

Hospitalization Pre-Approval Form (Bright Superb Health)

住院預先批核申請書 (明智顯耀醫療計劃)



Please select the service 請選擇服務

- Request of Guarantee Letter of Payment 申請付款保證書
- Pre-approval of oversea hospitalization 申請海外住院預先批核

Inter Partner Assistance Hong Kong Limited (IPA) is a service provider appointed to provide claims services for "Bright Superb Health". Please contact IPA Hotline for any claim enquiry. Tel : (852) 8101 8011 Fax : (852) 8200 8377 Email : sunlife.hk@ip-assistance.com.

This form must be completed in full for us to process the application for the "Guarantee Letter of Payment/ Pre-Approval"

***We only guarantee the medical costs associated which has been approved/ mentioned in GOP**

國際救援(亞洲)公司被委任為處理「明智顯耀醫療計劃」索償事務之服務商。如有關任何索償事項查詢，請致電IPA供之專線。電話：(852) 8101 8011 傳真：(852) 8200 8377 電郵：sunlife.hk@ip-assistance.com

您必須填妥此表格所需的全部資料，以便辦理「付款保證書/預先批核」之申請。

***我們只會就在此保證書上已獲批准提及的醫療費用作出保證**

Consultant's Information 顧問資料					
Consultant Name 顧問姓名		District/ Branch Code 區域/分行編號		Consultant Code 顧問編號	
				Contact Phone No. 聯絡電話	
Part A 第一部份 - To be completed by insured or policyholder if insured is below 18 years old (Please attach hospital / medical expense receipts with this form) 請由受保人填寫，如受保人未滿 18 歲，則由保單持有人填寫(請連同住院/醫療費用單據一併交回)					
Personal Particulars 個人資料					
Name of Policyholder 保單持有人姓名		Family Name 姓 Given Name 名		Chi 中文 Policy No. 保單編號	
Name of Insured 受保人姓名		Family Name 姓 Given Name 名		Chi 中文	
HK Identity Card No. of Insured 受保人香港身份證號碼			Date of Birth 出生日期		Age 年齡
			YY/MM/DD (年/月/日)		Sex M / F 性別 男 / 女
Country of Residence in the past 12 months of the insured 受保人過去 12 個月之常居地					
Daytime Contact Telephone No. 日間聯絡電話			E-mail Address 電郵地址		
Shortfall Collection Credit Card Authorization Form 繳付差額費用之信用卡授權書 (applicable to application for "Guarantee Letter of Payment" and please send the credit card copy along with this form to us for verification 只適用於「付款保證」申請及請填妥此申請書連同信用卡副本交給我們核實)					
If the amount paid by IPA to the hospital exceeds the eligible claims including balance of deductible arising from this hospitalization, this Form authorizes IPA to collect the shortfall amount from the following credit card account. The credit cardholder should be the Policyholder of this policy. The shortfall collection notice will be sent to you 5 days prior to the collection. 如IPA直接支付予醫院的費用超出是次住院應付的賠償額(包括墊底費)，此授權書將授權IPA從以下信用卡帳戶收取此差額。持卡人必須為此保單持有人。IPA將於收取差額費用 5 天前郵寄結欠付款通知書通知閣下。					
Credit Card Authorization Form 信用卡付款授權書 (the section must be completed 此部份必須填寫)					
I hereby authorize and direct Inter Partner Assistance Hong Kong Limited to debit the outstanding shortfall due from my credit card account. 本人授權及指示國際救援(亞洲)公司從本人信用卡戶口扣除到期之差額費用。					
Cardholder's Name 持卡人姓名		HKID Card No. 持卡人香港身份證號碼		Signature of Cardholder (must be the same as that on the Credit Card) 持卡人簽署(須與信用卡上簽名相同)	
Credit Card Account No. 信用卡號碼		Credit Card Expiry Date 信用卡到期日		X _____ Date Signed 簽署日期 / / YY/MM/DD (年/月/日)	
Inter Partner Assistance Hong Kong Limited (IPA) reserves the right to enforce the "Guarantee Letter of Payment" (GOP) arrangement for treatments. The approval of GOP is subject to the terms and conditions of the relevant policy provision and the acceptance of the "GOP Letter" by the hospitals. 國際救援(亞洲)公司保留執行「付款保證」安排的權利。「付款保證書」之批核須受有關保單條款及細則約束並有關醫院是否接受「付款保證書」。					
Personal Information Collection Statement 個人資料收集聲明					
I/We understand and consent that, any personal data collected by Sun Life Hong Kong Limited ("Sun Life") (whether collected in this form or otherwise) may be used by Sun Life 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) complying with all laws, regulations, regulatory guidance, court orders or obligation or requirement under an agreement, or other commitment, between Sun Life or any entity within the Sun Life Group and the regulator or government in any jurisdiction (in relation to money laundering, terrorist financing and tax evasion or otherwise) to which Sun Life and it's related companies are subject to (of Hong Kong or any other countries); and (ix) purposes which are directly related to any of the above purposes. Sun Life may also use my/our contact details, demographic information and policy details to contact me/us with marketing information regarding Sun Life and third party pensions, financial and insurance products, including by phone calls, mail, email, SMS or any type of electronic message. Sun Life may not so use my/our data unless Sun Life have received my/our consent (which includes an indication of no objection). I/We know I/we can tick the box below if I/we do not consent to receive such marketing information. Sun Life may disclose my/our personal data for any of the above purposes: (a) to third parties who provide services in Hong Kong or elsewhere which assist Sun Life 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 Sun Life's insurance agents and MPF intermediaries; (e) to Sun Life'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 or authority to whom Sun Life and its related companies are required to make disclosure to as a result of applicable law, regulation, regulatory guidance, court order or obligation or requirement under an agreement, or other commitment, between Sun Life or any entity within the Sun Life Group and the regulator or government in any jurisdiction (in relation to money laundering, terrorism and tax evasion or otherwise) that Sun Life and it's related companies are subject to or required to comply with (of Hong Kong or any other countries) and (h) as otherwise required or permitted by law. Sun Life 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 Sun Life is unable to process my/our application or continue to provide services to me/us. I/We have the right to seek access to and request correction of any personal data Sun Life holds about me/us by sending a written request to The Manager, Customer Service Centre, Sun Life Hong Kong Limited, 8/F, Sun Life Tower, The Gateway, 15 Canton Road, Kowloon, Hong Kong. Sun Life may charge a reasonable fee for the processing of any such requests. "Sun Life Group" means Sun Life together with its subsidiaries, subsidiary undertakings and associated companies (whether direct or indirect) from time to time.					
<input type="checkbox"/> Please tick here to reject receiving marketing information from Sun Life.					

