

團體門診醫療賠償表格
Group Outpatient Claim Form

僱主名稱 Name of Employer		團體保單號碼 Group Policy Number	
僱員姓名 Name of Employee		(如病者與僱員並非同一人, 請填寫以下部份。) (If the patient is different from the Employee, please complete the following part.)	
香港身份證 / 團體證書號碼 HK I.D. Card / Group Cert. No.		與僱員之關係 Relationship with Employee	<input type="checkbox"/> 配偶 Spouse <input type="checkbox"/> 子女 Children
醫生收據正本總數 No. of Original Receipt(s)		病者姓名 Name of Patient	
收據總額 Total Receipt(s) Amount	(港元) (HKD)	香港身份證 / 團體證書號碼 HK I.D. Card / Group Cert. No.	

聲明及授權 Declaration and Authorization

本人/我們謹此授權: (1) 任何僱主、醫生、醫院、診所、保險公司、政府部門、其他機構或人仕, 凡曾已或將會知悉或持有本人/我們之個人資料 (不論是醫療或其他資料), 均可向貴公司或其代表透露、發放或轉交該等資料, 以作為處理本申請及其後之保單復效和理賠事宜; (2) 貴公司或任何其指定之醫護人員或化驗所, 可就本申請及其後之保單復效和理賠事宜, 替本人/我們進行所需之醫療評估及測試以審核本人/我們之健康狀況。即使本人/我們死亡或喪失能力, 此授權書仍具效力, 而本人/我們之繼承人及承讓入亦會受此授權書約束。本授權書之影印本與正本均有同等效力。

I/We further hereby authorize: (1) any employer, doctor, hospital, clinic, insurance company, government office or any organization or person who has or may hereafter have any record, knowledge or information of me/us (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to this application and any reinstatement or claim arising therefrom; (2) the Company or any of its appointed medical/paramedical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of me/us in relation to this application for insurance and any reinstatement or claim arising therefrom. This authorization shall bind the successors and assignees of me/us and remain valid notwithstanding death or incapacity. A photocopy of this authorization shall be valid as the original.

本人/我們亦同意香港人壽保險有限公司向本人/我們之僱主提供有關本人/我們之賠償資料。

I/We also confirm that the claims settlement information regarding myself/ourselves may be released to my/our Employer by Hong Kong Life Insurance Limited.

病者簽署(十八歲或以上)
Signature of Patient (18 years of age & over)

僱員簽署
Signature of Employee

簽署日期(日/月/年)
Signed Date (D/M/Y)

EBC-F057-0410/002

僱員福利部 Employee Benefit Department

團體門診醫療賠償表格
Group Outpatient Claim Form

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醫生收據正本總數 No. of Original Receipt(s)		病者姓名 Name of Patient	
收據總額 Total Receipt(s) Amount	(港元) (HKD)	香港身份證 / 團體證書號碼 HK I.D. Card / Group Cert. No.	

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病者簽署(十八歲或以上)
Signature of Patient (18 years of age & over)

僱員簽署
Signature of Employee

簽署日期(日/月/年)
Signed Date (D/M/Y)

EBC-F057-0410/002

僱員福利部 Employee Benefit Department

Instructions 指示

1. This form is to be completed in **BLOCK LETTER**. Separate forms must be used for different patients.
此申請表格由僱員以正楷填寫，每表格只供一位病者使用。
2. Claim(s) submitted within **30 days** from the date of treatment. Otherwise, the claims will be declined for reimbursement.
索償申請於治療日起**三十天**內遞交。否則該索償不會受理。
3. Original receipt for each consultation bearing the following information must be submitted: (a) Date of consultation; (b) Name of patient; (c) Amount of charge and (d) Diagnosis. The receipt must bear the attending doctor's signature and stamp.
呈交之醫生收據正本必需附有(甲)診症日期，(乙)病者姓名，(丙)費用及(丁)診斷之症狀等資料。並附有醫生簽署及印鑑。
4. Attending doctor's referral letter must be submitted with this form if you are claiming for Specialist Consultation, X-ray & Lab. Test, Physiotherapy, Chiropractic treatment and Prescribed Medicine reimbursement.
凡申請專科診治，X光化驗，物理治療，脊椎治療及藥物處方賠償，需連同醫生轉介信，一併交回本公司。

For Internal Use Only

Type	No. of Claim(s)	Incurrent Amount	Paid Amount	Sub-total Amount
General Consultation				
Chinese Herbalist and Bonesetter				
Specialist Consultation				
X-ray & Lab Test				
			Total Paid Amount (HKD)	

Prepared by : _____ Approved by : _____ Date : _____

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