



Hospital Cash Claim Form – Part I (To be completed by the Policy Owner/Life Insured/Claimant) 住院現金索償表格 – 第一部份 (由保單持有人 / 受保人 / 索償人填寫)

Policy Number 保單編號

Important Notes 重要指示

Please ensure the following to avoid unnecessary delay in the claim process:

請確保下列各項，以免延誤索償進度：

1. This form is fully completed and signed by the Policy Owner/Life Insured/Claimant.
由保單持有人 / 受保人 / 索償人詳細填妥及簽署此申請表。
2. Heng An Standard Life (Asia) Limited ("Company", "We") shall have the right to reject this form if you fail to fulfill the Company's requirements.
若閣下未能符合恒安標準人壽(亞洲)有限公司(「本公司」、「我們」)的有關規定，本公司有權拒絕此表格。
3. Submit the relevant documents listed in "Document Checklist".
遞交在「所需文件指引」列出的相關文件。
4. We may require additional information from you or third parties in order to assess your claim.
我們就審核是次賠償申請，或需向閣下或其他人士索取額外資料。
5. Any cost of obtaining documents is not reimbursable under the Policy.
本保障範圍並不包括任何有關領取文件的費用。
6. The completion and submission of this form is not an acceptance of your claim.
填妥及提交此表格並不代表我們已接受閣下的索償申請。
7. Please submit claim application within **30 days** from the date of admission to Hospital.
索償申請需在入院後**30天**內遞交。
8. Any changes or amendments in this form must be countersigned in full signature.
必須在此表格內任何更改或修改的地方簽署作實。
9. Please provide all of the following requested personal information. Any incomplete information may result in a delay or rejection in processing your request.
請提供所有下列個人資料，如閣下未能提供完整的資料可能會導致延遲或拒絕處理閣下的申請。
10. If information in this form is different from our existing record(s), the Company will update your relevant record(s) accordingly and such update will be applied to all policies under your ownership.
如閣下在此表格所提供的資料與本公司現有記錄不同，本公司將相應更新閣下相應的記錄，該更新將適用於閣下作為保單持有人之所有保單。
11. If you would like to have the original document returned to you, you hereby authorise the Company to make and keep certified true copies of the original documents. Please state the name and address of the person to whom the original documents should be returned. Please note that any original document(s) submitted to and returned by the Company is(are) so submitted and returned at the risk of the claimant(s), the beneficiary(ies) or any other person(s). The Company shall not liable for any losses whatsoever suffered or incurred by the claimant(s), beneficiary(ies) or any other person(s) as a result of the loss of or damage to the original document(s) whether through the postage system.
如閣下欲取回所遞交之正本文件，則閣下謹此授權本公司影印該等文件及擁有該等文件正本加簽核實之副本。請列明所退還文件之收件人姓名及地址。請注意所有正本不論寄給本公司或本公司退回給索償人或受益人或相關人士，若在郵遞過程中或其它原因令有關正本文件遺失或破損，而導致索償人或受益人或相關人士蒙受任何損失，本公司均不負任何責任。

Document Checklist 所需文件指引

Below is a list of minimum documents required to proceed your claim. Additional documents might be requested by the Company.

以下是處理索償所需的最低文件清單。如有需要，本公司或許要求提供其他文件。

Basic Documents:

基本文件：

- Hospital Cash Claim Form Part I
住院現金索償表格第一部份
- Hospital Claim Form Part II - Attending Physician's Report to be completed by the attending physician of Life Insured
住院現金索償表格第二部份 - 由受保人的主診醫生填寫的醫生報告
- Original or certified true copy of identification of the Policy Owner and Life Insured/Claimant
保單持有人及受保人 / 索償人的身份證明文件正本或核實副本
- Copy of discharge summary
出院摘要副本
- Original or certified true copy of medical expenses receipt(s), hospital receipt(s)
醫療費用收據、住院收據正本或核實副本

If applicable below:

如適用：

- Copy of sick leave certificate/Policy report/Traffic accident report
病假紙 / 警察報告 / 道路交通事故責任認定書副本
- Copy of laboratory report
化驗報告副本
- Copy of claims settlement advice from other insurer
其他保險公司發出的賠償細算表副本
- If hospitalization outside Hong Kong, submit outpatient medical record booklet copy and provide details reason(s) of seeking treatment outside Hong Kong
如非於香港住院，遞交醫院門診病歷小冊及詳述非香港求診的原因

Section A – Information of Policy Owner and Life Insured 甲部 – 保單持有人及受保人資料

First Policy Owner 第一保單持有人

Name 姓名		HKID Card/Passport No. and Issuing Country 香港身份證 / 護照號碼及簽發國家	
Contact Phone No. 聯絡電話號碼		Occupation and Industry 職業及行業	
Nationality 國籍		Email Address 電郵地址	
Residential Address 住宅地址			
Correspondence Address (If different from residential address) 通訊地址 (若與住宅地址不同)			

