



# 如何申請醫院全包形式定額收費醫療套餐免找數安排服務？ How to apply for Hospital All-Inclusive Package Cashless Arrangement Service?



此醫院全包形式定額收費醫療套餐免找數安排服務適用於「富通」醫療產品。「醫世保」、「裕醫保」及「御醫保特級」除外。  
This Hospital All-Inclusive Package Cashless Arrangement Service is applicable to FTLife Medical Product. Except for MediPro, MediGold & MediGold Plus.

請根據閣下需要，選擇致電首護醫療支援服務熱線預約醫生進行會診或到指定醫院向閣下所選擇之醫生求診。確定需要進行醫院全包形式定額收費醫療套餐時，請根據情況進行以下步驟：

According to your needs, you may choose to call the Pioneer Medical Services Hotline to arrange consultation with a specialist doctor or to consult doctor at designated hospital(s). Once confirmed Hospital All-Inclusive Package will be performed, please follow the instructions according to the applicable situation:

<b>1A</b>	<p>需要醫生轉介：</p> <p>致電以下專用首護醫療支援服務熱線預約醫院專科醫生進行會診。 香港：(852) 3792 0280</p> <p>當確定需要進行醫院全包形式定額收費醫療套餐時，醫院專科醫生會協助填寫本醫院全包形式定額收費醫療套餐免找數安排服務申請書（「表格」）的第二部份。</p> <p><b>When doctor referral is needed:</b></p> <p>Dial the following Pioneer Medical Services Hotline for reservation of consultation with a specialist doctor. Hong Kong: (852) 3792 0280</p> <p>Once Hospital All-Inclusive Package needs are confirmed, the specialist doctor would complete Part II of this Hospital All-Inclusive Package Cashless Arrangement Service (the "Form").</p>
<b>Or 或</b>	
<b>1B</b>	<p>不需要醫生轉介，直接到閣下之指定醫院醫生處求診（只適用於港怡醫院）。 當確定需要進行醫院全包形式定額收費醫療套餐時，請確保受保人的主診醫生正確填寫表格的第二部份。</p> <p><b>When no doctor referral is needed,</b> consult the doctor of your choice (only applicable to Gleneagles Hong Kong Hospital). Once Hospital All-Inclusive Package needs are confirmed, please ensure the attending doctor of the Insured completes Part II of the form.</p>
<b>2</b>	<p>受保人或保單持有人需填妥表格的第一部份。並於受保人進行全包形式定額收費醫療套餐前最少四個工作天將表格遞交予富通或精算服務有限公司（"AIS"）及其下公司互康集團（"HMG"）。 Insured/ Policy Owner shall complete Part I of the form and send the form to FTLife or Actuarial Insourcing Services Limited ("AIS") and its subsidiary company Healthmutual Group Limited ("HMG") at least 4 working days prior to the Insured's Hospital All-Inclusive Package surgery or procedure.</p>
<b>3</b>	<p>如您的申請成功，富通會於一個工作天內通知您。AIS/HMG將向醫院發出「付款保證書」。 If your application is successful, FTLife will inform you within 1 working day. AIS/HMG will issue a "Letter of Guarantee" to the hospital.</p> <p>*請注意：如醫療費用不超過我們據此表格批准之金額，於受保人完成醫院全包形式定額收費醫療套餐後，醫院會將單據（「單據」）直接交給我們。在理賠手續辦妥後，您將會收到富通發出的賠償通知書。如有差額（定義見下文），您必須在離開醫院前支付差額。 *Please note: If the medical expenses do not exceed the amount we have approved under this Form, then upon the Insured's completion of the Hospital All-Inclusive Package surgery/procedure, the hospital will send the invoice (the "Invoice") directly to us. You will receive a claims statement after the claim is processed. If there is any Shortfall (as defined below), you will need to pay the shortfall before you leave the hospital.</p>