本人 / 吾等明白及同意香港永明金融有限公司(「永明」) 可以將其所收集的任何個人資料(不論由此表格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) 為遵守所有永明及其關連公司所受限制(香港或其他國家)法例、法規、法規指引、法庭命令或永明或永明集團內的任何實體與任何管轄區域的監管機構或政府之間的協議項下的義務或要求或其他承諾(其相關於洗黑錢、恐怖分子資金籌集、逃稅或其他); 及(ix) 與上述任何目的直接有關的其他目的。

永明亦可使用本人/吾等的聯絡資料, 基本個人資料及保單資料, 就永明及第三方的退休金、金融及保險產品的推廣資訊, 以包括電話、郵件、電郵、電話短訊或任何電子信息等方法聯絡本人/吾等。除非得到本人/吾等之同意(包括表示不反對), 否則永明不可使用本人/吾等之資料為該用途。本人 / 吾等明白若本人/吾等不同意接受此等推廣資訊, 可於下列方格內填上別號。

永明可為以上任何目的披露本人/吾等的個人資料予 (a) 為協助永明就上述用途 (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) 永明的保險代理人及強積金中介人; (e) 永明的關連公司 (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) 香港保險業協會 (或任何相似的保險公司協會) 及其會員; (g) 永明及其關連公司因受(香港或其他國家)之法例、法規、法規指引、法庭命令或永明或永明集團內的任何實體與任何管轄區域的監管機構或政府之間的協議項下的義務或要求或其他承諾(其相關於洗黑錢、恐怖分子資金籌集、逃稅或其他)限制而需向其作出披露的任何人士或監管當局; 及(h)按法例要求或准許的其他人仕。

永明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, 可導致永明無法處理本人/吾等的申請或繼續提供服務予本人/吾等。本人/吾等有權查閱及要求更正永明持有有關本人/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客戶服務中心經理。永明可就處理任何該等要求收取合理費用。

*「永明集團」指永明及其不時之附屬公司、附屬企業和相聯公司 (無論是直接的還是間接的)。

若不同意收取由永明發出的推廣資訊, 請於方格內填上別號。

DECLARATION AND AUTHORIZATION 聲明及授權

I/WE HEREBY DECLARE AND AGREE that: (a) all the foregoing statements and answers in this claim form together with those in any required medical questionnaire or other document submitted by me/us in connection with this claim are full, complete and true. (b) Sun Life Hong Kong Limited (the "Company") may be unable to process this claim if I/we fail to provide any information related to this claim.

I/WE FURTHER AUTHORIZE that: (a) any licensed physician, medical practitioner, hospital, clinic or medically related facility, institution, insurance company, government, private office or person that has any record or knowledge or information of me/ the Insured to disclose, release or transfer to Sun Life Hong Kong Limited or its appointed representatives any such record, knowledge or information. (b) the Company or its appointed medical/paramedical examiner or laboratory to perform necessary medical assessment and tests to evaluate the health status of me/the Insured in relation to this application. (c) I specifically authorize the disclosure of all information about communicable diseases and infections, including but not limited to any sexually transmitted disease, HIV infection, Acquired Immune Deficiency Syndrome (A.I.D.S.) and A.I.D.S. related complex (A.R.C.). This authorization shall irrevocably bind the successors and assignees of me/the Insured and remains valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original.

