QBE Hongkong & Shanghai Insurance Limited - Macau Branch
Rua do Comandante Mata e Oliveira, No. 32, Edf. Associação Industrial de Macau, 8 andar B & C, Macau
Tel: +853 2832 3909 Email: claims.mac@qbe.com

昆士蘭聯保保險有限公司 – 澳門分公司
澳門馬統領街32號廠商會大廈8樓B、C座
電話：+853 2832 3909 電郵：claims.mac@qbe.com
www.qbe.com/mo

FirstCare Claim Form 摯關懷索償申請表

A. NOTES 注意事項

1. Please send this form together with original receipt(s) and any relevant document(s) to the company within 60 days starting from the first day of treatment.
   請將本索償申請表連同收據正本及任何有關文件於開始接受治療起計的六十天內送交本司。
2. This claim form must be fully completed.If any further information is required, the patient may be asked to provide a more detailed statement to the company. In that event, the patient shall furnish a further statement.
   索償申請表必須全部填寫，若需要額外資料，本司或會要求病人提供更詳細之陳述，在此情況下，病人須提供有關陳述。
3. The issue of this claim form is not an admission of liability by the company.
   發出此索償申請表並不代表本司承認任何責任。
4. If there is insufficient space or further comment on any area is considered necessary, please use additional pages.
   若填報資料的位置不足，請填寫於附加紙上。

B. CLAIMANT'S CERTIFICATE 索償人證書 (To be completed by the patient 此欄須由病人填寫)

Policy No. 保單號碼：	Name of the insured 保戶姓名：	
Name of the insured person 受保人姓名：		Telephone No. 電話號碼：
Name of patient 病人姓名：		I.D.card / Passport No. 身份證 / 護照號碼：
Date of birth 出生日期：	Gender ☐ Male 男 性別： ☐ Female 女	Occupation 職業：
Relationship with the insured ☐ Self 本人 ☐ Spouse 配偶 與保戶關係： ☐ Child 子女		

Have you had any treatment for this or related or similar conditions? ☐ Yes 是 ☐ No 否
閣下是否曾經因同一或相關或類似的病情而接受治療？
If "Yes", please give details. 如「是」，請提供資料。

Doctor's name
醫生姓名：

Date(s)
日期：

Address
地址：

Do you need the original hospital receipt to you submit this case to any other insurance company(s)? ☐ Yes 是 ☐ No 否
閣下是否需要本公司退回正本醫療收據以向其他保險公司作出賠償申請？

If "Yes", "please provide the name of the insurance company(s) & policy number(s); otherwise we will not return the required documents to you.
如「是」，請提供該保險公司的名稱及保單號碼。否則，本公司將不會發還有關文件。

Name of insurance company
保險公司名稱：

Policy No.
保單號碼：

Was the hospitalization / surgery a result of an accident? ☐ Yes 是 ☐ No 否
此次住院 / 手術是否由於意外引致？
If "Yes", please give details. 如「是」，請提供資料。

Date(s)
日期：

Time
時間：

am / pm
上午 / 下午

Place
地點：

Brief description
扼要描述：

Who is your usual doctor?
閣下慣常求診的醫生。

Doctor's name
醫生姓名：

Address
地址：

C. DECLARATION & AUTHORIZATION 聲明及授權

1. I/We hereby declare that all of the above information given is true, correct and complete.
   本人/我們謹此聲明上述所有資料均屬真實、正確及完整。
2. I/We understand that QBE Hongkong & Shanghai Insurance Limited – Macau Branch reserves the right to seek medical information from my/our medical practitioner(s) and I agree to supply any further information at my own expense.
   本人/吾等明白昆士蘭聯保保險有限公司-澳門分公司保留向我/我們的醫生索取醫療資料的權利，本人同意以本人的費用提供任何進一步資料。
3. I/We authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health to furnish to QBE Hongkong & Shanghai Insurance Limited – Macau Branch or its authorized representative any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photostat copy of this authorization shall be considered as effective and valid as the original.
   本人/吾等現授權任何醫院、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，醫療或醫院紀錄予昆士蘭聯保保險有限公司-澳門分公司或其代理人。此授權書之影印本亦屬有效。

I.D.card / Passport no.
身份證 / 護照號碼：

Signature of the patient
病人簽署：

Date
日期：

D. ATTENDING PHYSICIAN'S STATEMENT 主診醫生證明書

(To be completed by the patient's attending physician / surgeon at the patient's own expense 此欄須由病人之主診醫生 / 外科醫生填寫，所需費用由病人自行承擔)

Name of patient
病人姓名：

Hospitalization 住院：	Name of hospital 醫院名稱：	
	Date of admission 入院日期：	Date of discharge 出院日期：
	Home leave ❑ Yes 是 ❑ No 否 離院記錄： If "Yes", please give details. 如「有」，請提供資料。 from to 由： 至： Reason of home leave 離院原因：	
Surgical procedure 手術：	Name of the procedure 手術名稱：	Date of operation 手術日期：
	Nature 性質：	

Chief complaints of the patient relating to this hospitalization / surgery
此次住院 / 手術的主要病因：

Diagnosis of conditions
病情診斷：

Underlying cause(s) of the diagnosis
得出此診斷結果之主因：

Brief discharge summary (including treatments, investigation procedures, results, and / or any complications and follow up plan)
出院撮要（包括治療、檢查、結果及 / 或任何併發症及跟進計劃）：

Date of the accident occurred or symptom first appeared 意外發生日期或首次出現病癥日期：	Date of first consultation for this condition or related or similar illness 病人首次就同一或相關或類似的病情求診日期：

To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? ❑ Yes 是 ❑ No 否
據閣下所知，病人以前是否曾患有或出現相同或類似病情或病癥？

