泰禾人壽保險有限公司 Tahoe Life Insurance Company Limited
（百慕達註冊之有限公司 Incorporated in Bermuda with limited liability）
總公司：香港太古城英皇道1111號太古城中心一座15樓
Head Office: 15/F, Cityplaza One, 1111 King's Road, Taikoo Shing, Hong Kong
www.tahoelife.com.hk | 客戶服務熱線 Customer Service Hotline: (852) 3767 8777

住院賠償申請表 Hospitalization Claim Form

第一部分 (由受保人 / 保單持有人填寫) PART I (To be completed by insured/policyowner)

保單編號 Policy no.	受保人姓名 Name of insured 身份證明文件號碼 Identity document no.:	年齡 Age 性別 Gender	☐ 首次索償 New Claim ☐ 再度索償 Further Claim ☐ 待決索償 Pending Claim ☐ 重批 / 覆核 Review/Appeal
保單持有人姓名 Name of policyowner	保單持有人聯絡電話 Contact Phone No. of policyowner	持牌保險中介人姓名及號碼 Name & code of licensed insurance intermediary	賠償號碼 **(公司專用)** Claim No. **(For office use only)**

受保人現職（倘有兼職請列明）職位及職責Present occupation of insured (if more than one, state all) and exact nature of occupational duties	公司或僱主名稱及地址 Name and address of business or employer

A. 如因意外受傷入院, 請填寫問題1至3 If Hospitalization was due to an ACCIDENT, please complete questions 1- 3

1. a.意外發生日期、時間及地點 Date, Time & Location of Accident

意外日期
Date of accident _____(日DD / 月MM / 年YYYY)

時間 Time _____ 上午 AM / 下午 AM

地點 Location _____

b. 意外如何發生? (請形容當時進行之活動,如適用) How did the accident happen? (Describe activities engaged if applicable)

c. 受傷部位及傷勢 Part(s) of body injured and type of injury

2a. 復職日期 Date returned to work

_____ (日DD /月MM /年YYYY)或OR

b. 預計復職日期 Expected Date of returning to work

_____ (日DD /月MM /年YYYY)

3. 有否報警 ? Did you report to the police?

❒ 否 No
❒ 有 Yes, 警署名稱 Police Station :
檔案編號 Ref. No.

B. 如因病入院, 請填寫問題4至5 If Hospitalization was due to an ILLNESS, please complete questions 4 and 5

4. a. 病徵及病狀 Signs and symptoms

b.就是次病況而言, 何時出現首次徵狀? For this episode, when did these symptoms first appear?

_____ (DD日/MM月/YYYY年)

c. 除此次病況外，閣下以往有否類似或相關病歷?Other than this episode, have you had any similar/ related past history?

❒ 否 No ❒ 有, 請提供有關詳情: Yes , please provide details

就診日期 Consultation date (日DD /月MM /年YY)	醫生/醫院名稱及地址 Name & address of Physician/ Hospital	診斷結果 Diagnosis

5. a. 曾因此病況就診之醫生/醫院名稱及地址 Name and address of the Physician/ Hospital who have treated for this illness

就診日期 Consultation Date (日DD/月MM/年YYYY)	醫生/醫院名稱及地址 Name & address of Physician/ Hospital

b. 請提供閣下慣常就 診之醫生/醫院名稱 Please provide details of your usual attending Physician/ Hospital.

醫生/醫院名稱及地址 Name & address of Physician/Hospital	聯絡電話 Contact Phone no.

C. 住院及診治詳情 HOSPITALIZATION AND CONSULTATION DETAILS

6. a. 醫院名稱 Name of Hospital

b. 入院日期 Date of Admission_____(日DD /月MM /年YYYY)

出院日期 Date of Discharge_____(日DD /月MM /年YYYY)

c. 入住深切治療部日期（如適用）
Admission period in Intensive Care Unit (if applicable)

由 From_____至 to_____(日DD /月MM /年YYYY)

d. 閣下有否於住院期間請假外出 ?
Have you taken any home leave during the hospital confinement?

