FALCON
Falcon Insurance Company (Hong Kong) Limited
富勤保險(香港)有限公司
A FAIRFAX Company

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HOSPITALIZATION & SURGICAL CLAIM FORM 住院及手術索償表格

This Claim Form is applicable to both inpatient and outpatient surgical claim 本索償表格適用於住院或門診手術索償

Claim Notes
1. This Form is applicable to hospitalization and day case surgery in hospital / clinic claims.
2. **Each Claim Form is for one Claimant (Patient) only.**
3. Original itemized bills and receipts and this completed Claim Form must be submitted within 90 days of incurring such expenses.

Claim Procedures
1. Attach the **Original** receipt(s) issued by the doctor and / or hospital or certified true copy of receipt(s) issued by other insurers (if applicable). Each receipt **MUST** state the following information:
   ■ Full name of patient ■ Date of treatment ■ Diagnosis ■ Breakdown of charges ■ Doctor's signature and official stamp ■ Name of surgery (if applicable) ■ Name of Hospital or Clinic
2. Please attach copies of hospital discharge summary, laboratory test report(s), pathology report, physician's statement and any other related information. All information required by us shall be furnished at the Claimant (Patient)'s own expense.
3. **Complete and sign this Form.**
4. Provide copy of claim settlement advice from other insurers, if applicable.
5. Please tick the appropriate box if certified true copy of receipt is required.
   Falcon Insurance Company (Hong Kong) Limited will retain the original receipt for record purpose.

索償注意事項
1. 此索償表格適用於住院及醫院 / 門診日間手術索償。
2. **每張索償表格只限一名索償人(病人)。**
3. 請於費用支出後 90 日內將正本詳列之賬單及收據連同填妥之索償表格一起遞交。

索償程序
1. 附上由醫生及 / 或醫院簽發的收據**正本**或由其他保險公司發出的收據核實副本 (如適用)。每張收據**必須**列明以下資料：
   ■ 病人姓名 ■ 治療日期 ■ 病症名稱 ■ 收費項目說明
   ■ 醫生簽署及蓋章 ■ 手術名稱 (如適用) ■ 醫院或診所之名稱
2. 請同時附上出院紙、化驗報告、病理報告、醫生報告及其他相關資料之副本。本公司要求遞交的所有資料之費用須由索償人(病人)支付。
3. **填妥此索償表格及簽署。**
4. 如適用，請提供其他保險公司之賠償結算通知書副本。
5. 如需索取收據之核實副本，請於適當空格內畫上✓號。
   收據正本將存檔於富勤保險(香港)有限公司。

PART 1 - TO BE COMPLETED BY CLAIMANT (PATIENT) 第一部份 – 由索償人(病人)填寫

1a. Policy No. 保單號碼

1b. Policyholder Name 保單持有人名稱

2. **Employee 僱員**

2a. Name in English 英文姓名
Surname 姓 Other Name 名

2b. Type of Personal Identification Document and Number 身份證明文件類別及號碼
(Please tick the appropriate box 請於適當方格內畫上✓號)
□ HKID Card No. 香港身份證號碼 □ Passport No. 護照號碼
□ Member Ref. No. 會員參考編號 □ Staff No. 職員編號 _____

3. **Claimant (Patient) (if other than Employee) 索償人(病人) (如非僱員)**

3a. Name in English 英文姓名
Surname 姓 Other Name 名

3b. Relationship 關係

3c. Type of Personal Identification Document and Number 身份證明文件類別及號碼
(Please tick the appropriate box 請於適當方格內畫上✓號)
□ HKID Card No. 香港身份證號碼 □ Passport No. 護照號碼
□ Member Ref. No. 會員參考編號 □ Staff No. 職員編號 _____

Please fill in Section A for hospitalization due to illness OR Section B for hospitalization due to accident. 如因疾病入院，請填寫 A 欄；如因意外入院，請填寫 B 欄。

Section A:
4. Describe the symptoms and abnormalities leading to this hospitalization.
請描述因何不適及有何異常引致是次入院
_____
5. Name, address & telephone no. of doctor / hospital first consulted for the illness.
首次求診之醫生姓名 / 醫院名稱，地址及電話號碼
_____
6. Date of the first consultation 首次求診日期
_____
7. Since when did these symptoms first appear? 病徵於何日首次出現?
_____

Section B:
4. When (date & time) did the accident happen? 意外於何時(日期及時間)發生?
_____
5. Where did the accident happen? 意外於何地發生?
_____
6. How did the accident happen? 請詳述意外發生經過?
_____
7a. Was the accident reported to the police? 就此次意外有否向警方報案?
□ Yes 有 (please provide copy of the police report 請提供警方報告副本)
□ No 沒有
7b. Was the accident a workplace injury? 此次意外是否工傷? □ Yes 是 □ No 否

8. If any prior treatment for the same or closely related cause was received, please provide details below: 如閣下以前曾接受過同樣或相關原因之治療，請填此欄：

