聯 豐 亨 保 險

Luen Fung Hang Insurance

聯豐亨保險填寫 For LFH Use
索償編號 Claim No.
收件日期 Received Date

住 院 及 手 術 索 償 申 請 表
HOSPITALIZATION & SURGICAL CLAIM FORM

申請住院索償須知 Note for filling a hospitalization claim form

1. 申請住院或手術索償，**必須提交正本紙質醫療收據**，醫療住院電子收費票據將不予受理。
   For hospitalization or surgical claim, **THE ORIGINAL PAPER MEDICAL RECEIPT must be submitted**; hospitalization electronic medical receipt will not be processed.
2. 此申請表必須填寫有關資料及簽署，如逾期遞交或所需資料不全，索償申請將不接受辦理。
   This claim form should be completed & signed, NO reimbursement will be made for late submission or insufficient information provided.
3. 此申請表適用於住院及醫院/診所的日間手術索償。每名受保人(病人)須獨立填寫一份申請表。
   This form is applicable to hospitalization and day case surgery in hospital/clinic claims. Each claim form is for one Insured (Patient) only.
4. 請於治療或出院後 90 日內附上醫院及醫生收據之正本，並連同此申請表一併交回聯豐亨保險有限公司醫療保險部。
   Claim Form should be completed & signed before submitted to Medical Insurance Department of Luen Fung Hang Insurance Company Limited together with original bill(s)/receipt(s) within 90 days from date of discharge or treatment.
5. 請連同附上病理學、內窺鏡、診斷性化驗/檢驗報告及手術室撮要副本。
   Please attach copies of histopathology, endoscopic, diagnostic/laboratory test report and operating theatre summary.
6. 查詢最新理賠進度及受保福利內容，請關注「聯豐亨保險」微信官方帳號並登入「iMed」系統查詢。
   For enquiring of the claims status and policy coverage, please follow "lfhinsurance" official account in WeChat and login "iMed" enquiry system.

甲部分–由受保僱員 / 成員填寫 PART I - To Be Completed by the Insured Staff / Member

僱主 / 保單持有人名稱 Name of employer/policyholder ____________ 保單號碼 Policy no. ____________

病人姓名 Name of patient ____________ 受保僱員 / 成員姓名 Name of insured staff/member ____________ 受保僱員 / 成員或保險證書編號 Insured staff/member or Cert no. ____________

病人身份證號碼 I.D. Card no. of patient ____________ 出生日期(日/月/年) Date of birth (dd/mm/yyyy)____________ 性別 Sex ________ 職業 Occupation ____________

與受保僱員關係 Relationship to the insured staff/member： ☐ 本人 Myself ☐ 配偶 Spouse ☐ 子女 Child

1. 您是否正就此次治療申領其他賠償? Are you making any other insurance or compensation claims as a result of this treatment?
   ☐ 是 Yes；若「是」，請提供保險公司名稱及保單號碼 If "Yes", please state the name of insurance company and policy number. ☐ 否 No
   保險公司名稱 Name of insurance company____________ 保單號碼或計劃名稱 Policy No. or Plan Name ____________
2. 您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? ☐ 有 Yes (請提供醫生資料 Please provide the doctor information) ☐ 否 No
   醫生姓名 Doctor's name ____________ 診症日期(日/月/年) Consultation date (dd/mm/yyyy)____________ 電話 Telephone No.____________
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? ☐ 是 Yes ☐ 否 No
   若「是」，此次意外是關於 If yes, this accident related to： ☐ 交通意外 Traffic ☐ 工作意外 Work ☐ 其他 Others
   意外日期及時間 (日/月/年 時:分) Date & Time of accident (dd/mm/yyyy hh:mm) ____________ 詳細地點 Place details ____________
   簡述意外經過 Brief description of the accident ____________
4. ☐ 如欲索回醫院收據的正本，請在空格內填上 ✔ 號(請注意：如申請已獲全數賠償，正本收據將不獲退回。除非本收據需用作註明用途，請說明用途/原因)
   Return of original hospital receipt after completion of claim processing, if yes, please ✔ the box (Please note: Original receipts will not be returned if the claim was fully reimbursed unless) return of original receipt is requested for specific purpose, please state the purpose/reason) 用途/原因 Purpose/Reason: ____________

