



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

牙科索償申請表 DENTAL CLAIM FORM

申請牙科索償須知 Note for filling a dental claim form

- 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.
- 此申請表只適用於牙科治療，並必須於完成牙科治療後 90 天內提交。每名受保人(病人)須獨立填寫申請表。
This form is applicable to dental treatment claim only, and submit within 90 days from dental treatment completion date. Each claim form is for one Insured (Patient) only.
- 聯豐亨保險有限公司有權要求受保人(病人)提供更多資料及文件或填寫其他專用索償表格。任何醫療報告、轉介信、證明書或行政費用須由受保人自行承擔。
Luen Fung Hang Insurance Company Limited is entitled to request for the Insured (Patient) provision of further information and documents or completion of other specific claim forms. Any charge for medical report, referral letter, certificate or administration is insured's responsibility.
- 請附上由牙科醫生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：
A. 病人/受保人姓名 B. 治療日期 C. 收費項目說明 D. 牙科醫生簽署及蓋章
Please attach the original receipts issued by the dentist or certified true copy of receipts issued by other insurers (if applicable). Each receipt MUST state the following information: A. Full name of Patient/Insured B. Date of treatment C. Breakdown of charges D. Dentist's signature and official stamp.

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 _____ 保單號碼 _____
Name of employer/policyholder _____ Policy no. _____
受保僱員 / 成員姓名 _____ 受保僱員 / 成員或保險證書編號 _____
Name of insured staff/member _____ Insured staff/member no. or Certificate no. _____
病人身份證號碼 _____ 家屬姓名 (如病人乃成員家屬) _____
I.D. Card no. of patient _____ Name of dependent (if patient is a dependent of insured staff/member) _____

1. 此次牙科治療是否由於一宗意外引致? Was the dental treatment 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) _____ 詳細地點 _____ 意外責任方 _____
Date & Time of accident (dd/mm/yyyy hh:mm) _____ Place details _____ Responsibility _____
簡述意外經過 _____
Brief description of the accident _____
2. 您是否正就此治療申領其他賠償? Are you making any other insurance or compensation claims as a result of this treatment?
☐ 否 No; 在任何情況下不設退回正本收據，如需副本作其他用途，請於遞交前自行影印收據。
Original receipt will not be returned in any circumstance. If copy of receipt for other purpose is needed, please make a copy before submission.
☐ 是 Yes; (必須填寫) 保險公司名稱 _____ 保單類別 _____ 保單號碼 _____
(Required information) Name of insurance company _____ Type of Policy _____ Policy No. _____
☐ 需要退回正本收據。請注意只退回附有索償餘額之正本收據以向上述保單申請其他索償，如本索償已獲全數賠償，正本收據將不獲退回。
如需要副本作其他用途，請於遞交前自行影印收據。
Return the original receipt. Please note that original receipts will not be returned if the claim was fully reimbursed unless, only the original receipt with unpaid claim balance will be returned for applying other claims which under the policy is provided above. If copy of receipt for other purpose is needed, please make a copy before submission.

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 the "LFH") (whether contained in this claim form or otherwise obtained) is provided and may be held, used and disclosed by the 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 of 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.

病人/受保僱員/成員簽署 (如病人不足 18 歲，則須受保僱員/成員簽署)

Patient's / Insured Staff's/Member's Signature (For patient whose age is below 18, insured staff's/member's signature is required)

簽署日期 (日/月/年)

Date signed (dd/mm/yyyy)

乙部分 – 由負擔治療之牙科醫生填寫，所需費用由受保人自行承擔
PART II – To Be Completed by the Dentist Providing Treatment at the Insured's Own Expenses

日期 (日/月/年) Date (dd/mm/yyyy)	牙齒號碼 Tooth No.	詳情 Particulars	是否矯齒？ Is treatment for orthodontics?	收費 Charges
1.				
2.				
3.				
4.				

請於接受治療之牙齒或範圍標記於下圖。Please mark the teeth/area of oral treatment on the chart below.

PERMANENT TEETH 恆齒

RIGHT

1

2

3

4

5

6

7

8

32

31

30

29

28

27

26

25

LABIAL

LINGUAL

DECIDUOUS TEETH 乳齒

9

10

11

12

13

14

15

16

24

23

22

21

20

19

18

17

LABIAL

LINGUAL

LEFT

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.	
牙科醫生姓名 Name of Dentist	牙科診所/醫院名稱 Name of Dental Clinic/Hospital
<div></div>	<div></div>
牙科醫生簽名及蓋章 Signature & Stamp of Dentist	簽署日期 (日/月/年) Date Signed (dd/mm/yyyy)
<div></div>	<div></div>

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業務顧問；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.



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 "Ifhinsurance" official account in WeChat and login "iMed" enquiry system.

聯豐亨保險網上查詢系統網頁版 Luen Fung Hang Insurance Online Enquiries website :
<https://imed.luenfunghang.com/omiq/login.jsp>