Second Policy Owner (if applicable) 第二保單持有人 (如適用)

Name 姓名		HKID Card/Passport No. and Issuing Country 香港身份證 / 護照號碼及簽發國家	
Contact Phone No. 聯絡電話號碼		Occupation and Industry 職業及行業	
Nationality 國籍		Email Address 電郵地址	
Residential Address 住宅地址			
Correspondence Address (If different from residential address) 通訊地址 (若與住宅地址不同)			

First Life Insured 第一受保人

Name 姓名		HKID Card/Passport No. and Issuing Country 香港身份證 / 護照號碼及簽發國家	
Occupation and Industry 職業及行業		Contact Phone No. 聯絡電話號碼	

Second Life Insured (if applicable) 第二受保人 (如適用)

Name 姓名		HKID Card/Passport No. and Issuing Country 香港身份證 / 護照號碼及簽發國家	
Occupation and Industry 職業及行業		Contact Phone No. 聯絡電話號碼	

Section B – Claim Details 乙部 – 理賠資料

Type of Claims 理賠種類	<input type="checkbox"/> New Claim 首次理賠 <input type="checkbox"/> Further Claim 再度理賠			
Is there any claim submitted to other insurance companies? 是否有向其他保險公司遞交索償申請?	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes (please provide below information) 是 (請提供下列資料)			
	Name of Insurance Company 保險公司名稱	Policy Number 保單號碼	Sum Insured 保額	Claim Status 賠償進度
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Complete this section if cause is due to an accident 若原因為意外導致，請填寫此部份

Date of Accident 意外發生日期	____/____/____ DD 日 / MM 月 / YYYY 年	Place of Accident 意外地點	_____
Details of Accident 意外詳情	_____		
Describe part(s) of body injured and extend of injury 請說明受傷部位及傷勢	_____		
Has this accident been reported to the Police? 曾否就是次意外報警?	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes (please provide information on the right) 是 (請提供右面資料)	Police Station 警署地點	_____
		Case Ref. No. 檔案編號	_____
Remarks: Please attach a photocopy of the Police Report/Traffic Accident Report/Police Statement/Alcohol Test Report. 註：請附上警察報告 / 交通意外報告 / 口供紙 / 酒精測試報告影印本。			

Complete this section if cause is due to an illness 若原因為疾病導致，請填寫此部份

Sign and symptoms 徵狀	_____		
Date symptoms first appeared 病徵首次出現日期	____/____/____ DD 日 / MM 月 / YYYY 年		
The hospital/physician first consulted for this injury/sickness 初診此傷 / 疾病的醫院 / 醫生資料	First consultation date 首次求診日期	____/____/____ DD 日 / MM 月 / YYYY 年	
	Name of physician/the hospital 醫生 / 醫院名稱	_____	
	Address of physician/the hospital 醫生 / 醫院地址	_____	
Details of confinement/ consultation 住院 / 求診詳情	Date and time of admission 入院日期及時間	____/____/____ DD 日 / MM 月 / YYYY 年	____ : ____ Time 時間
	Date and time of discharge 出院日期及時間	____/____/____ DD 日 / MM 月 / YYYY 年	____ : ____ Time 時間
	Name of the hospital 醫院名稱	_____	
	Address of the hospital 醫院地址	_____	
Any surgery performed during hospitalization or as a Day Case Procedure? 住院期間是否有進行手術或作日間手術?	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes (please provide details) 是 (請提供詳情)		
	Date of surgery 手術日期	____/____/____ DD 日 / MM 月 / YYYY 年	
	Name of surgery 手術名稱	_____	

Section B – Claim Details 乙部 – 理賠資料

Complete this section if cause is due to an illness 若原因為疾病導致，請填寫此部份

Other hospitals/physicians consulted for this injury/sickness 曾應診此傷 / 疾病的其他醫院 / 醫生資料	Name of the Hospital/Physician 醫院 / 醫生名稱	Address 地址	Consultation Date 求診日期
	_____	_____	____/____/____ DD 日 / MM 月 / YYYY 年
	_____	_____	____/____/____ DD 日 / MM 月 / YYYY 年
	_____	_____	____/____/____ DD 日 / MM 月 / YYYY 年
If applicable, please provide details of other treatment/investigation performed for this injury/sickness 如適用，請提供其他就此傷病作治療 / 檢驗的詳情	Start date 開始日期	End date 結束日期	Treatment/Investigation 治療 / 檢驗
	____/____/____ DD 日 / MM 月 / YYYY 年	____/____/____ DD 日 / MM 月 / YYYY 年	_____
	____/____/____ DD 日 / MM 月 / YYYY 年	____/____/____ DD 日 / MM 月 / YYYY 年	_____
	____/____/____ DD 日 / MM 月 / YYYY 年	____/____/____ DD 日 / MM 月 / YYYY 年	_____

