

**Please read the following instructions before completing this claim form:-**

在填寫此賠償申請表前，請細閱下列各項說明：

- To avoid return of claim due to incomplete information, please answer all questions. 為免因資料不全而被退回索償申請，請回答所有問題。
- If you need us to return the original receipts after claim processing, please state your request on the top of this form together with your signature and attach one set of copied original receipts. Please note that those claims receipts will not be returned after 3 months from the submission date. 如你需要本公司於索償處理後退回收據正本，請於此申請上方列明並在旁簽署及附上一份需退回收據的副本一份。請注意，於索償文件遞交日起計三個月後，本公司概不退回收據或索償文件。
- If a surgical procedure or operation has been performed during the hospitalization, Part II must be completed by the surgeon. If no surgical procedure or operation is involved, Part II must be completed by the attending doctor. 如病者在住院期間曾施行外科手術，第二部份須由外科醫生填寫。如無需施行外科手術，第二部份需由應診醫生填寫。
- All receipts and bills from the doctor, surgeon and hospital must be the original, and must be submitted together with this claim form within 90 days of the date discharged from hospital. 請將所有應診醫生、外科醫生及醫院帳單及收據之正本，連同此表格在出院後九十天內交回本公司。

Name of Employer : \_\_\_\_\_ Policy No. : \_\_\_\_\_  
僱主名稱 保單號碼

**Part I - To be completed by the Insured Member 此部份由受保成員填寫**

(If the Insured Member is a child under 18 years of age, please fill in and sign this form by the Employee concerned.)  
若受保成員是僱員子女而少於十八歲，此表格須由僱員代為填寫及簽署

1a. Name of Employee : \_\_\_\_\_  
僱員姓名

b. I.D. Card No./Certificate No. : \_\_\_\_\_ Date of Employment : \_\_\_\_\_ MM DD YY  
身份證號碼或保險證號碼 受僱日期 月 日 年

c. Residential Address : \_\_\_\_\_  
住址

2a. Name of Patient (if other than Employee) : \_\_\_\_\_  
病者姓名 (若病者非僱員)

b. Relationship with Employee : \_\_\_\_\_  
病者與僱員關係

3a. Did the patient receive treatment for the same sickness by another doctor?  Yes  No  
病者曾否因同樣病症接受其他醫生之治療? 有 無

b. If yes, please give details.  
如曾接受其他醫生之治療，請提供該醫生的資料。

Date : \_\_\_\_\_ Name of the Doctor : \_\_\_\_\_  
日期 醫生姓名

Address of the Doctor : \_\_\_\_\_  
醫生地址

4. As a result of this hospitalization, will the Insured claim or receive any form of compensation from other insurance companies? If yes, please give details.  
就是次住院，閣下會否申請或接受其他同類型之保險賠償? 若有，請詳述。

No  Yes Name of Insurance Company : \_\_\_\_\_ Policy No. : \_\_\_\_\_  
無 有 保險公司名稱 保單號碼

**Declaration and Authorization 聲明及授權**

I declare that I am the insured member of the above mentioned policy and all the information supplied by me on this form is complete and true to the best of my knowledge and belief. I also declare that I have read and understood the Personal Information Collection Statement stated below. I authorize any medical attendant, hospital, clinic, insurance company or other organization, institution or person, who has any records or knowledge of me or my health to divulge to MassMutual Asia Ltd. any information required for the purpose of evaluating the claims application. A photocopy of this authorization shall be as valid as the original. I also confirm that the claims information regarding myself may be released to my Employer or related parties from MassMutual Asia Ltd. 現聲明本人乃上述保單之受保成員，就本人所知及所信以上所填報之資料均正確無訛。本人亦聲明已閱讀及明白下列個人資料收集聲明。本人茲授權持有本人健康或任何資料之註冊西醫、醫院、診所、保險公司、機構、協會或人仕，可以將有關資料提供予美國萬通保險亞洲有限公司，作為賠償申請之參考。此授權書之副本與正本有同等效力。本人亦同意美國萬通保險亞洲有限公司可向本人之僱主或相關人士提供有關本人之索償資料。

