Sun Flower Insurance Brokers Limited
Room 1108, Hing Yip Commercial Centre
282 Des Voeux Road Central, Hong Kong
Tel: (852) 2521-1881 Fax: (852) 2521-1919
Web: www.sunflowervip.com www.sunflowermpf.com

MEDICAL INSURANCE – HOSPITALIZATION & SURGICAL CLAIM FORM
醫療保險 – 住院及手術賠償表格

東京海上火災保險(香港)有限公司
The Tokio Marine and Fire Insurance Co. (HK) Ltd.
27th Floor, United Centre,
95 Queensway, Hong Kong
Tel. (852) 2529-4401
Fax. (852) 2529-2509
http://www.tokiomarine.com.hk

This form is applicable to both inpatient and outpatient surgical claim
本表格適用於住院或門診手術賠償

PART I - TO BE COMPLETED BY THE PATIENT

甲部 – 由病人填寫

Please "✓" if original receipts should be returned 如欲退回正本收據，請填 '✓' ☐

Name of Policy Holder 保單持有人名稱：		
Name of Employee 僱員姓名：		Policy No. 保單編號:
First 4 digits of HKID or Passport No 僱員身份證 或 護照號碼 最前四個字 (e.g.例: B123): ————————————→	☐ ☐ ☐ ☐	

Name of Patient 病人姓名：	I.D. Card No :身份證號碼：	
Occupation 職業：	Date of Birth 出生日期：	Sex 性別：☐ M 男 ☐ F 女
Relationship to the Policy Holder 與保單持有人關係：	☐ Self 本人 ☐ Spouse 配偶 ☐ Child 子女 ☐ Staff / Member / Domestic Helper 僱員 / 成員 / 家庭傭工 ☐ Dependent 僱員 / 成員家屬	

(1) Have you had any prior treatment for this or related conditions?
閣下是否曾經因同一病況而接受治療？

NO 沒有 ☐ YES 有 ☐ Doctor's Name 醫生姓名：_____

Address 地址：_____

_____

Date(s)日期：_____

(2) Are you making any other insurance claim as a result of this hospitalization / surgery?
有關此次住院／手術，閣下有否申請其他保險賠償？

NO 沒有 ☐ YES 有 ☐ Name of Insurance Company 保險公司名稱: _____

Policy No. 保單號碼：_____

(3) Was the hospitalization / Surgery a result of an accident?
此次住院／手術是否由於一宗意外引致？

NO 沒有 ☐ YES 有 ☐ Date 日期：_____ Time 時間：_____ Place 地點：_____

Brief Description 經過：_____

_____

DECLARATION & AUTHORIZATION 聲明及授權書:

I/We hereby declare that to the best of my/our knowledge and belief, the above statement and particulars contained are true and complete in every respect and are made without reservation of any kind. I also authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish to The Tokio Marine and Fire Insurance Company (Hong Kong) Limited ("the Company") or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation prescriptions or treatment and copies of all hospital or medical records. The information provided by me/us to the Company is collected to enable the Company to carry on insurance business and may be used for the purpose of (i) any insurance or financial related product or service or any alterations, variations, cancellation or renewal of the said products or services; (ii) any claim or investigation or analysis of such claim; and (iii) exercising any right of subrogation; and may be transferred to (iv) 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; (v) any association, federation or similar organization of insurance companies ("Federation") that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation; and (vi) any members of the Federation by the Federation for any of the above or related purposes.

本人／我們現聲明上述所填報的一切資料均屬正確無訛，並無任何保留。 本人更授權持有本人健康或任何資料之醫院、醫生、保險公司或機構，可以將部份或全部有關本人傷患之病歷、診斷報告及藥方等資料給與東京海上火災保險(香港)有限公司 (「貴公司」)或其代理人。 本人／我們明白本人／我們提供的資料爲 貴公司提供保險業務所需，並可能使用於下列目的: (i) 任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期； (ii)任何索償，或該等索償的調查或分析；及 (iii) 行使任何代位權； 並可能移轉予: (iv) 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； (v) 現存或不時成立的任何保險公司協會或聯會或類同組織(「聯會」)，以達到任何上述或有關目的，或以便聯會執行其監管職能，或其他基於保險業或任何聯會會員的利益而不時在合理要求下賦予聯會的職能；及 (vi) 或透過聯會移轉予任何聯會的會員，以達到任何上述或有關目的。

Moreover, the Company is hereby authorized to obtain access to and/or to verify any data provided by me/us with the information collected by the Federation from the insurance industry.

I/We understand that I/we have the right to obtain access to and to request correction of any personal information concerning myself/ourselves held by the Company. Requests for such access can be made in writing to the Compliance Officer, 27th Floor, United Centre, 95 Queensway, Hong Kong. A photostat copy of this authorization shall be considered as effective and valid as the original.

此外，本人／我們授權 貴公司可向聯會從保險業內收集的資料中查閱及/或核對本人／我們任何資料。

本人／我們明白本人／我們有權查閱及要求更正由 貴公司持有有關本人／我們的個人資料。如有需要查閱，本人／我們可用書面寄香港金鐘道 95 號統一中心 27 樓，向 貴公司條例遵行主任提出。

Date 日期 _____ Signature of Patient 病人簽署 _____

PART II – TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT'S OWN EXPENSES
乙部 – 由主診醫生填寫，所需費用由索償人自行承擔

(1) Name of Patient 病人姓名：

(2) Hospitalization 住院

Name of hospital 醫院名稱：

Date of Admission 入院日期： Date of Discharge 出院日期:

(3) Surgical procedure 手術

Date of operation 手術日期: Name of the procedure 手術名稱:

Nature 性質:

(4) Chief complaints of the patient relating to this hospitalization / surgery 此次住院／手術的主要病因：

(5) Diagnosis of conditions 診斷：

(6) Brief discharge summary: (including treatments, investigation procedures, results, and / or any complications and follow up plan.)
出院撮要：（治療及以後治療計劃，包括診查辦法、結果、併發症及跟進計劃）

(7) Date of the accident occurred or symptom first appeared. 首次出現病徵日期或意外發生日期。

(8) Date of first consultation for this condition or related illness 病人首次求診日期

(9) To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto?
如閣下所知，病人以前曾否患有同類病況？

NO 沒有 ☐ YES 有 ☐ Please state dates and describe

請說明何時及當時情況

(10) Is the patient referred by another doctor? 病人是否經其他醫生轉介？

NO 沒有 ☐ YES 有 ☐ Name and address of the referral doctor

轉介醫生的姓名和地址

(11) Is Condition due to Pregnancy？此疾病是否由於懷孕而引致？

NO 沒有 ☐ YES 有 ☐

Name of Attending Physician / Specialist (with qualification)
主診/專科醫生的姓名 (資歷)

Address
地址

Telephone
電話

Signature of Attending Physician / Specialist
主診/專科醫生簽名

Date
日期

This claim form is endorsed by the Hong Kong Medical Association and
the Medical Insurance Association of the Hong Kong Federation of Insurers