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/我們同意如為處理有關本索償事宜，聯豐亨保險有限公司(以下稱"聯豐亨保險")可使用所收集及持有關於我/我們/被保險人的個人資料 (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/被保險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/被保險人死亡或在法律上失去行為能力，對我/我們/被保險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/我們明白無論索償申請批核與否，所有相關文件將交由受保僱員/成員任職機構/公司的人力資源部處理。本人/我們明白及同意載於本索償申請表內之「收集個人資料聲明」。

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 (hereinafter called "LFH") (whether contained in this claim form or otherwise obtained) is provided and may be held, used and disclosed by LFH to individuals/organizations associated with LFH 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 LFH 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 documents should be handled by the HR Dept. of the organization/company where the Insured Staff/Member work, whether the claim will be reimbursed or not. I/We understand and agree to the "Personal Information Collection Statement" attached in this claim form.

受保僱員/成員簽署 Signature of Insured Staff/Member ____________ 病人(十八歲以上) 簽署 Signature of Patient (18 years of age and over) ____________ 簽署日期(日/月/年) Date signed (dd/mm/yyyy) ____________

收集個人資料聲明

您提供的資料，為聯豐亨保險有限公司("本公司")提供保險業務所需，並可能使用於下列目的：
1.處理及審批您的保險申請或您將來提交的保險申請；2.執行您保單的行政工作及提供與您保單相關的服務；3.分析或調查、處理及支付您保單有關的索償；4.發出繳交保費通知及向您收取保費及欠款；5.任何與保險有關的產品或服務的任何更改、變更、取消或續期；6.就以上用途聯絡您；7.本公司行使任何代位權；8.其它與上述用途有直接關係的附帶用途；及 9.遵循適用法律、規則、規例、實務守則或指引規定的要求，或協助相關本地或海外的政府、監管機構執法或進行調查，包括但不限於美國《海外帳戶稅收合規法案》和跨政府協議。
本公司亦可因應上述用途將您的個人資料移轉予下列各方(包括澳門境內或境外)：
1.就上述用途，向本公司提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問(包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商)；2.處理索賠個案的理賠師、理賠調查員及醫療顧問；3.追討欠款的收數公司或索償代理；4.保險資料服務公司及信貸資料服務公司；5.再保公司及再保經紀；6.本公司的法律及專業事務顧問；7.任何金融服務供應商的「行業協會或聯會」；8.任何有關的公司，或任何其他從事與保險或再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；9.澳門金融管理局；及 10.法例要求或許可的政府機關。
您在此授權本公司可向「行業協會或聯會」從保險業內收集的資料中查閱及/或核對您任何資料。此外，經您同意，本公司可能會以其它方式使用及披露您的個人資料。
使用資料作直接促銷：本公司擬使用您的資料作市場推廣的直接促銷。本公司會遵從《個人資料保護法》內有關直接促銷的規定。若您不同意本公司使用或提供您的資料予其他人士，藉以用於直接促銷，您應通知本公司以行使您不同意此安排的權利，或在以下的方格內填上✔；☐ 本人不同意貴公司使用本人的個人資料作直接促銷，並不希望接收任何推廣及直接促銷。
任何關於查閱及/或更正資料及/或索取關於私隱政策及所持有的資料種類的要求，應以書面向本公司提出，地址為：澳門宋玉生廣場 398 號中航大廈四樓。

