中銀集團保險有限公司
BANK OF CHINA GROUP INSURANCE COMPANY LIMITED

索償編號 (公司專用)
Claim No. (for office use)

香港中環德輔道中 71 號永安集團大廈九樓 9/F., Wing On House, 71 Des Voeux Road Central, Hong Kong. 電話 Tel：28670888 傳真 Fax：3906 9906

CHINA EXPRESS ACCIDENTAL EMERGENCY MEDICAL PLAN CLAIM FORM「中 國 通」意外急救醫療計劃索賠申請書

Please complete and sign this claim form and make sure the original copies of invoices and receipts are attached 請填妥本申請書及簽署後連同有關單據正本一併遞交。

PART I – CLAIMANT'S STATEMENT (IN BLOCK LETTER) 第一部份 – 索償人資料 (請用正楷填寫)

Policy No. 保單號碼	Name of Insured 保戶名稱
Name of Insured Person 受保人姓名	Occupation 職業
HKID Card No. / Passport No. / China re-entry Card No. 香港身份證 / 護照/ 回鄉卡號碼	Date of Birth 出生日期
Name of Claimant(if not Insured Person) 索償人姓名 (如非受保人)	Relationship with Insured Person 與受保人關係
Correspondence Address 通訊地址	

Insured Person / Claimant Must Complete The Following 受保 / 索償人必須填寫以下部份

Please choose item(s) you are claiming for and complete the following 請選擇及填妥您所申請索償的項目

- ◯ Accidental Emergency Medical 意外急救醫療
- ◯ Death from Sudden Sickness 急性病身亡
- ◯ Accidental Death or Permanent Disablement 意外身亡或永久完全傷殘
- ◯ Luggage Loss 行李物品損失

1. Date and Time of Accident 意外發生日期及時間	Date 日期：________ (DD 日) / ________ (MM 月) / ________ (YYYY 年) Time 時間：_______________ AM 上午/ PM 下午
2. Place of Accident 意外發生地點	
3. a. Brief Description of Accident and the region of injury 意外詳情及受傷部位 b. Have you reported the incident to police? 您是否已向警方報案 If "Yes", please state the name of Police Station, the police report no. and a copy of policy report. 如"是"，請列明報案的警署、報案編號及警方報告副本一份	a. b. ◯ No ◯ Yes ______________________________
4. Has the Insured Person ever sustained similar injury or treated by other doctor(s) for similar or related accident / illness in the past? 受保人以往是否有類似的受傷情況或因類似的疾病求診 If "Yes", please provide details and date. 如"是"，請提供詳情及日期	◯ No ◯ Yes ______________________________
5. Has the claimant submitted or does the claimant intend to submit this case to any other insurance company(s)? 索償人有否或將會是次住院申請向其他保險公司提出索償 If yes, please provide name of insurance company(s) & Policy number. 若"有"，請提供該保險公司名稱及保單編號	◯ Yes 有, ◯ No 無 ______________________________
6. Please provide name and address of family doctor 請提供閣下家庭醫生之姓名及診所之地址	

7. Luggage Loss 行李物品損失

Full Description of luggage, including brand name, model and serial no 物品的詳細資料，包括品牌、型號及產品編號	Date of Purchase 購買日期	Purchase Price 購買時價值	Amount Claimed 索償金額

Please provide relevant original supporting documents to prove the loss, such as Airlines Irregularity Report, Police Report, Purchase Receipt of the luggage claimed.
請提供有關文件正本證明事件經過及損失，如航空公司發出的物件損失報告、警方報告、失物購買單據。

Authorization

I act on behalf of myself and my dependents hereby authorize any medical practitioner, hospital, clinic, insurance company to disclose to the Bank of China Group Insurance Co., Ltd. all information concerning the above disability and any prior medical history for the purpose of proceeding the medical claim. A photostat of this authorization shall be as valid as the original.

Declaration

I hereby declare that the above statement and answers are true and correct. I understand that any misrepresentation of the above statement and answers will cause my/our claim invalid.

