

## MEDICAL INSURANCE - HOSPITALIZATION & SURGICAL CLAIM FORM

### 醫療保險- 住院及手術索償表格

Please complete and sign this claim form and make sure that the original copy of invoices and receipts are attached. (Please complete in BLOCK LETTER)  
 請填妥及簽署此賠償申請表並附上所有醫療收據正本 (請用正楷填寫)

<b>PART I - To Be Completed by the Patient 甲部 - 由病人填寫</b>		
Name of Policyholder / Employer 保單持有人/僱主名稱	Policy No 保單號碼	Certificate No. 証書號碼
Name of Employee (For group account only) 僱員姓名 (只適用於團體合約)	Day Time Contact Tel No. 日間聯絡電話	
Name of Patient 病人姓名	Date of Birth(DD 日/MM 月/YY 年) 出生日期	Sex 性別
1. Describe the symptoms and abnormalities which led to the hospitalization 請列出病人因何不適及有何症狀導致是次入院		
2. Since when had these symptoms first appeared 病人於何日首次出現上述症狀	3. Date of the first consultation 初診日期	
4. Name, address and telephone no. of doctor/hospital the patient first consulted for the illness 初診醫生姓名 / 醫院名稱、地址及電話		
5. Has the patient been treated by other doctor(s) for similar or related illness in the past? 病人曾否因同一或有關之病症而向其他醫生求診? Yes 是 <input type="checkbox"/> No 否 <input type="checkbox"/> If "yes", please specify 如 "是", 請詳述 <u>Treatment Date 診治日期</u> <u>Name &amp; Address of doctor(s) / hospital(s) 醫生姓名 / 醫院名稱及地址</u>		
6. Was this hospitalization caused by an accident? 該住院是否因意外引致? Yes 是 <input type="checkbox"/> No 否 <input type="checkbox"/> If "yes", 如 "是" Please state when, where and how did it happen 請詳述意外發生的日期、地點及經過  <u>Did the patient report such accident to the Police? 病人有否就這宗意外報警? Yes 有 <input type="checkbox"/> No 沒有 <input type="checkbox"/> If "yes" 若有</u> <u>Name/address of police station? 警署名稱/地址 (Please attach a copy of the police report 請提交有關報告副本)</u>		
7. Has the patient submitted or does the patient intend to submit a claim to another insurance company(ies) as a result of this hospitalization/surgery? 有關是次索償, 病人是否已經或有意向其他保險公司遞交索償申請? Yes 是 <input type="checkbox"/> No 否 <input type="checkbox"/> If "yes", 如 "是" Please provide name, address and policy number of the other insurance company(ies). 請提供有關保險公司之名稱、地址及保單號碼 <u>Name and Address of Insurance Company 保險公司名稱及地址</u> <u>Policy Number 保單號碼</u>		
8. Please provide name and address of family doctor (or the doctor usually consulted by the patient) 請提供病人之家庭醫生(或經常求診醫生)的姓名及地址		

### DECLARATION AND AUTHORIZATION 聲明及授權

I/We declare that the above statements and answers made by me/us are true and complete to the best of my/our knowledge. I/We hereby authorize any employer, physician, hospital, insurance company, other organization or person who has any record or knowledge with reference to the accident, or the health and medical history of the patient, to give such information to Wing Lung Insurance Co Ltd or its representative, such authorization to survive me/us in so far as legally possible. A photocopy of this authorization will be as valid as the original.  
 I/ We confirm that I/We have read and understood the "Personal Information Collection Statement" attached in this Claim Form.

本人/吾等謹此聲明, 以上所填報之一切資料, 均屬真實完整無訛。本人/吾等現授權持有有關上述意外事件資料或本人/吾等健康資料或病歷之僱主、醫生、醫院、保險公司、機構或人士, 將全部此等有關之資料給予永隆保險有限公司或其代表。如法律上可行, 本授權書在本人/吾等身故後仍然有效。此授權書之影印本與正本均具同等效力。

本人/吾等確認已閱讀並清楚明白附於本索償表格內之「收集個人資料聲明」。

X

Signature of Patient 病人簽署

Name 姓名

Date Signed 簽署日期

( N.B. : If the patient is under 18 years of age, this form should be signed by his/her parent. 注意: 如病人是十八歲以下, 此表格需由其家長簽署。 )

**Continued on Part II to be completed by the attending doctor 繼續乙部由主診醫生填寫**

**PART II - To Be Completed by Attending Physician / 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): \_\_\_\_\_

Date of Admission 入院日期 (DD 日/MM 月/YY 年) \_\_\_\_\_ Date of Discharge 出院日期 (DD 日/MM 月/YY 年) \_\_\_\_\_

