

住院索償表格

Hospitalization Claim Form

Please complete and return this form with the supporting documents (see "Claims Document Checklist" on page 2) to **Metropolitan Life Insurance Company of Hong Kong Limited at Level 20, Cityplaza 3, 14 Taikoo Wan Road, Taikoo Shing, Hong Kong**

請填妥本索償表格，連同其他所需文件(見第二頁之「索償文件參考表」)，寄回**香港太古城太古灣道14號太古城中心3期20樓，美商大都會人壽保險香港有限公司**。

PART I 第一部份 (To be completed by Insured / Claimant 由受保人或索償人填寫)

A. INSURED INFORMATION 受保人資料

Policy No 保單編號	Name of Insured 受保人姓名	ID Card No 身份證號碼	Age 年歲	Tel No 聯絡電話
			Sex 性別	
Correspondence Address 通訊地址				<input type="checkbox"/> New Claim 首次索償
				<input type="checkbox"/> Further Claim 再度索償
Present Occupation 現職	Name & Address of employer 僱主名稱及地址			<input type="checkbox"/> Reply Document 回覆文件
				<input type="checkbox"/> Review / Appeal 重審/覆核

B. DETAILS OF HOSPITALIZATION 住院詳情

Hospitalization Period 住院日期 From 由 MM/DD/YY 月/日/年 To 至 MM/DD/YY 月/日/年	Are you making any other insurance claim regarding this hospitalization 有否向其他保險公司就是次住院提出索償 <input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有, Please provide 請提供 name of insurance company 保險公司名稱 policy number(s) 保單號碼
Name of Hospital 醫院名稱	

Consultation details 就診詳情	Consultation Date (MM/DD/YY) 就診日期 (月/日/年)	Name and address of doctor / hospital 醫生/醫院名稱及地址
(a) The doctor / hospital first consulted for this illness / injury 首次就診此傷病之醫生/醫院資料	_____	_____
(b) The doctor / hospital which referred the Insured to hospital 建議入院之醫生/醫院資料	_____	_____
(c) Other doctor / hospital seen for this illness / injury 其他曾診治此傷病之醫生/醫院資料	_____	_____
(d) Usual doctor / hospital for general illnesses 慣常求診一般疾病的醫生/醫院資料	_____	_____

HOSPITALIZATION DUE TO ILLNESS 因病患住院	HOSPITALIZATION DUE TO ACCIDENT 因意外受傷住院
1. Describe the symptoms 詳述病徵	1. Date, time and place of accident 意外日期、時間及地點 MM/DD/YY 月/日/年 <input type="checkbox"/> AM 上午 <input type="checkbox"/> PM 下午 Place 地點
2. When did the symptoms first appear 上述徵狀何時首次出現 MM/DD/YY 月/日/年	2. How did the accident happen 意外發生經過
3. Was the condition a recurrent episode or a chronic disease 上述之情況是否舊病復發或慢性疾病 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, Date of first attack 首次發病日期 MM/DD/YY 月/日/年 Disease details 病況資料	3. Part of body injured and type of injury 受傷部位及傷勢
	4. Was the accident reported to the Police 有否就是次意外報警 <input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有, Please provide name of police station and reference number 請提供報案警署名稱及報案號碼 Please provide copy of police report / statement 請提供警察報告/口供紙

CLAIMS DOCUMENT CHECKLIST 索償文件參考表

(To facilitate our assessment of your claims, please complete and provide the following basic documents to us.)

(以便本公司盡快審核閣下的索償個案，請完成及提交以下之基本所需文件。)

Basic Document Required 基本所需文件	Claimed Benefit 索償保障	
	Hospital Cash / Surgical Cash / Intensive Care Unit Benefit 住院現金 / 外科手術現金 / 深切治療部保障	Hospital Expense Reimbursement 住院費用索償
Fully completed Hospitalization Claim Form Part I 住院索償表格第一部份	✓	✓
Fully completed Hospitalization Claim Form Part II 住院索償表格第二部份	✓	✓
Original Hospital Receipts 住院收據正本		✓
Hospital Receipt Copies 住院收據副本	✓	
Policyowner's ID Copy 保單持有人身份証副本	✓	✓
Compensation Breakdown from Other Insurer 其他保險公司之賠償細則表		✓ (if applicable 如適用)
Police Report / Police Statement 警察報告/口供紙	✓ (if applicable 如適用)	✓ (if applicable 如適用)

Note: (i) Supplementary documents / information may be further required from you or other related parties for claims assessment.