❒ 否 No ❒ 如有, 請列明外出之日期及時間
Yes, please state the date and time of your home leave.

7. 首次就診之醫生資料 The Physician first consulted for this illness/ accident

醫生名稱及地址 Name and address of the Physician

求診日期 Consultation date :

(日DD /月MM /年YYYY)

8. 建議 / 轉介入院之醫生資料 The Physician who referred the insured to hospital

轉介醫生名稱及地址Name and address of the referral Physician

轉介日期 Referral date :

(日DD /月MM /年YYYY)

D. 同期之索償 CONCURRENT CLAIMS

9. 閣下有否就此事向其他保險公司 / 機構申請索償？Did you apply for compensation from other insurers/ organization for the same event?

❒ 否 No ❒ 有, 請提供有關詳情: Yes , please provide details

保險公司 / 機構 Insurance Company/ Organization	保單號碼 Policy No,	索償類別 Benefit(s) to Claim	結果 / 狀況 Result/ Status

E. 付款指示 (只需選擇自動轉賬或支票其中一項) PAYMENT INSTRUCTION (select either autopay or cheque only)

(如沒有註明方式或資料不清晰，將以港幣支票支付 If payment instruction is not specified or information is not clear, HKD cheque will be issued)

自動轉賬 By Autopay

☐ 現時本公司紀錄之自動轉賬戶口；或
Current direct debit authorisation bank account in the company record; or

☐ 以下指定之港幣銀行戶口 (附上銀行戶口證明)
Specified HKD bank account below (Bank account proof is attached)

銀行號碼 Bank No.		分行號碼 Branch No		戶口號碼 Account No.								
			-				-							

注意事項：

(1) 銀行賬戶持有人姓名必須與**保單持有人**姓名相同。

(2) 請提供賬戶持有人的銀行賬戶證明，而該證明須列有銀行賬戶持有人姓名及銀行賬號。

(3) 自動轉賬只適用於香港銀行及款項將以港幣支付。

(4) 若自動轉賬不成功，本公司將以港幣支票支付相關之賠償款項。

Notes:

(1) Bank account holder name must be the same as **policyowner's** name.

(2) Please provide account holder's bank account proof which shows account holder name and account number.

(3) Autopay is only applicable to banks in Hong Kong and the payment will be paid in Hong Kong Dollar.

(4) If the autopay is failed, the respective claim payment will be paid by HKD cheque.

支票 By cheque (若沒有選擇支票貨幣，將以港幣支票支付。 If no cheque currency is selected, HKD cheque will be issued)

支票貨幣 Cheque currency

☐ 港幣Hong Kong Dollar ☐ 保單貨幣Policy Currency

F. 所需文件指引 請於下方格內加上 "√" 號表示連同以賠償申請表遞交的文件：

DOCUMENT CHECKLIST Please put a "√" in the box below to indicate the documents submitted with this claim form：

文件類別 Document Type	住院保障 Hospital & Surgical Benefit	住院現金保障 Hospital Cash Benefit
❒ 受保人及保單持有人之身份證明文件副本 Copy of identity document of the insured & policyowner	√	√
❒ 賠償申請表第一部分 (由保單持有人填寫) Claim Form Part I (Completed by the policyowner)	√	√
❒ 賠償申請表第二部分 (由受保人之主診醫生填寫) Claim Form Part II (Completed by the insured's Attending Physician)	√	√
❒ 醫院收據及收費單 (費用明細表) Hospital Receipt(s) and Statement(s) of Charges	√ （正本）(Original)	√ （副本）(Copy)
❒ 出院總結 / 出院紙副本 Copy of Discharge summary/ Discharge slip	√	√
❒ 化驗 / X-光 / 電腦掃描 / 磁力共振 / 病理檢驗報告副本 Copy of Laboratory / X-ray/ CT scan/ MRI/ Pathological Report(s)	√	√
❒ 中國內地醫院之病案首頁、入院紀錄、出院總結、每日醫囑單及體溫表本 Copy of Admission Note, Discharge Summary, Discharge Certificate, Daily Medical Record & Temperature Sheet of hospital in Mainland China	√	√
❒ 註冊醫生 / 醫院轉介信副本 Copy of Referral letter by Registered Physician /Hospital	√	√
❒ 其他保險公司或機構之賠償細算表 Copy of Compensation Breakdown from other insurer/ party	√	#