Section C – Payment Instructions 丙部 – 付款指示

Payment Currency 賠償貨幣	<input type="checkbox"/> HK Dollars 港幣 <input type="checkbox"/> Policy Currency 保單貨幣			
Settlement Option 賠款方式	<input type="checkbox"/> Cheque 支票 (Local banks only 只限本地銀行)			
	<input type="checkbox"/> Bank Transfer 銀行轉帳 (Local banks only 只限本地銀行) Name of Bank Account Holder 賬戶持有人姓名 _____ Name of Bank 銀行名稱 _____ Bank No. 銀行編號 Branch No. 分行編號 Account No. 賬戶號碼 <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; height: 20px;"></td> <td style="width: 25%; height: 20px;"></td> <td style="width: 50%; height: 20px;"></td> </tr> </table>			
<input type="checkbox"/> Telegraphic Transfer (TT) 電匯 (Overseas payment only 只限海外戶口) English Name of Account Holder 賬戶持有人英文姓名 _____ Bank Account No. 銀行賬戶號碼 _____ Bank Name and Branch 銀行及分行名稱 _____ Address of Bank 銀行地址 _____ SWIFT Code 匯款銀行代碼 _____ Intermediary Bank SWIFT Code (if applicable) 中轉銀行代碼 (如適用) _____ Country of Intermediary Bank (if applicable) 中轉銀行之國家 (如適用) _____				
Remarks 備注： 1. The account must be owned by the Policy Owner. 戶口必須為保單持有人持有的銀行戶口。 2. If the payment currency selected is different from the policy currency, the amount of our payment to you will be converted from an amount denominated in the policy currency at an exchange rate as determined by us. 如賠償貨幣與保單貨幣不同，賠償之金額將根據我們釐定之兌換率由保單貨幣轉換而成。 3. Bank charges may be incurred by client for TT. You are recommended to check with the bank before. 銀行或會向閣下徵收電匯的相關手續費。建議於遞交指示前閣下先向銀行查詢。 4. Please note that this request should not be treated as an admission of our liability and we reserve all rights for assessing your claim after collecting all relevant documents subject to terms, conditions and exclusions of the relevant policy. 請留意：此項要求並不代表閣下的索償現正獲得成功審批。同時，我們在收集全部證明文件後，將根據保單一切條款才作出最後審批。 5. If the currency of the bank account provided in this form for claim settlement is different with the payment currency selected in above (e.g. USD account is provided for HKD payment settlement), the insurance benefit in Payment Currency will be paid to your designated bank account which may then be converted by your bank from Payment Currency to the currency of your bank account based on the exchange rate as determined by the bank. The Company takes no responsibility for the exchange rate imposed by your bank. 如在本表格指定作賠償金額直接轉賬存款之戶口的貨幣與賠償貨幣戶口不同 (如提供美元戶口作港元賠償)，以賠償貨幣支付之保險賠償金額將入賬於閣下指定之戶口，貴銀行可能隨即根據其釐定之匯率折算為戶口之貨幣。本公司不會就貴銀行釐定的匯率折算負上任何責任。				

Section D – Personal Information Collection Statement 丁部 – 個人資料收集聲明

I/We, the Policy Owner/Life Insured/Claimant of the above policy, hereby jointly and severally declare that:
 本人 / 吾等，上述保單的保單持有人 / 受保人 / 索償人，在此共同及分別確認：

- I/We confirm that I/we have read and understood the Personal Information Collection Statement ("PICS") of Heng An Standard Life (Asia) Limited ("the Company"). I/We agree that the Company may collect, use, store, process, disclose, transfer and otherwise share our personal data in accordance with the terms of the PICS. For the latest version of PICS, it can be downloaded from the Company website (<https://www.hengansl.com.hk>) or available upon request.
 本人 / 吾等確認已閱讀及明白恒安標準人壽 (亞洲) 有限公司 (「貴公司」) 的收集個人資料聲明。本人 / 吾等確認已經閱讀並且明白本聲明。本人 / 吾等同意貴公司可依照本聲明的條款收集、使用、儲存、處理、披露、轉移及以其他方式分用吾等的個人資料。有關最新版本的收集個人資料聲明，可於貴公司網站上 (<https://www.hengansl.com.hk>) 下載或向恒安標準人壽 (亞洲) 有限公司索取。
- I/We hereby declare that any personal data provided by me/us to the Company (whether by way of this application or otherwise) which is in relation to a third party not being myself/ourselves has been obtained by me/us in compliance with the Personal Data (Privacy) Ordinance, and the relevant third party has explicitly agreed to the disclosure of his/her personal data to the Company for the purposes set out in the PICS. I/We agree to indemnify and hold harmless the Company against all losses, liability and costs which the Company may incur or suffer as a result of, or in connection with, any breach of my/our declaration contained in this paragraph.
 本人 / 吾等謹此聲明，任何由本人 / 吾等向貴公司提供 (不論是透過本申請或其他方式提供) 有關第三者 (而非本人 / 吾等) 的個人資料乃是以符合個人資料 (私隱) 條例規定的手法取得，而有關第三者已明確同意向貴公司披露其個人資料作「個人資料收集聲明」所述的用途。本人 / 吾等同意彌償及確保貴公司免受因本人 / 吾等違反於本文下的聲明而產生或引致的任何損失、責任或費用。

