Group Hospitalization & Surgical Insurance Claim Form
團體住院及手術保險賠償申請書

Sun Life Financial 永明金融

INSTRUCTIONS 說明

1. Part A of this application must be completed by the employee and signed by the patient and Part B by the employer (Policy Owner) if applicable and then submitted within **90** days of incurring such expenses.
2. If a surgical procedure or operation has been performed during the hospitalization, Part C must be completed by the surgeon. If no surgical procedure or operation is involved, Part C must be completed by the attending physician.
3. No claim will be admitted unless Part C is duly completed by a registered medical practitioner. The Company will not be responsible for any fee required for the completion of this application or any follow up cost thereafter.
4. Referral letter must be attached for claim for specialist consultation.
5. Employee may logon to Group Insurance e-Services at www.sunlifegroupinsurance.com.hk to check your processed claim record.
6. All invoices, bills and receipts submitted with this application must be original copies and issued by the physician, surgeon or hospital
7. Return Certified True Copy of receipts after claim processing? ☐ Yes ☐ No

1. 此申請書之甲部必須由僱員填寫及病人簽署，而乙部則須由僱主(保單持有人)填寫如適用，並於付款後九十天內遞交。
2. 如住院期間曾施行外科手術，丙部須由外科醫生填寫。如無需施行外科手術，丙部則由主診醫生填寫。
3. 丙部必須由註冊之執業醫生填寫，否則該索償將不予受理。此外，本公司概不負責任何有關填寫此申請書之費用。
4. 專科賠償，必須附上轉介信。
5. 僱員可隨時登入 www.sunlifegroupinsurance.com.hk 之永明金融團體保險 e-Services 查閱閣下已被處理的賠償記錄。
6. 所有連同本申請書遞交之發票、帳單或收據必須為正本，並由有關主診醫生、外科醫生或院方發出。
7. 賠償辦妥後需退回收據的核實副本？ ☐ 是 ☐ 否

Part A – To be completed by employee 甲部 － 由僱員填寫

1. Name of Employer (Policy Owner) 僱主名稱 (保單持有人) | Policy No. 保單號碼

2. Name of Employee 僱員姓名 | Age 年齡 | H.K.I.D.Card No. of the Insured Employee (**Must be Completed**) 受保僱員之香港身份證號碼 **(必須填寫)**

3. Name of Patient (If other than Employee) 病人姓名 (如非僱員) | Age 年齡 | Relationship to Employee 與僱員關係 ☐ Self 本人 ☐ Spouse 配偶 ☐ Children 子女

4. Was the hospitalization/surgery a result of an accident? 此次住院/手術是否由於一宗意外引致?
☐ No 不是 ☐ Yes 是 Date of Accident 意外日期 _____ Time 時間 _____ Place 地點 _____
Brief description of how the accident happened 簡述意外經過 _____

5. Has the patient received medical treatment or advice or been hospitalized for the same or an interrelated cause in the last three (3) months? If "Yes", please specify date of treatment or advice, name of attending physician, period of hospitalization and name of hospital.
病人曾否於過往三個月內因同一或有關病患而接受治療或住院? 若「是」，請提供接受治療、住院日期、醫生及醫院名稱。

6. Are you making any other insurance claim as a result of this hospitalization/surgery? If "Yes", please specify name of the Insurance Company and Policy Number.
有關此次住院/手術，閣否申下有否請其它保險賠償? 若「有」，請提供保險公司名稱及保單號碼。

DECLARATION AND AUTHORIZATION 聲明及授權

The claimant (I/We) hereby declare, agree and understand, as the case may be, as evidenced by my/our signature(s) hereunder, that:
索償人（本人/吾等）聲明、同意及明白以下各項（視乎情況適用而定），並在此申請表簽署作實：

