聯豐亨保險
Luen Fung Hang Insurance

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

門診賠償申請表
OUT-PATIENT CLAIM FORM

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

保單號碼
Policy no. _____

僱員 / 成員姓名
Name of employee/member _____

身分証號碼
I.D. Card no. _____

僱員或保險證書編號
Staff or Certificate no. _____

家屬姓名 (如病人乃成員家屬)
Name of dependent (complete only if patient is dependent) _____

病者現在有否受保於其他保險公司的醫療計劃 ?
Is the patient presently insured for medical benefits with other companies?

沒有 ☐ No　　有 ☐ Yes

如有，請列明保險公司名稱及保單號碼
If "Yes", please state name of insurance co. and policy no. _____

Date of Consultation 診症日期 (年 YY/月 MM/日 DD)	Receipt Charge 收據金額	Date of Consultation 診症日期 (年 YY/月 MM/日 DD)	Receipt Charge 收據金額

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，聯豐亨保險有限公司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，向聯豐亨保險有限公司或其代理人，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 Company Limited (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 Company Limited on 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 photostat 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)

受保人簽署 / 成員簽署
Signature of Insured Employee / Member

簽署日期
Date signed

(請轉下頁 Please turn over)

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提示
Instructions

1 此申請表需填寫有關資料及簽署，並於事發後*90 日內連同收據正本交回聯豐亨保險醫療保險理賠部。
(*個人保險需按保單條款爲準)
Claim Form should be completed & signed before submitted to Health Claim Division of Luen Fung Hang Insurance together with original bill(s)/receipt(s) within *90 days from date of loss.
(*Individual policy should be referred to policy provision)

2 須附具詳細門診費用賬單暨收據正本，提供治療日期，病者姓名，病症及主治醫生之印鑑及簽署。
Original bill(s) and receipt(s) for the claimed expenses must be attached showing the date of treatment, patient's name, diagnosis, and the attending physician's stamp and signature.

3 申請賠償專科診治或 X- 光 / 醫學檢驗費用須具主診醫生之處方或介紹信。
Claim for expenses incurred in specialist consultation and/or claim for X-ray examination/laboratory tests must be supported by attending physician's prescription and/or recommendation together with claim documents.