(ii) Company reserves the right to request for original documents if the company deemed necessary.

注意: (i) 本公司或需於稍後向閣下/其他有關人士索取額外文件/資料以作理賠審核之用。

(ii) 如有需要，本公司保留權利要求閣下提交文件正本。

REQUEST FOR RETURN OF ORIGINAL DOCUMENTS 退回正本文件

If you want to get back the original documents submitted, please put a tick beside the corresponding box(es) below:

如閣下欲退回已呈交之正本文件，請於下列有關文件欄內劃上“✓”號：

- Original receipts 醫療費用收據正本
- Compensation Breakdown from Other Insurer 其他保險公司之賠償細則表
- Others (please specify) 其他(請註明) _____

DECLARATION AND AUTHORIZATION 聲明及授權

I hereby declare that the above information given on this claim application form is true and complete to the best of my knowledge.

I understand and agree that any personal data collected or held by Metropolitan Life Insurance Company of Hong Kong Limited ("the Company") (whether contained in this claim form or otherwise) may be (i) used or stored, (ii) disclosed or transferred (whether within or outside Hong Kong) by the Company to its affiliated companies, reinsurance and claims investigation company, industry association / federation, any members of the federation or any individuals / organizations associated with the Company or any third party to (i) process the claim; (ii) provide all services related to this claim or to promote other financial products and services, direct marketing, and data matching, and to communicate with me for such purposes; or (iii) enable the federation to carry out its regulatory functions or such other functions that may be assigned to the federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the federation. Moreover, the Company is hereby authorized to obtain access to and / or to verify any of my data with the information collected by the federation from the insurance industry.

I understand that I have the right to obtain access to and to request correction of any personal information held by the Company or be given reasons for any refusal of access. I also understand that a reasonable fee may be charged by the Company for process of any access.

I hereby irrevocably authorize any employer, doctor, hospital, clinic, insurance company, government office or any organization, or persons who have any records, knowledge or information (whether medical or otherwise) of me to disclose, release or transfer to the Company or its representative such information pertinent to this claim. The authorization shall bind my successors and assignees and remain valid notwithstanding my death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as original.

本人就此聲明在索償表格上所提供的資料均屬本人所知的事實。

本人明白及同意美商大都會人壽保險香港有限公司(貴公司)，可以(i)使用或儲存，(ii)透露或轉移(論在本港或海外)，任何貴公司所收集或持有之任何本人的個人資料(不論是否此索償表格所載或從其他途徑所取得)給貴公司之任何關聯公司，再保公司及理賠調查公司，行業協會/聯會，聯會之成員及與貴公司有關之人士或機構，以(i)辦理此索償；(ii)提供所有有關此索償之服務及推廣其他財務產品及服務，直接促銷及資料核對等用途，及因此等用途而與本人聯絡；或(iii)執行聯會的監察功能；或執行本署保險業或任何聯會會員利益而予予聯會的其他功能。此外，貴公司獲授權向聯會查閱及/或核實該會已搜集本人之資料。

本人明白本人有權自貴公司查閱及申請更改所有貴公司持有之有關本人的任何資料，或獲得任何被拒絕查閱的理由。貴公司有權酌情收取任何查閱資料的行政費用。

本人授權任何僱主、醫生、醫院、診所、保險公司、政府部門或其他機構及人士，如具有本人的任何紀錄、知識或資料，可將該等資料向貴公司代表透露，發放或移交，用以作為該份索償申請的參考。此授權書對本人的繼承人均有約束力，即使在本人死亡或喪失行為能力後仍然有效。此授權書的影印本具有與正本同等的效力。

