How to apply Cashless Facility?
如何申請無憂出院免找數服務?

1

Please contact THE ONEcierge One Team Health Management Hotline (852) 8120 9066 for reservation of Appointed Specialist Doctors ("Appointed Specialists") consultation.

請致電臻一優才醫護管理團隊熱線 (852) 8120 9066 預約特選專科醫生(「特選醫生」)會診。

2

Complete Part 1 of Cashless Facility for Hospitalization Application Form (the "Form") and consult a Appointed Specialist.

填妥無憂出院免找數服務申請表(「表格」)甲部，及到特選醫生之診所求診。

3

Your Appointed Specialist will complete Part II of the Form and send to FWD Life Insurance Company (Bermuda) Limited ("FWD") 4 days prior to Insured's hospitalization.

您的特選醫生會填寫表格乙部，並於被保人入院前最少四個工作天前遞交予富衛人壽保險(百慕達)有限公司(「富衛」)。

4

If your application is successful, FWD will inform you within 1 working day. When you accept the arrangement of Cashless Facility, your Appointed Specialist will explain the medical costs and its arrangement to you. Your Appointed Specialist will arrange hospitalization with the appointed hospital you have chosen. Please pay the Annual Deductible Balance (if any) when admitting to the hospital.

如果您的申請成功，富衛會於一個工作天內通知您。如您接受是次出院免找數服務安排，您的特選醫生會向您解釋醫療費用及其付款安排。您的特選醫生將會聯絡您的特選醫院安排入院，請您於入院時繳付每年自付費餘額 (如有)。

5

You will receive a claims statement after the claim is processed. If there is any shortfall, please settle within 21 days of receipt of the shortfall invoice.

在理賠辦妥後，您將會收到富衛發出的賠償通知書。如有差額，請於收到差額通知書後 21天內繳付。

Notes:

1) Final decision of Cashless Facility is subject to the discretion of FWD.
   富衛保留無憂出院免找數服務最終批核權利。
2) If hospitalization is due to illness / disability classified under exclusion or the applied treatment fees exceeds your benefit entitlement or there is outstanding shortfall owed to FWD, no Cashless Facility will be successfully arranged.
   如因不受保事項而引致入住醫院、申請之治療費用超出保障金額或尚有差額未繳付予富衛，均不會獲成功安排無憂出院免找數服務。

Cashless Facility for Hospitalization Application Form
無憂出院免找數服務申請表

Hotline 查詢熱線 (852) 3123 3123

Application no. 申請書號碼 (For internal use only 祇供內部填寫)

Please complete this form and send to FWD Life Insurance Company (Bermuda) Limited (the "Company" or "FWD") by e-mail (support@hmg.com.hk) at least 4 days prior to the hospitalization. If Efficient and Seamless Claims Resolution is successfully arranged for the Insured, FWD would provide Cashless Facility to the Insured.
請填妥此表格並於入院前最少四個工作天，以電郵方式**(support@hmg.com.hk)** 遞交予富衛人壽保險(百慕達)有限公司("公司"或"富衛")。如被保人獲成功安排優質高效理賠程序，富衛將為被保人提供「無憂出院免找數服務」。

Part I (To be completed by Insured / Policyowner) 甲部 (由被保人 / 保單持有人填寫)

A. Insured's Particulars 被保人資料

Policy No. 保單號碼	Name of Policyowner 保單持有人姓名	Name of Insured 被保人姓名	I.D. No. / passport No. 身份証號碼/護照號碼
Contact Phone No. 聯絡電話號碼		E-mail Address 電郵地址	

B. Details of Hospitalization住院詳情

For Hospitalization due to Accident, please complete questions 1 to 3 & 6 below 因意外導致住院, 請填寫以下第 1 至 3 及 6 題
For Hospitalization due to illness, please complete questions 4 to 6 below 因疾病導致住院, 請填寫以下第 4 至 6 題

1. When & where did the accident occur? 意外在何時及何地發生？

2. How did the accident occur? 意外發生經過

3. Part of body injured (e.g. Left ankle etc.) and type of injury 受傷部位 (如左足踝) 及傷勢

4. Give a brief description of Insured's symptoms 請描述被保人之病徵及病狀

5. How long had he/she been experiencing these symptoms prior to the first consultation? 在被保人首次就診前，該等病徵已存在多久?

6. Give details of consultations 請填報診治詳情	Date (DD/MM/YYYY) 日期 (日/月/年)	Name(s) & Address of Doctor / Hospital 醫生 / 醫院名稱及地址
(a) The doctor first consulted for this illness 首次診治的醫生資料	(a)	
(b) The doctor who referred the Insured to hospital 建議入院的醫生資料	(b)	
(c) All other doctors consulted during this illness / accident 曾診治此病 / 意外之其他醫生資料	(c)	
(d) Doctors seen for any similar condition in the past 過往曾診治同類病況的醫生資料	(d)	

