HSBC Life 滙豐保險

HSBCMIN

HSBC Voluntary Health Insurance Scheme Medical Claim Form
滙豐自願醫保計劃醫療索償表

HSBC Life (International) Limited, incorporated in Bermuda with limited liability (the "Company" or "HSBC Life")
滙豐人壽保險(國際)有限公司(註冊成立於百慕達之有限公司)(「本公司」或「滙豐保險」)

Medical Concierge Hotline
醫療禮賓熱線：
(852) 3128 0122

Please submit the form and relevant documents to one of the available channels below. 請將表格和相關文件用以下其中一種方式遞交。

- *Scan the QR code on your right hand side to upload documents to "Document Upload Service" on HSBC website*
  您可以掃瞄右方的二維碼上載相關文件到滙豐網站上的「文件上載服務」；OR 或
- *Mail to 18/F, Tower 1, HSBC Centre, 1 Sham Mong Road, Kowloon, Hong Kong 郵寄至香港九龍深旺道1號滙豐中心1座18樓；OR 或*
- *Submit to any HSBC Branch 可於任何滙豐分行遞交*

Part I – to be completed by the insured person or claimant in English or Chinese
甲部 – 由受保人或索償人以英文或中文填寫

Details of Insured Person 受保人資料

Policy No. 保單號碼：	Name of Insured Person 受保人姓名	I.D. Card/Passport No. 身份證／護照號碼

Contact Number 聯絡電話 _____ Email Address 電子郵件地址 _____

Details of Pre- and Post-Confinement/Day Case Procedure Outpatient Care 入院前或出院後／日間手術前後的門診護理詳情

Date of Outpatient 門診日期	Period of hospitalisation or date of surgery 住院期間或手術日期
(____／____／____) DD日 MM月 YYYY年	(____／____／____) to 至 (____／____／____) DD日 MM月 YYYY年 DD日 MM月 YYYY年

Details of Body Check Up (applicable to Gold level and Diamond level only) 身體檢查詳情(只適用於金級及鑽級)

Date of body check-up 身體檢查日期	Type of check-up 檢查類別
(____／____／____) DD日 MM月 YYYY年	_____

Name and address of hospital and/or health care provider 醫院及／或醫療服務提供者之名稱及地址

Details of Hospitlisation and Surgery 住院及手術詳情

Hospitalisation/surgery due to 住院／手術原因 ☐ Illness 疾病 (Please fill in section I 請填寫I部) ☐ Accident 意外 (Please fill in section II 請填寫II部)

(I) Hospitalisation/Surgery due to Illness 因疾病住院／手術

Description and duration of symptoms 請詳述病徵及該病徵已存在多久

Name of hospital/outpatient center and address in respect of hospitalisation/surgery relating to the current claim
就有關此索償，住院／手術之醫院／日間手術中心名稱及地址

Have you had any prior treatment for this or related condition? ☐ Yes 是 ☐ No 否
您是否曾經接受任何此類或相關疾病的治療?

If yes, please provide details below. 如是，請提供以下資料 Name & Address of attending physician/surgeon 主診醫生／外科醫生姓名及地址	Consultation Date 求診日期 (____／____／____) DD日 MM月 YYYY年
_____	

(II) Hospitalisation/Surgery due to Accident 因意外住院／手術

Date and time of accident 意外日期及時間	Location of accident 意外地點
(____／____／____) DD日 MM月 YYYY年	_____

Brief description of the accident, part of body injured and type of injury 意外經過、受傷部位及傷勢

Claims with other insurance company(ies) 向其他保險公司索償

Are you making claims to any other insurance company as a result of the treatment? 有關是次治療，您有否向其他保險公司申請索償？	If yes, please provide details below and a copy of the settlement advice from the other insurers 如有，請提供以下資料及提供其他保險公司之賠償結算通知副本
☐ Yes 是 ☐ No 否	(a) Name of insurance company 保險公司名稱 _____ (b) Policy Number 保單號碼 _____

Request for Document Return 退還文件要求

☐ Please "✓" this box if you wish to obtain Certified True Copy(ies) of original invoice(s) and receipt(s) after claim processing. 如您欲索取醫生的發票和收據核證副本，請在空格內填上「✓」號。