1. All the foregoing statements and answers in this application together with those in any required medical examination, questionnaire, amendment or other document signed by me/us in connection with this application are full, complete and true. I/We also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. Sun Life Hong Kong Limited, including its successors or assigns (collectively referred to as "the Company") may be unable to process this application if I/we fail to provide any information required to this application.
此申請表上所載的聲明及答案，以及經本人/吾等簽署之所需的體格檢驗、問卷、修改書及其他文件，均屬真確無訛，詳細完整，並構成申請的依據及其中部份。本人/吾等明白倘有任何未知是否屬於重要事項的資料均須在此透露。倘本人/吾等未能提供此申請所需資料，可導致香港永明金融有限公司，包括繼承人或承讓人，(在此稱為「公司」)未能處理此申請。
2. I/We fully understand that the Company is not bound by any statement which I/we may have made to any person if not written or printed here.
本人/吾等完全明白公司不受一些本人/吾等沒有在此申請表上提及或刊印向任何人士定立的聲明所約束。
3. **PERSONAL INFORMATION COLLECTION STATEMENT**
I/We understand and consent that, any personal data collected by the Company (whether collected in this application form or otherwise) may be used by the Company for the following purposes: (i) processing and evaluating this application and any other applications I/we make; (ii) administering and providing services in relation to this product and any other products I/we hold; (iii) processing and investigating claims; (iv) conducting customer surveys; (v) researching and designing financial, insurance or pensions products for customer use; (vi) selecting and participating in reward, loyalty or privileges program and related service for me/us ; (vii) contacting me/us for the above purposes; (viii) purposes which are directly related to the above purposes; and (ix) complying with applicable laws, regulation or court order.
The Company may disclose my/our personal data for the above purposes: (a) to third parties who provide services in Hong Kong or elsewhere which assist the Company to carry out the above purposes, including claims investigators, medical advisors, medical service providers, emergency assistance service providers, reinsurers and professional advisors (provided that such contractors are required to keep all such personal data confidential and may only use the personal data to provide those services); (b) to my/our bank for payment purposes; (c) to my/our insurance broker (if any); (d) to the Company's insurance agents and MPF intermediaries; (e) to the Company's related companies (as defined in the Companies Ordinance) including pensions services provider, insurance companies and financial services companies; (f) to the Hong Kong Federation of Insurers (or any similar association of insurance companies) and its members; (g) to any person to whom the Company or its related companies (inside or outside Hong Kong) is under an obligation to make disclosure under the requirements of any law, regulation or court order binding on or applying to or to which the Company or its related companies (inside or outside Hong Kong) is subject to, or under and for the purposes of any guidelines issued by regulatory or other authorities with which the Company or its related companies (inside or outside Hong Kong) is expected to comply and (h) as otherwise required or permitted by law.
The Company may also use and disclose my/our personal data in other ways with my/our consent or as otherwise required or permitted by law.
I/We understand that the information I/we give is voluntary, but failure to provide the requested personal data may mean the Company is unable to process my/our application. I/We have the right to seek access to and request correction of any personal data the Company holds about me/us by sending a written request to Group Insurance Administration, Sun Life Hong Kong Limited, 8/F, Sun Life Tower, The Gateway, 15 Canton Road, Kowloon, Hong Kong. The Company may charge a reasonable fee for the processing of any such requests.
個人資料收集聲明
本人/吾等明白及同意公司可以將其所收集的任何個人資料（不論由此申請表所收集或由其他途徑取得）作以下用途: (i) 處理及評估本人/吾等的此項申請及任何其他申請；(ii)管理本人/吾等所持有的本項及其他產品，並提供相關服務；(iii) 處理及調查索償個案；(iv) 進行客戶調查；(v) 為客戶研究及設計金融、保險或退休金產品；(vi) 為本人/吾等甄選及參與獎賞、忠實或特選客戶計劃；(vii) 因上述目的與本人/吾等聯絡；(viii) 與上述目的直接有關的任何其他目的；及 (ix) 為遵守適用的法例、法規或法庭命令。
公司可為以上目的披露本人/吾等的個人資料予 (a) 為協助公司就上述用途（不論在香港或其他地方）而提供服務的第三方，包括索償調查員、醫療顧問、醫療服務提供者、緊急支援服務供應商，再保險公司，專業顧問（條件是有關承辦商須把所有個人資料保密並只會為提供有關服務而使用個人資料）；(b) 本人/吾等的銀行作繳款用途；(c) 本人/吾等的保險經紀（如有）；(d) 公司的保險代理人及強積金中介人；(e) 公司的關連公司（根據公司條例訂明）包括退休金服務提供者、保險公司及金融服務機構；(f) 香港保險業聯會(或任何相似的保險公司協會)及其會員；(g) 公司及其關連公司（不論在香港與否）為遵守監管當局或其他機構發出之指引或其就法例、法規或法庭頒令所約束或規定之責任而需向其作出披露的任何人士；及 (h) 按法例要求或准許的其他人仕。
公司可就法例准許或於獲得本人/吾等的同意後披露或將本人/吾等的個人資料作其他用途。
本人/吾等明白本人/吾等所提供之個人資料均屬自願，然而倘若未能提供所需個人資料，可導致公司無法處理本人/吾等的申請。本人/吾等有權查閱及要求更正公司持有有關本人/吾等的個人資料，有關要求可以書面形式郵寄至香港九龍廣東道 15 號港威大廈永明金融大樓 8 樓香港永明金融有限公司團體保險行政部。公司可就處理任何該等要求收取合理費用。
4. I/We further authorized: (a) any doctor, hospital, clinic, insurance company, government office or any organization or person who has any record, knowledge or information of me/the Insured (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to this application; and (b) the Company or any of its appointed medical/paramedical examiners or laboratories to perform necessary medical assessments and tests to evaluate the health status of me/the Insured in relation to this application. This authorization shall bind the successors and assignees of me/the Insured and shall remain valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original.
本人/吾等同時授權：(甲) 任何擁有任何本人/受保人之記錄、詳情或資料（醫療或其他資料）之醫生、醫院、診所、保險公司、政府部門、機構或人士就此申請向公司或其代表披露、透露或轉移此等記錄、詳情或資料；及 (乙) 公司或公司指定之醫生/醫護人員或化驗所進行必要之健康評估及檢驗，以評估與此申請之本人/受保人的健康情況。此授權書對本人/受保人之繼承人及受讓人有約束力，並於本人/受保人身故後或喪失能力後仍然有效。此授權書的正本及影印本同屬有效。
5. I/We agree to pay to the Company for any non-eligible expense(s) or expense(s) which exceed the benefit coverage of the policy which is/are paid to the medical service providers by the Company on behalf of me/us.
本人/吾等同意承擔及繳付由公司向醫療服務機構直接結清的任何不合條件的費用或超越本保單福利保障範圍的任何費用。