Section E – Declaration & Authorisation 戊部 – 聲明及授權

I/We, the Policy Owner/Life Insured/Claimant of the above policy, hereby jointly and severally declare that:

本人 / 吾等，上述保單的保單持有人 / 受保人 / 索償人，在此共同及分別確認：

- I/We hereby declare and agree on behalf of myself/ourselves and other person referred to this form ("Relevant Persons") that all statements and answers to all questions, whether or not written by my/our own hand, are to the best of my/our knowledge and belief complete and true.
本人 / 吾等謹此代表本人 / 吾等及其他在此申請表提及之人士 (「相關人士」) 聲明及同意上述一切陳述及問題的所有答案，不論是否本人 / 吾等親手所寫，就本人 / 吾等所知所信，均為事實全部並確實無訛。
- I/We authorise any employer, licensed physician, medical practitioner, hospital, clinic, other medically related facility, insurance company, bank, government institution, any association, federation or similar organisation of insurance companies, other organisation, institution or person, that has any records or knowledge of me/us and who has attended or may hereafter attend to myself/ourselves to disclose such information to the Company; the Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessments and tests to evaluate the health status of myself/ourselves in relation to this claim. This authorisation shall remain valid notwithstanding my/our death or incapacity (including but not limited to mental incapacity). A photocopy of this authorisation shall be as valid as the original. To avoid any uncertainty, this authorization shall binding on my/our successors, assignees, executors and administrators.
本人 / 吾等授權任何僱主、註冊醫生、醫療從業員、醫院、診所、其他有關醫療機構、保險公司、銀行、政府機構、其他協會、聯會或類似保險公司之組織、其他組織、機構或人士，凡知道或持有任何有關本人 / 吾等之記錄者，及曾診驗或可能將會診驗本人 / 吾等，均可將該等資料提供給貴公司。貴公司或任何其他指定之醫生或化驗所，可就此索償申請替本人 / 吾等進行所需之醫療評估及測試，作為審核本人 / 吾等之健康狀況。此授權在本人 / 吾等去世後或於無行為能力 (包括但不限於精神上無行為能力) 時繼續生效。本授權書的影印副本跟正本同樣有效。為免任何疑問，此授權書對本人 / 吾等之繼承人、受讓人、遺囑執行人及遺產管理人均具有約束力。
- I/We understand and acknowledge the Company or any of its appointed medical examiners or laboratories may perform the necessary medical assessment and tests to evaluate the health status of the Life Insured in relation to the proposal for assurance and any claims arising therefrom.
本人 / 吾等明白及確認貴公司或任何由貴公司指定之醫生、醫務人員或化驗所，可就此申請或任何有關索償申請替受保人進行所需之醫療評估及測試，以審核受保人之健康狀況。
- I/We understand and acknowledge the Company shall have the right to request me/us or any other person who may be entitled to obtain claim settlement under the policy including without limitation any Relevant Persons, to provide (and/or complete and sign such document relating to) such information and supporting documentation the Company may reasonably require including without limitation, name, place of birth, residential and mailing addresses, taxpayer identification number, social security number, citizenship, residency, tax residency and the tax regime(s) to which the Relevant Person is subject in respect of tax reporting or payment responsibility.
本人 / 吾等明白及確認貴公司有權要求本人 / 吾等或可能有權獲得賠償金額的任何其他人士包括但不限於任何相關人士提供貴公司可能合理索取的資料及附助確證的文件 (及 / 或填寫及簽署與此相關的文件)，包括但不限於姓名、出生地點、住宅和郵遞地址、納稅人識別編號、社會安全號碼、國籍、居留地、稅務居留地及相關人士在報稅或納稅責任方面須遵守的稅制。
- I/We declare and agree that I/we have the full authority from and consent of the Relevant Persons to make the above declaration, agreements and authorisations.
本人 / 吾等聲明及同意已獲相關人士授權作出上述聲明、同意及授權。

The Policy Owner is resident for tax purposes of any countries or jurisdiction(s) other than Hong Kong?

保單持有人是否為除香港以外任何國家或司法管轄區的稅務居民？

Yes 是 No 否

If yes 若是

For Policy Owner 就保單持有人而言

In respect of such countries or jurisdiction(s) I/we have not previously provided Heng An Standard Life (Asia) Limited with information about your Tax Identification Number(s)?

本人 / 吾等未曾向恒安標準人壽 (亞洲) 有限公司提供有關該國家或司法管轄區的稅務編號？

Yes 是 No 否

If both answers are yes, I/we understand the **Policy Owner** must provide Heng An Standard Life (Asia) Limited a separate "Self-Certification Form".

