Group Medical Insurance - Hospitalization & Surgical Claim Form
團體醫療保險 - 住院及外科索償申請表

Please send the completed claim form together with all required documents to Bolttech Insurance Group Medical Claims Department **19/F, Tower 1, Millennium City 1, 388 Kwun Tong Road, Kwun Tong, Kowloon, Hong Kong** , Customer Service Hotline (852) 3123 3344

請將填妥的索償申請表及一切所需文件寄回保特保險團體保險賠償部
香港九龍觀塘觀塘道 388 號創紀之城 1 期第 1 座 19 樓 , 客戶服務熱線 (852) 3123 3344

Part I - To be completed by The Insured / Claimant 甲部 - 由被保人或索償人填寫	
Policy no. 保單號碼	
Name of Policy Owner/Policyholder 保單權益人 / 保單持有人名稱	Contact no. * 電話號碼 *

*For the use of this claim only 只限於此索償之用

A. Insured's Particulars 被保人資料		
Name of Insured (Surname first) 被保人姓名 (先填寫姓氏)		ID Card/Passport no. 身份證 / 護照號碼
Date of birth (DD/MM/YY) 出生日期 (日 / 月 / 年)	Sex 性別	Occupation/Position 職業 / 職位
Mailing address of Insured 被保人郵寄地址	Email address 電郵地址	

B. Accident Particulars 意外詳情		
Date of accident 意外發生日期	Time 時間	Place 地點
Brief description of accident 描述意外發生經過		
Part(s) of body injured 受傷部位		

C. Illness Particulars 疾病詳情
Brief description of symptoms 描述病徵及病狀
How long have these symptoms existed prior to the first consultation? 在被保人首次就診前，該等病徵已存在多久 ？

D. Consultation and Hospitalization Particulars 診治及住院詳情

Particulars	Date (DD/MM/YY) 日期 (日 / 月 / 年)	Name(s) and address of doctor/hospital 醫生 / 醫院名稱及地址
(1) The doctor first consulted for this illness/ accident 首次診治此病 / 意外的醫生資料		
(2) The doctor who referred the Insured to hospital 建議入院的醫生資料		
(3) All other doctors consulted during this illness/ accident 曾診治此病 / 意外的其他醫生資料		
(4) Doctors seen for any similar condition in the past 過往曾診治同類病況的醫生資料		
(5) Usual attending doctor's name and address 慣常就診的醫生姓名及地址	Not Applicable 不適用	
(6) If taken any home leave during this hospitalization, please state the date(s). 若於住院期間請假外出，請列明日期。		Not Applicable 不適用

E. Other Insurance coverage 其他保險資料

(1) Are you making any other insurance claim as a result of this case? if "Yes", please state below details.
有關此次個案，閣下有否申請其他保險索償？若有，請填寫以下資料。 ☐ No 沒有 ☐ Yes 有

Name Insurance Company 保險公司名稱 _____ Policy No. 保單號碼_____ Type of Policy 保單類別 _____

(2) Does the Insured have any Social Welfare Benefit? If "Yes" please state below detail and provide payment detail copy to us. ☐ No 沒有 ☐ Yes
被保人曾否就是次住院 / 意外獲得任何社會保險保障？若有，請填寫以下資料及提供詳細賠償表。

Name of Social Welfare Benefits
社會保險保障名稱_____

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.

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。

Declaration & Authorisation 聲明及授權

In accordance with the provisions of the Personal Data (Privacy) Ordinance of Hong Kong, by signing below, I/ we consent that the personal information collected or held by Bolttech Insurance (Hong Kong) Company Limited ("bolttech Insurance") (whether contained in this Application or otherwise obtained) is provided and may be disclosed to individuals or organizations within or outside of Hong Kong for the purpose of administration of claim or analysis of it. Moreover, I/we hereby authorize bolttech Insurance to obtain access to and/or to verify any of my/our data with the information collected by any association, federation or similar organization of insurance companies that exists or is formed from time to time (the "Federation") from the insurance industry.

根據香港個人資料(私隱)條例，本人 / 我們簽署，並同意保特保險(香港)有限公司「(保特保險」)得到或持有之本人個人資料 (該等資料可能在此表格提供 或從其他途徑得到) 可透露予本港或海外之個人或組織機構以作處理索償或任何分析之用途。

此外，本人 / 我們現授權保特保險由現存或不時成立的任何保險公司的協會或聯會或類同組織(以下簡稱「聯會」)從保險業內收集的資料中查閱及/ 或核對本人 / 我們之任何資料。

I/We hereby declare that all the above information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief. I/We have not withheld any material information and acknowledge that failure to supply true and accurate answers to this request or inform bolttech of all material information may render bolttech unable to accept or process this request and all rights to recover under the Policy shall be forfeited. I/We understand that the issuance or completion of this application does not constitute admission of liability or guarantee payment of the claim on behalf of bolttech.