Note 注意：

(1) Certified True Copy will not be issued if the claims are fully reimbursed. 如索償已獲全數賠償，核證副本將不獲發出。

(2) The originals will not be returned and will only be retained for 3 months from the claim processed date. 正本文件將不獲退還，並將只從索賠處理完成日期起計保留3個月。

No Claim Discount (NCD) 無索償折扣 (Only Applicable to HSBC Voluntary Health Insurance Flexi Plan)（只適用於滙豐自願醫保靈活計劃）

Important Note 重要通知

If after a no claim discount has been deducted, a claim incurred in respect of previous five (5) Policy Years becomes payable under This Plan, the no claim discount shall be re-calculated by taking into account the relevant claim payable, and the Policyholder shall return to the Company immediately the difference between the recalculated amount (in respect of no claim discount) and the no claim discount actually offered to the Policyholder. 在扣除無索償折扣後，若本公司須就前五(5)個保單年度內產生的索償按本計劃支付賠償，則無索償折扣應根據有關賠償額而重新計算，及保單持有人須立即向本公司交回實際提供予保單持有人的無索償折扣與重新計算的無索償折扣金額之間的差額。

Payment Instruction 付款指示

☐ By Bank Account 經銀行戶口

Transfer to the Policyholder's sole or joint name bank account below 轉賬至以下保單持有人之個人或聯名銀行戶口

Bank Name and Branch 銀行及分行之名稱	Bank No. 銀行編號	Branch No. 分行編號	Account No. 賬戶號碼

Notes 註:

If no identity verification has been performed by Bank staff for this request, please also submit adequate proof showing the Policyholder's full name and the bank account number (such as copy of bank book, ATM card, bank statement etc) to the Company. If we do not receive the copy of the required document(s), the payment will be made by cheque payable to the Policyholder (if and to the extent that any claim is valid and acceptable) and mailed to the Policyholder's correspondence address. 如此申請並沒經由銀行職員作出身份核實，請同時提交印有保單持有人全名及銀行戶口號碼之充足證明(如銀行存摺或自動櫃員機卡或月結單副本等)。若您沒有提供上述所需文件，(如有關索償有效並已被接納)款項將以支票形式寄予保單持有人之通訊地址。

☐ By Cheque 以支票形式

Mail the cheque to the Policyholder's correspondence address 寄往保單持有人之通訊地址

For your attention 請注意：

1. Any claim for Eligible Expenses made by the Insured Person in any foreign currency shall be converted to HKD at the opening indicative counter exchange selling rate published by The Hong Kong Association of Banks in respect of that foreign currency for the date on which the actual Eligible Expenses are settled by the Policyholder or the Insured Person. If such rate is not available on the date concerned, reference shall be made to the rate as soon as it is available afterwards. If no such rate exists, the Company shall convert the foreign currency at the rate certified as appropriate by the Company's bankers which shall be deemed to be final and binding. 任何以外幣索償的合資格費用，必須按保單持有人或受保人支付實際合資格費用當日，該貨幣在香港銀行公會發布的貨幣開市參考賣出牌價兌換成港元。若當日沒有可參考的兌換率，本公司必須參考緊接當日後的最新兌換率。若香港銀行公會沒有該外幣的兌換率，本公司會以本公司使用的銀行認可兌換率作為最終的安排。
2. Subject to the terms of the Policy, unless otherwise specified, claim payment will be made according to the current payment instruction (if any) registered with the Company. 根據保單條款，如無明確指示，賠償會按本公司的現有記錄轉賬(如有)。
3. If the receiving bank is a non-HSBC or different currency bank account, bank charges or exchange rate difference may incur which will be deducted from the amount payable by the said receiving bank and/or HSBC, if applicable. The Company will not be liable for any charges due to different bank or currency or rejection of transaction by the receiving bank as a result of inconsistent bank account details. 如收款戶口非滙豐銀行或不同貨幣戶口，該銀行及／或滙豐銀行可於款項中收取服務費用或兌換差價，如適用。本公司將不會承擔任何因不同銀行或貨幣而導致被收取之費用或因銀行戶口資料不乎而被拒絕轉賬之責任。

