香港人壽 hong kong life

住院免找數安排服務申請書
Cashless Arrangement Service for Hospitalization Application Form

- 發出此申請書並不表示本公司已接納是次申請。在此申請過程中，無任何性質之手續費需支付予本公司之僱員或保險中介人。
  The issuance of this application form does not constitute an admission of liability. No fee, commission or charge of whatever nature is required to pay to the employees or Insurance Intermediary of the company with respect to this application.
- 請回答申請書第一部份所有問題。申請書第二部份必須由主診醫生填寫並由保單權益人/受保人支付有關費用。
  Please answer ALL the questions in Part I of this application form. Part II of this application form MUST be completed and signed by the attending physician. The completion of this part is at Policyowner/Life Insured's own expenses.
- 請確保保單權益人/受保人在此申請書的簽署必須和投保書簽署一致。
  Please make sure the signature of Policyowner/Life Insured on this application form is in consistent with that appearing on the policy application form.
- 此住院免找數安排服務由天一協援社有限公司（下稱「天一」）提供予香港人壽保險有限公司（下稱「香港人壽」）指定保單之受保人。如有關任何查詢，請致電客戶服務熱線。 電話：(852) 2290 2886。
  The Cashless Arrangement Service for Hospitalization is provided by TY Solutions Limited (hereinafter called "TY") to the Life Insured as specified by the Hong Kong Life Insurance Limited (hereinafter called "Hong Kong Life"). Please contact Customer Service Hotline for any enquiry. Tel: (852) 2290 2886.

1. 保險中介人姓名 Name of Insurance Intermediary		2.保險中介人編號 Insurance Intermediary Code		3. 聯絡電話 Contact Tel. No.	

第一部份 PART I — **保單權益人/受保人聲明(由保單權益人/受保人填寫) POLICYOWNER/LIFE INSURED'S STATEMENT (to be completed by Policyowner/Life Insured)**

4. 保單號碼 Policy No.		5. 受保人姓名 Name of Life Insured	英文 in English	中文 in Chinese	
6. 身分證/護照號碼 ID Card / Passport No.		7. 性別 Sex	☐ 男 Male ☐ 女 Female	8. 聯絡電話 Contact No.	
9. 出生日期 | 年齡 Date of Birth | Age	日 DD / 月 MM / 年 YYYY 年齡 Age	10. 電郵地址 E-mail Address			

如住院因意外引致，請填報第 11-13 項。
Complete Item 11-13, If Hospitalization was due to Accident.

11. 意外發生日期、時間和地點 Date, Time and Place of Accident	日期 Date 日 DD / 月 MM / 年 YYYY	時間 Time		地點 Place	

12. 意外發生經過
How did the accident happen

13. 受傷部位及受傷程度
Which part(s) of body injured and the extent of injury

如住院因疾病引致，請填報第 14-17 項。
Complete Item 14-17, If Hospitalization was due to Illness.

14. 請敘述所患疾病及症徵
Describe the nature of illness and the symptoms

15. 首次出現上述疾病及症徵之日期
Date of the above illness and symptoms first appeared

16. 首次求診之醫生姓名
Name of the first consulted doctor

17. 首次求診日
Date of first consultation

香港人壽保險有限公司 Hong Kong Life Insurance Limited
香港皇后大道中183號中遠大廈15樓 15/F Cosco Tower, 183 Queen's Road Central, Hong Kong
網址 Website : www.hklife.com.hk ■ 電郵 E-Mail : info@hklife.com.hk ■ 查詢熱線 Hotline : 2290 2888 ■ 傳真 Fax : 2530 5682

收取差額費用之信用卡授權書(由保單權益人填寫)
Credit Card Authorization Form for Shortfall Collection (to be completed by Policyowner)

- 本人作為持卡人，現授權香港人壽保險有限公司（「香港人壽」）自本人之信用卡戶口內扣除到期之差額。
  I, Cardholder, hereby authorize Hong Kong Life Insurance Limited ("Hong Kong Life") to debit the outstanding shortfall due from my credit card account.

