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醫療保險賠償部
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INDIVIDUAL HEALTH INSURANCE - HOSPITALIZATION & SURGICAL CLAIM FORM
個人醫療保障計劃 - 住院及手術賠償申請表

PART A - Member Information (to be completed by the policy holder)
甲項 - 成員資料 (由保單持有人填寫)

Policy No. 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)

Will you claim other insurance/compensation for this hospitalization/surgery? * Specify the Policy No. if it is insured by Generali Hong Kong Branch
此次住院/手術是否獲得其他保險金或補償金? * 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。

☐ No 否 ☐ Yes, Name of Insurance Company/Type of Compensation:
是, 保險公司名稱/補償金類別: _____

* Other Generali Medical Policy No.: 其他忠意醫療保單號碼: _____

☐ Please return a Certified True Copy of the receipt(s). (*not applicable for submission by e-means)
請退回醫療費用收據核實副本。(*不適用於電子途徑遞交)

Has the patient had any prior treatment for this condition? 病者曾否在同一病況下就醫或治療?

☐ No 否 ☐ Yes, please state date: 是, 請填寫日期: _____

If hospitalization was the result of an accident, please give date and a brief description of the accident:

如因意外受傷而入院, 請略述其發生之日期、地點及情況: _____

☐ Non-Work related 與工作無關 ☐ Work related, please advise if you have submitted this hospitalization / surgery claim to Employees Compensation Insurance
與工作有關, 此次住院/手術是否已申請顧員賠償保險索償 ☐ No 否 ☐ Yes 是

Notes for filing a claim:
1. Claim must be submitted and received by the Claims Department within 90 days of treatment.
2. Part A should be completed by the insured employee/member while Part B by Attending Doctor.
3. Original bills and receipts must be attached showing the date of treatment, patient's name, diagnosis and the Attending Doctor's stamp and signature. Please request Hospital to provide the itemized details and charges breakdown for laboratory, medication, treatment treatment/procedure.
4. Referral must be attached for specialist consultation.
5. For hospital claim, claim form must be sent to Claims Department within 90 days after discharge.
6. Original bills or receipts will not be returned (unless clearly stated). Please make copy as required.
7. If the hospitalization was made outside HKSAR, please specify the name of country and provide claim supporting document in English or Chinese.
8. If the hospitalization was made in Hospital Authority Hospital, please attached with the Discharge Summary for provision of diagnosis and surgery information.
9. Incomplete form or omission of required information may cause delay in processing.

申請賠償須知:
1. 賠償申請必須在診治日期後90 日內交回賠償部。
2. 此表格之甲項須由僱員/會員填報, 而乙項則須由主診醫生填報。
3. 必須附上正本單據及收條, 單據及收條須包括診治日期、病者姓名、診斷以及主診醫生蓋章及簽署。請要求院方提供化驗、藥物及其他治療的詳細資料及收費。
4. 專科賠償, 必須附上轉介推薦書。
5. 住院賠償申請必須在出院後 90 日內交回賠償部。
6. 所有正本單據及收條俱不會發還(除非清楚註明), 請自行影印副本。
7. 如入住海外醫院, 請提供國家名稱及英文或中文版本之賠償文 件。
8. 如入住醫院管理局醫院, 請提供由病房簽發的出院摘要, 以便提供病症及手術資料。
9. 若此申請表未完全填妥或未有提供足夠理賠資料, 賠償處理將被延誤。

Declaration & Authorization / 聲明及授權書

I/We acknowledge that I/we have been provided (https://eclaims.generali.com.hk/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 d (i) of the Personal Information Collection 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, approving and underwriting the application, administering and reinsuring the 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 or photographic 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

PART B - To be completed by the Attending Doctor, for Hospitalization & Surgical Claim at the Claimant's own expenses.
乙項 - 由主診醫生/外科醫生填寫，所需費用由索償人自行承擔

Name of Patient: 病者姓名:		Name of Hospital: 醫院名稱:	
Date of Admission (DD/MM/YYYY): 入院日期(日/月/年):		Date of Discharge (DD/MM/YYYY): 出院日期(日/月/年):	

Accommodation Level: 病房類別:	☐ Ward **大房**	☐ Semi Private **半私家房**	☐ Private **私家房**	☐ Day case **門診手術**

1. Clinical History 臨床病歷:

1a. Symptom(s)/complaint(s) and underlying cause(s) for this hospitalisation/treatment/investigation:
病者就此次住院/治療/檢驗所出現的相關症狀/主訴及其病因:

_____

1b. Date of the symptom(s) first appeared /accident occurred (DD/MM/YYYY):
病者首次出現病徵/事故發生的日期（日/月/年）: _____

1c. Date on which the patient first consulted you for this medical condition(s)/injury (DD/MM/YYYY):
病者就此疾病/受傷後，首次向閣下求診的日期（日/月/年）: _____

1d. Has the patient received continuous treatment related to this sickness since then? 自首次求診後，病者有否繼續接受同類治療?