Claims Document Checklist 索償文件清單

Basic Documents 基本文件

- ☐ Part I is fully completed & signed by the Policyholder/Insured Person 索償表甲部經由保單持有人／受保人填寫並簽署
- ☐ Part II is fully completed & signed by the Attending Physician/Surgeon with chop (to be obtained by Insured Person/claimant) 索償表乙部經由主診醫生／外科醫生填寫，簽署並蓋印（由受保人／索償人索取）
- ☐ Original receipt(s) of the medical expenses (including but not limited to deposit receipt) 醫療費用收據正本（包括但不限於按金收據）
- ☐ Copy of settlement advice from other insurer (if applicable) 其他保險公司之賠償結算通知副本（如適用）
- ☐ Copy of Histopathology, Laboratory Test Report, Endoscopic, Ultrasonogram, X-Ray, CT Scan, MRI, Diagnostic Written Report(s) and Operating theatre summary (if applicable) 病理學、化驗報告、內窺鏡、超聲波、X-光、電腦掃描、磁力共震、手術室摘要及診斷之書面報告副本（如適用）
- ☐ Copy of Bank Account Proof (applicable for Policyholder's sole or joint name bank account other than Policyholder's premium deduction account) 銀行戶口證明文件副本（適用於保單持有人之個人或聯名非保費轉賬戶口）

Notes 註:

1. The claim application of confinement and pre-or post-confinement treatment expenses can be submitted together. However, the claim application must be submitted within 90 days after the date on which the Insured Person is discharged from the Hospital, or (where there is no Confinement) the date on which the relevant Medical Service is performed and completed. 索償申請可連同入院、前或後有關之門診治療費用一拼遞交，惟必須於出院或接受相關治療完結後的90天內提出索償。
2. Please ensure completion of the above checklist to avoid unnecessary delay in claim process. 請確保完成以上各項以免延緩索償進程。
3. We will inform you as soon as possible if we require additional information from you or we consider that your claim has to be assessed from third parties (such as doctor, hospital, etc.). As the time required for obtaining the information is variable, the processing time of your claim will likely be lengthened. Any and all expenses (relating to obtaining information and/or reports from third parties in respect of the claim or any related matters) incurred will be borne by the Policyholder. 若我們有需要就審核是次賠償申請而向閣下或其他人士（如醫生、醫院等）索取額外資料，我們會盡快通知閣下。因索取有關資料需時賠償申請的審核時間會較長。就有關此索償，從第三方獲得之資料及／或報告而產生之任何及所有費用須由保單持有人所承擔。

Declaration and Authorisation 聲明及授權

I/we hereby certify that all the answers and statements given above are true and complete and that I/we have not withheld any information. 本人（等）在此聲明以上所提供的資料均屬正確無訛且並無缺漏。

I/we authorise any physician, hospital, clinic, insurance company or other individual organisation or government office that has any records or knowledge of me/us or my/our health, to disclose to HSBC Life (International) Limited or its representative any information relevant to this claim. This authority shall remain valid notwithstanding my death or incapacity and a copy of this authorisation shall be as effective and valid as the original. 本人（等）授權任何知道本人（等）健康情況及據知任何紀錄之醫生、醫院、診所、保險公司或其他私人、政府機構向滙豐人壽保險（國際）有限公司或其代表提供本人（等）之有關資料。此授權書於本人（等）死亡或喪失能力後依然生效。本授權書之影印本亦屬有效。