Date 日期: Signature of Patient 病人簽署 (*):

(*) In the event of the patient whose age is less than 18, this part should be signed by the insured employee. 倘若病人之年齡在十八歲以下，此申請表須由受保僱員簽署。

5-00-0034/05-2018

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香港九龍紅磡德豐街22號海濱廣場二座10樓
電話：(852) 3183 2099 傳真：(852) 2302 0173
Sun Life Hong Kong Limited 香港永明金融有限公司
(Incorporated in Bermuda 於百慕達註冊成立)
A member of the Sun Life Financial group of companies 永明金融集團成員之一

Part B – To be completed by employer (Policy Owner) (if applicable) 乙部 ─ 由僱主填寫（如適用）

For and on behalf of the Employer 茲代表僱主

Name of Signatory 簽署人姓名：

Job Title 職位：

Date 日期：

Authorized Signature 授權人簽署

Part C – Must be completed by surgeon or attending physician at the claimant's own expense 丙部－必須由外科醫生或主診醫生填寫，所需費用由索償人承擔

(1) PARTICULARS OF THE PATIENT 病人資料

Name of Patient 病人姓名 H.K.I.D.Card No. 香港身份證號碼 Age 年齡

(2) DETAILS OF HOSPITALIZATION AND TREATMENT 住院詳情及治療

Name of Hospital 醫院名稱

Date of Admission 入院日期 Date of Discharge 出院日期

Level of Hospital Ward 病房類別 ☐ Private 私家病房 ☐ Semi-private 二等病房 ☐ Ward 普通病房 ☐ Clinical Surgery 門診手術

Nature of the Surgical Procedure 手術名稱 Date of Operation 手術日期

(3) DIAGNOSIS AND MEDICAL HISTORY 診斷及病歷記錄

a) Chief complaints / symptoms of the patient relating to this hospitalization/surgery 此次住院/手術的主要原因/病徵

b) Date of the accident or when symptoms first appeared 首次出現病徵或意外發生日期

c) Date on which the patient first consulted you for this condition or related illness 病人首次求診日期

d) To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? If yes, please state dates and give details.
據閣下所知，病人以前曾否患有同類或類似情況？若有，請說明何時及當時病況。

e) Final Diagnosis 最後診斷

f) Was condition due to or associated with the following? (Please tick the appropriate boxes) 此病症是否與下列情況有關？（請選擇適合方格）

☐ the influence of drugs or alcohol 受藥物或酒精影響
☐ infertility or sterilization 不育或絕育
☐ cosmetic or plastic surgery 美容或整形手術
☐ mental or nervous disorder 精神病或神經錯亂
☐ congenital deformities or anomalies 先天性畸形或異常
☐ correction of eye sight 視力矯正
☐ AIDs, venereal disease, sexually transmitted disease 愛滋病、性病或性接觸傳染病
☐ pregnancy 懷孕 (date of commencement of pregnancy 受孕日期)
☐ accidental bodily injury 意外受傷
☐ contraception 避孕
☐ self-inflicted injury 自我傷害
☐ developmental condition 發育不全
☐ hereditary condition 遺傳性疾病
☐ general check-up 一般身體檢查
☐ vaccination 預防疫苗

g) Brief discharge summary (including treatments, investigation procedures, results, and/or any complications and follow up plan).
出院撮要:（治療及以後治療計劃，包括診查辦法、結果，併發症及跟進計劃）。

h) Please provide reason(s) for hospitalization if this type of cases can be managed on day case / outpatient basis. 如類似個案可以在門診處理，請提供人入院之理由。

i) If the patient has consulted other physician during this hospitalization, please provide the following details: 如病人在是此住院曾經其他醫生診斷，請提供以下詳細資料:

Name of physician consulted 醫生姓名 Reason 理由

What treatment had the physician performed? 此醫生提供什麼治療計劃?

j) If the patient was referred by another physician, please give the name and address of the referring physician. 如病人是經其他醫生轉介，請提供該醫生之姓名及地址。

k) Are you the patient's usual physician? 你是否病人常見醫生? ☐ Yes 是 ☐ No 否

l) Has the patient taken any home leave during this hospitalization? 病人有否於住院期間離開醫院 ?

☐ No 沒有 ☐ Yes 有

If "Yes", please state the date and time 若「有」，請詳述日期及時間

I hereby certify that all information given above is accurate and true to the best of my knowledge 本人特此證明據本人所知，上述所有資料是準確和真實。

Name of Physician/Surgeon :
主診醫生或外科醫生姓名

Signature of Physician/Surgeon with Official Chop
主診醫生或外科醫生簽署及蓋章

Qualifications :
資歷

Address :
地址

Telephone :
聯絡電話

Date 日期 :