住院和手術賠償申請書
Hospital and Surgical Claim Form

提供此賠償申請書或進行有關此索償調查並不表示富通保險有限公司（以下簡稱“富通保險”）確認此項索償或同意豁免保單條款中的任何規定。
By providing this claim form and subsequently investigating the claim, FTLife Insurance Company Limited ("FTLife") shall not be held to admit the validity of the claim nor to waive any requirement as provided under the provisions of the policy.

Important Notes: 重要事項:

For the required documents for claim, please scan the QR code.
有關理賠所需文件，請掃描二維碼。

❑ 首次索償 New Claim　　❑ 再次索償 Further Claim

索償類別 Benefit to Claim

❑ 住院醫療賠償 Hospital Reimbursement　　❑ 住院現金賠償 Hospital Cash

保單號碼 / 保障名稱 Policy Number / Benefit Name

1) _____(_____)　　2) _____(_____)

3) _____(_____)　　4) _____(_____)

註: 如沒有指定理賠次序，本公司將決定是次理賠次序。
FTLife will determine the claim sequence if no claim sequence is indicated.
富通保險保留決定最終理賠次序的權利。
FTLife reserves the right for the final claim sequence

是次索賠是否已申請 e-步通免找數安排服務? ❑ 否 No ❑ 有 Yes
Has this claim been applied e-ConNET Cashless Services?

聯絡方式 (適用於賠償申請和電子核證副本申請)
Contact Method (Applicable to Claim Application and Electronic Certified True Copy Application)

以下二選一 Choose 1 only

❑ 保險顧問或經紀（請填寫以下資料）
Consultant or Broker (Please fill in the details below)

姓名 Name	
保險顧問或經紀編號 Consultant or Broker Agent Code	
電話號碼 Phone Number	

* 以上填寫之保險顧問或經紀將是閣下授權唯一能跟進及處理是次索償的人士
Consultant or Broker filled in above would be regarded as the only authorized person to follow up and handle the claim.

❑ 保單持有人（請填寫以下資料）
Policy Owner (Please fill in the details below)

姓名 Name	
電郵地址 Email Address	
電話號碼 Phone Number	

請將填妥的賠償申請書連同所需文件一併交予本公司理賠部辦理。地址：九龍觀塘海濱道123號綠景NEO大廈7樓。電話：2866 8898
Please send the completed claim form and supporting documents to our Claims Dept. Address: 7/F, NEO, 123 Hoi Bun Road, Kwun Tong, Kowloon. Tel. 2866 8898

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第一部份-由受保人填寫（如受保人未滿18歲，則由保單持有人代填）(請於適當之方格內加上 "✓" 號)
Part I - To be completed by the Insured (or Policy owner if insured is under age 18) (Please tick the appropriate box(es))

賠付安排
Claim Settlement Arrangement

❑ 直接轉賬服務 (如之前未有申請，請填寫直接轉賬服務申請 / 更改表或掃描右面二維碼透過手機應用程式申請)
Faster Payment Service (If not yet applied, please complete the Request for application / change of Faster Payment Service Form or scan the QR code on the right to submit the application via mobile app)

❑ 支票
Cheque(s)

A. 受保人個人資料 Personal Particulars of the Insured

1. 受保人姓名 Name of Insured	2. 身份證 / 護照號碼 ID / Passport No.	3. 年齡 / 性別 Age / Sex

4. 現時職業及詳細職責 Current occupation and job duties with details	5. 僱主名稱 (如僱主與投保時不同，請說明何時轉工) Name of Employer (If the employer is different from the one stated in the application, please state when it was changed)

6. 僱主地址
Address of Employer

B. 住院詳情 Information of Hospitalization

1. 醫院 / 診所名稱及地址：Name and address of Hospital:	2. ❑ 門診手術 Outpatient Surgery 手術日期 (日/月/年) Surgery Date (DD/MM/YY): _____ ❑ 住院 Hospitalisation 入院日期 (日/月/年) Admission Date (DD/MM/YY): _____ 出院日期 (日/月/年) Discharge Date (DD/MM/YY): _____

3. 有否於上述住院期間一天內請假外出超過6小時？
Has the Insured taken any home leave for more than 6 hours a day during the confinement? ❑ 否 No ❑ 有 Yes
如有， 請列出有關的確實日期 (日/月/年) ：
If yes, please state the exact date (DD/MM/YY): _____

C. 如住院是疾病引致 If Hospitalization was due to Illness

1. 請敘述入住醫院前之徵狀？What were the symptoms presented before consultation?	2. 首次就診之前， 受保人患此等徵狀的時間有多久？How long has the Insured been having these symptoms before first consultation?
3. 何時因此徵狀而首次求診 (日/月/年)？When was the first consultation for these symptoms (DD/MM/YY)?	4. 出院時之診斷？What was the diagnosis?