本人 / 我們謹此聲明，上述所有資料及細節均是準確無誤，真實及為事實之全部，並且是盡本人 / 我們所知及所信而作答的。本人 / 我們並沒有 隱瞞任何重要資料，並明白如未能提供真實及準確無誤之資料或通知保特任何有關此賠償申請之重要資料，將可能導致保特不能接受或處理此 索償申請及喪失所有追討保單權益之權利。本人 / 我們明白此索償表格之發出及填妥並不代表保特承認責任或保證賠償。

I/We have read, understood and accepted the Personal Information Collection Statement of the Company ("PICS"). By signing below, I/We confirm this application and agree that the Company may use and disclose all personal data about me/us that the Company currently or subsequently hold for the purposes as set out in the PICS, and I understand I can scan the QR code below for review of the PICS or else I can request a copy of the PICS by calling the Company's Customer Service Hotline at 2603 9435.

本人/我們已閱讀、明白及接受本公司的收集個人資料聲明。透過以下簽名，本人/我們確認此申請並同意本公司可根據收集個人資料聲明列出之目的使用及披露本公司目前或將來持有的關於本人/我們的所有個人資料，並理解本人可以掃描以下二維碼查看本公司的收集個人資料聲明，或可致電本公司的客戶服務熱線 2603 9435 索取收集個人資料聲明副本。

Date (DD/MM/YY) 日期 (日 / 月 / 年)	Place 簽署地
Signature of claimant 索償人簽署	Signature of close relative of claimant (if applicable) 索償人近親簽署 (如適用)
	Relationship with claimant 與索償人關係
For Adviser's use only 理財顧問專用	
Adviser name 理財顧問姓名	Adviser code & location 理財顧問編號及地區

Part II - To be completed by the attending doctor/surgeon at the claimant's own expenses
乙部 - 由主診醫生填寫，所需費用由索償人自行承擔

Patient name (in full) 病人姓名 (全名)	Name of hospital 醫院名稱
Date of admission (DD/MM/YY) 入院日期 (日 / 月 / 年)	Date of discharge (DD/MM/YY) 出院日期 (日 / 月 / 年)
Level of hospital ward 病房級別 ☐ Private 頭等房 ☐ Semi-private 二等房 ☐ Ward 三等房 ☐ Clinical Surgery 門診手術	

A. Clinical history 求診記錄

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

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

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

B. Hospitalization details 住院詳情

(1) Final diagnosis
最後診斷_____
Date of operation (DD/MM/YY)
手術日期 (日 / 月 / 年)_____

(2) Name of procedure
手術名稱_____
Nature
性質_____

(3) If the patient has consulted other doctors during this hospitalization, please provide below detials;
如病人於住院期間曾向其他醫生求診，請提供以下資料：

Name of Doctor Consulted
醫生姓名_____
Reason
原因_____

Treatment performed
治療詳情_____

(4) Brief Discharge Summary (including Treatments, investigation procedures, results; and/or any complications and follow up plan.)
出院撮要 (包括治療、診查程序、結果；及 / 或併發症及跟進計劃。)

(5) Please state if this type of case can be managed on day care/out-patient basis. if yes, please provide reasons for hospitalization.
請述明此次病症是否能在日間護理 / 診所內進行治療。若是，請提供住院原因。

☐ No 不是 ☐ Yes 是

C. Professional comment 專業意見

1. In your opinion, was the patient hospitalized as a result of recurrent episode or a chronic illness or related to a previous complaint/diagnosis. If "yes", please provide the date of the first episode and details.
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。

_____

2. Was the condition due to or associated with the following? (Please tick the appropriate boxes)
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）

- ☐ Accidental bodily injury 意外身體受傷
- ☐ Pregnancy 懷孕
- ☐ Congenital condition 先天性疾病 / 異常
- ☐ Self-inflicted injury 自我傷害
- ☐ Infertility or sterilization 不育或絕育
- ☐ Developmental condition 發育問題
- ☐ Abuse of drugs or alcohol 濫用藥物或酒精
- ☐ Contraception 避孕
- ☐ Hereditary condition 遺傳性問題
- ☐ Mental disorder 精神紊亂
- ☐ Treatment for cosmetic purpose 美容性質的治療
- ☐ General check-up 一般身體檢查
- ☐ Refractive error 屈光不正
- ☐ Vaccination 疫苗接種
- ☐ Venereal disease, sexually transmitted disease or AIDS/HIV related illnesserror 性病，性傳播疾病或愛滋病 / 愛滋病毒有關的疾病