如以上兩個答案都是皆是，本人 / 吾等明白保單持有人必需向恒安標準人壽 (亞洲) 有限公司單獨提交一份「自我證明表格」。

If the Life Insured is on or above the age of 18, the form should be signed by him/her and the Policy Owner. If the Life Insured is below the age of 18, the Policy Owner should sign on his/her behalf. If the Life Insured and Policy Owner are not able to sign on the form, the Claimant should sign on their behalf.

如受保人年滿 18 歲，則由受保人及保單持有人簽署。如受保人未滿 18 歲，則由保單持有人簽署。如受保人及保單持有人未能簽署，則由索償人簽署。

Name of Life Insured/Claimant
受保人 / 索償人姓名

Signature of Life Insured/Claimant
受保人 / 索償人簽署

Date of Signature (DD/MM/YYYY)
簽署日期 (日 / 月 / 年)

Name of First Policy Owner
第一保單持有人姓名

Signature of First Policy Owner
第一保單持有人簽署

Date of Signature (DD/MM/YYYY)
簽署日期 (日 / 月 / 年)

Name of Second Policy Owner (if applicable)
第二保單持有人姓名 (如適用)

Signature of Second Policy Owner (if applicable)
第二保單持有人簽署 (如適用)

Date of Signature (DD/MM/YYYY)
簽署日期 (日 / 月 / 年)

Heng An Standard Life (Asia) Limited (662679) is registered in Hong Kong at 12/F., Lincoln House, Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong. Authorised by the Insurance Authority of Hong Kong to write Class A, Class C and Class I long term business in Hong Kong.

恒安標準人壽 (亞洲) 有限公司 (662679) 的註冊公司地址為香港鰂魚涌英皇道 979 號太古坊林肯大廈 12 樓，其已獲香港的保險業監管局授權於香港承保 A 類、C 類及 I 類之長期業務。

© 2024 Heng An Standard Life (Asia) Limited, reproduced under licence. All rights reserved.

© 2024 恒安標準人壽 (亞洲) 有限公司，已獲授權複製。版權所有，保留一切權利。



Hospital Cash Claim Form – Part II 住院現金索償表格 – 第二部份

Policy Number 保單編號 _____	Name of Policy Owner 保單持有人姓名 _____	Name of Life Insured 受保人姓名 _____
-----------------------------	---------------------------------------	-------------------------------------

Private & Confidential 私人及機密

TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT'S OWN EXPENSES
由主診醫生填寫，所需費用由索償人自行承擔

Important note 重要事項

Your patient is insured with us and to enable us to assess the claim, please complete this form with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement.

您的病人為本公司的受保人，請您詳細填寫此申請表並盡可能提供一切有關資料，以便本公司審核此索償。您的協助可使本公司加快索償安排。

Section A – Patient Details 甲部 – 病人資料

Name of the Patient 病人姓名	_____		
HKID Card/Passport No. 香港身份證 / 護照號碼	_____		
Occupation 職業	_____		
Are you the patient's usual physician? 你是否病人慣常求診的醫生？	<input type="checkbox"/> No 否	<input type="checkbox"/> Yes, medical records traceable to 是，醫療紀錄可追溯至	_____/_____/_____ DD 日 / MM 月 / YYYY 年

Section B – Hospitalization Details 乙部 – 住院詳情

Date and time of admission 入院日期及時間	_____/_____/_____ DD 日 / MM 月 / YYYY 年	_____:_____ Time 時間
Date and time of discharge 出院日期及時間	_____/_____/_____ DD 日 / MM 月 / YYYY 年	_____:_____ Time 時間
Name of the hospital 醫院名稱	_____	
Had the patient been confined in Intensive Care Unit? 病人是否有入住深切治療部？	<input type="checkbox"/> No 否	<input type="checkbox"/> Yes, please provide below information 是，請提供以下資料 From 由 ____/____/____ To 至 ____/____/____ DD 日 MM 月 YYYY 年 DD 日 MM 月 YYYY 年
Any home leave taken by the patient during the said hospitalization period? 病人在上述住院期間是否有請假離院？	<input type="checkbox"/> No 否	
	<input type="checkbox"/> Yes, please provide below information 是，請提供以下資料 Date 日期 From 由 ____/____/____ To 至 ____/____/____ DD 日 MM 月 YYYY 年 DD 日 MM 月 YYYY 年 Time 時間 <input type="checkbox"/> AM 上午 ____:____ <input type="checkbox"/> AM 上午 ____:____ <input type="checkbox"/> PM 下午 ____:____ Time 時間 <input type="checkbox"/> PM 下午 ____:____ Time 時間 Reason 原因 _____	