Name of Hospital 醫院名稱 \_\_\_\_\_

Level of hospital ward 病房級別: Private 頭等房 Semi-private 二等房 Ward 三等房 Clinical Surgery 門診小手術**1. Clinical History 求診記錄**

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

b) Symptoms / 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  
\_\_\_\_\_  
\_\_\_\_\_

c) 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. Hospitalization Details 住院詳情**

a) Final Diagnosis 最後的診斷 \_\_\_\_\_ Date of Operation 手術日期(DD 日/MM 月/YY 年) \_\_\_\_\_

b) Operation procedure(s) performed 手術的名稱 \_\_\_\_\_

c) If the patient has consulted other physician during this hospitalization, please provide the following 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 physician consulted 醫生姓名 \_\_\_\_\_ Reason 原因 \_\_\_\_\_

What treatment had the physician performed 治療詳情 \_\_\_\_\_

d) Please give a brief discharge summary (including onset and duration of signs and symptoms/disease, etiology, types and results of major examinations, treatments, complications and follow up plan)請提供出院摘要(包括開始時及持續出現的徵兆/症狀、病因、主要檢查的種類及結果、治療、併發症及覆診詳情)  
\_\_\_\_\_  
\_\_\_\_\_

e) Please provide reason(s) for hospitalisation if this type of cases can be managed on day care / out-patient basis.

若此次病症能在日間護理/診所內進行治療, 請提供住院原因。

**3. Professional Comment 專業意見**

a) In your opinion, was the patient hospitalised as a result of recurrent episode or a chronic illness or related to a previous complaint / diagnosis.

If "yes", please provide 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。

b) 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)

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

**Others 其他**a) If the patient was referred by another doctor, please provide the referring doctor's name and address.如病人由其他醫生轉介, 請提供轉介醫生的姓名和地址。  
\_\_\_\_\_  
\_\_\_\_\_b) Are you the patient's usual physician? 閣下是否該病人的慣常醫生? Yes 是 / No 否

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。

**X**

Signature &amp; Chop of attending physician / 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 physician/Surgeon &amp; qualifications 主診醫生姓名/外科醫生姓名及資歷

Date 日期 (DD 日/MM 月/YY 年)

## **PERSONAL INFORMATION COLLECTION STATEMENT**

The information you provide to Wing Lung Insurance Co. Ltd. (“the Company”) is collected to enable us to carry on our business by providing insurance and other financial products and services in Hong Kong (“the Business”). This includes but not limited to the personal data contained in the proposal form or in any document in relation to the general insurance services and products or any claim made under the product.

Provision of the personal data to the Company by you is voluntary. However, failure to supply personal data may result in the Company being unable to provide insurance and/or related products and services to you, process claims under insurance policies issued and/or arranged by the Company, and/or process any of all other requests, enquiries, complaints from you and/or to comply with any laws or guidelines issued by the regulatory or other authorities.

You agree that your personal data may be used by us for the purposes of:

- the evaluation, assessment, communication, daily operation, administration and enforcement of services and facilities in relation to any insurance or any financial related product or service or any alternations, variations, cancellation or renewal of the such product or service;
- assessment and processing of any claim or investigation or analysis of such claim and any subsequent legal proceedings;
- any sales, promotion, marketing of other general insurance products and services provided by us;
- exercising any right of subrogation, if applicable;
- compliance with the laws, statutes, rules, regulations and codes of conduct and practice binding on the Company in relation to our business;
- purposes of statistical or actuarial researches carried out by the Company; and
- other purposes connected with, or necessary to carry out any of the activities set out above.

Your personal data will be kept confidential by us, but you agree that we may be transferred to:

- any related subsidiary or affiliated company or any other company carrying on insurance or reinsurance related business or any intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes in or out of Hong Kong;
- any association, federation or similar organization of insurance companies (“Federation”) that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation;
- any member(s) of the Federation by the Federation for any of the above or related purposes;
- any auditors, accountants, lawyers, other professional advisers, employees, sub-contractor, agent, contractor or third party who provides administrative, telecommunications, computer, payment, debt collection, data processing or storage or other services provider providing services relevant to the Company’s business; and
- Wing Lung Bank Group for the purposes of :-
  - management, operation and maintenance of the Company’s business; and
  - design and improvement of the Company’s business.

In this statement, the following terms shall have these following meanings:

“Bank” means Wing Lung Bank Ltd.;

“Wing Lung Bank Group” mean the Bank, any subsidiary undertaking of the Bank, any related company of the Bank, any associated company of the Bank, any direct and/or indirect parent undertaking of the Bank, any subsidiary undertaking of any such parent undertaking, any of their related companies, any of their associated companies including, for the avoidance of doubt, undertakings within the group of China Merchants Group Ltd (and “Group member” shall be construed accordingly); and

The expressions “subsidiary undertaking”, “parent undertaking” and “undertaking” bear the meanings under the Companies Ordinance (Cap.32).