Date admitted / Treated 入院 / 治療日期	Date discharged 出院日期	Cause 原因	Name & Address of Doctor 醫生姓名及地址	Name & Address of Hospital 醫院名稱及地址

9a. Have you ever filed or will you file any other insurance or compensation claim as a result of this treatment? 閣下有否因此次治療而曾經或將會申請其他保險賠償或補償?
□ Yes 有 (please provide relevant claim settlement advice with breakdown & complete 9b & 9c) (請提供有關賠償明細表及填妥問題 9b 及 9c)
□ No 沒有

9b. (i) Name of the Insurance Company 保險公司名稱
(ii) Policy No. & Membership No. 保單編號及會員編號

9c. Type of Insurance / Compensation 保障或補償類別

□ Return certified true copy of receipt(s) after claim processing. 如欲索回收據之核實副本，請於方格內填上✓號。

Declaration and Authorization 聲明及授權書

1. I hereby declare that the foregoing statements, including any statement attached, are true, correct and complete to the best of my knowledge and belief. 本人謹在此聲明，以上所述一切是根據本人所知所信正確填寫，並為完全和真確。
2. Personal Information Collection Statement
   The information you provide to **Falcon Insurance Company (Hong Kong) Limited** ("the Company") is collected to enable the company to carry on insurance business and may be used for the purpose of (i) any insurance or financial related product or service or any alternations, variations, cancellation or renewal of such product or service; (ii) any claim or investigation or analysis of such claim; and (iii) exercising any right of subrogation. The information may be transferred to (i) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claim or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; (ii) 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"; and (iii) any members of the "Federation" by the "Federation" for any of the above or related purposes. Moreover, the Company is hereby authorized to obtain access to and / or to verify any of your data with the information collected by the "Federation" from the insurance industry. You have the right to obtain access to and to request correction of any personal information concerning yourself held by the Company. Requests for such access can be made to our Data Protection Officer (Suites 307-11, 3/F, Cityplaza Four, 12 Taikoo Wan Road, Taikoo Shing, Hong Kong Tel.: 2232 2888 Fax: 2232 2799).
   收集個人資料聲明
   閣下提供的資料，為**富勤保險(香港)有限公司**(「貴公司」)提供保險業務所需，並可能使用於下列目的：(i) 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；(ii) 任何索償，或該等索償的調查或分析；(iii) 行使任何代位權。該等資料可能移轉予：(i) 任何有關的公司，或任何其他從事與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目的；(ii) 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；及 (iii) 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目的。此外，在此授權貴公司由 "聯會" 從保險業內收集的資料中查閱及 / 或核對閣下任何資料。閣下有權查閱及要求更正由貴公司持有有關閣下的個人資料，如有需要，可向本公司資料保護主任 (香港太古城太古灣道 12 號太古城中心第四期 3 樓 7-11 室 電話：2232 2888 傳真：2232 2799) 提出。
3. Consent & Authorization
   In accordance with the provisions of the Personal Data (Privacy) Ordinance of Hong Kong, I / and on behalf of the Claimant* consent, by signing below, that the personal information of me / the Claimant* provided by me / us* and held by the Company (whether contained herein or otherwise obtained) may be held, used, disclosed, released and transferred by the Company to the parties and for the purposes mentioned in the "Personal Information Collection Statement". I hereby authorize / and on behalf of the Claimant hereby authorize* (i) any doctor, hospital, clinic, or insurance company, government office or any organization or persons who has any records / knowledge / information of me / the Claimant* (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to the claim herein and / or the disability resulting from the said claim; (ii) the Company or any of its appointed medical / para-medical examiners or laboratories to perform necessary medical assessment and tests to evaluate the health status of me / the Claimant* in relation to (i) above. This authorization shall bind the successors and assignees of me / the Claimant* and remains valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original. (*Delete where appropriate)
   同意及授權書
   根據香港個人資料(私隱)條例，就簽署此索償表格，本人 / 謹代表索償人*同意貴公司可持有或使用任何有關本人 / 索償人*之個人資料 (不論是否從此索償表格或其他途徑所得)，或將該等資料透露、發放或轉交予 "收集個人資料聲明" 內提及之組織、機構或人仕作為有關之用途。本人謹此授權 / 謹此代表索償人授權* (i) 任何擁有本人 / 索償人*的醫療記錄或資料之醫生、醫院、診所、保險公司、政府部門或其他機構及人仕，向貴公司或其代表透露及提供關於本人 / 索償人*之記錄或資料；(ii) 貴公司或其指定之醫護檢查人員或化驗所對本人 / 索償人*進行與 (i) 有關之身體檢查及化驗。此授權對本人 / 索償人*之繼承人及受讓人均有約束力，即使在本人 / 索償人*身故或喪生行為能力後仍然有效。 (*請將不適用者刪除)

