫生 Doctors consulted in the past for same or similar or related condition			

住院詳情　Hospitalization Details

5. 就此傷病入住的醫院資料 Details of hospital confinement for the illness or injury	入院日期(年/月/日) Date of Admission (YY/MM/DD)	出院日期(年/月/日) Date of Discharge (YY/MM/DD)	原因/病因 Reason/Diagnosis	醫院名稱及地址(請附上病歷咭，如有) Name and Address of hospital (please attach patient card copy if available)

6. 有否於住院期間離院? Have you taken any home leave during confinement?	☐ 是， Yes, 時間及原因 Duration & Reason		☐ 否 No

其他資料　Other Information

7. 閣下曾否因同一事故申索/接受其他機構包括保險公司、政府及僱主之傷殘保障賠償?(如是者，請提供以下資料)
Are you claiming/receiving similar benefit for the same event with any other organizations including insurance company, the government, and employer compensation? ☐ 是 Yes ☐ 否 No
(If yes, please provide the following information)

保險公司/機構 Insurance Company/Organization	保障類別/保單號碼/團體保險編號 Benefit Type / Policy No. / Group Member No.	申索/接受之傷殘保障賠償 Benefits Amount Claimed/Received	結果/狀況 Result/Status

聲明及授權

本人謹此明白及同意：
(1) 所有在本申請書的一切陳述及答案，不論是否本人親手所寫，就本人所知所信，均為事實無訛；
(2) 本人/我們明白本人/我們提供的資料為聯豐亨人壽保險股份有限公司(以下簡稱「貴公司」)提供保險業務所需，並可能使用於下列目的：
- 任何與保險或財務有關的產品或服務，包括但不限於保險、理財、退休金或退休金計劃，或該等產品或服務的申請及任何更改、變更、取消、續期及/或復效的申請；
- 不時向本人/我們推薦及提供產品及/或服務，及執行、維持、管理及營運該等產品及/或服務；
- 任何索償，或該等索償的調查、分析、處理、評估、釐定或回應該等索償；
- 行使任何代位權；
- 防止及/或偵查罪行、欺詐及其他不誠實的行為；及

可能移轉予下述各方（無論在澳門特別行政區境內或境外）作為上述列出目的之用：
- 任何再保險及索償調查公司、有關的保險行業協會及聯會和該等協會及聯會的會員；
- 任何向貴公司及/或其相關聯公司提供業務運作有關的行政、電訊、電腦、市場推廣及/或其他服務的代理人、承包人、商業夥伴及第三方服務供應者；
- 根據對貴公司具法律約束力的規定，或因監管或其他管理機構所要求貴公司遵守的指引，履行對任何人士的披露責任；
- 任何對貴公司有保密責任的人。

(3) 本人/我們明白本人/我們有權查閱及要求更正由貴公司持有有關本人/我們及/或受保人的個人資料；及/或要求不將該等個人資料用於直接促銷的用途。如有需要，本人/我們可向貴公司提出，地址：澳門新口岸宋玉生廣場 398 號中航大廈四樓。

本人/我們明白及授權，且不得撤回：
(1) 本人/我們授權貴公司可向有關的保險行業協會及聯會和該等協會及聯會的會員從保險業內收集的資料中查閱及/或核對本人/我們及/或受保人任何資料。
(2) 任何知悉或擁有本人/我們/被保人之工作、病假記錄、意外或損失(任何類別)之詳情、健康狀況、病歷或任何治療或諮詢記錄及曾為或將為本人/我們/被保人診治之機構、組織或人士，向貴公司透露有關資料。即使本人/我們/被保人死亡或喪失能力，此授權書仍然存有法律效力，而本人/我們/被保人之繼承人及轉讓人亦會受此授權書約束。此授權書之正本與副本同屬有效。
(3) 貴公司或任何其認可之驗身醫生或化驗所，替本人/我們/被保人進行所需之醫療評估及測試，並對本人/我們/被保人之健康狀況進行審核及評估，作為處理本申請及其後與之有關的賠償事宜。此等化驗包括，但並不限於，膽固醇及有關之血脂肪、糖尿病、腎或肝功能失常、愛滋病或感染人體免疫力缺乏症病毒、免疫系統失常或體內藥物、毒品、尼古丁及其他代謝產物之含量等化驗。