Personal Information Collection Statement

The information you provide to Luen Fung Hang Insurance Company Limited ("the Company") is collected to enable the Company to carry on insurance business and may be used for the purpose of:
1.processing and evaluating your insurance application and any future insurance application you may make; 2.administering your insurance policy and providing services in relation to your insurance policy; 3.analysis or investigating, processing and paying claims made under your insurance policy; 4.invoicing and collecting premiums and outstanding amounts from you; 5.any alterations, variations, cancellation or renewal of any insurance related product or service; 6.contacting you for any of the above purposes; 7.exercising any right of subrogation; 8.other ancillary purposes which are directly related to the above purposes; and 9.complying with applicable law, rules, regulations, codes of practice or guidelines or assisting with law enforcement purposes, investigations by policy or other government or regulatory authorities in Macau or elsewhere; including but not limited to FATCA and the IGA.
The Company may disclose your personal data for the above purposes to the following classes of transferees who may be located in Macau or outside of Macau:
1.third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist us to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors); 2.in the event of a claim, loss adjudicators, claims investigators and medical advisors; 3.in the event of default, debt collectors and recovery agents; 4.insurance reference bureaus or credit reference bureaus; 5.reinsurers and reinsurance brokers; 6.the Company's legal and professional advisors; 7.any financial services provider "industry association or federation". 8.any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; 9.The Monetary Authority of Macao; and 10.government agencies and authorities as required or permitted by law.
The Company is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the "industry association or federation" from the insurance industry. Moreover, the Company may also use and disclose your personal data otherwise with your consent.
Use of Personal Data in Direct Marketing : The Company intends to use the data subject's data in direct marketing. The Company will comply with the provisions of the Lei da Protecção de Dados Pessoais. If you do not wish the Company to use or provide to other persons your data for use in direct marketing, you may exercise your opt-out right by notifying the Company, or ✔ tick the box below; ☐ I object to the use and provision of my personal data for direct marketing purpose, and do not wish to received any promotional and direct marketing materials.

The person to whom requests for access to data and/or correction of data and/or for information regarding policies and practices and kinds of data held are to be addressed to the Company at No.398 Alameda Dr. Carlos D' Assumpção, Edifício CNAC, 4º Andar, Macau.

澳門宋玉生廣場 398 號中航大廈四樓 No.398, Alameda Dr. Carlos D' Assumpção, Edificio CNAC, 4º Andar, Macau
電話 Tel：28700033 圖文傳真 Fax：28700088 電子郵箱 Email: imed_enq@luenfunghang.com 網址 Website: http://www.luenfunghang.com

乙部分 – 由主診醫生/外科醫生填寫，所需費用由受保人自行承擔
PART II – To Be Completed by the Attending Physician/Surgeon at the Insured's Own Expenses

病人姓名(全名)
Patient Name (if full) ______________________________
醫院名稱
Name of Hospital ______________________________

病房類別 Room Type ☐ 私家房 Private ☐ 半私家房 Semi-Private ☐ 普通房 Ward ☐ 隔離病房 Isolation Room ☐ 日間治療 Day Case

入院日期 Date of Admission ______ /______ /________ _____ : _____
日 dd 月 mm 年 yyyy 時 hh 分 mm

出院日期 Date of Discharge ______ /______ /________ _____ : ______
日 dd 月 mm 年 yyyy 時 hh 分 mm

A. 求診記錄 Clinical History

1. 病人是次主要因何徵狀或申訴而入院/接受治療？What were the patient's chief symptom(s)/complaint(s) for this hospitalization/treatment ?
____

2. 病人就上述病況或有關疾病或受傷之首次求診日期？Date on which the patient first consulted you for this condition or related illness/injury?
____

3. 該等病徵/傷患在病人首次求診前已存在多久？How long had the patient been experiencing these symptoms before the first consultation?
____

