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

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DENTAL CLAIMS FORM 牙科賠償申請表

Please fill in all details and attach this slip to your claims with the following information and return to our office.
請塡妥下列所需資料並附上索償文件寄回本公司

To be filled with original accounting statements and other relevant documents. ***請附交賬項聲明及其他有關文件***

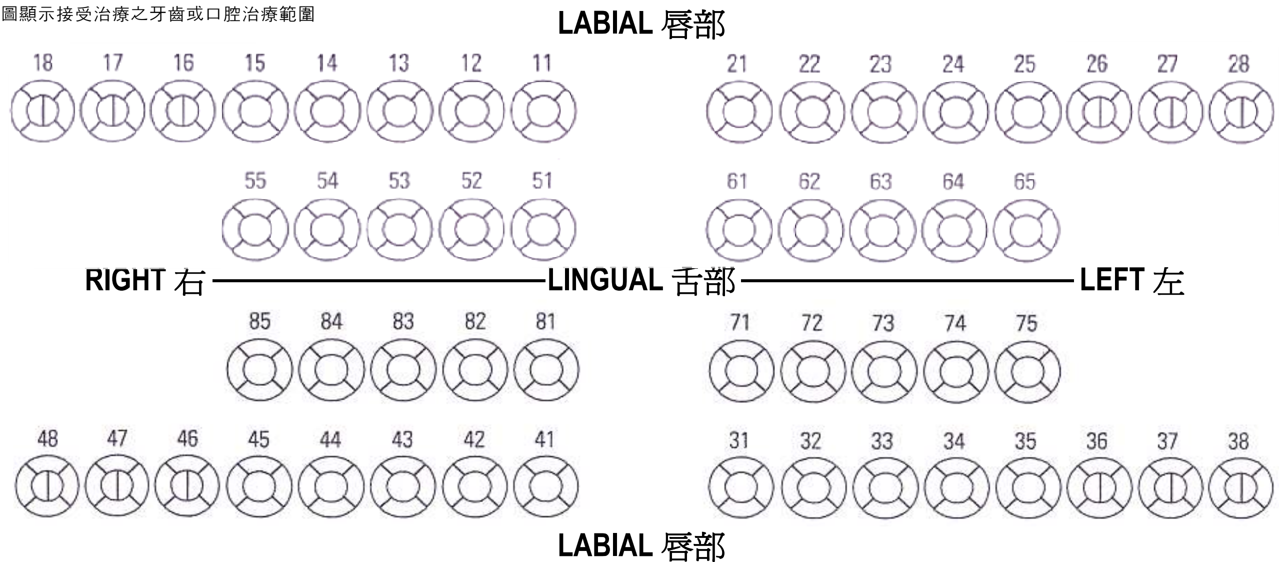
To Be Completed by the Insured 由被保人填寫 (or Parent if insured is a minor 若被保人爲小童，可由家長塡寫。)

Employer/Policyholder 顧主/保單持有人	Policy No. 保單編號
Insured Name 被保人姓名	Insured's ID No. or Insured No. 被保人身分證號碼或被保人號碼
Name and ID No. of parent (If insured is a minor) 若被保人爲小童,請註明家長之姓名.	
Dentist's Name 牙科醫生姓名	Dentist's Address 牙科醫生地址

To Be Completed by the Dentist Providing Treatment 由負責治療之牙科醫生填寫

Date (dd/mm/yy) 日期(日/月/年)	Particulars 詳情	Charges 收費
1.		
2.		
3.		
4.		
5.		
6.		

Please mark teeth treated or area of oral treatment on the following chart.
請在下列圖顯示接受治療之牙齒或口腔治療範圍



Remarks 備註	
Date (dd/mm/yy) 日期 (日/月/年)	Signature of Dentist 牙科醫生簽署

Luen Fung Hang insurance Company Limited
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If any of the dental treatments or services were necessitated as a result of an accident please give brief descriptions of the accident.
若任何牙醫治療或服務是因意外造成，請簡述意外經過。

Where did the accident take place?
意外發生地點?

When did the accident take place?
意外發生日期?

Was the accident of nature requiring report to the police? ☐ Yes 是 ☐ No 否
意外是否需要向警方報告?