D. 如住院是意外引致 If Hospitalization was due to Accident

1. a. 意外日期 (日/月/年) ：Date of accident (DD/MM/YY): _____ b. 意外發生的確實時間：Time of accident: _____ c. 意外發生的地點：Place of accident: _____	2. a. 意外如何發生？How did the accident happen? _____ b. 有否報警？ Did you report this case to police? ❑ 否 No ❑ 有 Yes 如有， 請附上口供紙或警察報告影印本 If yes, please attach a photocopy of witness statement or police report
3. 受傷部位？Which parts of the body were injured? _____	4. 受傷程度？What was the extent of the injury? _____

E. 就診詳細情況及其它資料 Details of Consultation and Other Information

1. 首次就診醫生的名稱和地址。Name and address of doctor who first treated you for the injury or the illness.	2. 建議入院的醫生名稱和地址。Name and address of doctor who referred you to hospital.	3. 過往就同樣病症曾求診的醫生名稱和地址。Name and address of doctors consulted in the past for similar condition.

4. 閣下有否於其他保險公司遞交是次保險賠償？
Did you submit this insurance claims to other insurance company? ❑ 否 No ❑ 有 Yes
保險公司名稱:
Company name: _____ 保單號碼:
Policy number: _____
索償次序:
Claim sequence: _____

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F. 個人資料收集聲明 Personal Information Collection Statement

本人 / 我們確認本人 / 我們已閱讀及明白富通保險有限公司 (以下簡稱 “富通保險”) 之個人資料收集聲明 (“該聲明”)。本人 / 我們聲明及同意貴公司可根據該聲明所述的任何目的收集及 / 或持有、使用及 / 或披露 / 分享任何個人資料 (不論是否從此表格或以其他方式獲得) 。本人 / 我們明白本人 / 我們必須於此表格提供所須資料，否則貴公司將可能無法執行該聲明之目的及 / 或向本人 / 我們提供產品或服務。本人 / 我們確認及同意本人 / 我們的個人資料可能披露 / 共享給該聲明所指明的第三方; 執法機構; 保險業就現有資料而對所提供的資料作出分析和檢查而使用的數據庫或登記冊作出於該聲明所述的任何目的。本人 / 我們明白該聲明的最新版本可於富通保險的網址下載： www.ftlife.com.hk，及可向貴公司索取。

I/We confirm that I/we have read and understood FTLife Insurance Company Limited (“FTLife”)’s Personal Information Collection Statement (“PICS”). I/We declare and agree that any personal data FTLife may collect and/or hold, use and/or disclose/share with (whether contained in this form or otherwise obtained) in accordance with the Purposes as set out in the PICS. I/We understand that if I/we do not provide the required personal data, FTLife may not be able to perform the Purposes and/or provide products or services to me/us. I/We acknowledge and agree that my/our personal data may be disclosed/shared with specified parties in the PICS; law enforcement authorities; databases or registers used by the insurance industry to analyse and check information provided against existing information for any of the Purposes stated in the PICS. I/We understand the updated version of the PICS is available for download from FTLife’s website: www.ftlife.com.hk, and will be made available upon request.

G. 聲明及授權書 Declaration and Authorization

對於報銷索償，本人 / 我們聲明索償費用已實際支付給醫療服務提供者，而不會也沒有就該等費用向其他保險公司 / 機構索償。
For reimbursement claim, I/We declare that the claiming medical expenses were actually paid to medical service providers, and will not and have not claimed at other insurers / institutions for reimbursement.

本人 / 我們聲明上述一切陳述及對問題的所有答案，就本人 / 我們所知所信均為事實之全部，並確實無訛。
I/We declare that the above statements and answers made by me/us are true and complete to the best of my knowledge.