本人/吾等聲明及同意下列各點: (甲) 本賠償申請表上所載的聲明及答案, 以及經本人/吾等簽署之所需的醫療問卷或經本人遞其他文件, 均屬真確無訛, 詳細完整。本人/吾等明白倘有任何未知是否於重要事項的資料均須透露。(乙) 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 (以下稱為「公司」) 未能處理此賠償申請。

本人/吾等同時授權以下各點: (甲) 任何註冊醫生、醫院、診所、保險公司、政府部門或任何其他持有有關本人/受保人之個人資料之人士或機構, 向香港永明金融有限公司或其代表透露, 發放或轉交任何有關資料。(乙) 公司或公司指定之醫護人員或化驗所, 可就此申請, 對本人/受保人進行所需之醫療評估及測試以審核本人/受保人之健康狀況。(丙) 本人/吾等特此授權上述人士或機構透露任何關於傳染性疾病及感染的所有資料, 包括但不限於任何經接觸傳染之疾病、人類免疫力缺乏病毒(HIV) 感染、後天免疫力缺乏之病(愛滋病)及愛滋病有關發症。此授權對本人/受保人之繼承人或受讓人具有約束力。即使本人/受保人死亡或無行為能力, 此授權書仍有效力。此授權書的影印本與正本具同等效力。

Signature of Insured / Policy Owner (if insured is below age 18)
 受保人/保單主權人(如受保人未滿 18 歲)

X _____
 Date Signed 簽署日期 / / YY/MM/DD (年/月/日)

Name of Insured / Policy Owner (in block)
 受保人保單主權人姓名 (請以正楷大寫)

ID / Passport No.
 身份證 / 護照號碼

Part B 第二部份 - To Be Completed By The Attending Physician / Surgeon 由主診醫生填寫

Full name of Patient 病人姓名	HK Identity Card No. 香港身份證號碼	Age 年齡	Sex 性別
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Medical History 病歷

1. Diagnosis / symptoms 診斷 / 病徵
 Chief complaint 主要申訴

2. Onset date of the symptoms / condition: 病發日期

3. Prior to this consultation, did patient first consult you for the related signs and symptoms? And when was the first consultation? 在是次求診日期時, 病人有否在台端執業之診所診治有關上述病況之紀錄? 如有, 病人始自何時求診?

NO 否 YES 有, the first consultation was since 第一次求診日期始自 _____ YY/MM/DD (年/月/日)

Hospitalization Details 住院詳情

Hospital Name 醫院名稱	Expected Admission Date 入院日期
Address of Hospital 醫院地址 <input type="checkbox"/> HK / 香港 <input type="checkbox"/> Overseas / 海外, please provide the full address 請提供詳細地址:	Hospital Tel and Hospital Fax No. 醫院電話及傳真號碼

Treatment Details 治療詳情

Surgery / treatment required 建議之手術 / 治療	Reason for this hospitalization 住院原因
Lab tests / Imaging / other diagnostic investigation required 建議之化驗 / 影像檢查 / 其他診斷性檢查	Anaesthesia 麻醉 - G.A. 全身麻醉 <input type="checkbox"/> L.A. 局部麻醉 <input type="checkbox"/>

If you have recommended the patient for specialist's opinion (other than attending Physician), please give specialist name and nature of treatment provided:
 如有轉介至專科診治, 請提供專科醫生之姓名及治療詳情:

Please indicate if the medical condition and its subsequent treatment are associated with the followings 請指出上述病況是否與下列情況有關:

<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	Congenital anomalies, infertility or sterilization / 先天性不正常情況, 不育或絕育
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	Under the influence of drugs or alcohol / 受酒精或藥物影響
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	Self-inflicted injuries or suicidal attempt while sane or insane / 不論在神智清醒與否下之自我傷殘或自殺行為
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	Mental or psychiatric problems / 心理或精神科
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	Pregnancy conditions or any related complications / 懷孕或由此引發之病況
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	Rest cure, rehabilitation, convalescence or extended care / 休養、康復、療養或延續護理
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	Dental care or General Check-up / 牙科治療, 身體檢查
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	Cosmetic / Plastic Surgery 美容 / 整形外科手術

Expected costs of the hospitalization / treatment 預計住院 / 治療費用

i Class of bed Standard private room price (Per day) 住院級別: 標準私家房價格 (每日)	ii Other hospital expenses (i.e. medicines, x-Ray or Lab) 其他醫院費用 (如: 藥物, X 光或化驗)
iii Doctor's fee with relevant breakdown 各項分類醫生費用:	
a) Physician's fee 醫生費 _____	b) Surgical fee 手術費 _____
c) Anaesthesia fee 麻醉費 _____	d) Specialist fee 專科醫生費 _____

Physician's Information 醫生資料

Signature of Physician 醫生簽署	Hospital / Physician Stamp 醫院 / 醫生蓋印
Physician Name in Block 醫生姓名	Date Signed 簽署日期 YY/MM/DD (年/月/日)
Name of contact person 聯絡人姓名	Contact person Tel & Fax No. 聯絡人電話 / 傳真號碼