- 本人確定於本授權書上之簽署樣式須與所持信用卡上之樣式相同。
  I confirm that my signature on this authorization form is the same as that on the credit card.

- 本人同意若此信用卡有效期屆滿後，香港人壽有權繼續於下述信用卡扣除到期之差額，無需另行通知。
  I agree that should the credit card expire in the future, Hong Kong Life shall continuously debit the outstanding shortfall due from the below credit card account without further notice.

- 如香港人壽直接向醫院支付的費用超出是次住院就合資格保障應支付的賠償額，此授權書將授權香港人壽從以下信用卡戶口收取有關差額。信用卡持卡人必須為此保單之保單權益人。香港人壽將於收取差額費用十四天前發出差額付款通知書通知保單權益人有關差額詳情。
  (請注意，我們只接受 Visa Card 及 Master Card。)
  If the amount paid by Hong Kong Life to the hospital exceeds the eligible claims arising from this hospitalization, this Form authorizes Hong Kong Life to collect the shortfall amount from the following credit card account. Credit card holder must be the Policyowner of this policy. Hong Kong Life will issue the shortfall notification 14 days prior to the collection. (Please note that we only accept Visa Card and Master Card.)

保單號碼 Policy No.		信用卡號碼 Credit Card Account No.	
持卡人姓名 Name of Cardholder		信用卡到期日 Credit Card Expiry Date	月 MM / 年 YY

本人授權及指示香港人壽保險有限公司如本部份上文所述，從本人的信用卡戶口扣除到期之差額費用。
I hereby authorize and direct Hong Kong Life Insurance Limited to debit the outstanding shortfall due from my credit card account detailed as above in this part.

☞ 持卡人簽署(須與信用卡上簽名相同) Signature of Cardholder(must be same as that on the Credit Card)	日 DD / 月 MM / 年 YYYY 日期 Date

香港人壽保險有限公司 Hong Kong Life Insurance Limited
香港皇后大道中183號中遠大廈15樓 15/F Cosco Tower, 183 Queen's Road Central, Hong Kong
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聲明及授權
Declaration and Authorization

本人/我們清楚明白及完全同意以下各項：(1) 香港人壽保險有限公司 (下稱「香港人壽」)收集所需的個人資料是為處理投保或其他保險或財務產品/服務之申請，及提供所有關於該等申請之繼後服務，處理理賠或其有關分析、統計或精算研究用途、訴訟、通訊、內部/外界審計、保持優質服務、直接銷售保險產品及資料核對、與任何因香港人壽提供的產品及/或服務之機構/人士溝通。香港人壽會將該等資料儲存、使用、透露、發放及/或轉交予 (不論在本港或海外) 任何從事與保險或再保險業務有關之公司、中介人、第三方管理人、第三方服務供應商(包括但不限於保險公司、銀行、律師、會計師，以及其他提供行政、電訊、電腦、付款、印刷、贖回或其他服務以令香港人壽的業務可以運作的第三方服務供應商)、理賠調查員、醫療賬單審查公司、有關提供保險業務服務之公司、專業顧問、研究人員、政府機關、任何保險業組織或聯會、信貸資料服務機構、收賬代理、伙伴金融機構、符合法例或法庭頒令的資料披露規定之單位、或根據監管或其他有關機構所發出的指引而作出披露之單位；(2) 本人/我們有權知悉香港人壽是否持有本人的資料及有權查閱該等資料，若認為有關本人/我們的資料不準確，有權要求香港人壽給予改正，同時有權查悉香港人壽對於資料的政策與實務做法，及獲告知香港人壽持有本人/我們資料的類別。任何關於查閱或改正資料申請，或欲查悉香港人壽對於個人資料的政策與實務做法或所持有的資料類別，可以書面形式致函香港皇后大道中 183 號中遠大廈 15 樓，向香港人壽資料保護主任提出；(3) 香港人壽有權就處理任何查詢資料的要求收取合理費用。