Declaration & Authorization

IT IS UNDERSTOOD AND AGREED:
(1) All statements and answers in this application whether or not written by my own hand are complete and true to the best of my knowledge and belief;
(2) The information provided by me/us to Luen Fung Hang Life Limited (hereinafter called "the Company") is collected to enable the Company to carry on insurance business and may be used for the purpose of：
- processing and/or approving applications for products and/or services and additions, alterations, variations, cancellations, renewals, and reinstatements of such products and/or services which may include, without limitation, insurance, provident fund or scheme, or other financial products or services;
- offering and providing products and/or services to me/us from time to time, and administering, maintaining, managing and operating such products and/or services;
- any claim or investigation, analyzing, processing, assessing, determining or responding of such claims;
- exercising any right of subrogation;
- preventing and/or detecting crimes, fraud and other dishonest behavior; and

may be transferred to the following parties (whether within or outside the Macau Special Administrative Region) for the purposes set out as above：
- reinsurance and claims investigation companies, relevant insurance industry associations and federations, and members of such industry associations and federations;
- agents, contractors, business partners, and third party service providers who provide administration, telecommunications, computer, marketing, and/or other services to the Company and/or any of its affiliated companies in connection with the operation of business;
- any person to whom the Company is under an obligation to make disclosure under the requirements of any law binding on the Company or under and for the purposes of any guidelines issued by regulatory or other authorities with which the Company are expected to comply;
- any other person under a duty of confidentiality to the Company which has undertaken to keep such information confidential.

(3) I/We understand that I/We have the right to obtain access to and to request correction of any personal information concerning myself/ourselves and/or the Insured Person(s) held by the Company and/or not to use data for direct marketing purpose. Requests for such access can be made to the Company, address: No. 398 Alameda Dr. Carlos D'Assumpcao, Edificio CNAC, 4 Andar, Macau.

IT IS UNDERSTOOD AND IRREVOCABY AUTHORIZED:
(1) The Company is hereby authorized to obtain access to and/or to verify any data provided by me/us and/or the Insured Person(s) with the information collected by the relevant insurance industry associations and federations, and members of such industry associations and federations from the insurance industry.
(2) any organization, institution, or individual that has any record or knowledge of my/our/the Insured's employment, sick leave records, accident or loss details (of any sorts), health, medical history or any treatment or advice, that when requested by an authorized representative of the Company may disclose any such information. This authorization shall bind my/our/the Insured's successors and assigns and remain valid notwithstanding my/our/the Insured's death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.
(3) The Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate my/our/the Insured's health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications drugs, nicotine or their metabolites.

/ /			
日期 (年/月/日) Date (YY/MM/DD)	索償人/被保人身份證號碼 ID Card No. of Insured Claimant	索償人/被保人姓名 Name of Insured/Claimant	索償人/被保人簽署 Signature of Claimant/Insured
/ /			
日期 (年/月/日) Date (YY/MM/DD)	代理人/見證人身份證號碼 ID Card No. of Agent/Witness	代理人/見證人姓名 Name of Agent/Witness	代理人/見證人簽署 Signature of Agent/Witness

公司專用 FOR OFFICE USE ONLY	Claim No.	Date Received	Captured By	Signature Verified by	Checked By	Approved By	Remarks

第二部份 - 醫生診斷報告(索償人自費由主診醫生/手術醫生填寫)

PART II - ATTENDING PHYSICIAN'S STATEMENT (to be completed by attending physician/surgeon at claimant's expense)

1. 病人姓名 Name of Patient		年齡/性別 Age / Sex		身分證號碼 ID Card No.	

2. 醫院名稱 Name of Hospital					
入院日期 Date of Admission	/ / 年 YYYY 月 MM 日 DD		出院日期 Date of Discharge	/ / 年 YYYY 月 MM 日 DD	

3. a. 病人首次求診日期 Date of first consultation for the patient's illness or injury	/ / 年 YYYY 月 MM 日 DD	首次出現病徵日期或意外發生日期 Date when symptoms first appeared or accident happened	/ / 年 YYYY 月 MM 日 DD

b. 病人就此次住院/手術所出現的相關症狀及主訴
Chief complaints and symptoms of the patient relating to this hospitalization/surgery

c. 如因意外住院，於首次診治時有否外部及表面之受傷痕跡?
If the hospitalization was due to accident, was there evidence of an external and visible bruise or wound at first visit? ☐ 是 Yes ☐ 否 No
請詳述受傷類別、部位、程度及原因
Please describe which part of the body injured and the cause, character and extent of the injury.

d. 據病人所述，過往曾否有同類或類似病症? 如有，請提供詳情。
According to the patient, has he/she been having same or similar conditions or symptoms before? If yes, please give details. ☐ 是 Yes ☐ 否 No

診治日期(年/月/日) Date of occurrence (YY/MM/DD)	性質/原因 Exact Nature/Cause of Attack	接受檢查/治療 Test/Treatment received	殘障持續時間 Duration of Disability	主診醫生 Physician Attended

e. 據閣下所知，病人過往曾否有同類或類似病症? 如有，請提供詳情。
In your opinion, has the patient ever had same or similar conditions or symptoms before? If yes, please give details. ☐ 是 Yes ☐ 否 No

f.

診斷 Diagnosis	病因 Underlying cause of diagnosis	確診日期 Date of diagnosis
		/ / 年 YYYY 月 MM 日 DD

g.