**Personal Information Collection Statement 個人資料收集聲明**

The information you provide to MassMutual Asia Limited or its Consultants (whether or not the information was supplied by you in this application or otherwise) is collected to enable the Insurer to carry on its insurance business and may be used for the purposes of: (1) evaluating and processing policy service requests, administering and reinsuring your insurance coverage with the Insurer; (2) adjudicating any insurance or related claims, or conducting any investigation or analysis of such claims; (3) promoting and providing any insurance or financial related product or service or any addition, alteration, variation, cancellation, renewal or reinstatement of such product or service; (4) exercising any right of subrogation; (5) calculating premiums or benefits; (6) data matching and direct marketing; (7) communicating with any person or organization relating to this and other insurance claims; (8) any other purpose relating to the settlement of your insurance coverage with the Insurer; and may be used, held, transferred or disclosed to (1) any related individual or company associated with the Insurer or any other company carrying on insurance or reinsurance related business or any intermediary or a claims or investigation or other service provider providing services relevant to insurance business or professional advisers for any of the above or related purposes; (2) any association, governmental authority of federation of insurance companies ("Authority") that exists or is formed from time to time for any of the above or related purposes or to enable the Authority to carry out its regulatory functions or such functions that may be assigned to the Authority from time to time and are reasonably required in the interest of the insurance industry or any members of the Authority; and (3) any selected party as we may consider necessary whether within or outside Hong Kong. You and all Relevant Persons have the right under the Personal Data (Privacy) Ordinance or the Law Relating to the Protection of Personal Data to have access to, and to correct any of your personal data held by the Insurer. Request whereof shall be made in writing and addressed to the Manager of the Employee Benefit, and delivered to the Insurer's head office at 4/F, MassMutual Tower, 38 Gloucester Road, Wanchai, Hong Kong; or Macau office at Avenida Praia Grande No. 517, Edificio Comercial Nam Tung 16-E2, Macau.

閣下提供的資料(不論是藉閣下於本申請中或透過其他途徑所提供)，為美國萬通保險亞洲有限公司或其顧問提供保險業務所需，並可能使用於下列目的：(1) 評審及處理保單服務要求，就閣下於本保險公司之保險保障提供行政及再保險服務；(2) 評核任何保險或相關索償，或就該等索償進行任何調查或分析；(3) 推銷及提供任何與保險或財務有關的產品或服務，或就該等產品或服務所作的任何增加、更改、變更、取消、續期或復效；(4) 行使任何代位權；(5) 計算保費或得益；(6) 資料核對及直接銷售；(7) 聯絡與此或其他保險索償有關的人士或機構；(8) 任何關於賠償閣下於本保險公司的保險保障的其他用途，及可能被使用、保存、轉移或披露予(1) 任何與本保險公司有聯繫的有關個人或公司，或任何其他從事與保險或再保險業務有關的公司，或與任何保險業務有關的中介人或索償或調查或其他服務提供者，或專業顧問以達到任何上述或有關目的；(2) 任何團體、政府機構或現存或不時成立之任何保險公司協會或同類組織(「該等機構」)以達到任何上述或有關目的，或以便該等機構執行其監管職能，或其他基於保險業或任何該等機構會員的利益而不時在合理要求下賦予該等機構的職能；及(3) 任何本保險公司認為有需要之有關人等(不論在香港或以外)。根據個人資料(私隱)條例或個人資料保護法，閣下及所有有關人士有權查閱和更正本保險公司持有閣下或有關人士的個人資料。閣下有有關人士可以書面方式呈交本保險公司位於香港灣仔告士打道38號美國萬通大廈4樓的總公司；或位於澳門南灣大馬路517號南通商業大廈16樓E2座的澳門分公司，向僱員福利部經理提出有關要求。

Signature of Insured Member/Employee: \_\_\_\_\_ Date : \_\_\_\_\_ MM DD YY  
受保成員/僱員簽署 日期 月 日 年

**PART II (overleaf) must be completed by the Insured Member's attending doctor. 第二部份(背頁)必須由診治受保成員之註冊西醫填寫。**

**MassMutual Asia Ltd. 美國萬通保險亞洲有限公司**

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Macau Branch Office-Avenida Praia Grande No. 517, Edificio Comercial Nam Tung 16-E2, Macau

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澳門分公司-澳門南灣大馬路517號南通商業大廈16樓E2座

Tel 電話: (852) 2919 9111 Fax 傳真: (852) 2919 9233  
Tel 電話: (853) 2832 2622 Fax 傳真: (853) 2832 2042

Name of Patient : \_\_\_\_\_ Age : \_\_\_\_\_ Admission date from : \_\_\_\_\_ to \_\_\_\_\_  
 病者姓名 年齡 住院日期由 至

**NOTE: No claim will be admitted unless the form below is duly completed by a registered medical practitioner. MassMutual Asia will not be responsible for any fee required for the completion of this report or any follow up cost thereafter.**  
 本部份必須由註冊之執業醫生填寫，否則該索償將不予受理。此外，本公司概不負責任何有關填寫此表格之費用。