√ 基本文件 Required Documents # 附加文件 Optional Documents

***本公司可能會按個別個案情況要求遞交額外資料 / 文件*
*The Company may request for the submission of extra information/ documents on case by case basis***

保單號碼 Policy no.：_____

個人資料收集聲明及使用 Personal Data Collection And Use

本人 / 我們確認本人 / 我們已閱讀及明白泰禾人壽之個人資料收集聲明 (「泰禾人壽個人資料收集聲明」)。
本人 / 我們聲明及同意在本表格所載或泰禾人壽保險有限公司 (「泰禾人壽」) 不時以任何方法收集所得、編製或持有的任何個人資料及關於本人 / 我們或本人 / 我們的保單或投資的其他資料，可根據泰禾人壽個人資料收集聲明收集及使用。
本人/ 我們特此確認並同意泰禾人壽根據泰禾人壽個人資料收集聲明使用及轉移本人/ 我們的個人資料。泰禾人壽個人資料收集聲明的最新版本可於以下網址下載：www.tahoelife.com.hk，及可向泰禾人壽索取。

I / We confirm that I / we have read and understood the Tahoe Life Personal Information Collection Statement (the "Tahoe Life PICS").
I / We declare and agree that any personal data and other information relating to me / us or my / our policy(ies) or investments contained in this form or collected, compiled or held by Tahoe Life Insurance Company Limited (the "Company") by any means from time to time may be collected and utilised in accordance with the Tahoe Life PICS.
I/We hereby give my / our acknowledgement and agree to the use and transfer of my / our personal data by the Company in accordance with the Tahoe Life PICS. The latest version of the Tahoe Life PICS is available for download from the website: www.tahoelife.com.hk, and is made available upon request.

☐ 本人 / 我們不同意根據泰禾人壽個人資料收集聲明 (參閱「為直接促銷目的而使用個人資料」部分) 為直接促銷之目的而使用和提供本人 / 我們的個人資料，亦不希望接收任何推廣及直接促銷材料。
I / We do not agree with the use and provision of my / our personal data for direct marketing purposes as set out in the Tahoe Life PICS (see "Use of Personal Data for Direct Marketing Purposes") and do not wish to receive any promotional and direct marketing materials.

聲明及授權 Declaration And Authorisation

聲明 - 本人 / 我們謹聲明並同意：不論是否由本人 / 我們親自書寫，所有與上列索償有關的陳述及所有問題的答案均按本人所知及所信均屬完整及真確。

授權
本人 / 我們謹此授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構或其他機構、組織或人士，凡知道或持有任何有關本人 / 我們之紀錄者、及 / 或曾診驗或可能將會診驗本人 / 我們者，均可將該等資料提供給泰禾人壽保險有限公司「泰禾人壽」；(2) 泰禾人壽或任何其指定之醫生或化驗所，可就此賠償申請替本人 / 我們進行所需之醫療評估及測試，作為審核本人 / 我們之健康狀況。此授權對本人 / 我們之繼承人及受讓人員具約束力；即使死亡或無行為能力時，此授權仍具效力。本授權書的影印本與正本均有同等效力。
本人 / 我們聲明本人 / 我們有權及同意作出上述授權。

DECLARATION - I/WE HEREBY DECLARE AND AGREE that all statements and answers to all questions in relation to the above claims whether or not written by myself/ourselves are to the best of my/our knowledge and belief complete and true.

