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INDIVIDUAL HEALTH INSURANCE - OUTPATIENT CLAIM FORM
個人醫療保障 - 門診賠償申請表

☐ Please return the Certified True Copy of receipts. 請退回收據核實副本。

# Policy No.保單號碼	* Other Generali Medical Policy No. 其他忠意醫療保單號碼:	# Policy Holder Name 保單持有人姓名

# Member No. (with family endfix) 成員編號 (包括家屬號尾碼)	Mobile No. 手提電話號碼	Patient Name 病者姓名	Patient's Date of Birth (DD/MM/YYYY) 病者出生日期 (日/月/年)

Please provide the required information for member identification. Any incomplete information will delay the reimbursement process.
請提供所需成員資料以便核實成員身份。如因資料不足而無法確認成員，索償申請可能因此延誤。

* Please specify Policy No. if it is insured by Generali Hong Kong Branch. 如屬於忠意保險香港分公司的醫療保單，請提供保單號碼，我們將一併處理。

Treatment Date (DD/MM/YYYY) 診治日期(日/月/年)	Claim Type (Please refer to your own Benefit Schedule) 申請賠償類別 (請先參閱閣下的保障表)	Doctor Name or Registration No. 醫生姓名或註冊編號	Currency 貨幣	Receipt Amount 收據金額	2nd Claim 餘額索償	Diagnosis 診斷名稱
	☐ GP ☐ SP* ☐ Lab* ☐ TCM ☐ Physio*/Chiro* ☐ Dental ☐ Others: _____					
	☐ GP ☐ SP* ☐ Lab* ☐ TCM ☐ Physio*/Chiro* ☐ Dental ☐ Others: _____					
	☐ GP ☐ SP* ☐ Lab* ☐ TCM ☐ Physio*/Chiro* ☐ Dental ☐ Others: _____					
	☐ GP ☐ SP* ☐ Lab* ☐ TCM ☐ Physio*/Chiro* ☐ Dental ☐ Others: _____					

Claim must be submitted and received by the Claims Department within 90 days of treatment. 賠償申請必須在診治日期後90 日內交回賠償部。

GP - General Practitioner's Consultation 普通科醫生
TCM - Chinese Herbalist/Bonesetter (both Herbalist Prescription and Official Receipt are required) 中醫治療跌打 (中草藥中醫之索償需附有中藥處方正本及正式收據)
Dental - Dental Services 牙科
Others - Other benefit type 其他類別

*** Referral letter is required 須附上醫生轉介信**
SP* - Specialist 專科醫生
Lab* - Diagnostic Laboratory Tests 診斷化驗測試
Physio/Chiro*- Physiotherapist/Chiropractor 物理治療/脊醫

For check-up, prescribed medication, or clinical surgery at clinic / day surgery center, the official receipts with diagnosis and/or the surgery name (if applicable) are required. For admission to General Ward of Hospital Authority Hospitals, please provide receipts and a copy of discharge summary. 身體檢查、醫生處方藥物等，或:於門診 / 日間手術中心進行之小型手術 ， 收據上必須顯示診斷名稱及/或手術名稱 (如適用)。如入住醫院管理局轄下之公立醫院的普通病房 ， 請提供收據及出院証明。

Declaration & Authorization / 聲明及授權書

I/We acknowledge that I/we have been provided (https://www.generali.com.hk/EN_US/personal_information) with the Personal Information Collection Statement (the "Statement") issued by Assicurazioni Generali S.p.A., Hong Kong Branch ("Generali"). I/We confirm that I/we have read and understood the Statement. I/We agree that Generali may collect, use, store, disclose, transfer and otherwise process my/our personal data in accordance with the terms of the Statement. I/We further confirm that I/we have obtained the express consent of the Insured Person and any other relevant individuals (where applicable) for providing their personal data to Generali for the purposes stated in the Statement and for allowing Generali to collect, use, store, disclose, transfer and otherwise process such personal data in accordance with the terms of the Statement.

I/We hereby declare and agree that all statements and information provided herein together with any subsequent alternations or supplements of it are collected to enable Generali to carry on insurance business and may be transferred to and/or used by Generali (including its subsidiaries, affiliated companies and associated companies, whether they are located or registered in Hong Kong or outside of Hong Kong) and any service providers as set out in paragraph e (i) of the Statement (whether they are located or registered in Hong Kong or outside of Hong Kong) for the purpose of adjudicating this insurance or related claims thereof, assessing, adjudicating, administering and processing this Individual Medical Claim and administering the Individual Medical Policy, and/or preventing money laundering and/or terrorist financing activities. Supply of information under this Form is a condition precedent to claim for the relevant benefit(s) available under the policy.

I/We also hereby authorize any medical attendant, hospital, clinic, insurance company or other organization, institution, or individual that has any record or knowledge of my/the Insured Person's health and medical history of any treatment or advice and that has been or may hereafter be consulted to disclose to Generali such information. This authorization shall bind my/the Insured Person's successors and assigns and remain valid notwithstanding my/the Insured Person's death or incapacity in so far as legally possible.

A faxed, photographic, or electronic copy of this authorization shall be as valid as the original.

如須索取【聲明及授權書】的中文譯本，請電郵至medicalcs@generali.com.hk或致電客戶服務熱線 (852) 3187-6831與忠意醫療保險賠償部聯絡。

Signature of Policy Holder 保單持有人簽署	Signature of Patient (Age 18 or above) 病者(18 歲或以上) 簽署	Date signed 簽署日期