本人 / 我們茲授權凡知道或擁有任何有關本人或受保人記錄的僱主、任何註冊西醫、醫院、診所、保險公司、其他機構或人士，均可將該等資料提供給富通保險有限公司。即使本人或受保人死亡或喪失能力，此授權書仍然有效，所有本人及受保人之繼承人及轉讓人亦會受此授權書約束。本授權書的影印本與正本具有同等效力。
I/We hereby authorize any employer, any registered medical practitioner, hospital, clinic, insurance company or other institution or person, that has any records or knowledge of me/us or the Insured(s) named to give such information to FTLife Insurance Company Limited. This authorization shall bind the successors and assignees of me/the Insured(s) and remain valid notwithstanding the death or incapacity of me/the Insured(s). A photocopy of this authorization shall be as valid as the original.

本人 / 我們明白若此住院和手術賠償申請書的中、英文兩個版本有任何抵觸或不相符之處，應以英文版本為準。
I/We understand that if there is any inconsistency or ambiguity between the English versions and the Chinese versions of this Hospital and Surgical Claim Form, the English versions should prevail.

保單持有人姓名 (大寫)
Name of Policy owner (in block letters): _____

身份證 / 護照號碼
ID / Passport No.: _____

保單持有人簽署
Signature of Policy owner: x _____

日期 (日/月/年)
Date (DD/MM/YY): _____

受保人姓名 (大寫)
Name of Insured (in block letters): _____

身份證 / 護照號碼
ID / Passport No.: _____

受保人簽署 (如與保單持有人不同及年滿18歲)
Signature of Insured: x _____
(If different with Policy owner & attained age 18)

日期 (日/月/年)
Date (DD/MM/YY): _____

見証人姓名 (大寫)
Name of Witness (in block letters): _____

身份證 / 護照號碼
ID / Passport No.: _____

見証人簽署
Signature of Witness: x _____

日期 (日/月/年)
Date (DD/MM/YY): _____

保險顧問 / 保單持有人備註 Consultant / Policy owner’s Remarks

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第二部份-申請人自費由主診醫生填寫

Part II - To be completed by the Attending Doctor at the claimant's own expenses

1. a. 病人姓名 Name of patient	b. 身份證/護照號碼 ID / Passport No.	c. 年齡 / 性別 Age / Sex	d. 職業 Occupation

2. a. 醫院名稱：
Name of Hospital:

b. 入院日期 (日/月/年)：
Admission date (DD/MM/YY):

c. 出院日期 (日/月/年)：
Discharge date (DD/MM/YY):

d. 閣下自何時開始診治此病人？ Since when did you first know the patient professionally?
由 Since (日 DD / 月 MM / 年 YY) 起

3. 病人就此病症的首次求診日期 (日/月/年)：
First consultation date for this illness or injury (DD/MM/YY): _____

4. 病徵或病因首次出現之日期 (日/月/年)：
Date of symptoms/complaints first appeared (DD/MM/YY): _____

5. 首次求診時之病徵或病因：
The symptoms/complaints at the first consultation date: _____

6. (a) 是次檢查、治療及住院日數（如有）是否和上述診斷有直接關係而且是醫療所需及由醫生建議? 否 No ❒ 是 Yes ❒
Were the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to the current diagnosis, and were medically necessary and recommended by you?
若不是，請詳述之：
If No, please give details: _____

Please answer the following questions if the insured requires hospitalization 若受保人需要住院，請回答以下問題：

(b) 該檢查及手術所需的設備是否僅在醫院可有? 否 No ❒ 是 Yes ❒
Were the medical test(s) and equipment for the procedure available only in hospital?

(c) 該檢查及手術可否在門診 / 日間手術中心進行? 可以 Can ❒ 不可以 Cannot ❒
Can the medical test(s) and the procedure be done on an outpatient basis / at day surgery centre?

