



CLAIM FORM 索償表格

Group Life Scheme - Hospital Cash Benefit 團體人壽計劃 - 住院現金保障

Claims for hospital cash benefits. To be filled in by both the employee or patient and doctor, any expense incurred will be borne by the employee or patient.
 住院現金索償。由僱員或病人和醫生共同填寫，所產生的費用由僱員或病人承擔。

HOW TO SUBMIT THIS FORM 如何提交此表格

After completing the form please send back to us:
 填妥表格後，請寄送給我們：

BY MAIL

Employee Benefits Claims, HSBC Life, 18/F, Tower 1, HSBC Centre, 1 Sham Mong Road, Kowloon, Hong Kong

郵寄

滙豐保險僱員福利索償部 - 香港九龍深旺道1號滙豐中心1座18樓

IMPORTANT NOTES 重要事項

- Claim must be submitted within 90 days from incurring such expenses. Otherwise, the claims will be declined for reimbursement.
 索償應於90日內申請，否則該索償會被拒絕接受辦理。
- We'll let you know the outcome of this claim within 10 business days.
 我們將在 10 個工作日內通知您此索償的申請結果。
- If you have any questions about your claim, please call (852) 3128 0153.
 如果您對索償有任何疑問，請致電(852) 3128 0153。
- We'll contact you as soon as possible if we need more information, or if we need to have your claim assessed by a third party such as an impartial doctor or hospital. This could cause a delay to your claim. The employee or patient is responsible for any expenses incurred while the claim is being processed.
 如果我們需要更多資料，或者需要讓第三方(例如公正的醫生或醫院)評估您的索償，我們會盡快與您聯絡。這可能會導致您的索償延遲。僱員或病人亦有可能需要支付索償期間產生的相關費用。

CLAIMS DOCUMENT CHECKLIST 索償文件清單

What you need to submit with this claim:
 請連同此索償一併提交以下文件：

Note: a discharge summary can replace Section 2 of the form if the hospital stay was in a government hospital (managed by Hospital Authority, ward level).

注意：如果住院是在政府醫院(由醫院管理局管理之普通病房)，則出院總結可以代替表格乙部。

- Copy of receipt(s) of the medical expenses (including deposit receipt)
 醫療費用收據副本(包括按金收據)
- Copy of Hospitalisation surgical package charges breakdown (if applicable)
 住院/手術套餐費細目副本(如適用)
- Copy of Laboratory test breakdown and amount
 化驗詳情及金額副本
- Copy of Drug list (include drug name, dosage, quantity and amount)
 藥物詳情副本(包括藥物名稱、劑量、數量及金額)
- Copy of Referral letter(s) from any specialists
 任何專科轉介信副本
- Copy of Histopathology or Laboratory Test Report, Endoscopic, Ultrasonogram, X-Ray, CT Scan, MRI etc., Diagnostic Written Report(s) and Operating theatre summary (if applicable)
 病理學或化驗報告、內窺鏡檢查、超聲檢查、X射線、CT掃描、磁力共振等診斷之書面報告及手術室摘要副本(如適用)
- Copy of employee / patient's proof of identity such as ID Card, Passport or Birth Certificate etc.
 僱員/病人的身份證明副本，例如身分證、護照或出生證明等
- Copy of document with the employee / patient's name and bank account details (if applicable)
 僱員/病人之個人本地銀行戶口證明文件副本(如適用)

SECTION 1: CLAIM INFORMATION 甲部 - 索償資料

To be completed in BLOCK LETTERS by the employee or patient 由僱員或病人以正楷填寫

1. GROUP LIFE SCHEME INFORMATION 團體人壽計劃資料

1A. EMPLOYER DETAILS 僱主資料

Group life policy no. 團體保單編號		Employer name 僱主名稱	
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1B. EMPLOYEE DETAILS 僱員資料

Mandatory field, otherwise, claim will not be processed 必須填寫，否則索償將不予處理

English Full Name 英文姓名	Contact no. 聯絡電話號碼	Email 電郵

1C. PATIENT DETAILS 病人資料

English Name of Patient (if different from above) 病人英文姓名(如與上述不同)	HK/Macau ID card no. 香港/澳門身份證號碼	Membership no. (Refer to E-medical card/Physical Medical Card) 成員編號(請參閱您的電子醫療卡/實體醫療卡)