AUTHORISATION
I/WE HEREBY AUTHORISE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution, or person, that has any records or knowledge of me/us and who has attended or may hereafter attend myself/ourselves to disclose such information to Tahoe Life Insurance Company Limited ("Tahoe Life"); (2) Tahoe Life or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ourselves in relation to this claim. This authorisation shall bind my/our successors and assignees and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.
I/We declare and agree that I/we have the full authority from and consent to make the above authorisations.

_____	_____	_____
保單持有人簽名 Signature of policyowner	受保人簽名 (年滿18歲或以上) Signature of insured (Age 18 or above)	日期 (日 / 月 / 年) Date (DD/MM/YY)
姓名 Name _____	姓名 Name _____	
身份證明文件號碼 Identity document no. _____	身份證明文件號碼 Identity document no._____	

與受保人關係
Relationship to the insured _____

保單號碼 Policy no.：_____

第二部分 (須由主診醫生填寫。所需費用由索償人自行承擔。)
Part II (To be completed by the Attending Physician at claimant's expense)

病人姓名 Name of patient	年齡 Age	性別 Gender	身份證明文件號碼 Identity document no.:	入院日期: Admission date 出院日期: Discharge date (日DD /月MM /年YYYY)

1.a. 病人有否入住深切治療部？
Had the patient been staying in Intensive Care Unit?

☐ 否 No ☐ 有 Yes，由 from _____ to _____
(日DD /月MM /年YYYY)

1. b. 在上述住院期間，病人有否請假離院？Had the patient taken any home leave during the said hospitalization period?

☐ 否 No ☐ 有 Yes , 請列出日期、時間及原因
Please state the date, time and reason

2.a. 就是次病症或意外，病人首次向閣下求診的日期？Date on which the patient first consulted you for this illness or injury?

_____(日DD /月MM /年YYYY)

b. 病人 在首次求診時，有何病徵及病狀出現？What were the signs & symptoms the patient complained at the first consultation?

c. 意外日期或首次求診前已出現病徵及病狀之日期 Date of accident OR signs & symptoms first appeared before the first consultation?

從 Since _____ (日DD /月MM /年YYYY) 或 OR

已存在Existed for _____日day(s) _____月month(s) _____年year(s)

d. 若是次住院因意外引致，請提供意外經過及受傷部位。
If the hospitalization is due to accident, please provide the accident details and injured areas:

e. 若是次住院因疾病引致，是次病況是否為復發性疾病？If the hospitalization is due to illness, please state whether it is a recurrent condition?

☐ 否 No ☐ 是 Yes 首次出現日期 Date of FIRST occurrence

_____(日DD /月MM /年YYYY)

3.a. 閣下是否病人慣常求診的醫生？
Are you the patient's usual physician?

☐ 否 No ☐是 Yes 醫療紀錄自Medical records from

_____(日DD /月MM /年YYYY)

b. 病人是否經由其他醫生轉介予閣下？
Was the patient referred to you by another physician?

☐ 否 No
☐ 是 Yes ,

_____
轉介醫生名稱及地址 Name and address of referral Physician

c. 就此病症而言，病人之前有否就有關之病況向其他醫生求診？
For this episode, had the patient previously been seen by other physician(s) for these symptom(s)?

☐ 否 No
☐ 有 Yes， 在 on _____(日DD /月MM /年YYYY)

由 by _____
(醫生姓名及地址 Name and address of Physician)

d. 住院期間，閣下有否轉介病人予其他專科醫生 / 醫生接受治療？
Did you refer the patient to receive other Specialist's / Physician's treatment during hospitalization?

☐ 否 No
☐ 有 Yes，請提供專科醫生姓名及轉介原因Please provide name of the Specialist / Physician and the referral reason

4. a. 最後診斷 Final diagnosis

b. 引致上述最後診斷的病因
What is/ are the underlying cause(s) for final diagnosis?

c. 病人何時被告知該診斷？由哪位醫生告知？
When was the patient informed of the diagnosis? By whom?

d. 手術名稱、進行日期及有關外科醫生姓名
Surgery performed with dates and surgeon's name

e. 請總結有關治療及檢驗結果。
Summary of medical treatment given and tests performed with results.

f. 若此次病症之治療/檢查可於日間中心或門診內進行，請提供是次住院之原因。Please provide reason(s) for this hospitalization if this type of treatment/test can be managed on daycare or out-patient basis?