Signature of Claimant 索償人簽署

Signature of Insured 受保人簽署

Claimant Name & ID Card No 索償人姓名及身份證號碼

#Insured Name & ID Card no 受保人姓名及身份證號碼

Date (MM/DD/YY) 日期(月/日/年)

#Date (MM/DD/YY) 日期(月/日/年)

Relationship with insured 與受保人關係

not required if insured is the claimant 如受保人同為索償人，此欄無須簽署或填寫

ENQUIRIES 查詢

For enquiries, please call our Customer Services Hotline on 2199 1000 during office hours, from Monday to Friday, 9:00am to 5:30pm and Saturday 9:00am to 1:00pm (except public holidays)

如有任何查詢，請於辦公時間內，星期一至星期五，上午九時至下午五時半，及星期六上午九時至下午一時(公眾假期除外)，致電客戶服務熱線 2199 1000。

MetLife Limited 大都會人壽保險有限公司

Metropolitan Life Insurance Company of Hong Kong Limited 美商大都會人壽保險香港有限公司

Level 20, Cityplaza 3, 14 Taikoo Wan Road, Taikoo Shing, Hong Kong 香港太古城太古灣道14號太古城中心3期20樓

MLHK-CLM-HP-CF-032008

住院索償表格 - 主診醫生報告

Hospital Claim Form – Attending Physician Statement

PART II 第二部份 (To be completed by attending physician at the Claimant's expense 由主診醫生填寫，費用由索償人支付)