2. MEDICAL SERVICE DETAILS FOR YOUR CLAIM 醫療服務詳情

2A. CLAIMING FOR AN ILLNESS 因患病而索償

Duration of symptoms 症狀持續時間	Description of illness symptoms 症狀之描述

SECTION 2: DOCTOR SECTION 乙部 – 由醫生填寫

To be completed in BLOCK LETTERS and signed by the consulting doctor. If the patient is confined in a government hospital (managed by Hospital Authority, ward level), discharge summary would replace the completion of this section of the form. 請以正楷填寫並由主診醫生簽署(若索償人入住香港醫管局轄下公立醫院之普通病房, 出院摘要可替代索償表格之乙部)

1. PATIENT DETAILS 病人資料

English Full Name 英文姓名	Date of birth 出生日期	HK/Macau ID card no. 香港/澳門身份證號碼	Patient's membership no. (required for the claim to be processed) 病人成員編號(此欄必須填寫否則索償申請將不獲辦理)
	____ - ____ - ____ DD日 MM月 YYYY年		

2. CLINICAL HISTORY 求診記錄

Date of first consultation 首次看診日期	Description of patient's symptoms 病徵	How long has the patient shown these symptoms? 病人在首次求診前該病徵持續了多久?
____ - ____ - ____ DD日 MM月 YYYY年		
Please list and provide reasons for any laboratory test(s)/ imaging test(s)/other diagnostic test(s) the patient required during their hospitalisation. 建議之化驗/影像檢查/其他診斷性檢查及接受該等檢查的原因。		

3. HOSPITAL AND SERVICES INFORMATION 住院詳情

Admission type 醫院/日間手術護理中心/醫療診所類型	Accommodation type 住院級別
<input type="checkbox"/> Inpatient 住院 <input type="checkbox"/> Hospital Outpatient Department 醫院門診部 <input type="checkbox"/> Day Case Procedure Center 日間中心	<input type="checkbox"/> Private 私家房 <input type="checkbox"/> Semi-private 半私家房 <input type="checkbox"/> Ward 大房
<input type="checkbox"/> Medical clinic 診所	<input type="checkbox"/> Hospital day ward 醫院日症 <input type="checkbox"/> Medical clinic 醫療診所

Please provide details of treatment, treatment sessions, tests conducted, on-going treatment and recovery plan below.
請提供是次住院詳情, 包括相關治療、檢查、測試結果、持續治療及康復計劃。

Date of treatment / admission and discharge 治療日期	Final diagnosis / ICD-10 Code 最後的診斷/國際疾病分類代碼	Type of surgery or treatment administered 手術或治療名稱	Did the patient leave the hospital at any point during their admission? 病人是否曾在住院期間離院?	Please provide reasons for the length of the hospital stay, including the reason for the number of days as an inpatient 請提供是次持續留院日數及其原因
Date of treatment / admission 治療/入院日期 ____ - ____ - ____ DD日 MM月 YYYY年			<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 不是	
Date of discharge 出院日期 ____ - ____ - ____ DD日 MM月 YYYY年			If 'yes', please fill in the date as '是', 請填寫日期 ____ - ____ - ____ DD日 MM月 YYYY年	
Has the patient been consulted by other Physician(s)/Surgeon(s) during this hospitalisation? 病人是否曾在住院期間向其他醫生求診?		<input type="checkbox"/> Yes, please provide information below. 是, 請在下方填寫資料。 <input type="checkbox"/> No 不是		
Name of Physician(s)/Surgeon(s) 醫生姓名	Reason 原因	Treatment performed 所提供的治療		

4. CANCER TREATMENT 癌症/腫瘤相關治療

Type of treatment administered
治療種類

- Surgical 外科治療
 Chemotherapy 化療
 Hormonal Therapy 荷爾蒙治療
 Target Therapy 標靶治療
 Radiotherapy 電療
 Immunotherapy 免疫療法
 Others 其他 _____

Name of drug administered 藥物名稱	Dosage 藥物劑量	Frequency of dosage 治療頻率	Duration of treatment 持續治療的時間	If the patient suffered any complications during treatment, please provide details. 如病人在接受治療期間出現併發症，請提供詳情。