If so, was the accident reported? (copy of documents to be enclosed) ☐ Yes 是 ☐ No 否
若是，是否已向警方報告? (請附交有關文件)

Date reported and where? (copy of documents to be enclosed)
報警日期及地址? (請附交有關文件)

Declaration and Authorization 聲明及授權書

I/We hereby declare, understand and agree that:

(1) I/We have obtained all necessary authorization from my/our dependents to supply their information to Luen Fung Hang Insurance Company Limited ("the Company") if my/our dependents are to be covered. I/We also understand that the information requested in this form is required in order for the Company to process this claims

(2) The information provided herein together with any subsequent alterations or supplements of it is collected or held to enable the Company to carry on insurance business and may be used, stored , disclosed and transferred (whether within or outside Macau) to any individuals/organizations associated with the Company or any selected third party as the Company may consider necessary including any other company carrying on insurance or reinsurance related business , any intermediary, claims investigator , medical facilities , other service provider providing services relevant to insurance business, professional advisor, government authority, industry association/federation or in the event of default , to debt collection agencies for the purpose of any scope of insurance coverage , claim processing/investigation or any analysis/data verification of within the insurance industry by way of matching procedures or otherwise, promotion of financial products and services by the Company and its affiliated companies, and communication with me/ us or any relevant organization/person as the Company may consider necessary. I/We have the right to obtain the "Privacy Policy Statement", access to and to request correction of any personal information concerning ourselves held by Company. Such request can be made in writing to the Company's Corporate Date Protection Officer.

(3) I/We certify that all the foregoing statements and answers in this claim form , including any attachments herein , are accurate , true , full , complete and given to the best of my/our knowledge and belief. I/We understand that in event of doubt whether a fact is material , it should be disclosed here.

(4) I/We understand that the Company may be unable to process this claim if I/We fail to provide any information required related to this application.

I/We further authorize any hospital , physician , medical practitioner , clinic or other medically related facility , insurance company , or any individual or organization/institution that has any records or knowledge of my/our or the insured's health and medical history or any treatment or advice that has been or may hereafter be consulted to disclose to the Company or its authorized representative such information . This authorization shall bind the successors and assignees of me/us and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as effective and valid as the original.

本人 / 我們謹此聲明，清楚明白及同意以下各項：

(1) 本人 / 我們已向家屬取得一切所需授權 (如適用)，可向聯豐亨保險有限公司 ("貴公司") 提供其個人資料。本人 / 我們亦明白本表內提供的資料是讓貴公司作處理本人 / 我們索償之用。

(2) 本人 / 我們明白及同意貴公司可收集或持有本表格內提供的資料(包括日後作出之修訂及補充)用於保險業務之用途，並可將該等資料儲存、使用、透露及轉交(不論在本澳或海外) 予任何與貴公司有關之人士 / 機構或任何貴公司認爲有需要之人等或被指定之第三者，包括其他從事與保險或再保險業務有關之公司、中介人、理賠調查員、醫療機構、有關提供保險業務服務之公司、專業顧問、政府機關、或保險業組織或聯會，以用作任何保障範圍，處理理賠 / 調查及其有關分析或核實資料；任何貴公司及其附屬公司之財務計劃、商品及服務之推廣活動；與本人 / 我們或貴公司認爲有關之機構 /人士溝通。本人 /我們有權致函向貴公司之個人資料保護主任索取「私隱政策聲明」，查詢及要求更正貴公司所持有有關之個人資料。

(3) 本人 / 我們謹此聲明上述所有聲明及答案，包括其他附件，均是無誤、真實及爲事實之全部，並且是本人 / 我們所知及所信提供的。本人 / 我們明白倘有任何未知是否屬於重要事項的資料均須向貴公司透露。

(4) 倘若本人 / 我們未能提供此申請所需資料，可導致貴公司未能處理此索償。

(5) 茲授權任何醫生、醫學界執業人士、醫院、診所及其他醫療有關的機構、保險公司或任何知悉本人 / 我們 / 被保人之健康狀況及病歷或任何治療或諮詢記錄及曾爲或將爲本人 / 我們 / 被保人診治之機構組織及人士向貴公司或其代理人透露有關資料。此授權書對本人 / 我們之繼承人及受讓人均有約束力，即使在本人 / 我們死亡或喪失行爲能力後仍然有效。此授權書之正本及副本具同等效力。

Date (dd/mm/yy) 日期(日/月/年)	Signature of Insured (or Parent if insured is a minor) 被保人(或家長)簽署