I understand that the information provided by me to Bank of China Group Insurance Company Limited ("BOCG Insurance") is collected to enable BOCG Insurance to carry on insurance business and may be used for the purpose of:

(i) processing and evaluating my insurance application and any future insurance application I may make; (ii) administering my insurance policy and providing services in relation to my insurance policy; (iii) analysis or investigating, processing and paying claims made under my insurance policy; (iv) invoicing and collecting premiums and outstanding amounts from me; (v) any alterations, variations, cancellation or renewal of any insurance related product or service; (vi) contacting me for any of the above purposes; (vii) exercising any right of subrogation by BOCG Insurance; (viii) other ancillary purposes which are directly related to the above purposes; and (ix) complying with applicable laws, regulations or any industry codes or guidelines.

BOCG Insurance may disclose my and/or the Insured Person(s)'s personal data for the above purposes to the following classes of transferees:

(a) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist BOCG Insurance to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors); (b) in the event of a claim, loss adjudicators, claims investigators and medical advisors; (c) in the event of default, debt collectors and recovery agents; (d) insurance reference bureaus or credit reference bureaus; (e) reinsurers and reinsurance brokers; (f) my insurance broker (if any); (g) BOCG Insurance's legal and professional advisors; (h) BOCG Insurance's related companies (as that term is defined in the Companies Ordinance); (i) any association, federation or similar organization of insurance companies ("Federation") and its members 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; (j) any member(s) of the "Federation" by the "Federation" for any of the above or related purposes; (k) 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; (l) the Insurance Claims Complaints Bureau and similar industry bodies; and (m) government agencies and authorities as required or permitted by law.

BOCG Insurance is hereby authorized to obtain access to and/or to verify any of my and/or the Insured Person(s)'s data with the information collected by the Federation from the insurance industry. Moreover, BOCG Insurance may also use and disclose my and/or the Insured Person(s)'s personal data otherwise with my consent. I have the right to obtain access to and to request correction of any personal information concerning myself and/or the Insured Person(s) held by BOCG Insurance. Requests for such access can be made to BOCG Insurance's Legal and Compliance Department (Tel: 2867 0888 / Fax: 3906 9939).

授權

本人現授權任何西醫、醫院、診所、保險公司及其他人士，均可向中銀集團保險有限公司提供本人或本人家屬之健康情況、傷病資料及病歷記錄，作爲審核有關醫療保險索賠之用。本授權書之影印本與正本有同等效力。

聲明

1、本人聲明上述所填報之資料均屬真實無訛，本人清楚明白如上述資料有誤或不實，可能導致本人或本人家屬的保障無效。

2、本人明白本人提供予中銀集團保險有限公司("中銀集團保險")的資料，爲中銀集團保險提供保險業務所需，並可能使用於下列目的:

(i) 處理及審批本人的保險申請或本人將來提交的保險申請；(ii) 執行本人保單的行政工作及提供與本人保單相關的服務；(iii) 分析或調查、處理及支付本人保單有關的索償；(iv) 發出繳交保費通知及向本人收取保費及欠款；(v) 任何與保險有關的產品或服務的任何更改、變更、取消或續期；(vi) 就以上用途聯絡本人；(vii) 中銀集團保險行使任何代位權；(viii) 其它與上述用途有直接關係的附帶用途；及(ix) 遵循適用法律，條列及業內守則及指引。

中銀集團保險亦可因應上述用途將本人及/或受保人的個人資料移轉予下列各方：

(a) 就上述用途，向中銀集團保險提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問（包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商）；(b) 處理索賠個案的理賠師、理賠調查員及醫療顧問； (c) 追討欠款的收數公司或索償代理；(d) 保險資料服務公司及信貸資料服務公司；(e) 再保公司及再保經紀；(f) 本人的保險經紀（若有）；(g) 中銀集團保險的法律及專業業務顧問；(h)中銀集團保險的關連公司(以《公司條例》內的定義爲準)；(i) 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」)及其會員，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；(j) 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；(k) 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；(l) 保險索償投訴局及同類的保險業機構；及(m) 法例要求或許可的政府機關。

本人在此授權中銀集團保險可向「聯會」從保險業內收集的資料中查閱及/或核對本人及/或受保人的任何資料。此外，經本人同意，中銀集團保險可能會以其它方式使用及披露本人及/或受保人的個人資料。本人有權查閱及要求更正由中銀集團保險持有有關本人及/或受保人的個人資料。如有需要，可向中銀集團保險法律與合規部提出 (電話：2867 0888，傳真：3906 9939)。

____
Signature (Patient/Parent if patient aged under 18)
病人簽署(十八歲以下請由監護人代簽)

____
Date (DD/MM/YY) 日期

____
Name 姓名

____
Contact No. (If Applicable) 聯絡電話 (如適用)

轉背頁 P.T.O.

