Sun Life Financial 永明金融

Hospitalization Benefit Claim Form
住院保障賠償申請表

CONSULTANT'S DETAILS 顧問資料

Name 姓名 ______	Code 編號 ______	District/Branch 區域/分行 ______	Contact Phone No 聯絡電話 ______

PART I 第一部份

To be completed by the Insured/Claimant and must be returned to the Company within 90 days from the date of discharge.
由受保人/申請人填寫並需於出院後九十天內交回公司。

☐ Please tick if Certified True Copy of original document is to be returned after claim decision is made.
請註明-須於理賠審結後退回正本文件的核正副本。

Policy No. 保單號碼	Name of Insured 受保人姓名	Age/Sex 年齡 / 性別	I.D. Number 身份證號碼
Claimed Benefit(s): 索償保障類別 : ☐ H&S 住院及手術費用保障 ☐ HI 住院入息保障 ☐ Others, please specify 其他，請註明		Case Type: 賠償個案類別 : ☐ New Claim 首次索償 ☐ Further Claim 再次索償	

APPLICABLE TO HOSPITALIZATION DUE TO ACCIDENT 因傷入院適用

1. When and where did the accident occur?
意外日期、時間及地點?
Date 日期 ______ Time 時間 ______ am / pm 上午 / 下午
Place 地點

2. How did it occur? Please describe it in detail.
意外發生的原因及經過之詳情。

3. Did the Insured/claimant report to the Police? If yes, please advise the name and address of the police station and their reference number or attach a copy of the police report.
受保人/申請人曾否就此事報警? 如有， 請列明警署名稱、 地址、報案號碼或提供一份警察報告。

4. (a) Which part of the body was injured?
受傷的身體部位?

(b) Type of Injury?
傷勢類別?

APPLICABLE TO HOSPITALIZATION DUE TO ILLNESS 因病入院適用

5. Please describe the signs & symptoms.
請描述病徵及病狀。

6. Duration of these symptoms prior to the first consultation.
上述病狀於首次就診前之時間。

7. Details of consultations:
就診詳情:

	Date 日期	Full Name and Address of Doctor/Hospital 醫生/醫院之全名及地址
(a) The doctor who was first consulted for these symptoms 首次就上述病徵、病狀就診的醫生	(a)	
(b) The doctor who referred the Insured to hospital 轉介受保人入院的醫生	(b)	
(c) All other doctors who were consulted for the illness 就診此病的其他醫生	(c)	
(d) The doctor that the Insured would normally consult for general illnesses 慣常爲受保人治療一般疾病的醫生。	(d)	

HOSPITALIZATION PERIOD 住院時期

8. Please state the time & date of the admission & discharge of the hospitalization.
請列明入、出院之時間及日期。

Date / Fro 日期 / 由 ______ Date / To 日期/ 至 ______
Time / From 時間 / 由 ______ AM / PM 上午 / 下午 Time / To 時間 / 至 ______ AM / PM 上午 / 下午

CLAIMS PAYMENT INSTRUCTION (Please put a " ✔ " in one of the options to settle claim payment)
賠償支付方式指示 (請在下面的其中一個方格內加上" ✔ " 號選擇支付賠償金額方式)

☐ 1. Cheque to Client via Consultant
支票經由顧問轉交給客人

☐ 2. Cheque Mail to Client's correspondence address
支票直接郵寄至客户通訊地址

☐ 3. Auto-credit (Allow for payment amount below HK$30,000 only. Please instruct with account information in 3a or 3b below)
自動轉賬 (只限港幣 30,000 以下的賠償，需於下面選擇 3a 或 3b 指示賬戶資料)

NOTE 備註 :
If no option or more than one option is selected, or auto-credit selected without providing account information below, the claim payment will be settled by cheque and sent via consultant.
如沒有選擇或選擇多過一個支付方式，或選擇自動轉賬但未有指示賬戶資料，賠償金額將會以支票發出，並由顧問轉交給客人。

Auto-credit Account Information 自動轉賬賬戶資料

☐ 3a. Auto-credit to current account number which is being used for premium payment (The account holder must be the policyowner)
轉賬至現時用於繳交保費之賬戶(戶口持有人必須爲保單主權人)

☐ 3b. Auto-credit to owner's OTHER account number (Must attach copy of Bank Book with Account Holder Name and Account No., endorsed as a certified true copy by the policyowner with original signature)
轉賬至新提供的保單主權人的賬戶 (必需附上顯示銀行賬戶姓名和號碼的存摺副本，保單主權人須在副本上加簽以確認爲核定副本。)