B. 住院治療及手術詳情 Hospitalization and Surgery Details

1. 最後的診斷
Final Diagnosis ______________________________
2. 手術詳細名稱
Detail name of surgery(s) performed ______________________________
3. 手術日期 (日/月/年)
Date of surgery (dd/mm/yyyy) ______________________________
外科醫生/助理外科醫生姓名
Name of Surgeon/Assistant Surgeon ______________________________
4. 請提供出院及/或檢查撮要（包括病因、主要檢查的種類及結果、治療、併發症及覆診日期和詳情）Please give a brief discharge and/or investigation summary (including etiology, types and results of major examinations, treatments, complications and follow up dates & plan)
____
5. 是次手術、檢查及治療可否門診/日間手術中心進行，而無須住院？Can the surgery, medical investigation and the treatment be done on an out-patient basis/at day surgery center instead?
☐ 可以 Yes 若是次手術、檢查及治療是住院進行的話，請說明原因。If the patient admitting to hospital for the surgery, medical investigation and treatment, please state the reason.
____
☐ 否 No i. 請提供不可在門診/日間手術中心進行的原因。Why it can't be done on an out-patient department/at day surgery center?
____
ii. 有否合併症？Any comorbidity? ☐ 有，請提供詳情 Yes, please specify details ______________ ☐ 否 No
6. 這是否緊急個案？Is it a case of emergency？ ☐ 是，請提供原因 Yes, please specify reason(s) ______________ ☐ 否 No
7. 如病人於住院期間曾被轉介向其他醫生求診，請提供以下資料 If the patient has been referred to consult other physician during this hospitalization, please provide the following：
求診醫生姓名 Name of physician consulted ______________ 原因 Reason ______________
治療詳情 What treatment had the physician performed ______________________________

C. 專業意見 Professional Comment

1. 就您的專業意見，病人是次住院治療是否因繼發性或慢性疾病所引致或與以往的主訴/診斷有關？
In your professional opinion, was the patient hospitalized as a result of recurrent episode or a chronic illness or related to a previous complaint/diagnosis.
☐ 是，請提供首次發病日期及詳情 Yes, please provide date of the first episode and details. ______________ ☐ 否 No
2. 病人以前曾否患有同類病況，而接受診治或入院治療？Has the patient ever been treated or hospitalized for the same or similar conditions before?
☐ 有，請說明日期及詳情 Yes, please state when and describe details. ______________ ☐ 否 No
3. 病人可有復發機會？ Any possibility of having a relapse? ______________________________
4. 病人之病情是否由先天性已存在的因素或異常所導致或有關連？Was the condition caused by or in any way associated with congenital condition or abnormalities?
☐ 是 Yes ☐ 否，請提供詳情 No, please specify details. ______________________________
5. 病人之病情是否出於或與以下問題關連(請在正確答案填上✔ 號) Was the condition due to or associated with the following?(Please ✔ the right answer(s))
☐ 懷孕 Pregnancy 開始懷孕日期 Approximate date of commencement______________
☐ 意外身體受傷 Accidental bodily injury
☐ 不育或絕育 Infertility or sterilization
☐ 精神紊亂 Mental disorder
☐ 自我傷害 Self-inflicted injury
☐ 避孕 Contraception
☐ 屈光不正 Refractive error
☐ 濫用藥物或酒精 Abuse of drugs or alcohol
☐ 發育問題 Developmental condition
☐ 一般身體檢查 General check-up
☐ 疫苗接種 Vaccination
☐ 性病，性傳播疾病或愛滋病/愛滋病毒有關的疾病 Venereal disease, sexually transmitted disease or AIDS / HIV related illness
☐ 遺傳性問題 Hereditary condition
☐ 美容性質的治療 Treatment for cosmetic purpose
☐ 以上全部不適用 None of the above
6. 如病人由其他醫生轉介，請提拱醫生的姓名和地址。
If the patient was referred by another physician, please provide the referring physician's name and address. ______________________________

本人特此聲明，就本人所知上述所有資料均準確無誤。I hereby certify that all information given above is accurate and true to the best of my knowledge.

____
主診醫生/外科醫生的姓名及專業資格
Name of Attending Physician/Surgeon & Professional Qualifications

____
主診醫生/外科醫生地址及電話
Address & Telephone No. of Attending Physician/Surgeon

____
主診醫生/外科醫生簽名及醫院蓋章 Signature of Attending Physician/Surgeon & Hospital Stamp

____
簽署日期 (日/月/年) Date Signed (dd/mm/yyyy)