C. Declaration and Authorization 聲明及授權

I HEREBY DECLARE AND AGREE that:

1. The above particulars and answers are complete and true, and this questionnaire will form part of the contract of the desired insurance on my life. I also authorize the Company to obtain, if necessary, confidential reports from any doctor/clinic/hospital that I have referred above.
2. Any personal data of myself or the insured (if different) collected and held by the Company may be used, stored, disclosed and transferred (whether within or outside Hong Kong) to such individuals/organizations associated with the Company and this Cashless Facility Service (the "Service"). These include any third party service provider and it's healthcare network team which is involved in providing this Service, reinsurers, claims investigators, industry associations/federations and debt collectors for the purposes of (i) assess and evaluate this application; (ii) provide all services related to this application and (iii) communicating with me or the Insured (if different) for such purpose.
3. I understand that I have or the Insured (if different) has the right to request access to and to request correction (if appropriate) of any personal information concerning myself or the Insured (if different) held by the Company or be given reasons for any refusal of access. I also understand that the Company has the right to charge a reasonable fee for process of any access.
   {Note: Any request for access or correction can be made in writing and addressed to the Head of Claims Department at 1/F., FWD Financial Centre, 308 Des Voeux Road Central, Hong Kong.}

本人謹此聲明並同意：

1. 我謹在此聲明及同意以上之資料是完全及正確，並就此問卷之內容成為本人保單之一部份.
   本人現授權貴公司可向以上之醫生/ 診所/ 醫院在有需要之情況下提取本人之醫療紀錄.
2. 由公司收集及持有本人或被保人（如有不同）的任何個人資料，可使用、儲存、透露及轉予（無論本港或海外）公司有關聯的人仕/ 或機構團體，包括第三方服務提供者及其醫療網絡團隊、再保公司、賠償調查員、保險業協會/ 聯盟及追收欠款公司，以作為(i)承保及評估本申請；(ii)提供有關本申請的所有服務；以及(iii)因上述目的與本人或被保人（如有不同）聯絡。
3. 本人明白，本人或被保人（如有不同）有權要求查閱及於查閱後有權要求更正（如適當時），公司所持有之有關本人或被保人（如有不同）的任何個人資料，或獲得任何拒絕查閱的理由；本人亦明白公司有權就處理任何查閱資料的要求，收取合理費用。
   [注意：任何查閱及更正要求可以書面方式寄往香港中環德輔道中308號富衛金融中心1樓賠償部主管收。]

I HEREBY AUTHORIZE AND AUTHORIZE ON BEHALF OF THE INSURED (if different):

1. Any registered practitioner, hospital, clinic, insurance company, government institution or other organization that has record or knowledge of my or the Insured's (if different) health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to FWD Life Insurance Company (Bermuda) Limited in relation to this claim.
2. The Company or any of its approved medical examiners or laboratories to perform necessary medical assessment and tests to evaluate my or the Insured's health status in relation to this claim.
3. In the event that the Company has settled any charges not covered by the policy or has made any payment over my/our/the Insured's eligible benefit limit of such policy, the Company shall have the right to collect such charges or amount overpaid from me/us/the Insured. If the company cannot collect such shortfall due to any reason whatsoever, the Company shall have the right, to the extent permitted by law, to deduct or set off the shortfall amount against any benefit or amount due or payable to me/us/the Insured or any account value, credit balance or accumulations under such policy or any other insurance policy between me and the Company, including but not limited to any death benefit, dividend, bonus or return of premium (for whatever reason).

本人在此授權或代表被保人（如有不同）授權：

1. 當有需要時，富衛人壽保險(百慕達)有限公司可要求持有或瞭解本人或被保人（如有不同）的健康及醫療記錄；或任何治療或忠告或曾向其求診或以後向其求診之任何註冊醫生、醫院、診所、保險公司、政府機構或其他團體透露有關被保人資料。
2. 公司或公司許可的醫療人員或化驗所，就本賠償申請，進行必要的醫學評估及測試，以評估本人或被保人的健康狀況。
3. 若貴公司曾為本人/我們/受保人支付任何不在受保障範圍內的費用，或支付超出有關保障限額的費用時，貴公司將有權向本人/我們/受保人收取該筆差額。若貴公司因不論任何其他原因以至未能收取該筆差額，貴公司將有權(法律允許的範圍內)把應收款項從此或任何本人於貴公司持有之其他保單的金額中抵銷扣除，包括但不限於任何身故賠償、股息、紅利或保費退還(不論何種原因)。

I ALSO UNDERSTAND that the Company may terminate or vary the terms of the Service in its sole discretion without further notice, and that the Company will not be responsible for any act, negligence or failure to act on the party of any third party service provider and its healthcare network team which is involved the provision of the Service.