本人/我們確認並知悉：(1)本人/我們將有責任遵守就本人/我們為公民或居民或作為住所的國家之有關法律、監管政策及/或其他法例要求；(2)如有疑問，本人/我們將徵詢獨立專業顧問有關購買、持有、提款、贖回或以其他方式處置所發保單或行使保單內的權利可能引致的稅務、法律或法規上的後果。香港人壽沒有就有關本人/我們之稅務或個人之公民身份提供任何意見；(3)香港人壽有權，就如需要並在法律許可的範圍內，提供有關本人/我們的個人資料和其他有關本人/我們的保單或於本申請書上所載之投資或以其他方式刊載的其他資料予政府部門、監管機構、法院、法庭、行政委員會及/或執法機構(包括本地及海外)。香港人壽也會就上述政府部門、監管機構、法院、法庭、行政委員會及/或執法機構所提出之任何問題及/或查詢作出回答，及在適當的情況下，會主動提供報告，以符合有關法律，法規和守則/行為。本人/我們明白，如果本人/我們拒絕給予上述之明示同意予香港人壽，香港人壽將無法出售任何保險產品，及提供任何服務給本人/我們。

本人/我們明白如欲拒絕接收香港人壽推廣資料，可任何時候以書面形式向香港人壽資料保護主任提出有關申請。

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、其他因香港人壽提供的產品及/或服務之機構/人士，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)，均可向香港人壽或其代表透露、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) 香港人壽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，如法律上可行時，此授權書仍具效力，而本人/我們之繼承人及承讓人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 hereby declare, understand and agree that: (1) Hong Kong Life Insurance Limited (hereinafter referred to as “Hong Kong Life”) only collects necessary personal information for the purpose of processing your application or any other applications for insurance or financial related products/ services and providing all on-going services relating to such applications, claim processing or any analysis of it, statistical or actuarial research, litigation, communication, internal/ external audit, to maintain quality services, direct marketing for insurance products and data matching, and communication with any relevant organization/ person in respect of any services and/ or products provided by Hong Kong Life. Any personal information collected or held by Hong Kong Life is to enable it to carry on insurance business and may be stored, used, disclosed, released and/ or transferred (whether within or outside Hong Kong) by Hong Kong Life to any other companies carrying on insurance or reinsurance related businesses or any intermediaries or third party administrators or third party service providers (including without limitation insurers, bankers, lawyers, accountants, and other third party service providers who provide administrative, telecommunications, computer, payment, printing, redemption or other services to Hong Kong Life) or claims investigator or medical bill review companies or other service providers providing services relevant to insurance business or professional advisors or researchers or government authorities or any associations or federation of insurance companies or credit reference agencies or debt collection agencies or partnering financial institutions or any organizations which meet disclosure requirements imposed by law or court orders or pursuant to guidelines issued by regulatories or other relevant authorities; (2) I/ We have the right to check whether Hong Kong Life holds data about me/ us and the right of access to such data and require Hong Kong Life to correct any data relating to me/ us which are inaccurate. I/ We also have the right to ascertain Hong Kong Life’s policies and practices in relation to data and to be kept informed of the kind of data held by Hong Kong Life. Such request can be made in writing and addressed to the Data Protection Officer of Hong Kong Life at 15/ F, Cosco Tower, 183 Queen’s Road Central, Hong Kong ; (3) Hong Kong Life has the right to charge a reasonable fee for the processing of any data access request.

