

QBE Hongkong & Shanghai Insurance Limited - Macau Branch

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昆士蘭聯保保險有限公司 - 澳門分公司

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電話: +853 2832 3909

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www.qbe.com/mo**HospitalSurance Claim Form 住院萬全保索償申請表****A. NOTES 注意事項**

- In the event that you or your family members are hospitalised while insured under the HospitalSurance plan, simply fill out this Claim Form and return it to the company within 60 days from the commencement of such confinement. To ensure fast payment of your claim, check that you have filled out and signed all sections, and that you have attached all the original necessary supporting documents.
當閣下或受保之家人在本保險承保範圍內，因意外或疾病而導致住院，祇需填妥此索償書，寄回本司。
索償書連同有關所有證明文件之正本必須在入院日期後60天內呈交給本公司。
祇要閣下清楚填寫及簽署下列各項，並附上所有有關證明文件之正本，閣下的索償申請將會儘速處理。
- 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。
- 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。
- 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. INSURED INFORMATION 投保資料

Policy No. 保單編號:	Claim No. 索償編號: (For office use only 供本公司填寫之用)
1. Name of Insured 投保人姓名: (English, please 請以英文正楷填寫)	
2. Usual Address 住址: (English, please 請以英文正楷填寫)	
	Res. or Office Tel. No. 住宅或辦公室電話:
3. Address for correspondence regarding this claim (if different from above) 通訊地址 (若與上述地址不同): (English, please 請以英文正楷填寫)	
	Tel. No. 電話:

C. PATIENT INFORMATION 病人資料

1. Full Name of Insured Patient 受保病人姓名:	
If the patient is not the insured, copy of documentary evidence such as marriage certificate, birth certificate etc. showing the relationship with the insured should be submitted together with this form. 如病人並非投保人，請隨本申請書附上有關證明文件，如結婚證書、出生證明書等，以茲證明病人與投保人之關係。	
2. Date of Birth 出生日期: Day 日 / Month 月 / Year 年	3. Occupation 職業:

D. CLAIM INFORMATION 索償申請資料

1. Describe Injury or Sickness 請述傷勢及病況:	
2. If Injury, please detail the circumstances of the accident 如因意外受傷住院，請將意外發生的詳細情形寫出:	
3. Has the patient ever seen a doctor for this or any similar condition in the past? 病人從前有否因同樣或類似情況而就醫? If YES, please give dates and names and addresses of doctors and/or hospitals 如有，請填寫診症醫生及/或醫院的名稱及地址:	
4. Period of Hospital Confinement for which claim is made 住院期間: Date of Admission 入院日期: Day 日 / Month 月 / Year 年 Date of Discharge or expected duration of hospitalisation 離院日期或預料住院期間: Day 日 / Month 月 / Year 年	
Time 時間:	

5. Name of Hospital 醫院名稱： Address 地址： Country (if outside Hong Kong) 國家 (如在香港以外地區)：			
6. If patient to whom this claim relates is or was hospitalised outside Hong Kong, please give the following additional information 如申請此項索償之病人入住香港以外地區之醫院，請填寫下列資料：			
a. Patient's usual address 病人在港住址：			
b. Purpose of the overseas trip 前往外地之目的：			
c. Intended itinerary or destination 預定之行程或目的地：			
d. Intended duration of the overseas trip:		From 計劃在外地停留期間：	to 至
		Day 日 / Month 月 / Year 年	Day 日 / Month 月 / Year 年
7. Patient's Usual Doctor Name 病人慣常就醫之醫生名稱： Address 地址： Patient Card No. 掛號咭號碼：			
		Tel. No. 電話：	
8. If the Insured Person to whom this claim relates is or was at any time during hospitalisation confined to an intensive care unit, please advise the following information 如申請此項索償之病人入住醫院之深切治療部，請填寫下列資料：			
Period in Intensive Care Unit: 入住深切治療部期間：		From 由	to 至
		Day 日 / Month 月 / Year 年	Day 日 / Month 月 / Year 年
9. Any concurrent claim about this hospitalisation with other insurance companies?			
有否就此住院同時向其他保險公司提出索償？		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	
If Yes, please state the name of the company and the policy number 如有，請列明其公司名稱及保單編號：			