手術詳情 Surgical procedure performed	手術性質 Nature of surgical procedure	手術日期 Date of surgical procedure
		/ / 年 YYYY 月 MM 日 DD

h. 請提供治療詳情及檢查種類
What kind of medical treatment was given and laboratory tests performed?

進行日期(年/月/日) Date Performed (YY/MM/DD)	步驟/治療/檢查詳情(類別，次數，結果/讀數) Details of Procedure/Treatment/Test (type, frequency, result/readings)	主診醫生/醫院 Physician Attended / Hospital Confined

i. 閣下是否該病人的慣常醫生?
Are you the patient's usual physician? ☐ 是 Yes ☐ 否 No
請提供病人的求診詳情.
Please list down the date and details of each visit of the patient to your clinic/ hospital in the order of dates.

求診日期(年/月/日) Consultation Date (YY/MM/DD)	主訴 Complaints	診斷 Diagnosis	治療/物理治療(療程) Treatment/Physiotherapy (Length of Course)

3. j. 病人是否經由其他醫生轉介? 如是，請提供詳情。
Was the patient referred to you by other physician? If yes, please give details. ☐ 是 Yes ☐ 否 No

該病人曾否因同類或有關類似病症或其他嚴重疾病向其他醫生求診或住院?
Did the patient consult any other physicians or admit in hospital for same or similar conditions or for any serious disorders? ☐ 是 Yes ☐ 否 No

如是，請提供詳情。
If yes, please give details.

求診日期/住院日期(年/月/日) Consultation Date/Period of Confinement (YY/MM/DD)	診斷/治療 Diagnosis/Treatment	其他醫生/醫院姓名及地址 Name and Address of other physicians/hospitals

4. a. 此疾病是否為再次復發或是慢性疾病?如是，請提供首次患病之日期及詳情
Was the illness a recurrent episode or a chronic disease? If yes, please give details and the date of first episode below. ☐ 是 Yes ☐ 否 No

b. 是次病徵是否由其他疾病引起? 如是，請提供詳情。
Were the symptoms a secondary condition to other illness? If yes, please give details below. ☐ 是 Yes ☐ 否 No

c. 此病可有復發機會? 如是，請提供詳情。
Any possibility of having a relapse? If yes, please give details below. ☐ 是 Yes ☐ 否 No

d. 該疾病是否可改以門診方式治理？如是，請提供住院原因。
Is it possible to provide this treatment on an outpatient basis? If yes, please give reason of performing on an inpatient basis below. ☐ 是 Yes ☐ 否 No

e. 是次入院是否醫療所需?
Is the hospitalization/treatment medically necessary? ☐ 是 Yes ☐ 否 No

一般而言，同類病況之平均住院日數?
In general, what is the usual duration of hospitalization for this illness?

f. 病人現時之病況及病情進展?
What is the current condition and prognosis of the patient?

g. 出院撮要(包括治療，診查、結果、併發症及跟進計劃)
Brief discharge summary (including treatment, investigation procedures, results, and/or any complications and follow-up plans)

5. 上述的傷病是否由於下列病症所引致? 請選擇並提供有關資料.
Was the illness or injury caused by or in any way associated with any of the following? Please tick where appropriate and give details.

- ☐ 故有病史 Past injury or illness
- ☐ 已存在之身體或精神缺陷 Pre-existing physical or mental defects
- ☐ 自致之傷害或自殺 Suicide or self-inflicted injury
- ☐ 藥物或酒精 Alcohol or drugs
- ☐ 吸入毒藥，瓦斯或濃煙 Poison, gas or fumes taken
- ☐ HIV/愛滋病有關之疾病,性病或由性接觸而傳染的疾病 HIV/AIDS related illness, venereal disease or sexually transmitted disease
- ☐ 不育或絕育 Infertility or sterilization
- ☐ 美容或整容手術 Cosmetic surgery or plastic surgery
- ☐ 精神病治療 Psychiatric treatment
- ☐ 精神病 Mental or nervous disorder
- ☐ 先天異常 Congenital deformities or anomalies
- ☐ 分娩，懷孕，流產，人工流產或產前護理 Childbirth, pregnancy, miscarriage, abortion or prenatal care
- ☐ 其他 Others

詳情 Details:

6. 任何與此索償有關之進一步資訊
Any further information you consider relevant to this claim

本人謹此聲明曾為病人就上述疾病或受傷作出檢查及治療，而據本人所知所信，以上填報各項答案均屬正確。
I hereby certify that I have personally examined and treated the patient for the above illness or injury and that the information as stated above is true and complete to the best of my knowledge and belief.

主診醫生的姓名及資歷
Name & Qualification of Attending Physician

主診醫生簽名及蓋章
Signature and Chop of Attending Physician

日期(年/月/日) DateYY/MM/DD

地址 Address

電話 Telephone No.