NOTE 備註 :
If the account holder is not the policyowner or the required documents are not submitted, the claim payment will be settled by cheque and sent via consultant.
如戶口持有人不是保單主權人或未有附上所需文件，賠償金額將會以支票發出，並由顧問轉交給客人。

DECLARATION AND AUTHORIZATION 聲明及授權

I/WE HEREBY DECLARE AND AGREE that: (a) 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 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. (b) **Sun Life Hong Kong Limited** (the "Company") may be unable to process this claim if I/we fail to provide any information related to this application. (c) the Company is not bound by any statement which I/we may have made to any person if not written or stated here. (d) all the information we provide for this claim and all other relevant forms or documents is provided to enable the Company to carry on insurance business and may be used for the purpose of any insurance product or any additions, alterations, variations, cancellation, renewal or reinstatement of them; any scope of insurance coverage, claim processing and analysis of it AND may be transferred to any related company or any other company carrying on insurance or reinsurance related business or claims investigator or other service provider providing services relevant to insurance business or any selected party as the Company may consider necessary.

I/WE HEREBY FURTHER DECLARE AND AGREE that I am/We are the account holder(s) of the account number provided and I/ We understand that **Sun Life Hong Kong Limited** has no liability for any loss resulting from a wrong account number provided.

I/WE FURTHER AUTHORIZE that: (a) any licensed physician, medical practitioner, hospital, clinic or medically related facility, institution, insurance company, government, private office or person that has any record or knowledge or information of me or my health to disclose, release or transfer to **Sun Life Hong Kong Limited** any such record, knowledge or information relating to this claim. (b) the Company or any of its appointed medical/paramedical examiner or laboratory to perform necessary medical assessment and tests to evaluate the health status of me/the Insured in relation to this application. (c) I specifically authorize the disclosure of all information about communicable diseases and infections, including but not limited to any sexually transmitted disease, HIV infection, Acquired Immune Deficiency Syndrome (A.I.D.S.) and A.I.D.S. related complex (A.R.C.). This authorization shall irrevocably bind the successors and assignees of me/the Insured and remains valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original.

本人/吾等聲明及同意下列各點：（甲）本賠償申請表上所載的聲明及答案，以及經本人/吾等簽署之所需的體檢、問卷、修改或其他文件，均屬真確無訛，詳細完整。 本人/吾等明白倘有任何未知是否於重要事項的資料均須透露。 (乙) 倘本人/吾等未能提供此申請所需資料，可導致**香港永明金融有限公司** (以下稱爲「公司」)未能處理此賠償申請。(丙) 本人/吾等對任何人所作出之任何聲明，如沒有在此申請書上填寫或印出，貴公司不須受其約束。(丁) 所有本人/吾等於此申請表及其他有關表格或文件上提供予公司的資料，爲公司經營保險業務所需，並可能使用於任何與保險產品的任何增訂、更改、變更、取消、續期或復效；任何承保事項、索償或索償分析。及可能轉移予：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、或索償調查或其他服務提供者、又或公司認爲必須知情的人士或組織。

本人/吾等同時聲明及同意本人/吾等爲上述賬戶編號之戶口持有人，並同意如提供之賬戶編號並非爲本人 / 吾等爲戶口持有人, **香港永明金融有限公司**將不會對本人/吾等索償損失負責。

本人/吾等同時授權以下各點：（甲）任何註冊醫生，醫院，診所，保險公司，政府部門或任何其他持有有關本人/受保人之個人資料(不論是否醫學資料)之人士或機構, 向**香港永明金融有限公司**或其代表透露, 發放或轉交任何與此申請之有關資料。(乙)公司或公司指定之醫護人員或化驗所，可就此申請，對本人/受保人進行所需之醫療評估及測試以審核本人/受保人之健康狀況。(丙) 本人/吾等特此授權上述人士或機構透露任何關於傳染性疾病及感染的所有資料，包括但不限於任何經接觸傳染之疾病、人類免疫力缺乏病毒(HIV) 感染、後天免疫力缺乏病 (愛滋病)及愛滋病有關發症。此授權對本人/受保人之繼承人或受讓人具有約束力。即使本人/受保人死亡或無行爲能力，此授權書仍有效力。此授權書的影印本與正本具同等效力。