醫院全包形式定額收費醫療套餐免找數安排服務之條款及條件：

## Terms and Conditions for Hospital All-Inclusive Package Cashless Arrangement Service:

- i) 醫院全包形式定額收費醫療套餐免找數安排服務不適用於以下醫療費用：  
No Hospital All-Inclusive Package Cashless Arrangement Service will be provided for medical expenses that are:
  - a) 超出我們就此表格所批准的金額的費用，或  
in excess of the amount we have approved under this Form, or
  - b) 不符合醫療必要或合理及慣常費用定義之費用；或  
the expense which does not meet the definition of Medically Necessary or Reasonable and Customary Charges; or
  - c) 過去免找數安排服務下之逾期差額（如有）；或  
overdue shortfall from previous cashless arrangement (if any); or
  - d) 未在表格上申報之手術/醫療費用；或  
the surgical/medical expenses which has not yet been declared on the Form; or
  - e) 不受該保單保障的費用。  
not covered by the Policy.
- ii) 由於我們是根據對醫學療程的估計批核您的免找數安排服務申請；故此，該批核並不代表我們對您的索償的所有項目均已批核或將會批核。我們保留權利在審閱單據後拒絕您的索償，並追回我們已付但不在該保單的保障範圍內的醫療費用（「差額」），（如有）。  
Since our approval of your application for this Cashless Arrangement Service is based on an estimation of the course of medical treatment, that approval does not mean that we have approved or will approve all items of your claim. We reserve the right to reject your claim upon evaluation of the Invoice, and recoup the part of the medical expenses which we have paid but is not covered by the Policy (the "Shortfall") (if any).
- iii) 富通對醫院全包形式定額收費醫療套餐免找數安排服務引起的一切事項擁有唯一及絕對決定權。  
FTLife has the sole and absolute discretion in relation to all matters arising from the Hospital All-Inclusive Package Cashless Arrangement Service.
- iv) 富通保留終止或變更醫院全包形式定額收費醫療套餐免找數安排服務的權利而無須另行通知。  
FTLife reserves the right to terminate or vary the Hospital All-Inclusive Package Cashless Arrangement Service in our sole discretion without further notice.

醫院全包形式定額收費醫療套餐免找數安排服務申請書  
Hospital All-Inclusive Package Cashless Arrangement Service  
Application Form



保單號碼  
Policy Number

保險代理 / 經紀姓名  
Name of Agent / Broker

保險代理 / 經紀編號  
Code of Agent / Broker

電話  
Telephone No.

此醫院全包形式定額收費醫療套餐免找數安排服務適用於「富通」醫療產品。「醫世保」、「裕醫保」及「御醫保特級」除外。  
This Hospital All-Inclusive Package Cashless Arrangement Service is applicable to FTLife Medical Product. Except for MediPro, MediGold & MediGold Plus.

請於填寫此表格前細閱「如何申請醫院全包形式定額收費醫療套餐免找數安排服務?」之條款及條件。請填妥此表格並於進行日間手術前最少四個工作天, 以傳真(852) 3010 8735或電郵support@hmg.com.hk方式遞交予AIS/HMG。  
Please read the section on “How to apply for Hospital All-Inclusive Package Cashless Arrangement Service?” and the “Terms and Conditions for Hospital All-Inclusive Package Cashless Arrangement Service” before completing this Form. Please send the completed Form to HMG by fax (852) 3010 8735 or e-mail support@hmg.com.hk at least 4 working days prior to performing the procedures.

第一部份-由受保人或保單持有人填寫

Part I - To be completed by the Insured / Policy Owner

A. 受保人及保單持有人個人資料 Personal Particulars of the Insured and Policy Owner			
1. 保單持有人姓名 Name of Policy Owner		2. 受保人姓名 Name of Insured	
		3. 受保人身份證 / 護照號碼 Insured's ID / Passport No.	
4. 受保人年齡 Age of Insured	5. 受保人性別 Sex of Insured	6. 保單持有人電話號碼 Telephone No. of Policy Owner	7. 保單持有人電郵地址 E-mail Address of Policy Owner
B. 受保人住院或日間手術詳情 Information of Confinement or Day Surgery of the Insured			
1. 住院或進行日間手術前有何等徵狀? What are the symptoms presented before confinement or day surgery?		2. 首次就診之前, 受保人有此等徵狀已多久? How long has the Insured been having these symptoms before the first consultation?	
3. 何時因此等徵狀而首次求診 (日/月/年)? When did the first consultation for these symptoms (DD/MM/YY) take place?			
4. 就診詳細情況及其他資料 Details of Consultation and Other Information			
a. 首次就該疾病或受傷診治受保人的醫生的名稱和地址: Name and address of the doctor who first treated the Insured for the injury or the illness:		b. 建議受保人入院的醫生的名稱和地址: Name and address of the doctor who referred the Insured to hospital:	c. 過往就同樣病症曾向其求診的醫生名稱和地址: Name and address of doctors consulted in the past for similar condition:

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 / 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.

2003

聲明及授權書 (由保單持有人及受保人簽署，如受保人未滿18歲，則由其家長或合法監護人簽署)。

**Declaration and Authorization** (To be signed by the Policy Owner and Insured OR to be signed by the Insured's parent / legal guardian if the Insured is under the age of 18).

本人/我們聲明上述一切陳述及對問題的所有答案均為事實之全部，並確實無訛。

I/We declare that the above statements and answers made by me/us are true, accurate and complete.

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承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 or the Insured named to give such information to FTLife Insurance Company Limited. This authorization shall bind the successors and assignees of me/the Insured and remain valid notwithstanding the death or incapacity of me/the Insured. A photocopy of this authorization shall be as valid as the original.