5. MEDICAL DIAGNOSIS AND ADVICE 診斷詳情

Can medical tests and procedures be done on an outpatient basis / at a Day Case Procedure Centre? 該檢查及手術是否可以在門診/日間手術中心進行?	If 'yes', please provide details for the reason. 若'可以'，請說明病人住院的原因。 If 'no', please give a reason for the hospital stay. 若'不可以'，請提供原因。
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 不是	

Was it an emergency hospitalisation or procedure? 這是否緊急個案?	If 'yes', please provide details. 如'是'，請提供詳情。
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 不是	

Was the current condition due to one of the following? 上述情況是否與以下問題有關?	<input type="checkbox"/> Accidental bodily injury 意外身體受傷 <input type="checkbox"/> Self-inflicted injury 自我傷害 <input type="checkbox"/> Abuse of drugs or alcohol 濫用藥物或酒精 <input type="checkbox"/> Infertility or sterilisation 不育或絕育 <input type="checkbox"/> Contraception 避孕 <input type="checkbox"/> Treatment for cosmetic purpose 美容性質的治療 <input type="checkbox"/> Vaccination 疫苗接種 <input type="checkbox"/> Pregnancy 懷孕 <input type="checkbox"/> Congenital condition 先天性疾病異常 <input type="checkbox"/> Mental disorder 精神紊亂 <input type="checkbox"/> Refractive error 屈光不正 <input type="checkbox"/> Developmental condition 發育問題 <input type="checkbox"/> Hereditary condition 遺傳性問題 <input type="checkbox"/> General check-up 一般身體檢查
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In your opinion, was the hospitalisation a result of a recurring / chronic illness or related to a previous condition? 您認為是次住院是因為複發性/長期疾病或之前的疾病?	<input type="checkbox"/> Yes, please provide details below. 是，請在下方提供細節。 <input type="checkbox"/> No 不是
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Date 日期	Details on the recurring / chronic illness or previous condition. 請就複發性/長期疾病或之前的疾病請提供詳情
____ - ____ - ____ DD日 MM月 YYYY年	

Is everything being claimed on this form medically necessary and recommended for the patient's current diagnosis? 是次檢查的治療及住院日數(如有)是否和上述診斷有直接關係而且是醫療所需及由醫生建議?	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 不是
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6. MEDICAL HISTORY 病歷紀錄				
Has the patient previously suffered from related conditions to this illness? 病人是否曾出現與此疾病相關的徵狀?		<input type="checkbox"/> Yes, please provide details below. 是，請在下方提供細節。 <input type="checkbox"/> No 不是		
Date of doctor's consultation or hospital admission 醫生就診或住院日期	Name of doctor 醫生姓名	Patient's symptoms 病徵	Doctor's diagnosis of patient's condition 診斷	Name of treatments administered (Add details of any past or upcoming surgical procedure/s) 所提供的治療 (請列明已接受或將會進行的手術名稱)
____ - ____ - ____ DD日 MM月 YYYY年				
7. DOCTOR INFORMATION 醫生資料				
7A. REGULAR DOCTOR'S INFORMATION 慣常醫生資料				
Are you the patient's regular doctor? 您是否該病人的慣常醫生?		<input type="checkbox"/> Yes, please proceed to section 7B. 是，請跳至7B。		<input type="checkbox"/> No, please provide patient's regular doctor's information below. 不是，請提供病人的慣常醫生的資料。
Full name 姓名	Address 地址			Contact no. 電話號碼
7B. REFERRED DOCTOR'S INFORMATION 轉介醫生資料				
Is the patient referred by another doctor? 病人是否由其他醫生轉介?		<input type="checkbox"/> Yes, please provide the referring doctor's information below. 是，請提供轉介醫生的資料。		<input type="checkbox"/> No 不是
Full name 姓名	Address 地址			Contact no. 電話號碼
8. DOCTOR'S DECLARATION AND AUTHORISATION 醫生聲明及授權書				
I declare that all information provided is true and complete to the best of my knowledge. 本人謹此聲明及同意上述一切陳述及問題的所有答案，就本人所知所信，均為事實全部並確實無訛。				
Name of attending doctor (Please add your qualifications) 主診醫生姓名 (請提供您的專業資格)	Address 地址			Contact no. 電話號碼
DOCTOR'S SIGNATURE 醫生簽署				
Signature and stamp of attending doctor 主診醫生簽名及蓋章			____ - ____ - ____ DD日 MM月 YYYY年 Date signed 簽署日期	