醫療保險 - 住院及手術索償表
Medical Insurance - Hospitalisation & Surgical Claim Form

甲部 - 須由病人填寫 Part I - To be completed by the Patient

保單持有人名稱 Name of Policyholder : ____________________ 保單號碼 Policy No.: ____________

僱員 / 成員姓名 Name of Employee / Member : ____________________ 僱員編號 (如適用) Employee No.(if any) : ____________

病人姓名 Name of Patient : ____________________

身份證 / 護照號碼 ID Card / Passport No.: ____________ 出生日期 Date of Birth : ____________ 性別 Sex : ☐男 M ☐女 F

職業 / 職位 Occupation / Position : ____________ 電話號碼 Contact No.: ____________

若因疾病而住院 **If hospitalisation was due to illness**

1. 請列出有關是次住院的病徵 Please give a brief description of symptoms which led to the hospitalization
2. 在有關疾病首次求診前，該病徵已出現多長時間？How long have these symptoms existed prior to the first consultation ?
3. 首次求診日期 Date of first consultation (日 DD / 月 MM / 年 YYYY) : ____________
4. 首次求診之醫生姓名及地址 Name and address of physician with first consultation :
5. 閣下曾否因同一有關之病症而向其他醫生求診？Have you had any prior consultation / treatment for similar or related illness by other physician ?

   ☐沒有 No ☐有 Yes 診治日期 Consultation / Treatment Date : ____________

   醫生姓名及地址 Name and address of physician : ____________
6. 病人慣常就醫之醫生姓名及地址 Patient's usual attending physician's name and address :
7. 於住院期間，有否請假外出？Have you taken any home leave during this hospitalisation ? ☐沒有 No ☐有 Yes

   請列明日期 Please state the date(s) : ____________

若因意外而住院 If hospitalisation was due to accident

意外發生日期 Date of Accident : ____________ 時間 Time : ____________ 地點 Place : ____________

經過 Brief Description : ____________

有關此次住院 / 手術，閣下有否申請其他保險索償？Are you making any other insurance claim as a result of this hospitalisation / surgery?

☐ 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」）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.

日期 Date : ____________ 病人簽署 Signature of Patient : ____________

若病人為小童，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 : ____________ 與病人關係 Relationship : ____________

請填妥索償表，連同正本收據及有關之醫療報告副本寄回富衛。

Please return the completed claim form together with the original receipt and relevant medical report copy to FWD.

乙部 - 由主診醫生填寫，所需費用由索償人自行承擔
PART II - To Be Completed by Attending Physician / Surgeon at the Claimant's Own Expenses

病人姓名(全名) Patient Name (in full): ____________________

入院日期 Date of Admission (日 DD / 月 MM / 年 YY) ____________________ 出院日期 Date of Discharge (日 DD /月 MM /年 YY) ____________________

醫院名稱 Name of Hospital : ____________________

病房級別 Level of Hospital Ward : ☐私家房 Private ☐ 半私家房 Semi-private ☐ 大房 Ward ☐ 門診小手術 Clinical Surgery

1. 求診記錄 **Clinical History :**

a) 病人就此疾病 / 受傷後，首次向閣下求診的日期 Date on which the patient first consulted you related to this illness / injury (日 DD / 月 MM / 年 YY) ____________________

b) 病人就此次住院 / 治療 / 檢驗所出現的相關症狀及主訴 Symptom(s) / complaint(s) of the patient relating to this hospitalisation / treatment / investigation

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c) 病人在首次求診前已患有此症狀多久？How long had the patient been experiencing these symptoms before the first consultation ? ____________________

2. 住院詳情 **Hospitalisation Details :**

a) 最後的診斷 Final Diagnosis ____________________ 手術日期 Date of Operation (日 DD / 月 MM / 年 YY) ____________________

b) 手術的名稱 Operation Procedure(s) Performed ____________________

c) 如病人於住院期間曾向其他醫生求診，請提供以下資料 If the patient has consulted other physician during this hospitalisation, please provide the following :

醫生姓名 Name of Physician Consulted ____________________ 原因 Reason ____________________

治療詳情 What treatment had the physician performed ____________________

d) 請提供出院撮要 (包括開始時及持續出現的徵兆 / 症狀、病因、主要檢查的種類及結果、治療、併發症及覆診詳情)。
Please give a brief discharge summary (including onset and duration of signs and symptoms / disease, etiology, types and results of major examinations, treatments, complications and follow up plan)

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e) 若此次病症能在日間護理 / 診所內進行治療，請提供住院原因。
Please provide reason(s) for hospitalisation if this type of cases can be managed on day care / out-patient basis.

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3. 專業意見 **Professional Comment :**

a) 就閣下意見，病人是次住院治療是否因繼發性或慢性疾病所引致或與以往的主訴 / 診斷有關？若答案為 " 是 "，請提供首次發病日期及詳情。
In your opinion, was the patient hospitalised as a result of recurrent episode or a chronic illness or related to a previous complaint / diagnosis. If "yes", please provide date of the first episode and details.

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b) 上述情況是否出於或與以下問題關連 (請在適當空格填上 ✓ 號) Was the condition due to or associated with the following? (Please tick the appropriate boxes)

☐ 意外身體受傷 Accidental bodily injury ☐ 懷孕 Pregnancy ☐ 先天性疾病 / 異常 Congenital condition

☐ 自我傷害 Self-inflicted injury ☐ 不育或絕育 Infertility or sterilization ☐ 發育問題 Developmental condition

☐ 濫用藥物或酒精 Abuse of drugs or alcohol ☐ 避孕 Contraception ☐ 遺傳性問題 Hereditary condition

☐ 精神紊亂 Mental disorder ☐ 美容性質的治療 Treatment for cosmetic purpose ☐ 一般身體檢查 General check-up

☐ 屈光不正 Refractive error ☐ 疫苗接種 Vaccination

☐ 性病，性傳播疾病或愛滋病 / 愛滋病毒有關的疾病 Venereal disease, sexually transmitted disease or AIDS/HIV related illness

4. 其它 **Others :**

a) 如病人由其他醫生轉介，請提供轉介醫生的姓名和地址。If the patient was referred by another doctor, please provide the referring doctor's name and address.

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b) 閣下是否該病人的慣常醫生？Are you the patient's usual physician ? ☐ 是 Yes ☐ 否 No
本人特此聲明，就本人所知，上述所有資料均準確無誤。I hereby certify that all information given above is accurate and true to the best of my knowledge.

____________________ ____________________

主診醫生 / 外科醫生簽名及蓋章 Signature and Chop of Attending Physician / Surgeon 地址及電話號碼 Address and Telephone No.

____________________ ____________________

主診醫生姓名 / 外科醫生姓名及資歷 Name of Attending Physician / Surgeon & Qualifications 日期 Date (日 DD / 月 MM / 年 YY)

本索償表格乙部已獲香港醫學會及香港保險業聯會屬下醫療保險協會認可。
Part II of this claim form is endorsed by the Hong Kong Medical Association and Medical Insurance Association of The Hong Kong Federation of Insurers.