I/ We confirm and acknowledge that: (1) I/ We shall be responsible for observing and complying with any applicable law, regulatory policy and/ or other statutory requirement of the country of my/ our citizenship, residence or domicile; (2) If in doubt, I/ We shall consult independent professional advisers concerning possible tax, legal or regulatory consequences of purchasing, holding, withdrawing, redeeming or otherwise disposing the policy issued or exercising any rights of the policy. Hong Kong Life has not provided any advice to me/ us around tax or a person’s citizenship status; (3) Hong Kong Life shall be entitled to, insofar as necessary and to the extent permitted by laws, furnish the relevant governmental authorities, regulator(s), court(s), tribunal(s), administrative board(s) and/ or law enforcement bodies (both local and overseas) with any of my/ our personal data and other information relating to my/ our policy(ies) or investments contained in this application or otherwise. Hong Kong Life may also answer any question or inquiry the said governmental authorities, regulator(s), court(s), tribunal(s), administrative board(s) and/ or law enforcement bodies, and as it sees appropriate, make any report at its own initiative in order to comply with the laws, regulations and codes of practice/ conduct. I/ We understand that Hong Kong Life will not be able to sell any insurance product to me/ us and provide any service if I/ We refuse to give the said express consent.

I/ We hereby understand that if I/ We do not want to receive any promotional information from Hong Kong Life, I/ We can make such request in writing to the Data Protection Officer of Hong Kong Life at any time.

I/ We hereby authorize: (1) any employer, doctor, hospital, clinic, insurance company, government office or any relevant organization/ person in respect of any services and/ or products provided by Hong Kong Life who has or may hereafter have any record, knowledge or information of me/ us (whether medical or otherwise) to disclose, release or transfer to Hong Kong Life or its representative such record, knowledge or information pertinent to this application and any reinstatement or claim arising therefrom; (2) Hong Kong Life 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 me/ us as well as the successors and assignees of me/ us and remain valid notwithstanding death or incapacity in so far as legally possible. A photocopy of this authorization shall be valid as the original.

☞		日 DD / 月 MM / 年 YYYY
保單權益人簽署 Signature of Policyowner	保單權益人姓名及身分證/護照號碼 Name & ID Card / Passport No. of Policyowner	日期 Date
☞		日 DD / 月 MM / 年 YYYY
受保人簽署 Signature of Life Insured	受保人姓名及身分證/護照號碼 Name & ID Card / Passport No. of Life Insured	日期 Date

S.V.

香港人壽保險有限公司 Hong Kong Life Insurance Limited
香港皇后大道中183號中遠大廈15樓 15/F Cosco Tower, 183 Queen's Road Central, Hong Kong
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第二部份 醫生診斷報告(保單權益人/受保人自費由主診醫生/手術醫生填寫)
PART II ATTENDING PHYSICIAN'S STATEMENT (to be completed by attending physician/surgeon at Policyowner/Life Insured's own expense)

1. 病人姓名 Name of Patient | 2. 年齡/性別 Age / Sex | 3. 身分證/護照號碼 ID Card / Passport No.

4. (a) 病人首次就該次之疾病／受傷向閣下求診之日期
Date of first consultation to you relating to this illness / injury
日 DD / 月 MM / 年 YYYY

(b) 首次病徵出現或意外發生之日期
Date when symptoms first appeared or accident happened
日 DD / 月 MM / 年 YYYY

(c) 閣下是否病人之慣常求診醫生?
Are you the patient's usual physician? ☐ 是 Yes ☐ 否 No

請按日期順序列出病人每次求診之日期和詳情。
Please list down the date and details of each visit of the patient to your clinic/ hospital in the order of dates.

求診日期 Consultation Date (日 DD/月 MM/年 YYYY)	主訴 Complaints	診斷 Diagnosis	治療 Treatment

(d) 該次入院／手術之主訴及病徵
Chief complaints and symptoms of the patient relating to this hospitalization/surgery

(e) 如該次入院是由意外導致的，首次求診時是否有表面明顯的瘀傷或傷口?
If the hospitalization was due to accident, was there evidence of an external and visible bruise or wound at first visit? ☐ 是 Yes ☐ 否 No

請敍述身體那部分受傷及受傷的原因，性質和程度。
Please describe which part of the body injured and the cause, character and extent of the injury.

