醫療保險 - 牙科賠償申請表
Medical Insurance - Dental Claim Form

甲部 - 須由就診者填寫
Part I - To be completed by the Patient

醫生發出之正本收據數量（　　）張。No. of original receipt(s) attached (　　).

僱主 / 保單持有人 Employer / Policyholder:	保單號碼 Policy No.:
僱員 / 成員姓名 Name of Employee / Member :	僱員編號 Employee Code : (如適用 if applicable)
就診者姓名 Name of Patient :	就診者身份證 / 護照號碼 ID Card / Passport No. of Patient :

若診治因意外引起，請提供 If the consultation/treatment was due to accident, please provide :

意外發生日期 Date of Accident : _____

時間 Time : _____

地點 Place : _____

經過 Brief Description : _____

賠償類別 Claim Type :

☐ (1) 例行口腔檢查 Routine Oral Examination (包括洗牙及預防治療 including Scale & Prophylaxis)

☐ (2) 其他牙科治療 Other Dental Treatment

賠償類別 (1)，只須填寫甲部。 如屬於賠償類別 (2)，必須填寫甲部及乙部。
Please complete part I only for claim type (1) and both Part I & II for claim type (2).

有關此次索償，閣下有否申請其他保險索償？Are you making any other insurance claim for this claim?

☐ 沒有 No　在任何情況下不設退回正本收據，如需副本作其他用途，請於遞交前自行影印收據。 Original receipt will not be returned in any circumstances. If copy of receipt for other purpose is needed, please make a copy before submission.

☐ 有 Yes　(必需填寫 Required information)

保險公司名稱 Name of the Insurance Company : _____

保單號碼 Policy No.: _____ 保單類別 Type of Policy : _____

請注意只退回附有索償餘額之正本收據以申請其他索償， 如需副本作其他用途，請於遞交前自行影印收據。

Please note that only the original receipt with unpaid claim balance will be returned for applying other claims. If copy of receipt for other purpose is needed, please make a copy before submission.

聲明及授權 DECLARATION & AUTHORISATION :

本人現聲明上述所填報的資料正確無訛。本人授權任何醫生、醫院、保險公司或機構，可以將部分或全部有關本人傷患之病歷（包括但不限於診症、診斷性檢驗結果、藥方或治療資料）給予富衛保險有限公司 / 富衛人壽保險（百慕達）有限公司（於百慕達註冊成立之有限公司）富衛（「富衛」）或其已獲授權之代理人。此授權書之副本與正本具同等效力。

本人現確認本人已閱讀、明白及同意富衛的收集個人資料聲明。本人同意富衛不時以任何方式收集、製作、匯編或保留任何關於本人的個人資料或保單的其他資料，可根據收集個人資料聲明使用。本人同意富衛可能將本人個人資料轉移，披露予收集個人資料聲明所載的資料承讓人（不論在香港境內或境外者），或讓其查閱或與其共同使用。本人知悉收集個人資料聲明的最新版本可於 https://www.fwd.com.hk 下載及可向富衛索取。

I hereby declare that the above information given is true and correct. I further authorise any physician, hospital, insurance company or organisation to furnish part of or all medical history (including but not limited to information in respect of consultations, diagnostic test results, prescriptions or treatment) with respect to any illness or injury of me to FWD General Insurance Company Limited / FWD Life Insurance Company (Bermuda) Limited (Incorporated in Bermuda with limited liability) ("FWD") or its authorised representative. A photocopy of this authorisation shall be considered as effective and valid as the original.

I confirm that I have read, understood and agreed to the Personal Information Collection Statement ("PICS") of FWD. I agree that any personal data and other information relating to me or my policy(ies) collected, generated, compiled, or held by FWD by any means from time to time may be utilized in accordance with the PICS. I agree that FWD may transfer, disclose, grant access to or share my personal data within or outside Hong Kong to the types of transferees set out in the PICS. I understand that the updated version of the PICS is available for download https://www.fwd.com.hk and is made available upon request.

就診者簽署 Signature of Patient : _____ 日期 Date : _____

若就診者為小童，則可由家長 / 合法監護人簽署 If the patient is a minor, the patient's parent / legal guardian can sign on his/her behalf

家長 / 合法監護人簽署
Signature of Parent / Legal Guardian : _____

與就診者關係
Relationship : _____

注意 NOTES :

(1) 請填妥賠償申請表，連同正本收據寄回本公司。
Please return the completed claim form together with the original receipt to the Company.

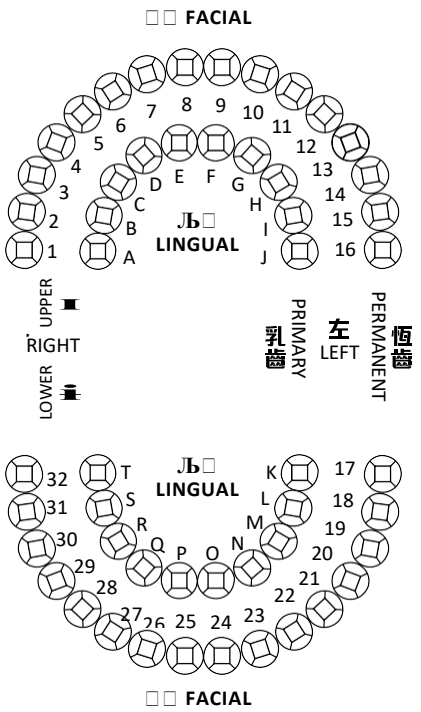
(2) 所有收據正本須蓋有診所印章及由牙醫簽署。
All original receipts must bear the clinic's chop and Dentist's signature.

乙部 - 須由負責治療之牙科醫生填寫
Part II - To be completed by the Dentist

就診者姓名
Name of Patient :_____

保單號碼
Policy No.: _____

請在下圖顯示接受治療之牙齒。
Please mark teeth treated on the following chart.



日期 Date of Service (日 / 月 / 年) (dd/mm/yy)	牙齒號碼 Tooth No.	部 位 No. of Surface / Root	治療詳情 Particulars (cause & description of services)	收費 Charges

以上情況是否屬先天性症狀？
Is the above condition arising from congenital condition?

☐ 是 Yes ☐ 否 No

如 " 不是 ", 請簡述致病原因。
If No, please state the cause of the above condition.

_____

牙科醫生姓名
Dentist's Name :_____

牙科醫生簽署及蓋印
Signature of Dentist and Chop_____

日期
Date _____