本人同時明白貴公司擁有隨時終止或更改此服務條款之最終權利而不需要另行通知，並且貴公司不會就第三方服務提供者及其醫療網絡團隊任何行為、疏忽或失實承擔任何責任。

[Note: This authorization shall bind my and the Insured's successors and assigns and remain valid notwithstanding my or the Insured's death or incapacity in so far as legally possible. A photocopy of this Authorization shall be as valid as the original].

(注意：本授權對本人或被保人的承繼人及轉讓人均有約束力，並且如法律上可行時，不論本人或被保人死亡及失去行為能力，本授權仍然有效。本授權的影印本與正本同樣有效。)

Data Protection - The Company has appointed a Data Protection Officer to handle any enquiries relating to your personal information. If you would like to obtain a copy of the FWD Life Insurance Co (Bermuda) Ltd Personal Data Policy and Practices, please write to the Corporate Data Protection Officer at 1/F., FWD Financial Centre, 308 Des Voeux Road Central, Hong Kong.
資料保護- 公司已委任一位資料保護主任，處理有關閣下個人資料的任何書面查詢。如閣下對資料保護有任何查詢，請來信寄香港中環德輔道中308號富衛金融中心1樓，富衛人壽保險(百慕達)有限公司資料保護主任收。

Date (DD/MM/YYYY) 日期 (日/月/年)	Place 簽署地
Signature of Policyowner 保單持有人簽署	Signature of Insured 被保人簽署

Part II (To be completed by Attending Doctor of the Insured) 乙部 (由被保人之主診醫生填寫)

Please tick 「✓」where appropriate 請在適當方格內填上「✓」號

A. Diagnostic Details 診斷詳情

Name of Patient 病人姓名	Sex 性別 ☐ Male 男 ☐ Female 女
Chief Complaint of the Current Consultation 是次就診之主訴	Onset Date of Symptoms (DD/MM/YYYY) 病徵出現日期 (日 / 月 / 年)
Diagnosis 診斷	Is it chronic / recurrent illness 是否慢性 / 復發疾病 ☐ Yes 是 First Onset Date (DD/MM/YYYY) 首次病徵出現日期 (日 / 月 / 年) ☐ No 否 ____________
Name of Referring Doctor / Usual Doctor 轉介 / 家庭醫生之姓名 (Please enclose referral letter 請提供轉介信)	

B. Treatment Details 治療詳情

Name of Hospital 醫院名稱		Room class 住房級別 ☐ Ward 普通 ☐ Semi-Private 半私家 ☐ Private 私家		
Estimated date of admission (DD/MM/YYYY) 預計入院日期(日/月/年)	Estimated length of stay (number of days) 預計住院日數(日)	Name of surgery 手術名稱		Anaesthesia 麻醉 ☐ L.A. 局部麻醉 ☐ G.A. 全身麻醉

Was the medical condition caused by or related to the followings 此病是否與下列情況有關或因其引致？

☐ dental treatment or surgery 牙科治療或手術
☐ cosmetic or plastic surgery 美容或外科整形手術
☐ obesity or weight control 治療過度肥胖或控制體重
☐ congenital, hereditary or developmental conditions 先天性，遺傳性或發育異常
☐ mental, psychological or psychiatric conditions 精神紊亂, 心理或精神疾病
☐ abuse of drugs or alcohol 濫用藥物或酗酒
☐ attempted suicide or self-inflicted injury 企圖自殺或自殘
☐ pregnancy, infertility or sterilization 妊娠, 不育或絕育
☐ preventive treatment or health checks 預防性治療或健康檢查

If hospitalization is arranged for scans, diagnostic testing or a procedure that is normally carried out in a day case, please explain why hospital confinement is necessary. 如是次住院之目的為檢驗，進行診斷掃描或一般日症手術，請說明住院之原因。	Attendance Fee per day (HK$) 每日醫生巡房費用 (港幣)	Surgeon's Fee (HK$) 手術費用 (港幣)	Estimated Total Costs for this hospitalization (HK$) 預計是次住院總費用 (港幣)

Doctor's Particulars and Signature 醫生資料及簽署

Name of Doctor (with qualification) 醫生姓名 (連帶資歷)	Telephone No. and Address 電話號碼及地址
Signature of Doctor 醫生簽名	Date (DD/MM/YYYY) 日期 (日 / 月 / 年)