If "Yes", please give details. 如「有」，請提供資料。
Please state dates and describe
請說明日期及當時情況：

Was the patient referred by another doctor? ❑ Yes 是 ❑ No 否
病人是否經其他醫生轉介？

If "Yes", please give details. 如「有」，請提供資料。

Name and address of the referral doctor
轉介醫生的姓名和地址：

Was the patient's injury / illness for this hospitalization due to or associated with any of the following? ❑ Yes 是 ❑ No 否
病人是次受傷 / 患病而住院是否由以下情況所致或有關？

If "Yes", please tick(✓)where appropriate:
如「是」，請在適當空格填上「✓」號：

- ❑ Pregnancy 懷孕
- ❑ Sterilization 絕育
- ❑ Infertility 不育
- ❑ Drug addiction / Alcoholism 濫用藥物 / 酗酒
- ❑ Cosmetic / Plastic surgery 美容 / 整容手術
- ❑ General check-up 例行身體檢查
- ❑ Vaccination / Immunization 疫苗注射 / 接種疫苗
- ❑ Congenital deformities / anomalies 先天性異常 / 畸形
- ❑ Refractive errors of eyes 眼睛折射
- ❑ Suicide / Attempted suicide / Self inflicted injury 自殺 / 企圖自殺 / 自殘身體
- ❑ HIV / AIDS 愛滋病病毒 / 愛滋病
- ❑ Psychiatric condition 精神病

Name of attending physician / specialist
主診 / 專科醫生姓名：

Qualification(s)
資歷：

Address 地址：	Signature of attending physician / specialist 主診 / 專科醫生簽署：
Tel no. 電話： Date 日期：	

Personal Information Collection Statement 個人資料收集聲明

In relation to the personal data collected by QBE Hongkong & Shanghai Insurance Limited – Macau Branch ("QBE Macau"), I/we agree and acknowledge that:

(a) the personal data requested is necessary for QBE Macau to process your application for insurance or claim and any such data not provided may mean this application or claim cannot be processed.

(b) the personal data collected in this form may be used by QBE Macau for the purposes stated in its Privacy Policy found at https://www.qbe.com/mo/en/privacy-policy. These include underwriting and administering the insurance policy being applied for (including obtaining reinsurance, underwriting renewals, claim processing, investigation, payment and subrogation and any related purposes).

(c) QBE Macau may transfer the personal data to the following classes of persons (whether based in Macau or overseas) for the purposes identified in (b) above:
   i. third parties providing services related to the administration of my/our policy (including reinsurance);
   ii. financial institutions for the purpose of processing this application and obtaining policy payments;
   iii. in the event of a claim, loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers;
   iv. another member of the QBE group (for all of the purposes stated in (b)) in any country; or
   v. other parties referred to in QBE's Privacy Policy for the purposes stated therein.

(d) I/we may gain access to, or request correction of my/our personal data (in both cases, subject to a reasonable fee), via email or post at:
   QBE Hongkong & Shanghai Insurance Limited – Macau Branch
   Address: Rua do Comandante Mata e Oliveira, No. 32, Edif. Associacao Industrial de Macau, 8 andar B & C, Macau
   Email: info.mac@qbe.com
   Telephone: +853 2832 3909

(e) That where I/we are providing personal data on behalf of another person to QBE Macau, I/we have obtained consent from the other person who have agreed that their personal data will be released to QBE Macau in accordance with paragraphs (a), (b) and (c) above.

(f) That in the event of differences between the English and Chinese, the English version shall prevail.

關於昆士蘭聯保保險有限公司 – 澳門分公司("澳門昆士蘭保險")收集之個人資料,本人 / 我等同意並承認:

(a) 索取之個人資料對於澳門昆士蘭保險處理本人 / 我等之保險或索償申請乃屬於必需。若未提供此類資料,可能導致無法處理此項申請或索償。

(b) 澳門昆士蘭保險可以將此表格所收集的個人資料用於其網頁 https://www.qbe.com/mo/zh-mo/privacy-policy。所載私隱政策當中表明之目的,其中包括承保和管理理本人 / 我等正在申請之保險(包括獲得再保險、承保續期、理賠、調查、付款、代位索償以及各種相關目的)。

(c) 澳門昆士蘭保險可為以上(b)項指明之目的,將個人資料轉移至以下(不論位於澳門或海外)之各類人士:
   i. 提供與本人 / 我等的保險(包括再保險)之管理有關的服務的第三方;
   ii. 金融機構 — 為處理此項申請並獲得保單付款之目的;
   iii. 當發生索償時,損失理算師、評估師、第三方管理人員、緊急服務提供者、法律服務提供者、零售商、醫療服務提供者和旅行社;
   iv. 昆士蘭保險集團不論位於任何國家或地區的另一成員(為以上(b)項所述各種目的而提供該個人資料);
   v. 昆士蘭保險私隱政策提及的其他人士—為著私隱政策所指的各種目的。

(d) 本人 / 我等可以透過以下電郵或郵遞方式查閱或要求更正自己的個人資料(在這兩種情況下均需支付一筆合理費用):
   昆士蘭聯保保險有限公司 – 澳門分公司
   地址:澳門馬統領街32號廠商會大廈8樓B及C座
   電郵:info.mac@qbe.com
   電話:+853 2832 3909

(e) 若本人 / 我等乃代表另一人士向澳門昆士蘭保險提供個人資料,本人 / 我等已徵得該人士同意根據以上 (a)、(b)、(c) 款將其個人資料披露予澳門昆士蘭保險。

(f) 若本文件之中、英文版之間意義有分歧,應以英文版本為準。