Section C – Consultation Details 丙部 – 診治資料

First consultation date 首次求診日期	____ / ____ / ____ DD 日 / MM 月 / YYYY 年	
Sign and symptoms complained of at the first consultation 首次求診時出現的徵狀		
Cause of consultation 求診原因	<input type="checkbox"/> Accident 意外 Date of accident 意外日期 ____ / ____ / ____ DD 日 / MM 月 / YYYY 年 Time of accident 意外時間 <input type="checkbox"/> AM 上午 _____ : _____ <input type="checkbox"/> AM 上午 _____ Time 時間	<input type="checkbox"/> Illness 病症 How long had the patient been experiencing these signs and symptoms before the first consultation? 首次求診前其徵狀已存在多久? _____
	Had the patient previously seen other physician (s) for these symptoms? 病人之前是否就有關之病況向其他醫生求診? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide below information 是，請提供以下資料 Name of physician/ the hospital 醫生 / 醫院名稱 _____ Address of physician/ the hospital 醫生 / 醫院地址 _____ Date 日期 _____ / ____ / ____ DD 日 / MM 月 / YYYY 年	
Diagnostic test details 診斷性檢查資料	Name of diagnostic test 診斷性檢查名稱	
	Reason 原因	
	Result 結果	
Final diagnosis 最後診斷		
Underlying cause of the diagnosis 引起診斷的主因		
Date of diagnosis 診斷日期	____ / ____ / ____ DD 日 / MM 月 / YYYY 年	
Was surgery performed? 是否進行手術?	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide below information 是，請提供以下資料 Date of Surgery 手術日期 _____ / ____ / ____ DD 日 / MM 月 / YYYY 年 Name of Surgery 手術名稱 _____	
Brief discharge summary (including investigation tests & results, details & results of the treatments, any complications and follow-up plans) 出院摘要 (包括確診測試及結果、治療詳情及結果、有否併發症及跟進計劃)	Remarks 註： Please attach copies of histopathology/endoscopic/diagnostic/laboratory test report/operation summary etc 請連同病理檢驗 / 內窺鏡 / 診斷性化驗 / 檢驗報告 / 手術摘要等副本一併交回。	
Has the patient ever been treated for the same/related conditions? 病人曾否患有同類 / 相關病況而接受治療?	<input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide details 是，請提供詳情 _____	