_____

2. Hospitalization Summary 住院詳情:

2a. Final diagnosis of the conditions 最後的診斷:
_____

2b. Date of Operation (DD/MM/YYYY):
手術日期(日/月/年): _____

2c. Describe the type of treatment /surgical procedure given to the patient: 此次住院之治療詳情/手術名稱:

_____

2d. Please give brief discharge summary (including clinical and pathological findings, etiology, complication, and follow-up plan)
請提供出院及/或檢查撮要（包括臨床和病理結果、病因、併發症及覆診詳情）

_____

_____

_____

2e. If the patient has consulted other Doctor during this hospitalization, please provide the following:
如病者於住院期間曾被轉介向其他醫生求診，請提供以下資料:

Name of Doctor consulted:
求診醫生姓名: _____

Reason:
原因: _____

What treatment had the Doctor performed? 治療詳情?

_____

_____

2f. Please provide the reason(s) for hospitalization if this type of cases can be managed on day care/outpatient basis:
請提供該檢查及手術不可在門診/日間手術中心進行之原因:

_____

_____

_____

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3. Professional comment 專業意見:

Was the condition due to or associated with the following? (Please tick the appropriate boxes)
上述情況是否出於或與以下問題關連? （請在適當空格填上✓號）

- ☐ Accidental bodily injury 意外身體受傷
- ☐ Self-inflicted injury 自我傷害
- ☐ Abuse of drugs or alcohol 濫用藥物或酒精
- ☐ Mental disorder 精神紊亂
- ☐ Refractive error 屈光不正
- ☐ Pregnancy 懷孕
- ☐ Infertility or sterilization 不育或絕育
- ☐ Contraception 避孕
- ☐ General check-up 一般身體檢查
- ☐ Vaccination 疫苗接種
- ☐ Congenital condition 先天性疾病/異常
- ☐ Developmental condition 發育問題
- ☐ Hereditary condition 遺傳性問題
- ☐ Treatment for cosmetic purpose 美容性質的治療
- ☐ Venereal disease, sexually transmitted disease, or AID/HIV related illness 性病, 性傳播疾病或愛滋病/愛滋病毒有關的疾病
- ☐ N/A 不適用

4. Others 其它:

4a. Is the patient referred by another doctor? 病者是否經其他醫生轉介?

☐ No 否 ☐ Yes, please state the name & address of the referring Doctor:
若是，請列轉介醫生的姓名及地址: _____

4b. Are you the patient's usual Doctor? 閣下是否該病者的慣常醫生? ☐ No 否 ☐ Yes, since (DD/MM/YY):
若是，自(日/月/年): _____

4c. Have you treated the above patient for this or related sickness before? 在這之前，閣下有否就同樣疾病治療病者?

☐ No 否 ☐ Yes, please give details (date of consultation and diagnosis): 若是, 請詳述之:

Date of consultation (DD/MM/YY) 治療日期(日/月/年)	Symptom/Diagnosis病徵/診斷

4d. Was the condition a recurrent episode or a chronic disease? 此病者情況是否再次復發或是慢性疾病?

☐ No 否 ☐ Yes, give details: 若是, 請詳述之: _____

5. Is the condition due to pregnancy? 情況是否屬懷孕引起的?

☐ No 否 ☐ Yes, give approximate date of commencement of pregnancy (this is required)
若是, 請提供懷孕開始日期(這是必需提供的) _____

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

Name of Attending Doctor:
主診醫生姓名: _____

Qualification:
專業資格: _____

Doctor's Signature & Chop:
主診醫生之印鑑及簽名: _____

Address:
地址: _____

Date Signed (DD/MM/YY):
日期(日/月/年): _____

Contact Phone No.:
聯絡電話號碼: _____