_____ _____
Signature of Claimant (Patient) / Parent or Legal Guardian (if Claimant (Patient) aged below 18) 索償人(病人)簽署 / 父母或合法監護人簽署 (如索償人(病人)年齡少於 18 歲)
Date 日期 (DD/MM/YY)

If there is any discrepancy between the English and Chinese versions, the English version shall apply and prevail. 英文版本與中文版本之間如有任何歧異，均以英文版為準。

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PART 2 - TO BE COMPLETED BY ATTENDING PHYSICIAN (at the claimant (patient)'s own expenses)
第二部份 – 由主診醫生填寫 (所需費用由索償人(病人)自付)

1. Name of patient 病人姓名	2. Name of Hospital 醫院名稱	3a. Date admitted 入院日期	3b. Date discharged 出院日期

4. Final diagnosis for hospitalization 住院之診斷	5. Symptoms and onset date 病徵及其何時開始

6. Aetiology of the medical condition 病因	7. Date of Operation 手術日期

8. Brief description of operating procedure performed 請簡述手術進行之步驟

9. When did the patient first consult you for this condition or other related symptoms?
病人何時因這種病症或其他有關病徵向閣下首次求診?

10. Was the patient referred to you by another doctor?
病人是否由另一醫生轉介?
☐ Yes 是 (please state the name of the doctor 請提供該醫生之姓名)
_____
☐ No 否

11. Has the patient ever been treated or hospitalized for the same or closely related condition before? If 'yes', please complete: 病人以往曾否因同樣或相關之病症而接受治療或住院? 如 '有'，請填寫：

Date of consultation / admission 門診 / 入院日期	Cause 原因	Treatment 治療	Name of Doctor / Hospital 醫生 / 醫院名稱

12. Have you recommended and secured the opinion or services of a Specialist?
閣下曾否獲得專科醫生之意見或服務?

☐ Yes 有 Please give the name of the Specialist and the reason why his/her opinion or services were required.
請提供該專科醫生之姓名及需要其意見或服務之理由。
_____
☐ No 沒有

13. In-hospital Doctor Visit Fees charged 醫生巡房收費

日數 _____ days 每日 @ _____

Total Fees 費用總額：_____

14. Are you the patient's usual physician? 閣下是否病者慣常求診之醫生?

☐ Yes 是 Please fill in the medical history 請填寫病歷： (please use additional paper if necessary 如有需要，請用附加紙張)

Date of consultation 門診日期	Symptoms / complaints 病徵 / 不適	Recommended tests / treatment 檢查 / 治療

☐ No 否 Please give the name(s) of the patient's usual doctor(s) that you know. 請提供閣下知悉之病者慣常求診之醫生姓名
_____

15. Was the condition due to or associated with the following? 上述情況是否因以下問題所致?

		Yes 是	No 否			Yes 是	No 否
(a)	AIDS, venereal disease or sexually transmitted disease 愛滋病，性病或因性接觸感染之疾病	☐	☐	(i)	Infertility or sterilization 不育或絕育	☐	☐
(b)	Accidental bodily injury 意外身體受傷	☐	☐	(j)	Mental disorder 精神疾病	☐	☐
(c)	Congenital condition 先天性異常	☐	☐	(k)	Pregnancy 懷孕	☐	☐
(d)	Contraception 避孕	☐	☐	(l)	Refractive error or correction of eyesight 屈光不正或矯視	☐	☐
(e)	Treatment for cosmetic purpose 美容性質的治療	☐	☐	(m)	Rest cure or sanitaria care 休養或療養	☐	☐
(f)	Developmental condition 發育問題	☐	☐	(n)	Self-inflicted injury 自我傷害	☐	☐
(g)	General medical check-up 一般身體檢查	☐	☐	(o)	The influence of drugs or alcohol 酒精或藥物之影響	☐	☐
(h)	Hereditary condition 遺傳性問題	☐	☐	(p)	Vaccination 疫苗	☐	☐

16a. Was the confinement due to childbirth 因分娩住院? ☐ Yes 是 ☐ No 否

16b. Approximate date of commencement of pregnancy 懷孕開始之大概日期

Day 日 Month 月 Year 年

16c. It should be classified as a 分娩類別
☐ Normal Delivery 順產
☐ Miscarriage 流產
☐ Caesarian Birth 剖腹生產
☐ Legal Abortion 合法墮胎 (please provide supporting documents 請提供有關文件)

I hereby declare that I was the Attending Physician of the above-named patient during hospital confinement, and that the answers given by me as above are full, complete and true to the best of my knowledge. 本人謹在此聲明，本人乃上述住院病人之主診醫生。以上所述一切是根據本人所知正確填寫，並為完全和真確。

Attending Physician's Signature & Official Stamp 主診醫生簽署及蓋章	Name, Qualifications & Address of Attending Physician 主診醫生之姓名，資歷及地址	Date 日期 (DD/MM/YY)

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EMPLOYEE BENEFITS DIVISION 僱員福利部