Section C – Consultation Details 丙部 – 診治資料

<p>Did the patient have the following past medical history/habit? 病人過往是否有以下之病史 / 習慣?</p>	<p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please tick where it is appropriate and give details 是，請在適當的位置上剔號及提供詳情</p> <table border="0"> <tr> <td><input type="checkbox"/> Asthma 哮喘</td> <td><input type="checkbox"/> Cardiac problem 心臟問題</td> </tr> <tr> <td><input type="checkbox"/> Diabetes mellitus 糖尿病</td> <td><input type="checkbox"/> Hepatitis B 乙型肝炎</td> </tr> <tr> <td><input type="checkbox"/> Hypertension 高血壓</td> <td><input type="checkbox"/> Unfavorable family history 家族病史</td> </tr> <tr> <td><input type="checkbox"/> Previous operation 曾接受手術</td> <td><input type="checkbox"/> Drug addiction 濫用藥物</td> </tr> <tr> <td><input type="checkbox"/> Drinking habit 飲酒習慣</td> <td><input type="checkbox"/> Smoking 吸煙習慣</td> </tr> <tr> <td><input type="checkbox"/> Family history of cancer 家族性癌症</td> <td><input type="checkbox"/> Others, please specify details: 其他；請說明詳情：</td> </tr> </table> <hr/> <p>Current prognosis of the above past medical history 上述病史癒後的情況</p> <p><input type="checkbox"/> Fully recovered 完全康復 <input type="checkbox"/> On treatment 治療中</p>	<input type="checkbox"/> Asthma 哮喘	<input type="checkbox"/> Cardiac problem 心臟問題	<input type="checkbox"/> Diabetes mellitus 糖尿病	<input type="checkbox"/> Hepatitis B 乙型肝炎	<input type="checkbox"/> Hypertension 高血壓	<input type="checkbox"/> Unfavorable family history 家族病史	<input type="checkbox"/> Previous operation 曾接受手術	<input type="checkbox"/> Drug addiction 濫用藥物	<input type="checkbox"/> Drinking habit 飲酒習慣	<input type="checkbox"/> Smoking 吸煙習慣	<input type="checkbox"/> Family history of cancer 家族性癌症	<input type="checkbox"/> Others, please specify details: 其他；請說明詳情：
<input type="checkbox"/> Asthma 哮喘	<input type="checkbox"/> Cardiac problem 心臟問題												
<input type="checkbox"/> Diabetes mellitus 糖尿病	<input type="checkbox"/> Hepatitis B 乙型肝炎												
<input type="checkbox"/> Hypertension 高血壓	<input type="checkbox"/> Unfavorable family history 家族病史												
<input type="checkbox"/> Previous operation 曾接受手術	<input type="checkbox"/> Drug addiction 濫用藥物												
<input type="checkbox"/> Drinking habit 飲酒習慣	<input type="checkbox"/> Smoking 吸煙習慣												
<input type="checkbox"/> Family history of cancer 家族性癌症	<input type="checkbox"/> Others, please specify details: 其他；請說明詳情：												
<p>Is it possible that this hospitalization was directly or indirectly caused by the factors listed in the right side, or made the situation worse? 是次住院是否有機會與右列之情況直接或間接引起、或加劇嚴重性？</p>	<p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please tick where it is appropriate and give details 是，請在適當的位置上剔號及提供詳情</p> <table border="0"> <tr> <td><input type="checkbox"/> Self-inflicted condition or suicide 自殘情況 / 自殺</td> <td><input type="checkbox"/> Under influence of alcohol or other psychoactive substances 受酒精或精神藥物影響</td> </tr> <tr> <td><input type="checkbox"/> Involvement in high risk activities 高危活動</td> <td><input type="checkbox"/> Past injury or illness 過往受傷或疾病</td> </tr> <tr> <td><input type="checkbox"/> Relating to pregnancy or childbirth 與懷孕或分娩相關</td> <td><input type="checkbox"/> Cosmetic or plastic surgery 美容或整形手術</td> </tr> <tr> <td><input type="checkbox"/> Congenital condition 先天性情況</td> <td><input type="checkbox"/> General health check 一般身體檢查</td> </tr> <tr> <td><input type="checkbox"/> AIDS and/or other sexually transmitted disease 愛滋病或其他性病</td> <td><input type="checkbox"/> Psychological condition 精神或心理因素</td> </tr> <tr> <td><input type="checkbox"/> Convalescence or custodial care 康復或療養</td> <td><input type="checkbox"/> Others, please provide details: 其他；請說明詳情：</td> </tr> </table> <hr/>	<input type="checkbox"/> Self-inflicted condition or suicide 自殘情況 / 自殺	<input type="checkbox"/> Under influence of alcohol or other psychoactive substances 受酒精或精神藥物影響	<input type="checkbox"/> Involvement in high risk activities 高危活動	<input type="checkbox"/> Past injury or illness 過往受傷或疾病	<input type="checkbox"/> Relating to pregnancy or childbirth 與懷孕或分娩相關	<input type="checkbox"/> Cosmetic or plastic surgery 美容或整形手術	<input type="checkbox"/> Congenital condition 先天性情況	<input type="checkbox"/> General health check 一般身體檢查	<input type="checkbox"/> AIDS and/or other sexually transmitted disease 愛滋病或其他性病	<input type="checkbox"/> Psychological condition 精神或心理因素	<input type="checkbox"/> Convalescence or custodial care 康復或療養	<input type="checkbox"/> Others, please provide details: 其他；請說明詳情：
<input type="checkbox"/> Self-inflicted condition or suicide 自殘情況 / 自殺	<input type="checkbox"/> Under influence of alcohol or other psychoactive substances 受酒精或精神藥物影響												
<input type="checkbox"/> Involvement in high risk activities 高危活動	<input type="checkbox"/> Past injury or illness 過往受傷或疾病												
<input type="checkbox"/> Relating to pregnancy or childbirth 與懷孕或分娩相關	<input type="checkbox"/> Cosmetic or plastic surgery 美容或整形手術												
<input type="checkbox"/> Congenital condition 先天性情況	<input type="checkbox"/> General health check 一般身體檢查												
<input type="checkbox"/> AIDS and/or other sexually transmitted disease 愛滋病或其他性病	<input type="checkbox"/> Psychological condition 精神或心理因素												
<input type="checkbox"/> Convalescence or custodial care 康復或療養	<input type="checkbox"/> Others, please provide details: 其他；請說明詳情：												
<p>Does the patient have any of the conditions shown on the right-hand side? If yes, please provide details and relevant investigation reports. 病人是否有右方情況出現？請提供詳情及相關檢查報告。</p>	<p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please tick where it is appropriate and give details 是，請在適當的位置上剔號及提供詳情</p> <table border="0"> <tr> <td><input type="checkbox"/> Cognitive Impairment 認知障礙</td> <td><input type="checkbox"/> Permanent need for wheelchair 永久需要使用輪椅</td> </tr> <tr> <td><input type="checkbox"/> Permanent loss of use of two limbs 永久喪失使用兩肢能力</td> <td><input type="checkbox"/> Loss of sight in both eyes 雙目失明</td> </tr> <tr> <td><input type="checkbox"/> Loss of hearing in both ears 雙耳失聰</td> <td><input type="checkbox"/> Permanent loss of speech 永久喪失語言能力</td> </tr> </table>	<input type="checkbox"/> Cognitive Impairment 認知障礙	<input type="checkbox"/> Permanent need for wheelchair 永久需要使用輪椅	<input type="checkbox"/> Permanent loss of use of two limbs 永久喪失使用兩肢能力	<input type="checkbox"/> Loss of sight in both eyes 雙目失明	<input type="checkbox"/> Loss of hearing in both ears 雙耳失聰	<input type="checkbox"/> Permanent loss of speech 永久喪失語言能力						
<input type="checkbox"/> Cognitive Impairment 認知障礙	<input type="checkbox"/> Permanent need for wheelchair 永久需要使用輪椅												
<input type="checkbox"/> Permanent loss of use of two limbs 永久喪失使用兩肢能力	<input type="checkbox"/> Loss of sight in both eyes 雙目失明												
<input type="checkbox"/> Loss of hearing in both ears 雙耳失聰	<input type="checkbox"/> Permanent loss of speech 永久喪失語言能力												
<p>Does the patient require rehabilitation treatment? If yes, please provide details of the rehabilitation program (including period required, type of treatment). 病人是否需要接受復康治療？若是，請提供復康方案詳情（包括所需時間、需接受的治療）。</p>													
<p>Please describe in detail the necessity of hospitalization or receiving rehabilitation treatment for current injury/sickness 請詳述是次傷病必須住院或接受復康治療的原因</p>													
<p>The prognosis of the condition 預計痊癒後的情況</p>	<p><input type="checkbox"/> Good 良好 <input type="checkbox"/> Fair 一般 <input type="checkbox"/> Poor 甚差</p>												
<p>Any possibility of having a relapse? 是否有復發的可能？</p>	<p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是</p>												