(d) 手術是否必須在全身麻醉下進行? 否 No ❒ 是 Yes ❒
The surgery could only be performed under general anaesthesia?
如手術在監察麻醉下進行, 請註明住院原因。
For surgery under Monitored Anaesthesia Care, please specify the reason for hospital stay.
_____

(e) 請註明臨床風險及須留院的醫療原因：
Please indicate the clinical risk(s) and medical reason(s) for hospitalization

❒ 現時健康狀況（合併症）
Current Health Status (Co-morbidity)
請明確說明：
Please specify: _____

❒ 預期較高手術風險
Expected higher risk at operation
請明確說明：
Please specify: _____

❒ 預期較高手術後風險
Expected higher post-operative risk
請明確說明：
Please specify: _____

❒ 其他
Others
請明確說明：
Please specify: _____

(f) 這是否緊急個案？ 否 No ❒ 是 Yes ❒
Is it a case of emergency?
如是，請明確說明。
If Yes, please specify: _____

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7. a. 最後診斷：
Final diagnosis:

_____

b. 診斷日期 (日/月/年)：
Diagnosis date (DD/MM/YY):

_____

c. 潛在原因導致該病症：
The underlying reasons leading to such illness or injury:

_____

d. 據你的意見，病人的預後情況如何？
In your opinion, what is the prognosis?

_____

e. 該情況是否慢性疾病或再次病發？
Is this a chronic illness or recurrent episode?

❑ 否 No

❑ 是 Yes, 請提供以下資料 please give details:

(i) 發病日期 (日/月/年)：
Onset date (DD/MM/YY): _____

(ii) 曾求診之醫生姓名及地址：
Name and address of doctor consulted:

_____

(iii) 首次診治日期 (日/月/年)：
First consultation date (DD/MM/YY): _____

(iv) 最後覆診日期 (日/月/年)：
Last follow up date (DD/MM/YY): _____

8. 手術
Surgical Procedure

手術日期 (日/月/年) Operation date (DD/MM/YY)	手術名稱 Procedure name	手術醫生之姓名 Surgeon's name
_____	_____	_____

9. 住院期間有關的治療及進展：
Details of medical treatment given with progress during hospitalization:

治療種類 Type of medical treatment	時期 Period	進展 Progress
_____	_____	_____

10. 住院期間有關的化驗及結果：
Details of laboratory tests performed with result during hospitalization:

化驗名稱 Name of laboratory tests	日期 Date	結果 Result
_____	_____	_____

11. 病人於住院期間有否離院外出? 如有，請提供其離院的日期及時間。 否 No ❑ 是 Yes ❑
Did the patient take any home leave during the confinement period?
If yes, please give details of the date and time.

_____

12. 病人是否經其他醫生或醫院轉介？ 否 No ❑ 是 Yes ❑
Did other doctor or hospital refer the patient to you?
若是，請提供轉介醫生姓名或醫院名稱及地址。
If yes, please provide name & address of referral doctor or hospital.

_____

13. 你曾否轉介該病人其他醫生或醫院？ 否 No ❑ 有 Yes ❑
Did you refer the patient to other doctor or hospital?
若有，請提供醫生或醫院名稱及地址。
If yes, please give the name & address of doctor or hospital.

_____

14. 你曾否於該病人住院期間轉介他/她往專科醫生？ 否 No ❑ 有 Yes ❑
Did you refer the patient to other medical specialist during the hospitalization period?
若有，請提供該專科醫生姓名、資歷及轉介原因。
If yes, please give the name & qualification of the specialist and explain the referral reason.

_____

15. 若因意外入院，請提供以下資料：
Please provide the details if the admission was due to Accident:

a. 意外日期 (日/月/年)：
Date of accident (DD/MM/YY): _____

b. 意外地點及經過？
Where and how did it happen?

地點：
Place: _____

經過：
Course of Event:

_____

c. 受傷程度 Extent of injury

否 No	有 Yes	
❒	❒	瘀痕 Bruises
❒	❒	腫脹 Swelling
❒	❒	割傷 / 擦傷 / 傷口 Laceration / abrasion / wound
❒	❒	挫傷 Contusion
❒	❒	如有其他，請說明 Others, please specify

若有，請詳述。 If yes, please describe the details.

d. 最後求診時的受傷情況。
Condition of the injury at last consultation.

_____

16. 有關疾病或意外是否由以下因素導致？ Was such illness or injury caused by the following factors?

否 No	是 Yes	
❒	❒	自致傷害 (原因及經過) Self-inflicted injury (How it happened & underlying cause)
❒	❒	酗酒 (酒類名稱、份量及維持多久) Alcoholic abuse (Name of alcohol, quantity & duration of consumption)
❒	❒	濫用藥物 (藥物名稱、份量及服食多久) Drug abuse (Name & dosage of drug and duration of consumption)
❒	❒	退化性轉變 (發病日期及求診詳情) Degenerative changes (Onset date & consultation details)
❒	❒	先天性缺陷 (診斷、發病日期及求診詳情) Congenital anomalies (Diagnosis, onset date & consultation details)
❒	❒	過往受傷/疾病 (原因及求診詳情) Past injury or illness (Cause and consultation details)
❒	❒	不育、絕育、懷孕、分娩或流產 (關係及詳情) Infertility, Sterilization, Pregnancy, Childbirth or Miscarriage (How it related and details)

若有，請詳述。 If yes, please describe the details.

