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

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. 客戶服務熱線 Customer Service Hotline：3187 5100 傳真 Fax：3906 9906

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

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

Note : Original documents submitted would be retained by our company. You are advised to keep a copy for reference. 注意：所遞交之正本文件將會存留於本公司，請自備副本參考。

Part I – Insured (patient) Details (To be completed by the insured / policyholder)
第一部份 – 受保人(病人)資料 (由受保人 / 投保人填寫)

Policy No. 保單號碼	Policyholder Name 投保人姓名
Patient Name (in full) 病人姓名	Occupation 職業
Patient's HKID Card No. / Passport No. / China re-entry Card No. 病人香港身份證 / 護照/ 回鄉卡號碼	Date of Birth 出生日期
Correspondence Address 通訊地址	

Must Complete The Following 以下部份，必須填寫

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
○ Accidental Death or Permanent Disablement 意外身亡或永久完全傷殘
○ Death from Sudden Sickness 急性病身亡
○ 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 否 ○ Yes 是 _____
4.	Has the Patient ever sustained similar injury or treated by other doctor(s) for similar or related accident / illness in the past? 病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 否 ○ Yes 是 _____

5. a) Has the patient submitted this case to any other insurance company(s)? If yes, please provide name of other insurance company(s), policy number(s), certified true copy of medical receipt(s) issued by other insurance company(s) along with their settlement breakdown (if applicable).
病人有否就是次住院申請**曾向**其他保險公司提出索償?若「有」,請提供該保險公司名稱、保單號碼、由該保險公司出具的收據核實副本(代替正本收據)及賠償明細表(如適用)。

□ No 無 □ Yes 有, _____

b) Will the patient submit this case to any other insurance company(s)? If yes, please provide name of other insurance company(s) and policy number(s).
病人是否**將會**就是次住院申請向其他保險公司提出索償? 若「是」,請提供該保險公司名稱和保單號碼。

□ No 否 □ Yes 是, _____

c) □ "✓" the box for returning certified true copy of medical receipt(s) after claim processing (Remarks: The arrangement for returning receipts will be processed according to the policy terms and conditions. Please note certified true copy of medical receipt(s) will not be returned if the claims are fully reimbursed.)
如欲索回收據核實副本，請在方格內填上「✓」號 (註: 退回收據安排將按保單條款處理。如申請已獲全數賠償，收據核實副本將不獲退回)。

d) If patient would like to claim the same loss under another policy with us (when applicable), please provide the policy number and "✓" the box.
若病人在本公司也有其他保單並且要求一併索償，請提供該保單號碼並在下方空格內畫上「✓」號。

□ Policy number 保單號碼: _____

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 (whether within or outside the Hong Kong Special Administrative Region):
(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) any industry or regulatory bodies responsible for handling insurance related complaints and/or disputes; 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，作為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，為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 (不論在香港特別行政區境內或境外)：
(a) 就上述用途，向中銀集團保險提供行政、通訊、電腦、付款、保安及其它服務的協力廠商代理、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資料處理服務商）；(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（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》內的定義為准)；(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仲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) 任何負責處理保險相關投訴及/或爭議之行業或監管機構；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 / Guardian if patient aged under 18)
病人簽署(十八歲以下請由監護人代簽)

_____
Date 日期 (日 DD/ 月 MM/ 年 YY)

_____
Name 姓名

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

Part II – Attending Physician's Statement (To be completed by attending physician at the patient / policyholder's own expenses)
第二部份 – 主診醫生證明書 (由主診醫生填寫，所需費用由病人 / 投保人承擔)

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，該病症已出現多久？
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畫？
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？(請圈出有關專案)

- 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）