<p>1a. Please give chief complaint for this hospitalization. 請提供主要陳訴病情。</p> <p>_____</p> <p>b. Please provide the diagnosis for this hospitalization. 請提供是次住院診斷。</p> <p>_____</p> <p>c. Describe the type of treatment/surgical procedure given to the patient. 闡述各項治療 / 外科手術。</p> <p>_____</p>	<p>c. Was the condition a recurrent episode or a chronic disease? If YES, when was the date of first attack? 此病症是否屬再次復發或慢性疾病？如是，請提供首次病發之日期。</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, it was a 這是 _____</p> <p>The date of first attack was on _____ 初次病發日期為 _____</p>																											
<p>2. When were the symptoms first presented before the first consultation or when did the accident happen? 症狀首次於何時出現？如屬意外，何時發生？</p> <p>_____</p> <p style="text-align: center;">MM 月      DD 日      YY 年</p>	<p>7. Was the condition caused by or in any way associated with the conditions mentioned below? 此病症是否由以下情況引致或有關連？</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:80%;"></th> <th style="width:5%; text-align: center;">Yes</th> <th style="width:15%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>a. the influence of drugs or alcohol intake? 毒癮、酗酒</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. AIDS, venereal disease or sexually transmitted disease? 後天免疫力缺乏症、性病</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. infertility or sterilization? 不育或節育</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. cosmetic or plastic surgery? 美容或整形手術</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. mental or nervous disorder? 精神病或神經錯亂</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>f. congenital deformities or anomalies? 先天性畸形或異常</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>g. suicide, insanity or self-infliction? 自殺、自殘身體</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>h. correction of eye sight? 視力矯正</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	a. the influence of drugs or alcohol intake? 毒癮、酗酒	<input type="checkbox"/>	<input type="checkbox"/>	b. AIDS, venereal disease or sexually transmitted disease? 後天免疫力缺乏症、性病	<input type="checkbox"/>	<input type="checkbox"/>	c. infertility or sterilization? 不育或節育	<input type="checkbox"/>	<input type="checkbox"/>	d. cosmetic or plastic surgery? 美容或整形手術	<input type="checkbox"/>	<input type="checkbox"/>	e. mental or nervous disorder? 精神病或神經錯亂	<input type="checkbox"/>	<input type="checkbox"/>	f. congenital deformities or anomalies? 先天性畸形或異常	<input type="checkbox"/>	<input type="checkbox"/>	g. suicide, insanity or self-infliction? 自殺、自殘身體	<input type="checkbox"/>	<input type="checkbox"/>	h. correction of eye sight? 視力矯正	<input type="checkbox"/>	<input type="checkbox"/>
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<p>3a. When was the first consultation for this treatment/sickness? 首次接受診治日期：</p> <p>_____</p> <p style="text-align: center;">MM 月      DD 日      YY 年</p> <p>b. Has the patient received continuous treatment related to this sickness since then? 病者是否因相同或相關的疾病繼續接受治療？</p> <p>_____</p>	<p>8. If the treatment is due to pregnancy, please give the date of conception. 如治療與妊娠有關，請提供受孕日期？</p> <p>_____</p> <p style="text-align: center;">MM      DD      YY 月      日      年</p>																											
<p>4. If hospitalization was due to accident, please state how occurred. Did the patient report to police? 如該住院由意外導致，請詳述意外發生之過程。病者曾否向警方報案？</p> <p>_____</p>	<p>9a. Is the hospitalization/treatment medically necessary? 此次住院/治療是否在醫療上是必須的？</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, please give details 請詳述 _____</p>																											
<p>5a. Was the patient referred to you by another doctor? If YES, please give name and address of the doctor(s). 病者是否經其他醫生轉介？如是，請提供醫生姓名及地址。</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是</p> <p>_____</p> <p>b. Do you know whether this patient has been treated by other doctor(s) for the same diseases/disorders? If YES, please give name/address of the doctor(s). 病者曾否因相同或相關的疾病經其他醫生診治？如是，請提供醫生姓名及地址。</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是</p> <p>_____</p>	<p>b. For the average patient, what is the usual duration of hospitalization for this sickness? 一般患上此病的病人需要住院多久？</p> <p>_____</p> <p>c. Is it possible to provide this treatment/investigation(s) on an outpatient basis? 此治療 / 檢查可否於門診進行？</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, please give details 請詳述 _____</p>																											
<p>6a. How long have you known this patient? How do you know this patient? 閣下於何時及怎樣認識病者？</p> <p>_____</p> <p>b. Have you treated the above patient for this or a related sickness before? 病者曾否因相同或相關的疾病接受閣下治療？</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, please give details 請詳述 _____</p> <p>_____</p>	<p>10. Did any complications arise during hospitalization? 病者曾否於住院期間發生併發症？</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, please give details 請詳述 _____</p>																											
<p>_____</p>	<p>11. Did the patient have home leave during hospitalization? 病者曾否於住院期間外出返家？</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, please give date(s) 請提供日期 _____</p> <p>_____</p>																											

**This report is a matter of importance to the Insured, please complete and return it without delay. Thank you very much.**

此報告對辦理賠償程序非常重要，請盡快填妥並寄回本公司以便辦理賠償手續。多謝合作。

Signature  
醫生簽署

Name and Qualifications of Surgeon/Attending Doctor : \_\_\_\_\_  
主診醫生姓名及專業資格：

Date : \_\_\_\_\_  
日期 月 日 年