D. Others 其他

(1) is the patient referred by another doctor? ☐ No 不是 ☐ Yes 是
病人是否經其他醫生轉介？

Name and address of the referral doctor
轉介醫生的姓名和地址 _____

(2) Are you the patient's usual doctor? ☐ No 不是 ☐ Yes 是
閣下是否該病人的慣常醫生？

I hereby certify that all information given above is accurate and true to the best of my knowledge.
本人特此聲明，就本人所知，上述所有資料均準確無誤。

Signature and Chop of attending Doctor/Surgeon 主診醫生 / 外科醫生簽名及蓋章	Address and Telephone no. 地址及電話號碼
Name of Attending Doctor/Surgeon & Qualifications 主診醫生 / 外科醫生姓名及資歷	Date (DD/MM/YY) 日期 (日 / 月 / 年)

Part III - Claims document checklist
丙部 - 索償文件清單

To avoid the delay of process, please follow this checklist and ensure that all required documents are attached.
為免賠償延誤，煩請依據本部指引，提交所需之理賠文件。

Please ✓ as appropriate:
請在適當空格填上 ✓ 號 :

☐ Claim Form 索償申請表格	▪ Claim Form Part I completed by Insured/Claimant 索償申請表格甲部 - 由被保人或索償人填寫 ▪ Claim Form Part II completed by attending doctor 索償申請表格乙部 - 由主診醫生填寫
☐ ID card copy of Insured and Policy Owner/ Policyholder 被保人及保單權益人 / 保單持有人之身份證副本	
☐ Original Receipts 收據正本	▪ Original receipts (including medical receipt, deposit receipt) 收據正本 (包括醫療收據，按金收據) ▪ Statement of Charges, etc. 收費詳情等
☐ Laboratorytest/ X-ray/Ultra-sound/ECG/ Diagnostic Imaging (MRI/ CT Scan /PET) 化驗 / X 光 / 超聲波 / 心電圖 / 影像 / 放射診斷 (磁力共振造影 / 電腦掃瞄 / 正電子電腦掃瞄)	▪ All report(s) 所有報告
☐ Other Insurance Cover 其他保險資料	▪ Compensation breakdown from other insurer/party 其他保險公司或機構之賠償細算表
☐ Confinement in Hospital Authority's Hospital in Hong Kong 入住香港醫院管理局醫院	▪ Discharge summary 出院紙 ▪ Sick leave certificate with exact diagnosis 列明診斷結果的病假證書
☐ Confinement in Hospital in Mainland China 入住中國內地醫院	▪ First page of medical record 病案首頁 ▪ Admission record slip 入院紀錄 ▪ Discharge summary 出院小結 ▪ Outpatient booklet 門診病歷
☐ Others 其他	▪ Please specify: 請列明 :
☐ Request for Return of Certified True Copies of Documents (For record keeping, please take your own copy before submission) 要求退還正本文件 (請於提交前自行複印文件以作記錄)	

Part IV - Completion guideline
丁部 - 填寫指引

(1) Please read the questions carefully before answer. All the answers provided on this claim form must be true, complete and accurate.

請在作答前小心細閱有關問題，於索償申請表上所提供之資料必須真實，完全及準確。

(2) This Claim Form should be signed by a close relative of the claimant if the claimant is unable to sign and in such case, proof of relationship shall be submitted together with this form. The Company shall have the right, at its sole discretion, to accept or reject the form signed by a close relative of the claimant.

若索償人未能簽署，此申請表應由索償人之近親簽署並提供關係證明。本公司有權全權酌情決定接受或拒絕由索償人的近親簽署的表格。

(3) This Claim Form with all required documents MUST be sent to the Company within 90 days from the date of incident. Any Claim Form submitted after the said 90-day period is deemed as "Late Submission" and written explanation MUST be provided. Otherwise, the Company is entitled to reject the claim application.

索償申請表連同一切所需文件必須在事故之日起計 90 日內送交本公司，任何在 90 日後遞交的申請均會被視為 " 逾期提交 "，而索償人必須提供書面解釋，否則本公司有權拒絕有關索償申請。

(4) Please send the completed claim form together with all required documents to 19/F, Tower 1, Millennium City 1, 388 Kwun Tong Road, Kwun Tong, Kowloon, Hong Kong

請將填妥的索償申請表及一切所需文件寄回香港九龍觀塘觀塘道 388 號創紀之城 1 期第 1 座 19 樓。

Personal Information Collection Statement (“PICS”)
收集個人資料聲明

Please scan the following QR code for review of Bolttech Insurance (Hong Kong) Company Limited’s (the “Company”) PICS. You can also request a copy of the PICS by calling the Company’s Customer Service Hotline at 2603 9435.

請掃描以下二維碼查看保特保險 (香港) 有限公司（「 本公司」） 的收集個人資料聲明。您亦可致電本公司的客戶服務熱線 2603 9435 索取收集個人資料聲明副本。

English

中文