Policy No. 保單號碼	Name of Patient 病人姓名	ID Card No. 身份證號碼	Age & Sex 年齡及性別																		
1. (a) Hospitalization Period 住院日期 From 由 MM/DD/YY 月/日/年 To 至 MM/DD/YY 月/日/年 (b) Period in Intensive Care Unit* 入住深切治療部日期* From 由 MM/DD/YY 月/日/年 To 至 MM/DD/YY 月/日/年 (c) Period of Home Leave during hospitalization* 住院期間請假外出日期* From 由 MM/DD/YY 月/日/年 To 至 MM/DD/YY 月/日/年		7. Was the symptom a secondary condition to some other illness / injury 是次病徵是否由其他疾病/傷患引起 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please give details 是, 請提供詳情 <table border="1"> <tr> <th>Illness/ Injury 疾病/傷患</th> <th>Symptom Onset 首次出現徵狀日期 (MM/DD/YY 月/日/年)</th> <th>First Consultation 首次求診日期 (MM/DD/YY 月/日/年)</th> <th>Name & Address of Doctor / Hospital 醫生/醫院名稱及地址</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		Illness/ Injury 疾病/傷患	Symptom Onset 首次出現徵狀日期 (MM/DD/YY 月/日/年)	First Consultation 首次求診日期 (MM/DD/YY 月/日/年)	Name & Address of Doctor / Hospital 醫生/醫院名稱及地址														
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2. (a) Chief complaints of the patient relating to this hospitalization / surgery 此次住院/手術之主要原因 (b) Were the complaints caused by an accident 此原因是否由意外導致 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide details how and where the accident happened 是, 請提供意外發生經過及地點 (c) Date of accident or symptoms first appeared 意外日期或首次出現病徵日期 MM/DD/YY 月/日/年		8. (a) Is the patient referred by another doctor 有否經其他醫生轉介 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please give details 是, 請提供詳情 <table border="1"> <tr> <th>Treatment Dates 診治日期 (MM/DD/YY 月/日/年)</th> <th>Name & Address of Doctor / Hospital 醫生/醫院名稱及地址</th> </tr> <tr> <td> </td> <td> </td> </tr> </table> (b) Has the patient ever had the same or similar conditions or symptoms relating thereto 病人以往曾否患有同類情況或徵狀 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please give details 有, 請提供詳情 <table border="1"> <tr> <th>Treatment Dates 診治日期 (MM/DD/YY 月/日/年)</th> <th>Name & Address of Doctor / Hospital 醫生/醫院名稱及地址</th> </tr> <tr> <td> </td> <td> </td> </tr> </table>		Treatment Dates 診治日期 (MM/DD/YY 月/日/年)	Name & Address of Doctor / Hospital 醫生/醫院名稱及地址			Treatment Dates 診治日期 (MM/DD/YY 月/日/年)	Name & Address of Doctor / Hospital 醫生/醫院名稱及地址												
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3. (a) Diagnosis of conditions 診斷	(b) Underlying cause 病因																				
4. (a) Surgical Procedure 手術 <u>Name of Surgical Procedure 手術名稱</u> <u>Date of Surgical Procedure 手術日期</u> MM/DD/YY 月/日/年 (b) Brief discharge summary (including treatments, investigation procedures, results; any complications and follow up plan) 出院摘要(包括治療、診查、結果、併發症及跟進計劃)		9. Was the conditions* caused by or contributed to by the following 診斷是否因下列*導致或促成 <table border="0"> <tr> <td>(a) congenital anomalies / infertility / sterilization 先天異常 / 不育 / 絕育</td> <td><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</td> </tr> <tr> <td>(b) under influence of alcohol / drugs / intoxicants / narcotics / sedatives / substance abuse 受酒精 / 藥物 / 酒精飲料 / 麻醉劑 / 鎮靜劑 / 物品濫用所影響</td> <td><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</td> </tr> <tr> <td>(c) intentionally self-inflicted injury / attempted suicide 蓄意自我傷害 / 企圖自殺</td> <td><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</td> </tr> <tr> <td>(d) mental illness / psychiatric / psychological disorder 精神病 / 精神 / 心理失常</td> <td><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</td> </tr> <tr> <td>(e) pregnancy / childbirth / miscarriage / abortion / complication 懷孕 / 分娩 / 流產 / 墮胎 / 其併發症</td> <td><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</td> </tr> <tr> <td>(f) rest cures / sanatorium / convalescence / rehabilitation 靜養療法 / 療養 / 康復或復康</td> <td><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</td> </tr> <tr> <td>(g) cosmetic / plastic / elective surgery 整容 / 整形 / 任何選擇性外科手術</td> <td><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</td> </tr> <tr> <td>(h) AIDS / HIV-related illness 愛滋病 / 免疫力衰減症有關之疾病</td> <td><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</td> </tr> <tr> <td>(i) dental treatment or surgery 牙齒治療或手術 natural teeth involved 天生牙齒(不包括假牙)</td> <td><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</td> </tr> </table>		(a) congenital anomalies / infertility / sterilization 先天異常 / 不育 / 絕育	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	(b) under influence of alcohol / drugs / intoxicants / narcotics / sedatives / substance abuse 受酒精 / 藥物 / 酒精飲料 / 麻醉劑 / 鎮靜劑 / 物品濫用所影響	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	(c) intentionally self-inflicted injury / attempted suicide 蓄意自我傷害 / 企圖自殺	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	(d) mental illness / psychiatric / psychological disorder 精神病 / 精神 / 心理失常	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	(e) pregnancy / childbirth / miscarriage / abortion / complication 懷孕 / 分娩 / 流產 / 墮胎 / 其併發症	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	(f) rest cures / sanatorium / convalescence / rehabilitation 靜養療法 / 療養 / 康復或復康	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	(g) cosmetic / plastic / elective surgery 整容 / 整形 / 任何選擇性外科手術	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	(h) AIDS / HIV-related illness 愛滋病 / 免疫力衰減症有關之疾病	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	(i) dental treatment or surgery 牙齒治療或手術 natural teeth involved 天生牙齒(不包括假牙)	<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
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I hereby certify that I have personally examined and treated the patient in connection to the above hospitalization and that the answers given above are all true to the best of my knowledge and belief. 本人謹此聲明曾為病人就上述住院期作出檢查及治療，而據本人所知所信，以上填報各項答案均屬正確。

Name of Physician 醫生姓名 _____ Signature 簽署 _____ Hospital Stamp 醫院蓋章 _____
 Qualification 資格 _____ Date 日期 _____
 Address 地址 _____ Tel No 電話 _____

*: Please delete as appropriate 請刪除(如不適用)

Note: In case of inconsistency between the Chinese and English version, the English version shall prevail 如中文版本的内容與英文版本有任何差異，均以英文版本為準