PART II – ATTENDING PHYSICIAN'S STATEMENT (Complete by attending physician at the claimant's own cost)
第二部份 – 主診醫生證明書 (由主診醫生填寫，如需繳付費用，須由索償人負責)

Patient Name (in full) 病人姓名	Date of Consultation (DD/MM/YY) (Outpatient Only) 求診日期 (日/月/年) (只限門診)	Date of Admission (DD/MM/YY) 入院日期(日/月/年)	Date of Discharge (DD/MM/YY) 出院日期(日/月/年)

1. Final Diagnosis 診斷結果

A. Please complete the following if the incident is caused by accident 如是次事故由意外引致，請填寫此部份	**B. Please complete the following if the incident is caused by sickness 如是次事故由疾病引致，請填寫此部份**
A2. Date of accident 意外日期	B2. Underlying cause(s) of this consultation or hospitalization 引致是次求診或住院之主要原因
A3. Region of injury and extent of injury 受傷部位及傷勢	B3. According to the medical history given by the patient, how long had he/she been experiencing these symptoms before the 1st consultation and the date of the 1st consultation 病人初次求診時，該病癥已出現多久？
A4. Underlying cause(s) of this accident 意外原因	B4. Date on which the patient first consulted you related to this medical condition(s) / injury 病人首次就上述病況或有關疾病或受傷之求診日期
A5. Present condition of injury 現時狀況	B5. How long, in your opinion, has the patient been suffering from this illness? 您認為病人患有該疾病多久？
A6. If the injury involves teeth damage, please confirm if the injured teeth are sound and natural before damage. 如意外引致牙齒受創，請確定牙齒受創前是否天然及健康。	B6. Is this hospitalization planned before? 是次住院是否預先計劃？
A7. What are the permanent disablements expected as a result of the injury? 請詳述因意外而導致永久傷殘的身體部位。	B7. Date of Death (if applicable) 死亡日期 (如適用)

8. What treatment had the doctor performed 治療詳情

9. Has the patient even had the same symptoms before/has the patient been treated or hospitalized for the same symptoms before? 病者以前曾否有同類情況或因同類情況就診？

If "yes", please state, to the best of your knowledge, on a separate sheet when and describe details (including a brief summary describing the onset date, duration of signs and symptoms,/disease, etiology types and results of major examinations, treatments, complications and follow-up plan.) 如"是"，請說明日期及詳情 (請另頁書寫並簽署作實)

Professional comment 專業意見:

Was the condition due to or associated with the following (Please circle the right answers) 上述情況是否因下列問題所致？(請圈出有關項目)

- Self-inflicted, fighting	自我傷害／毆鬥	Yes 是	No 否
- Abuse of drugs or alcohol	濫用藥物或酒精	Yes 是	No 否
- Poisoning	中毒	Yes 是	No 否
- Chronic disease	慢性疾病	Yes 是	No 否
- Infectious disease	傳染病	Yes 是	No 否
- AIDS/HIV related illness, venereal disease or sexually transmitted disease	後天免疫力缺乏症（愛滋病）／與人類免疫力缺乏病毒（HIV）、性病或因性接觸感染之疾病	Yes 是	No 否
- Pregnancy, infertility or sterilization	懷孕、不育或絕育	Yes 是	No 否
- Mental disorder, insanity	精神病／精神錯亂	Yes 是	No 否
- Congenital condition, hereditary condition, developmental condition	先天性症狀或疾病／遺傳性症狀或疾病／發育期狀況	Yes 是	No 否
- General check up	一般身體檢查或防疫注射	Yes 是	No 否
- Travel against medical advices	違反醫生勸告下前往事故發生地點	Yes 是	No 否

I hereby certify that all information given above is accurate, complete and true to the best of my knowledge 本人謹此聲明，以上所填報之資料，均屬完全、真實及無訛。

Signature of attending doctor/Surgeon with Practice/Hospital Stamp
主診／外科醫生簽署／醫院蓋章

Address and Telephone No.
地址及電話

Name of attending doctor/Surgeon
主診／外科醫生姓名

Date (DD/MM/YY)
日期（日／月／年）