

(Internal Use Only 此欄由本公司填寫)		Claim No. 索償編號	Date Received 接收日期
PART 1 - TO BE COMPLETED BY THE PATIENT 甲部 - 由病人填寫			
Name of Employer / Policyholder 僱主/團體名稱		Policy No. 保單編號	
Name of Insured Employee / Member 僱員/成員姓名			
Certificate / Staff No. 受保證明書/職員編號		Daytime Contact No. 日間聯絡電話	

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	日 D	月 M 年 Y Gender 性別 <input type="checkbox"/> M 男 <input type="checkbox"/> F 女
Relationship to the Insured Employee / Member 與被保僱員/成員之關係 <input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Child 子女 <input type="checkbox"/> Others 其他			
1 Have you / the claimant had any prior treatment for this or related conditions 閣下/索償申請人否曾經因同一情況而接受治療? <input type="checkbox"/> NO 沒有 <input type="checkbox"/> YES 有 Name of Doctor 醫生姓名 _____ Address 地址 _____ Date(s) 日期 _____			
2 Are you / the claimant making any other insurance claim as a result of this hospitalization / surgery 有關此次住院/手術, 閣下/索償申請人否申請其他保險賠償? <input type="checkbox"/> NO 沒有 <input type="checkbox"/> 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? <input type="checkbox"/> NO 不是 <input type="checkbox"/> YES 是 Accident Date 意外日期 _____ Time 時間 _____ Place 地點 _____ Brief Description 經過 _____			

Note
1) This form and relevant original medical receipts must be submitted to MIC within 30 days from the date of discharge from hospital. Otherwise, the claim shall be declined for reimbursement.
2) Claim payment will be subject to the terms and conditions set out in the corresponding Master Policy.
3) Incomplete form or omission of required information may cause delay in processing.

注意
1) 在出院後三十天內, 索償人士必須將此申請表連同有關正式收據提交予本公司處理, 逾期無效。
2) 一切賠償款項將根據有關主保單上的條文計算。
3) 若此申請表未完全填妥或未有提供足夠理賠資料, 賠償處理可能會被延誤。

Declaration & Authorization

I/We hereby declare and agree that any personal information collected or held by Macau Insurance Company Limited ("the Company") (whether contained in this claim application or otherwise obtained) is provided and may be held, used, and disclosed by the Company to individuals/organizations associated with the Company or any selected third party (within or outside of Macau, including reinsurance and claims investigation companies and industry associations/federations) for the purposes of processing this application and providing subsequent services, and data matching, and to communicate with me/us for such purposes. I/We understand that I/we have the right to obtain access to and to request correction of any personal information held by the Company concerning me/us (and my/our dependants, if any). I/We also hereby irrevocably authorize:

- any organization, institution, or individual that has any record or knowledge of my/the Insured(s)'s health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to the Company such information. This authorization shall bind my/the Insured(s)'s successors and assigns and remain valid notwithstanding my/the Insured(s)'s death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.
- the Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate my/the Insured(s)'s health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.

聲明及授權書

本人/我們現聲明並同意, 澳門保險股份有限公司 ("貴公司") 可保留、使用或透露貴公司所收集或保留之任何有關本人/我們的個人資料 (在此申請書所載或從其他途徑取得), 給予貴公司有關的人士/機構或任何被選定的機構 (在本澳或海外的, 包括再保險及賠償調查公司, 及有關的行業協會/聯會), 用作處理本申請及提供其後的服務, 及資料核對等用途, 及因此等用途與本人/我們聯絡。本人/我們明白到本人/我們有權向貴公司查閱及申請改正所有與本人/我們 (及受本人/我們受供養人, 如適用) 的個人資料。本人/我們不可撤回地授權:

- 任何知悉或擁有本人/被保人之健康狀況及病歷或任何治療或諮詢記錄及曾為或將為本人/被保人診治之機構、組織或人士, 向貴公司透露有關資料。即使本人/被保人死亡或喪失能力, 此授權書仍然存有法律效力, 而本人/被保人之繼承人及轉讓人亦會受此授權書約束。此授權書之正本與副本同屬有效。
- 貴公司或任何其認可之驗身醫生或化驗所, 替本人/被保人進行所需之醫療評估及測試, 並對本人/被保人之健康狀況進行審核及評估, 作為處理本申請及其後與之有關的賠償事宜。此等化驗包括, 但並不限於膽固醇及有關之血脂肪、糖尿病、腎或肝功能失常、愛滋病或感染人體免疫力缺乏症病毒、免疫系統失常或體內藥物、毒品、尼古丁及其他代謝產物之含量等化驗。

Signature of Claimant (18 years of age & over)
索償人 (十八歲或以上) 簽署

Signature of Insured Employee / Member
受保僱員/成員簽署

Date Signed
簽署日期

PART 2 - TO BE COMPLETED BY THE SURGEON OR ATTENDING PHYSICIAN 乙部 - 由主診醫生填寫									
Name of Patient 病人姓名 _____									
Name of Hospital 醫院名稱 _____									
Admission Date 入院日期		D 日	M 月	Y 年	Discharged Date 出院日期		D 日	M 月	Y 年

1a	Please give chief complaint / diagnosis for this hospitalization 住院期間主要病狀/診斷 _____
1b	Describe the type of treatment / surgical procedure given to the patient 病人所接受的治療/手術 _____
2	When were the symptoms first presented or when did the accident happen 首次出現病徵或意外發生的時間? _____
3a	When was the first consultation for this treatment / sickness 此項治療/疾病的首次就醫時間? _____
3b	Has the patient received continuous treatment related to this sickness since then 病人其後有否就同一疾病繼續接受治療? _____
4	If hospitalization was due to accident, please state how it happened 倘因意外引致住院, 請闡述事發經過 _____
5	Was the patient referred to you by another doctor 病人是否經由其他醫生轉介? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 Doctor's Name 醫生姓名 _____ Address 地址 _____
6a	Have you treated the patient for this or related sickness before 以前曾否為該病人就同一或相關疾病進行治療? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 Details 詳情 _____
6b	Was the condition a recurrent episode / a chronic disease? If YES, state the date of first attack 該狀況是否經常出現或為長期病患? 如是*, 請註明首次出現的日期 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 Details 詳情 _____
7	If the treatment is due to pregnancy, please give the date of conception 倘因懷孕引致治療, 請註明受孕日期 D 日 M 月 Y 年
8a	Is the hospitalization / treatment medically necessary 該次住院/治療是否有醫學上的必要? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 Details 詳情 _____
8b	For the average patient, what is the usual duration of hospitalization for this sickness 就一般情況而言, 該疾病需要住院多少天? _____
8c	Is it possible to provide this treatment on an outpatient basis 該疾病是否可改以門診方式治理? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 Details 詳情 _____
9	Did any complications arise during hospitalization 病人在住院期間有否出現併發症狀? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 Details 詳情 _____
Other remarks 其他備註 _____	

Name of Attending Physician / Specialist (with qualifications) 主診/專科醫生姓名 (及資歷)	Address 地址 _____
	Telephone 電話 _____
Signature of Attending Physician / Specialist 主診/專科醫生簽名	Date 日期 _____