本人 / 我們明白及同意 I/We understand and agree that:

- 1) 遞交此醫院全包形式定額收費醫療套餐免找數安排服務申請書或由貴公司簽發付款保證信均不得被詮釋為等同於貴公司承擔賠償責任。Neither submission of this Hospital All-Inclusive Package Cashless Arrangement Service Application Form nor the issuance of Letter of Guarantee by the Company shall be construed as admission of liability on the part of the Company.
- 2) 倘本人/我們未能提供此申請所需資料，可導致貴公司未能處理此申請。the Company may be unable to process this application if I/we fail to provide any information related to this application.
- 3) 同意離開醫院前自行承擔支付任何超出預計醫療套餐的醫療費用。to undertake to settle the bill before my discharge if any services or expenses incurred over the Hospital All-Inclusive Package.
- 4) 倘是次服務的費用不在本人保單的保障範圍內，本人同意賠償予貴公司或貴公司可在本人將來任何保單下可獲給付的賠償內扣除。to indemnify the Company against all expenses incurred on my behalf, which are not payable under my policy provisions or the Company may deduct any indebtedness in any future claim of my any policies.

本人/我們明白若此醫院全包形式定額收費醫療套餐免找數安排服務申請書的中、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 version and the Chinese version of this Hospital All-Inclusive Package Cashless Arrangement Service Application Form, the English version shall prevail.

保單持有人簽署

Signature of Policy Owner

: x

見証人簽署

Signature of Witness

: x

保單持有人姓名 (大寫)

Name of Policy Owner (in block letters) :

見証人姓名 (大寫)

Name of Witness (in block letters) :

身份證 / 護照號碼

ID / Passport No.

:

日期 (日/月/年)

Date (DD/MM/YY)

:

日期 (日/月/年)

Date (DD/MM/YY)

:

受保人簽署 (年齡十八歲或以上必須簽署)

Signature of Insured (whose age is 18 or above): x

If the Insured is under the age of 18, please provide the following information:

受保人姓名 (大寫)

Name of Insured (in block letters) :

身份證 / 護照號碼

ID / Passport No.

:

日期 (日/月/年)

Date (DD/MM/YY)

:

第二部份 - 由受保人的主診醫生填寫(費用由保單持有人支付)

**Part II - To be completed by the Attending Doctor of the Insured (Cost to be borne by Policy Owner)**

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
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**醫療詳情 Medical Condition**

2. 第一次求診日期(日/月/年) First consultation date (DD/MM/YY):
3a. 是否為病人的常用醫生? Are you the usual medical attendant of the patient?    否 No    是 Yes  b. 如是, 請提供病人首次求診日期 (日/月/年): If 'Yes', please provide patient's first consultation date (DD/MM/YY):
4. 病人是否經其他醫生或醫院轉介? Did other doctor or hospital refer the patient to you?    否 No    是 Yes  若有, 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.
5. 診斷 Diagnosis:
6. 求診時之病徵或不適: The symptoms/complaints on the date of the consultation:
7. 病徵或不適首次出現之日期 (日/月/年): Date on which symptoms/complaints first appeared (DD/MM/YY):
8. 手術 Surgical Procedure  a. 手術日期 (日/月/年) Date of Operation (DD/MM/YY) : _____  b. 手術名稱 Name of Operation : _____  c. 醫院姓名 Name of Hospital : _____
9a. 醫院全包形式定額收費醫療套餐 Hospital All-Inclusive Package  i. 醫療套餐名稱 Name of Hospital All-Inclusive Package: _____  ii. 套餐編號 (如有) Plan code (if applicable): _____  iii. 價格 Price: _____  iv. 如有額外收費, 請列明收費項目、價格及原因 If Additional charge incurred, please list the details of charge, amount and the reason.

## 9b. 不適用醫院全包形式定額收費醫療套餐 Not applicable to Hospital All-Inclusive Package

原因 Reason: \_\_\_\_\_

手術名稱 Name of Surgery: \_\_\_\_\_

1. 手術前診金 Pre-Consultation Fee: \$ \_\_\_\_\_ X \_\_\_\_\_ 次 times

2. 手術後診金 Post Consultation Fee: \$ \_\_\_\_\_ X \_\_\_\_\_ 次 times

3. 醫生手術費 Surgeon Fee: \$ \_\_\_\_\_ 4. 手術室費 Facility Fee: \$ \_\_\_\_\_

5. 麻醉師費 Anesthetic Fee: \$ \_\_\_\_\_ 6. 其他費用 Other miscellaneous expenses: \$ \_\_\_\_\_

**醫生聲明及簽署 Doctor's Declaration and Signature**

本人謹此證明本人已親自為病人就上述之病症或受傷進行檢查，並確認以上提供的有關病人現時及過去的情況的資料就本人所知所信屬實。

I hereby certify that I have personally examined the patient and attended to his/her 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)

\_\_\_\_\_

\_\_\_\_\_