



EAGLE STAR

醫療索償表格
MEDICAL CLAIM FORM

爲使敝公司能迅速地處理貴保戶之賠償申請，請於就醫後 30 日內填妥此表格及連同有關單據一併交回。

In order to help us to process your claim promptly, please complete and return this form with original receipts / discharge not within 30 days after receiving treatment.

所有問題均須由受保人完全作答

保單號碼

ALL QUESTIONS MUST BE ANSWERED BY INSURED PERSON

Policy No. _____

1. 保戶姓名
Name of Insured _____
病人姓名
Name of Patient _____ 與保戶關係
Relationship with Insured _____
病人職業
Occupation of Duties of Patient: _____ 聯絡電話
Telephone No. _____

2. 住院詳情
Details of the hospitalization
(a) 醫院名稱
Name of Hospital : _____
(b) 入院日期
Date of Admission : _____
(c) 主診醫生姓名
Name of the attending doctor(s) : _____

3. 閣下是否正就此次住院申領其他賠償
Are you making any other insurance or compensation claim as a result of this hospitalization:
否 No 是 Yes 保單號碼 保險公司名稱
Policy No Name of insurance company

4. 若住院由疾病導致
IF HOSPITALIZATION WAS DUE TO ILLNESS:
(a) 病人之病徵
Describe the patient's symptoms _____
(b) 入院前多久此病徵才被發現
How long had the patient been having these
Symptoms before admission into hospital? _____
(c) 請詳述 日期 醫生姓名地址及電話
Give details of : Date Name(s), Address(es) and Telephone No.(s)
(i) 此症之首位主診醫生
the doctor first consulted
for this illness _____
(ii) 轉介往醫院之醫生
the doctors who referred
the patient to hospital _____
(iii) 診治病人之其他醫生
all other doctors consulted
during this illness _____
(iv) 過去五年內所有醫生
all other doctors consulted
during the past five years _____

EAGLE STAR INSURANCE COMPANY LIMITED
(INCORPORATED IN THE ENGLAND & WALES WITH LIMITED LIABILITY)
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5. 若住院由意外導致
IF HOSPITALIZATION WAS DUE TO ACCIDENT :
- (a) 意外何時發生
When did it happen?
日期 _____ 時間 _____
Date: _____ Time : _____
- (b) 請述意外經過
Describe how it happened

- (c) 請述受傷情況
Describe the injuries

- (d) 曾到何警署報案
Police station to which the accident was reported _____
- (e) 檔案編號
Police reference No. _____

6. 索償單 STATEMENT OF CLAIM			由保險公司填寫 OFFICE USE ONLY
類別 TYPE OF BENEFITS	每日 PER DAY (HK\$)	總額 TOTAL (HK\$)	ADJUSTED AMOUNT (HK\$)
房租 Room, Board & General Nursing			
醫院雜費 Hospital Special Services			
醫生巡房費 In-Hospital Doctor's Call			
住院專科醫生費附醫生介紹信 In-Hospital Specialist Consultation (Doctors referral attached)			
深切治療 Intensive Care			
手術費 Surgical Fee			
麻醉師費 Anaesthetist's Fee			
手術室費 Operating Theatre Fee			
出院後之覆診費 Post-Surgical Expenses			
其他 Others :			

聲明:

本人謹此聲明以上填寫一切均屬本人所知的事實。

本人現授權任何醫院、醫生、保險公司或機構提供有關本人所有疾病、受傷、病歷等資料、診治、配藥或治療紀錄于鷹星保險有限公司或其代理人，此授權書之影印本亦屬有效。

DECLARATION AND AUTHORIZATION

I declare that the answers given above are true to the best of my knowledge and belief.

I authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health to furnish Eagle Star Insurance Company Limited or its authorized representative with any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical record. A photostat copy of this authorization shall be considered as effective and valid as the original.

Signature of Insured 保戶簽署

Signature of Patient 病人簽署

Date 日期

由主診醫生填寫，有關費用由索償者支付

TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT'S OWN EXPENSE

Please complete in block letters

Name of Patient:	I.D. Card No.:
Date of Admission:	Date of Discharge:
Name of Hospital:	
(1) Diagnosis of Conditions:	
(2) a) The first date of consultation for this illness _____ b) the last date of consultation for this illness _____	
(3) According to the patient, how long had he/she been experiencing these symptoms?	
(4) Was the patient referred to you by another doctor? NO YES If yes, please give name(s) and address(es) or the doctor(s) _____ _____	
(5) a) Nature of medical treatment given _____ b) Type of operation performed _____ _____ _____ Date performed _____ Name of Surgeon _____	
(6) To the best of your knowledge, has the patient previously been treated or hospitalized for this or any other disorder? NO YES If yes, please give details. <u>Date</u> <u>Disease / Disorder</u> <u>Details of Treatment / Hospitalization</u> <u>Doctor's / Hospital's Name</u> _____ _____	
(7) Are conditions due to or associated with the following:- (i) Pregnancy? NO YES (ii) The influence of drugs or alcohol? (iii) AIDS, venereal disease, sexually transmitted disease? (iv) Infertility or sterilization? (v) Cosmetic or plastic surgery? (vi) Mental or nervous disorder? (vii) Congenital deformities or anomalies? (viii) Suicide, insanity or self-infliction?	
_____ Name of Attending Physician	_____ Signature of Attending Physician
_____ Qualification	_____ Date

CLAIM DOCUMENTATION

Please complete and return this Claim Form together with the following document (original copy), if appropriate, for our handling:

1. HOSPITALIZATION

- (i) Hospital statement showing
 - Itemized charges
 - Name of the patient
 - Period of confinement

- (ii) Receipt(s) of all attending doctors/specialists/anaesthetists/surgeons/physiotherapists showing
 - Name of the patient
 - Date of consultation
 - Diagnosis and/or treatment given
 - Amount charged

2. POST SURGERY OUT-PATIENT

- (i) Doctor's receipt showing
 - Name of the patient
 - Date of consultation
 - Diagnosis and/or treatment given
 - Amount charged

索償文件

請填妥本索償表並提交以下所需證明文件(正本)寄回本公司以便處理閣下之賠償事宜。

1. 住院索償：

- (i) 醫院賬單詳列
 - 各項費用
 - 病人姓名
 - 留院日期

- (ii) 所有主診醫生／專科醫生／麻醉師／外科醫生／物理治療師之賬單詳列
 - 病人姓名
 - 求診日期
 - 診斷證明及／或治療紀錄

2. 住院後之覆診費：

- (i) 醫生賬單詳列
 - 病人姓名
 - 求診日期
 - 診斷證明及／或治療紀錄
 - 費用

鷹星保險有限公司

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