By signing below, I/we confirm the above application and agree that the Company may use and disclose all personal data about me/us that the Company currently or subsequently hold for the purposes as set out in the Notice relating to the Personal Data (Privacy) Ordinance (which may otherwise be referred to as 'Personal Information Collection Statement') that HSBC have most recently notified me of, and I understand I can scan the QR code below or URL https://www.hsbc.com.hk/content/dam/hsbc/hk/docs/insurance/notice-relating-to-the-personal-data-privacy-ordinance.pdf for review or else I can request a copy by visiting my local HSBC Branch or through the Life Insurance Service Hotline: 本人（等）在下方簽署即確認上述申請並同意 貴公司可按本表格隨附的關於個人資料（私隱）條例的通知內列出的用途使用及披露 貴公司現時或其後持有有關本人（等）的全部個人資料。該條例亦是 貴公司最近通知本人有關「個人資料收集聲明」，本人亦明白「個人資料收集聲明」可以掃瞄下方的二維碼或網址https://www.hsbc.com.hk/content/dam/hsbc/hk/docs/insurance/notice-relating-to-the-personal-data-privacy-ordinance.pdf瀏覽及可向滙豐各分行或致電(852) 2583 8000索取。

Personal Information Collection Statement (English)

個人資料收集聲明（中文）

Signature 簽署

Signature of Life Insured 受保人簽署	Signature of Policyholder 保單持有人簽署
Name 姓名:	Name 姓名:
Date 日期:	Date 日期:

For Bank Use

☐ Client's identity card copy attached ☐ Copy of Client's other bank account information checked (only applicable if customer choose to pay to non premium deduction acount)			Branch Chop
Staff Name	Staff ID No.	Contact No.	
Servicing Staff IA No.	Servicing Staff RI No.	Branch No.	

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Part II – to be completed by the attending physician/surgeon at the claimant's own expenses in English or Chinese
乙部 – 由主診醫生／外科醫生以英文或中文填寫，所需費用由索償人自行承擔

A. Details of Insured Person (Patient) 受保人（病人）資料

1. Name of Insured Person (Patient) 受保人（病人）姓名：	2. Date of birth 出生日期（DD日／MM月／YYYY年）
3. ID card/Passport no. 身份證／護照號碼：	4. Age 年齡：

B. Clinical History 臨床病歷

5. (a) Date of first consultation 首次求診日期（DD日／MM月／YYYY年）：_____

   (b) Symptom(s)/chief complaint(s) presented onset date 出現病徵／主訴病徵日期（DD日／MM月／YYYY年）：_____

6. How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前該病徵已存在多久?

7. Is it a chronic/recurrent illness? 是否慢性／復發疾病? ☐ Yes 是 ☐ No 否

8. Diagnosis of condition (ICD10 WHO version 國際疾病分類代碼) 病情診斷：

C. About Hospitalisation/Day Case Procedure/Advanced Diagnostic Imaging Test 有關住院／日間手術／先進影像診斷檢查

9. (a) Name of hospital/day case procedure centre/medical clinic 醫院／日間手術護理中心／醫療診所名稱

   ☐ Inpatient 住院 ☐ Hospital OPD 醫院門診 ☐ Day Centre 日間中心 ☐ Medical Clinic 醫療診所

   _____

   (b) Ward class 住院級別

   ☐ Private 私家房 ☐ Semi-private 半私家房 ☐ Ward 大房 ☐ Hospital day ward 醫院日症
   ☐ Day case procedure centre 日間手術護理中心／ Medical clinic 醫療診所

   (c) Date of admission/treatment 入院／治療日期（DD日／MM月／YYYY年）_____

   (d) Date of discharge 出院日期（DD日／MM月／YYYY年）_____

10. Final diagnosis at the time of discharge 出院時最後的診斷

11. Name of surgery/treatment 手術或治療名稱

12. Has the patient been consulted by other Physician/Surgeon(s) during this hospitalisation? 病人曾否於住院期間向其他醫生／外科醫生求診?

    ☐ Yes 是 ☐ No 否

    (a) Name of Physician/Surgeon 醫生／外科醫生姓名_____

    (b) Reason 原因_____

    (c) Treatment Performed 治療詳情_____

13. Please provide details of the hospitalisation, including treatment, investigations, tests conducted, on-going treatment and recovery plan. 請提供是次住院詳情，包括相關治療，檢查，測試結果，持續治療及康復計劃。

14. Did the patient take any home leave during the hospital confinement? 病人是否於住院期間離院？ ☐ Yes 是 ☐ No 否

    If yes, please specify the reason and the period of home leave 如有，請註明該離院時段和原因

15. Please provide details of the period of hospitalisation including reasons for number of days as in-patient. 請提供是次持續留院日數及其原因。