(f) 病人以往曾否患有同類或類似病症或病徵? 如有，請提供詳情。
Has he/she been having same or similar conditions or symptoms before? If yes, please give details.

(g) 診斷
Diagnosis

(h) 建議之手術/治療
Surgery / treatment suggested

(i) 建議之化驗/影像檢查/其他診斷性檢查
Lab Tests / Imaging / Other Diagnosis Investigation suggested

(j) 住院原因
Reason for this Hospitalization

(k) 在該次入院前有否接受其他檢查/治療(如有)?
What tests and procedures have been done prior to this hospitalization (if any)?

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(l) 病人是否由其他醫生轉介到閣下？ 如是，請提供詳情。
Was the patient referred to you by other physician? If yes, please give details.

(m) 此疾病是否為復發性/慢性疾病？ 如是，請提供首次病發之詳情及日期。
Was the illness a recurrent episode / chronic disease? If yes, please give details and the date of first episode below.

(n) 就該次治療，是否可在門診進行? 如是，請提供住院治療的理由。
Is it possible to provide this treatment on an outpatient basis? If yes, please give reason of performing on an inpatient basis.

(o) 病人是否需定期服藥或治療? 如是，請提供詳情。
Is the patient on regular medication or medical treatment? If yes, please provide the details.

(p) 請圈出與該次疾病/受傷有關之以下因素並提供詳情。
Please circle the following factors which is associated with the illness / injury and provide details.

過去的受傷或疾病/整容或整形手術/濫用酒精或藥物/分娩，懷孕，流產，人工流產或產前檢查/不孕或絕育/自殺或自致之傷害/先天性畸形或異常/精神或神經紊亂/例行身體檢查或接種疫苗/人體免疫力缺乏病毒/後天免疫力缺乏症有關的疾病，性病或性接觸傳染病/其他
Past injury or illness / Cosmetic surgery or plastic surgery / Abuse of Alcohol or drugs / Childbirth, pregnancy, miscarriage, abortion or prenatal care / Infertility or sterilization / Suicide or self-inflicted injury / Congenital deformities or anomalies / Mental or nervous disorder / General check-up or vaccination / HIV/AIDS related illness, venereal disease or sexually transmitted disease / Others

詳情:
Details:

(q) 預計費用
Estimated Costs

醫院名稱
Name of Hospital

預計入院日期
Estimated Admission Date　日 DD / 月 MM / 年 YYYY

預計留院日數
Estimated Length of Stay　日 day

請提供預計費用之完整分類。
Please provide full breakdown of estimated costs.

項目 Items	費用 Charges	項目 Items	費用 Charges
醫生手術費用 Surgeon's Fee		麻醉師費用 Anaesthetist's Fee	
手術室費用 Operation Theatre Fee		其他醫院費用 Other Hospital Expenses	
每日醫生巡房費 Daily Ward Round Fee		專科醫生收費 Specialist's fee	
每日房費 Daily Room Charge		住房級別: 普通病房/半私家/私家/其他 Class of bed: Ward / Semi-Private / Private / Others	
預計該次住院總費用 Estimated total fee for this confinement			

(r) 閣下認為與此申請有關之其他資料。
Any further information you consider relevant to this request.

本人特此證明，本人已親自檢查並治療上述疾病或受傷，並盡本人所知及所信上述資料是真實及完整的。
I hereby certify that I have personally examined and treated the patient for the above illness or injury and that the information as stated above is true and complete to the best of my knowledge and belief.

醫生簽署及印章 Signature and Chop of Attending Physician	醫生姓名及資格 Name and Qualification of Attending Physician	日 DD / 月 MM / 年 YYYY 日期 Date

地址 Address	電話號碼 Telephone No.

香港人壽保險有限公司 Hong Kong Life Insurance Limited
香港皇后大道中183號中遠大廈15樓 15/F Cosco Tower, 183 Queen's Road Central, Hong Kong
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