Signature, Name and ID No. of Owner/Claimant (if other than Insured) 保單主權人/申請人之簽署、姓名及身份證號碼 (如非受保人)	Signature of Insured 受保人簽署	Witness 見證人	Date (dd/mm/yyyy) 日期

In the event that the Insured is physically incapacitated and prevented from signing, PART I may be signed by a close relative or other representative authorized by the Insured.
如受保人因傷殘不能書寫， 其家屬或其代表可代爲填寫此申請書及簽字。

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. You have the right to obtain access to and to request correction of any personal information concerning yourself held by the Company. Request for such access can be made in writing and addressed to the Company's Customer Service Centre.
根據「個人資料(私隱)條例」的規定，公司有權就處理任何查詢資料的要求收取合理費用。閣下有權查閱及要求更正由公司持有有關閣下的個人資料。如有此項要求，可書面提交公司之客戶服務中心。

1-04-4011/06-2010

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Customer Service Centre
8/F, Sun Life Tower, The Gateway, 15 Canton Road, Kowloon, Hong Kong
Tel (852) 2103 8928 Fax (852) 2103 8938

客戶服務中心
香港九龍廣東道15號港威大廈永明金融大樓8樓
電話 (852) 2103 8928 傳真 (852) 2103 8938

Sun Life Hong Kong Limited 香港永明金融有限公司
(Incorporated in Bermuda 於百慕達註冊成立)
A member of the Sun Life Financial group of companies 永明金融集團成員之一

第二部份 － 醫事報告〔由主診醫生填寫，所須費用由索償人承擔〕

一. 病人姓名	二. 性別 / 年齡	三. 身份証號碼

四. 入院日期 (日日/月月/年年)　　出院日期 (日日/月月/年年)

五. 病人的臨床病歷

(甲) 病人何時首次向你會診病症/傷勢？

(乙) 此次入院/治療之病徵及病狀？

(丙) 此次住院之潛在原因？

(丁) 根據病人提供之臨床病歷，病人經歷此病徵 / 病狀多久才作出首次求診及首次求診日期？

(戊) 根據閣下意見，病人已經歷此病徵 / 病狀多久？

六. 病人之住院歷史

(甲) 最終診斷結果 ________________________ 手術日期: ________________________

(乙) 完成之手術名稱 ____

(丙) 如閣下於病人在此住院期間求診其他醫生，請提供以下資料:

醫生姓名 ________________________ 原因 ________________________

此醫生爲病人所提供之治療 ____

(丁) 請提供簡短出院紀錄〔包括有關此病徵 / 病狀之開始發出日期及時間，此病之成因，主要檢查、治療之種類及結果、任何併發症及跟進計劃。)

(戊) 此病人住院期間，曾否歸家渡宿？如「有」，請列明日期、時間及原因。

(己) 若此住院治療可在日間診所處理之個案，請提供此次住院原因。

七. 專業意見

(甲) 根據閣下意見，此次住院之疾病是否復發事件、長期疾病或與過往身體不適/已診斷之疾病？如「是」，請提供首次事件之時間及細節。

(乙) 病人以前有否患有同類或類似病況、病人以前曾否因同類或類似病況接受治療或住院？

如「有」，請根據閣下所知列明，如有需要，請用另外一張紙列明何時及詳述細節 (包括撮要形容此病徵 / 病狀之開始發出日期及時間，此病之成因，主要檢查、治療之種類及結果、任何併發症及跟進計劃)。

(丙) 此病症是否因或與以下有關 (請圈出合適答案)：

意外身體損傷 / 濫用藥物或酒精 / 後天免疫力缺乏症(AIDS)或任何人體免疫力缺乏病毒(HIV)有關的疾病、性病或性接觸傳染病 / 懷孕、不育或絕育 / 視線折射誤差 / 整容或整形外科 / 精神或神經錯亂 / 先天性疾病 / 遺傳性疾病 / 發育性疾病 / 自招損傷 / 例行身體檢驗或注射 / 以上所列均不符合

(丁) 如此病症與懷孕有關疾病，請提供上一次經期日期：

八. 閣下是否經其他醫生轉介，請提供轉介醫生之姓名及地址。

本人在此聲明， 本人檢查及治療此病人之傷病，以上之所陳述乃本人對病人健康狀況之意見。

簽名: ________________________ 主診醫生的姓名(蓋印): ________________________

資歷: ________________________ 地址: ________________________

日期: ________________________ 電話號碼: ________________________