16. Is it possible that the treatments/investigations of the patient be managed on an out-patient basis? 病人的治療／檢查是否可在門診進行？

    ☐ Yes 是 Please provide reason(s) for this hospitalisation 請提供是次必須留院接受治療之原因

    _____

    ☐ No 否 Please provide reason(s) 請提供原因_____

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D. Professional Opinion 專業意見

17. (a) In your opinion, was the hospitalisation a result of recurrent episode/chronic illness or related to a previous condition? 您認為是次住院是因為復發性／長期疾病或之前的疾病／意外？

☐ Yes 是 ☐ No 否 If yes, please provide dates and details. 請提供日期和説明細節

(i) Date 日期（DD日／MM月／YYYY年）_____

(ii) Details 細節_____

(b) Was the condition due to or associated with the following? 上述情況是否與以下問題有關?

☐ Accidental bodily injury 意外身體受傷 ☐ Self-inflicted injury 自我傷害 ☐ Abuse of drugs or alcohol 濫用藥物或酒精
☐ Mental disorder 精神紊亂 ☐ Refractive error 屈光不正 ☐ Developmental condition 發育問題
☐ Infertility or sterilization 不育或絕育 ☐ Contraception 避孕 ☐ Treatment for cosmetic purpose 美容性質的治療
☐ Vaccination 疫苗接種 ☐ Pregnancy 懷孕 ☐ Congenital condition 先天性疾病／異常

E. Cancer/Tumour-Related Treatment 癌症／腫瘤相關疾病

18. (a) Type of treatment administered 治療種類

☐ Surgical 外科治療 ☐ Chemotherapy 化療 ☐ Hormonal Therapy 荷爾蒙治療
☐ Target therapy 標靶治療 ☐ Radiotherapy 電療 ☐ Immunotherapy 免疫療法
☐ Other 其他

_____

(b) Date of treatment 治療日期（DD日／MM月／YYYY年）_____

19. Please provide details of the treatment including drug name, dosage, frequency and duration of treatment, all other types of treatment and any complications 請提供治療細節如藥物名稱，藥物劑量，治療頻率，持續治療的時間及其他治療類別和其併發症

F. About the Health History 有關診治記錄

20. Has the patient previously suffered from related conditions of this illness? If yes, please provide the dates of physician's/surgeon's consultation/hospital admission, details of conditions and diagnosis 病人曾否出現與此疾病相關的徵狀？如有，請提供醫生／外科醫生就診日期，入院日期，有關徵狀及診斷

☐ Yes 是 ☐ No 否

Date of physician's/ surgeon's consultation or hospital admission 醫生／外科醫生就診或住院日期 （DD日／MM月／YYYY年）	Name of physician/ surgeon/hospital 醫生／外科醫生姓名或醫院名稱	Symptoms 病徵	Diagnosis 診斷	Treatments given (please state name of surgical procedure if performed or to be performed) 所提供的治療（請列明已接受或將會進行的手術名稱）

G. Other 其它

21. (a) Are you the patient's usual physician/surgeon? 您是否該病人的慣常醫生／外科醫生? ☐ Yes 是 ☐ No 否

(b) Referring physician's/surgeon's name and address, if applicable 轉介醫生／外科醫生的姓名和地址，如適用

(i) Name of physician/surgeon 醫生／外科醫生姓名_____

(ii) Telephone 電話號碼_____

H. Declaration and Authorisation 聲明及授權

I hereby declare and agree that all statements and answers to all questions are complete and true to the best of my knowledge and belief. 本人謹此聲明及同意上述一切陳述及問題的所有答案，就本人所知所信，均為事實全部並確實無訛。

Name of attending physician/surgeon (with qualifications) 主診／外科醫生姓名（資歷）

Signature and name chop of attending physician/surgeon 主診／外科醫生簽名及蓋章

Address 地址

Contact Telephone No. 聯絡電話號碼

Date 日期（DD日／MM月／YYYY年）

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