Section D – Personal Information Collection Statement 丁部 – 個人資料收集聲明

1. I confirm that I have read and understood the Personal Information Collection Statement (“PICS”) of Heng An Standard Life (Asia) Limited (“the Company”). I agree that the Company may collect, use, store, process, disclose, transfer and otherwise share my personal data in accordance with the terms of the PICS. For the latest version of PICS, it can be downloaded from the Company website (<https://www.hengansl.com.hk>) or available upon request.

本人確認已閱讀及明白恒安標準人壽 (亞洲) 有限公司 (「貴公司」) 的收集個人資料聲明。本人確認已經閱讀並且明白本聲明。本人同意貴公司可依照本聲明的條款收集、使用、儲存、處理、披露、轉移及以其他方式分用本人的個人資料。有關最新版本的收集個人資料聲明，可於貴公司網站上 (<https://www.hengansl.com.hk>) 下載或向恒安標準人壽 (亞洲) 有限公司索取。

2. I hereby declare that any personal information of third parties provided by me to the Company (whether provided under this claim form or otherwise provided) has been obtained by me in compliance with the Personal Data (Privacy) Ordinance and the relevant third parties have agreed to the disclosure of their personal information to the Company for the purposes as set out in this personal information collection statement. I agree to indemnify and hold harmless, on demand, the Company against all losses, liabilities and costs which the Company may incur arising out of, or in connection with, any breach of the declaration set forth in this paragraph.

本人特此聲明，由本人提供予貴公司的任何第三方個人資料 (無論載於此索償表格或從其他途徑所提供) 乃由本人在遵守個人資料 (私隱) 條例的情況下獲得，且有關第三方已同意為此等個人資料收集聲明所載之目的向貴公司提供其個人資料。本人同意應貴公司要求，就貴公司因發生任何違反本文中所述的聲明，而可能招致或與之相關的任何損失、責任及費用，對貴公司作出賠償，並使貴公司免受損害。

Section E – Declaration 戊部 – 聲明

I **HEREBY CERTIFY** that I have personally examined and treated the patient in connection with the above condition and that the facts as given above present my opinion of his/her condition and are true and complete to the best of my knowledge and belief. I hereby declare that no information has been withheld by me at the request of the patient or his/her family. I agree to make the declaration on Part II of this claim Form.

本人謹此證明已親自為病人就上述狀況進行檢查及治療，並確認上述資料為本人對病人的情況作出之意見。所有答案，就本人所知所信，均為事實全部並確實無訛。本人在此聲明，沒有病人或其家屬要求隱瞞任何資料。本人同意就此索償表格第二部分作出聲明。

Name of the Medical Practitioner
醫生姓名

Qualification and Specialty
資格及專業

Signature of the Medical Practitioner (with chop)
醫生簽署 (加蓋印章)

Name and Address of the Hospital
醫院名稱及地址

Contact Phone No.
聯絡電話

Date of Signature (DD/MM/YYYY)
簽署日期 (日 / 月 / 年)

Heng An Standard Life (Asia) Limited (662679) is registered in Hong Kong at 12/F., Lincoln House, Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong. Authorised by the Insurance Authority of Hong Kong to write Class A, Class C and Class I long term business in Hong Kong.

恒安標準人壽 (亞洲) 有限公司 (662679) 的註冊公司地址為香港鰂魚涌英皇道 979 號太古坊林肯大廈 12 樓，其已獲香港的保險業監管局授權於香港承保 A 類、C 類及 I 類之長期業務。

© 2024 Heng An Standard Life (Asia) Limited, reproduced under licence. All rights reserved.

© 2024 恒安標準人壽 (亞洲) 有限公司，已獲授權複製。版權所有，保留一切權利。