中国太平
CHINA TAIPING


**中國太平保險(香港)有限公司**
**China Taiping Insurance (HK) Company Limited**
香港銅鑼灣新寧道8號民安廣場19字樓
19/F, Ming An Plaza, 8 Sunning Road, Causeway Bay, Hong Kong.
Tel: (852) 2815 1551 Fax: (852) 2541 6567 E-mail: info@hk.cntaiping.com Website: www.hk.cntaiping.com


# 住院及手術賠償申請表
# HOSPITALIZATION & SURGICAL CLAIM FORM

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

| | |
|---|---|
| Name of Policyholder 保單持有人名稱 : | |
| Policy No. 保單編號 : | Plan No. 計劃組別 : |
| Name of Employee/Member 僱員/成員姓名 :<br>(For group insurance policy only) | |
| Insured No./Certificate No. 保戶編號/受保證書編號 (if applicable 倘適用) : | |

| | | |
|---|---|---|
| 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 Policyholder 與保單持有人關係 : | □ Self 本人 □ Spouse 配偶 □ Child 子女<br>□ Staff/Member 僱員/成員 □ Dependant 僱員/成員家屬 | |

(1) a. Is condition congenital? 此是否先天性缺陷? □ Yes 是 □ No 否

b. If confinement is due to childbirth, please indicate the commencement of Pregnancy. 如住院是因生育導致，請提供開始懷孕日期 :

_____

c. 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 不是 □ Yes 是 □ Date 日期 : _____ Time 時間 : _____ Place 地點 : _____
Brief Description 經過 : _____

**DECLARATION & AUTHORIZATION 聲明及授權書 :**
I hereby declare that the above information given is true and correct.
I further authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish to China Taiping Insurance (HK) Company Limited or its authorized representative, and any all information with respect to any illness or injury, medical history, consultation prescriptions or treatment and copies of all hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.
本人現聲明上述所填報的資料正確無訛。
本人茲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病之病歷，診斷報告及藥方等資料給予中國太平保險(香港)有限公司或其代理人。此授權書之影印本與正本具同等效力。

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 & Time of Admission 入院日期及時間 : _____ Date & Time of Discharge 出院日期及時間 : _____

(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) Is this pre-existing disease? 此是否原有之傷病?
No 否 ☐ Yes 有 ☐ How Long? 已存在多久? _____

(7) Is condition congenital? 此是否先天性缺陷? No 否 ☐ Yes 是 ☐

(8) 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)

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

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

(11) To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto?
據閣下所知，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 _____

(12) Is the patient referred by another doctor? 病人是否經其他醫生轉介?
No 否 ☐ Yes 是 ☐ Name and address of the referral doctor _____
轉介醫生的姓名及地址 _____

(13) Have you recommended and secured the opinion or services of a specialist? No 否 ☐ Yes 是 ☐ If "Yes", please answer:
閣下是否推薦病人要接受專科醫生意見及診治? 如答案 "是"，請解答 :
a. Name of Specialist 專科醫生姓名 : _____
b. Reason 原因 : _____

(14) a. In-hospital Doctor Visits Fee charge 住院期內醫生巡房費用
_____ day 日 @_____ / day 每日費用 Total Fee 總數 : _____
b. Specialist Consultation charged 專科醫生診症費用 : _____
c. Each Surgical Fee charged 各項手術費用 : _____

Name of Attending Physician/Specialist (with qualifications)
主診/專科醫生姓名 (資 歷)

Address
地 址

Telephone
電 話

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

Date
日期