聯豐亨保險 有限公司
Luen Fung Hang Insurance Company Limited

保險公司填寫 For LFH Use
Claim No.
Received Date

住院及手術賠償申請表
HOSPITALIZATION & SURGICAL CLAIM FORM

本表格適用於住院
This form is applicable to in-patient

請附上有關之醫院及醫生收據之正本並連同此申請表一併寄回
Original bills and receipts for the claimed expenses must be attached with the Claim Form

甲部 – 由病人填寫
PART I – TO BE COMPLETED BY THE PATIENT

僱主或保單持有人名稱
Name of employer/policyholder _____

保單號碼
Policy no. _____

受保僱員 / 成員姓名
Name of insured employee/member _____

病人姓名
Name of patient _____

身分証號碼
I.D. Card no. _____

保戶編號 / 受保証書編號
Insured no./Certificate no. _____

性別
Sex _____

與保單持有人關係
Relationship to the policyholder

出生日期
Date of birth _____

本人 ☐ Self　配偶 ☐ Spouse　子女 ☐ Child

職業
Occupation _____

僱員 / 成員 ☐ Staff/Member　僱員 / 成員家屬 Dependent

(1) 閣下有否曾經因同一病況而接受治療 ?
Have you had any prior treatment for this or related conditions ?
沒有 ☐ No　有 ☐ Yes

醫生姓名
Doctor's name _____

地址
Address _____

診症日期
Consultation date _____

(2) 有關此次住院 / 手術，閣下有否申請其他保險賠償
Are you making any other insurance claim as a result of this hospitalization/surgery?
沒有 ☐ No　有 ☐ Yes

保單號碼
Policy no. _____

保險公司名稱
Name of insurance company _____

(3) 此次住院 / 手術是否由於一宗意外引致 ?
Was the hospitalization/surgery a result of an accident ?
沒有 ☐ No　有 ☐ Yes

日期
Date _____

簡述意外經過
Brief description _____

時間
Time _____

地點
Place _____

聲明及授權書

本人/我們聲明此表格內填報的資料，就本人/我們所知所信全部正確無訛，並無任何保留。本人/我們同意如爲處理有關本索償事宜，聯豐亨保險可使用所收集及持有關於我/我們/受保人的個人資料 (包括在此索償表格內或其他地方之資料) 或將該等資料給予有關之人士或機構 (包括在澳門境內或境外之再保公司、賠償調查公司、保險業協會/聯會及其他提供保險業有關服務之公司等)。

本人/我們並授權持有任何關於本人/我們/受保人的健康或醫療記錄或資料之人士或機構，向聯豐亨保險或其代理人，提供與本索償事宜或與保險公司的追償權有關之記錄或資料。即使我/我們/受保人死亡或在法律上失去能力，對我/我們/受保人的繼承人及受託人而言，本授權將繼續生效。本授權書之影印本將與正本具有同等效力。

本人/我們明白索償申請批核與否，所有相關文件將交由本人任職機構人力資源部處理

DECLARATION AND AUTHORIZATION

I/We hereby declare that to the best of my/our knowledge and belief the above statement and particulars contained herein are in all respects true and complete and are made without reservation of any kind. I/We agree that any of my/our/the Insured's personal information collected or held by Luen Fung Hang Insurance (whether contained in this claim form or otherwise obtained) is provided and may be held, used and disclosed by the Company to individuals/organization associated with the Company or any selected third party (within or outside Macau, including reinsurance and claim investigation companies and industry associations/federations and other service provider providing services relevant to insurance business) for the purpose of processing this claim.

I/We further authorize any organization, institute or individual that has any records or knowledge or my/our/the Insured's health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to Luen Fung Hang Insurance or its authorized representatives such information which is/are relevant to the settling of this claim and/or the Insurer's rights of recovery. This authorization shall bind my/our/the Insured's successors and assigns and remain valid notwithstanding my/our/the Insured's death or incapacity in so far as legally possible. A photocopy of this authorization shall be considered as effective and valid as the original.

I/We understand that all the related document should be handled by our HR Dept., whether the claim will be reimbursed or not.

病者 (十八歲以上) 簽署
Signature of Patient (18 years of age and over)

受保僱員 / 成員簽署
Signature of Insured Employee / Member

簽署日期
Date signed

(請轉下頁 Please turn over)

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

(1) 病人姓名
Name of patient _____

(2) 住院
Hospitalization

醫院名稱
Name of hospital _____

入院日期
Date of admission _____ 出院日期
Date of discharge _____

(3) 手術
Surgical procedure

治療詳情
Nature of medical treatment given _____

手術名稱
Name of procedure _____

手術日期
Date of operation _____ 外科手術醫生
Surgeon _____

(4) 此次住院 / 手術的主要申訴或徵狀
Major complaint(s)/symptom(s) of the patient relating to this hospitalization/surgery

_____

(5) 診斷
Diagnosis of conditions _____

(6) 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)
Brief discharge summary (including treatments, investigation procedures, results, and/or any complication and follow up plan)

_____

_____

(7) 首次出現病徵日期或意外發生日期
Date of the accident occurred or symptom first appeared _____

(8) 病人首次求診日期
Date of first consultation for this condition or related illness _____

(9) 此病可有復發機會 ?
Any possibility of having a relapse ? _____

(10) 以上情況是否屬先天性異常 ?
Is this condition arising from congenital abnormalities ? 不是 ☐ No 是 ☐ Yes

如 "不是" 請簡述致病原因
If "No", please state the cause of the diagnosis _____

(11) 據閣下所知，病人以前曾否患有同類病況 ?
To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto ? 沒有 ☐ No 有 ☐ Yes 請說明何時及當時情況 Please state dates and describe

_____

(12) 病人是否經其他醫生轉介 ?
Is the patient referred by another doctor ? 沒有 ☐ No 有 ☐ Yes 轉介醫生的姓名及地址 Name and address of the referral doctor

_____

(13) 如上述情況由懷孕引致，請說明開始懷孕日期
If condition is due to pregnancy, please give approximate date of commencement

_____

_____ 地址
Address _____

主診 / 專科醫生的姓名 (資歷)
Name of Attending Physician/Specialist (with qualifications) _____

電話
Telephone _____ 傳真
Fax _____

_____

主診 / 專科醫生簽名 / 醫院蓋章
Signature of Attending Physician/Specialist/Hospital Stamp 日期
Date _____