Moreover, we are hereby authorized to obtain access to and/or to verify any of your and/or the Insured Person(s) data with the information collected by the Federation from the insurance industry.

Under the relevant laws and regulations, you have the right to check whether we hold your personal data and to obtain access to that data, to request correction of any personal information concerning yourself held by the Company, to ascertain our policies and practices in relation to the data and to be informed of the kind of data held by us. We reserve the right to charge you a reasonable fee for complying with any request for access to your data. You also have a right, at any time and without charge, to request to opt out from receiving any direct marketing communication from us. If you wish to exercise these rights, please write to our Data Protection Officer. Nothing in this statement shall limit your rights under the relevant laws and regulations.

If there is any inconsistency or conflict between the English and Chinese versions, the English version shall prevail.

The Data Protection Officer  
Wing Lung Insurance Co. Ltd.  
45 Des Voeux Road,  
Central, Hong Kong  
Tel: 2826 8259  
Fax: 2526 7045

March 2012  
Wing Lung Insurance Co. Ltd.

## 收集個人資料聲明

閣下向永隆保險有限公司(「本公司」)提供的資料，是收集作為本公司在香港提供保險和其他金融產品和服務所需。當中包括但不限於你在申請表填寫或任何與一般保險服務和產品有關之文件上或任何透過產品索償上所載之個人資料。

閣下是自願向本公司提供個人資料。然而，若閣下未能提供個人資料，可能導致本公司不能為閣下提供保險及/或相關產品與服務，處理經由本公司發出及/或安排的保單之下的索償事宜，及/或處理閣下的任何或所有其他要求、查詢或投訴及/或遵守法例規定或監管或其他管理機構所發出的指引。

閣下同意閣下的個人資料可被本公司用於以下用途：

- 審計、評估、溝通、日常運作、管理或執法任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期；
- 評價及處理任何索償或索償分析及任何日後的法律訴訟之用；
- 任何本公司提供的其他一般保險產品及服務銷售、市場營銷及推廣用途；
- 行使任何代位權，如適用；
- 履行一切約束本公司業務、客戶個人資料的法律、法規、規則、規例、工作守則及慣例；
- 由本公司所進行或本公司所參與的統計或精算研究；及
- 其他任何與上述所需及有關的行動。

本公司持有的閣下資料將予保密，但是在閣下的同意下，本公司可能會將有關資料移轉予：

- 任何在香港或在香港以外地方的有關的公司、附屬公司或子公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關的目的；
- 現存或不時成立的任何保險公司協會或聯會或類同組織(「聯會」)，以達到任何上述或有關的目的，或以便「聯會」執行其監管職能，或其他基於保險業或任何「聯會」會員的利益而不時在合理要求下賦予「聯會」的職能；
- 或透過「聯會」移轉予任何「聯會」的會員，以達到任何上述或有關的目的；
- 任何核數師、會計師、律師、其他專業顧問、僱員、分包商、代理人、承包商或提供行政、電訊、電腦、付賬、債務追討、數據處理或儲存或有關提供本公司服務的第三者供應商；及
- 永隆銀行集團作以下用途:-
  - 管理、運作及保養本公司服務；及
  - 設計及改善本公司服務。

在本聲明內，下列詞語具以下涵義:-

「銀行」指永隆銀行有限公司；

「永隆銀行集團」指銀行、銀行的任何附屬企業、銀行的任何關連公司、銀行的任何相聯公司、銀行的任何直接和/或間接母企業、任何前述母企業的任何附屬企業、其任何關連公司或相聯公司，為免產生疑問，包括招商局集團有限公司轄下各企業(而「本集團成員」須據此解釋)；及「附屬企業」，「母企業」及「企業」具有香港法例第32章公司條例所指之相同涵義。

此外，本公司亦據此獲授權由「聯會」從保險業內收集的資料中查閱及/或核對閣下及/或受保人任何資料。

根據有關法律及法規，閣下有權要求查閱本公司是否擁有閣下的資料並取得此等資料、更正本公司持有有關閣下的資料之紀錄及確定本公司處理資料慣例和獲告知本公司持有的資料類別。本公司保留就依從閣下要求查閱閣下的資料而向閣下收取合理費用的權利。閣下亦有權在將來任何時間選擇拒收任何本公司的直銷產品及服務的推廣資訊而閣下毋須承擔任何費用。如閣下欲行使以上權利，請以書面形式通知本公司的資料保護主任。本聲明不會限制閣下就有關法律及法規可行使的權利。

本條款及細則的中、英文如有歧異，概以英文本為準。

資料保護主任  
永隆保險有限公司  
香港中環德輔道中 45 號  
電話：2826 8259  
傳真：2526 7045

2012年3月  
永隆保險有限公司