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

FTLife 富通保險

保單號碼
Policy Number

保險顧問姓名
Consultant Name

保險顧問編號
Consultant Code

電話
Telephone No.

❒ **住院醫療賠償 Hospital Reimbursement**
❒ **住院現金賠償 Hospital Cash**

提供此賠償申請書或進行有關此索償的調查並不表示富通保險有限公司（以下簡稱“富通保險”）會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.
填表之前請詳細閱讀後頁的“填表須知”。
Please read the Instructions overleaf carefully before you complete this claim form.

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）
Part I - To be completed by the Insured (or Policy owner if insured is under age 18) ❒ 首次索償 New Claim ❒ 再次索償 Further Claim

退件及郵遞安排 Return Documents & Postal Arrangement
請於下列適當之方格內加上“✓”號 Please tick the appropriate box(es) below

❑ 退回正本收據 Return original receipt(s) ❑ 支票直接寄往通訊地址 Mail cheque(s) to corresponding address directly

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. 電話號碼 Telephone No.

5. 現時職業及詳細職責 Current occupation and job duties with details	6. 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)	7. 僱主地址 Address of Employer

B. 住院詳情 Information of Hospitalization

1. 醫院名稱及地址： Name and address of Hospital:	2. a. 門診手術日期 (日/月/年) Outpatient Surgery Date (DD/MM/YY): 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):

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 admission?	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. 有否就此住院同時向本公司之團體保險部或其他保險公司提出索償？如有，請列明保單號碼及公司名稱。
Any concurrent claim about this hospitalization with our Group department or other companies? If yes, please give the policy number and the name of the company.

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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

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) :

填表須知 Instructions

1. 請回答申請書第一部份所有問題並簽署聲明及授權書。
   Please answer ALL the questions of Part I of this claim form and sign the declaration and authorization.
2. 此申請書第二部份必須由主診醫生填寫並由您支付有關費用。
   Part II of this claim form MUST be completed and signed by the doctor who attended the Insured for his injury or illness. The completion of this part is at own expenses.
3. 如有必要，本公司將要求您提供其他文件，例如病假紙、醫生報告、物理治療報告、X光報告等以便審核。
   We may ask for other documents or information from you if deemed necessary, such as Sick Leave Certificate, Medical Certificate, Physiotherapy Report, X-Ray Report.
4. 請將填妥的索償申請書連同其他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 forms and other supporting documents to our Claims Dept. Address: 7/F, NEO, 123 Hoi Bun Road, Kwun Tong, Kowloon. Tel. 2866 8898.
5. 請注意，閣下於此索償申請表頁一上填寫的保險顧問將會是閣下授權唯一能跟進及處理是次索償的人士。
   Please note that the consultant that stated on page 1 would be regarded as the only authorized agent to follow up and handle the claim.

保險顧問備註 Consultant’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. 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):

7. 手術 Surgical Procedure

a. 手術日期 (日/月/年)：
Operation date (DD/MM/YY):

b. 手術名稱：
Procedure name:

c. 手術醫生之姓名：
Surgeon's name:

8. 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

9. 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

10. 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。
Did the patient take any home leave during the confinement period? If yes, please give details of the date and time.

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11. 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.

12. 你曾否轉介該病人其他醫生或醫院？ Did you refer the patient to other doctor or hospital? 否 No ❒ 有 Yes ❒

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.

13. 你曾否於該病人住院期間轉介他/她往專科醫生？ Did you refer the patient to other medical specialist during the hospitalization period? 否 No ❒ 有 Yes ❒

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.

14. 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?

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.

15. 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.

16. 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.

17. 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)