_____

17. 據閣下所知，病人以前有否患有相關的病況或其他嚴重疾病? 若有，請提供診治日期及主治之醫生姓名及地址。
To the best of your knowledge, has the patient ever been treated for the related conditions, or any other serious disorder? If yes, please provide the treatment date & name of attending doctor.

_____

18. 其他資料
Other remarks

本人謹此證明本人已親自為此病人就上述之病症或受傷進行檢查及治療，並確認上述病人現時及過去的情況乃本人所知的實情及其全部。
I hereby certify that I have personally examined & treated the patient and attended to his illness or injury, and that the information about his current and past condition as stated above is true to the best of my knowledge and belief.

_____
主診醫生姓名 (專業資歷)
Name of Attending Doctor (with qualification)

_____
簽署 (及印章)
Signature (with chop)

_____
地址及電話號碼
Address & Phone No.

_____
日期 (日/月/年)
Date (DD/MM/YY)

電子核證副本（醫療收據）申請書
Electronic Certified True Copy Request Form (Medical Receipts)

保單號碼: **Policy Number:**	
門診手術 / 入院 / 意外日期 (日/月/年): **Date of Outpatient Surgery / Hospital Admission / Accident (DD/MM/YY):**	

本人 / 我們特此要求富通保險有限公司就上述日期之賠償申請中已遞交之醫療收據以電郵形式發出電子核證副本給以下收件人：(二選一)
I / We hereby request FTLife Insurance Company Limited to issue Electronic Certified True Copy for the medical receipts submitted in the captioned date of claim to the following recipient: (Choose 1 only)

❑ **保險公司**
Insurer

保險公司名稱: Insurer Name:	
保單號碼: Policy Number:	

❑ **本人**
Self

電郵地址: Email Address:	
電話號碼: Phone Number:	

個人資料收集聲明 Personal Information Collection Statement

本人 / 我們確認本人 / 我們已閱讀及明白富通保險有限公司 (以下簡稱 "富通保險") 之個人資料收集聲明 ("該聲明")。本人 / 我們聲明及同意貴公司可根據該聲明所述的任何目的收集及 / 或持有、使用及 / 或披露 / 分享任何個人資料 (不論是否從此表格或以其他方式獲得)。本人 / 我們明白本人 / 我們必須於此表格提供所須資料，否則貴公司將可能無法執行該聲明之目的及 / 或向本人 / 我們提供產品或服務。本人 / 我們確認及同意本人 / 我們的個人資料可能披露 / 共享給該聲明所指明的第三方; 執法機構; 保險業就現有資料而對所提供的資料作出分析和檢查而使用的數據庫或登記冊作出於該聲明所述的任何目的。本人 / 我們明白該聲明的最新版本可於富通保險的網址下載：www.ftlife.com.hk，及可向貴公司索取。

I/We confirm that I/we have read and understood FTLife Insurance Company Limited ("FTLife")'s Personal Information Collection Statement ("PICS"). I/We declare and agree that any personal data FTLife may collect and/or hold, use and/or disclose/share with (whether contained in this form or otherwise obtained) in accordance with the Purposes as set out in the PICS. I/We understand that if I/we do not provide the required personal data, FTLife may not be able to perform the Purposes and/or provide products or services to me/us. I/We acknowledge and agree that my/our personal data may be disclosed/shared with specified parties in the PICS; law enforcement authorities; databases or registers used by the insurance industry to analyse and check information provided against existing information for any of the Purposes stated in the PICS. I/We understand the updated version of the PICS is available for download from FTLife's website: www.ftlife.com.hk, and will be made available upon request.

保單持有人姓名 (大寫)
Name of Policy owner (in block letters): _____

身份證 / 護照號碼
ID / Passport No.: _____

保單持有人簽署
Signature of Policy owner: x _____

日期 (日/月/年)
Date (DD/MM/YY): _____