5. a. 癒後情況：The prognosis of the condition

☐ 良好 Good ☐ 一般 Fair ☐ 甚差 Poor

b. 有否復發的可能？Any possibility of having a relapse ?

☐ 否 No ☐ 有 Yes

6. 病人是次住院原因是否出於或與下列情況有關連？Was the confinement reason of the patient due to or associated with the following situations?

☐ 否 No
☐ 是 Yes，請在適當位置劃上剔號及提供詳情 please tick where appropriate and provide details

- ☐ 酗酒/濫用藥物 alcoholism/drug abuse
- ☐ 後天免疫力缺乏症 (愛滋病) 或與後天免疫力缺乏症有關之疾病 AIDS or AIDS related complex disease
- ☐ 性病或經由性接觸感染之疾病 venereal disease, sexually transmitted diseases
- ☐ 先天性症狀或由出生時導致之缺陷 congenital or birth defects
- ☐ 情緒，精神或神經病 emotional, mental, nervous disorders
- ☐ 懷孕 / 分娩 / 不育或絕育 pregnancy/childbirth/infertility, sterilization
- ☐ 參與危險性之運動/活動 engaging in hazardous sport/activity
- ☐ 美容或整形手術 cosmetic or plastic surgery
- ☐ 康復或療養 rehabilitation or convalescence
- ☐ 一般檢查 /監察 General Checkup / monitoring
- ☐ 其他，請說明：Others, please specify

7. a. 病人過往有否以下病史 / 習慣？ Did the patient have the following PAST medical history/ habit?

☐ 否 No

☐ 是，請在適當位置劃上剔號及提供詳情 Yes, please tick where appropriate and provide details

☐ 哮喘 asthma	☐ 心臟病 cardiac problem	☐ 糖尿病 diabetes mellitus
☐ 乙型肝炎 hepatitis B	☐ 高血壓 hypertension	☐ 濫用藥物 drug addiction
☐ 飲酒習慣 drinking habit	☐ 吸煙習慣 smoking habit	☐ 家族病史 unfavorable family history
☐ 曾接受手術 previous operation	☐ 其他，請說明詳情：others, please specify details:	

b. 請詳述首次診斷出上述病史之醫生姓名、地址 / 醫院名稱
By whom was the above PAST medical history first detected? Please provide the name and address of the Physician/Hospital.

c. 請提供上述病史之首次診斷日期及治療詳情
Please provide first diagnosis date and treatment details of the above PAST medical history

d. 上述病史之預後情況 Current prognosis of the above past medical history : ☐ 完全康復 Fully recovered ☐ 治療中 On treatment

因意外受傷入院請填寫此欄 PLEASE COMPLETE IF HOSPITALIZATION WAS DUE TO ACCIDENT

8. a. 現時受傷情況 Present condition of injury

b. 病人之職業及職責 Patient's occupation and exact nature of occupational duties

c. 以病人之職業而論，閣下認為此傷勢會否令病人完全不能工作？請列明原因
Bearing in mind the patient's occupation, in what way do you feel the injuries would /would not totally prevent the patient from working? Please specify.

本人 / 我們現聲明此申請書上所填寫之資料皆為本人 / 我們所知及所信之事實。
I/ We hereby declare that the information given on this form is true to the best of my/our knowledge and belief.

醫生姓名 Name of physician _____ 資歷 Qualification _____

醫院名稱 (如適用) Hospital name (if applicable) _____ 電話號碼 Phone no. _____

醫生簽署連同醫院/醫生蓋章 Signature & Hospital/Physician chop _____ 日期Date _____(日DD /月MM /年YYYY)