E. DECLARATION AND AUTHORIZATION 聲明及授權書	
1. I declare that the above information is true and complete to the best of my knowledge and belief; 本人茲聲明上述資料正確無訛及為事實之全部；	
2. I hereby authorize on behalf of myself and my dependents, any physician, hospital, clinic, or other organization to disclose to QBE Hongkong & Shanghai Insurance Limited – Macau Branch or its representative any and all information concerning the disability resulting in the above hospital confinement. A photostatic copy of this authorization shall be as effective and valid as the original. 本人現授權診症醫生、醫院、診所或其他機構將有關上述住院的資料送交昆士蘭聯保保險有限公司 – 澳門分公司或其代表，以便進行申請索償。遞交此索償申請書之影印本同樣有效；	
3. I hereby request and authorize QBE Hongkong & Shanghai Insurance Limited – Macau Branch to pay benefit due in respect of this claim by cheque to the Insured. 本人現申請及授權昆士蘭聯保保險有限公司 – 澳門分公司將此項索償款項以支票形式支付予投保人。	
Signature of the Insured 投保人簽署：	Date. 日期：
Signature of the Patient 病人簽署：	Date. 日期：
NOTE: If the insured is claiming on his own behalf or the patient concerned is a child under 18 years of age, only the insured's signature is required. 註：如投保人為自己或十八歲以下子女申請賠償，祇需簽署投保人一欄。	

F. ATTENDING PHYSICIAN'S STATEMENT 主診醫生報告

This section must be completed by the attending physician at the claimant's own expenses
注意：此項必須由主診醫生填寫，所需費用由索償人自行承擔

Patient Name (in full)

病人姓名：

Name of Hospital

醫院名稱：

Date of Admission

入院日期：

Day 日 / Month 月 / Year 年

1. Preliminary information of this patient

病人的初步資料：

(a) Clinical diagnosis

臨床診斷：

(b) Treatment Plan

治療計劃：

(i) any therapeutic medication/treatment?

是否需要接受藥物或其他治療？

☐ Yes 是

☐ No 否

(ii) any operation?

是否需要接受手術？

☐ Yes 是

☐ No 否

If yes, specify name

倘若需要，請提供手術名稱：

(c) Date on which the patient first consulted you for this medical condition(s)/injury

病人因該傷病首次向你求診的日期：

(d) Symptoms and complaints for this hospitalization/treatment

此次住院/手術的症狀及主要病因：

(e) According to the medical history given by the patient, how long had he/she been experiencing these symptoms before the above first consultation?

根據病人提供的病歷記錄，病人在首次求診前已經歷了該病徵有多久？

2. Additional information of this patient

病人的詳細資料：

(a) Final Diagnosis

最後的診斷：

(b) Date and Name of Operation(s) performed

手術的名稱及日期：

(c) Underlying cause of this medical condition for the hospitalization

此次入院症狀的基本原因：

(d) Has the patient been treated by other doctor(s) for similar or related illness in the past?

病人曾否因類似或有關症狀接受其他醫生的治療？

☐ Yes 是

☐ No 否

If yes, please specify treatment date and name and address of the doctor(s)

倘若病人曾接受其他醫生的治療，請提供該醫生的姓名及地址及治療日期：

(e) If the patient was referred to you by another doctor, please provide the referring doctor's name and address.

如果該病人是由其他醫生轉介，請提供該醫生的姓名及地址：

(f) If you have consulted other specialist during this hospitalization, please provide the following

倘若於住院期間你曾因上述傷病諮詢其他專科醫生，請提供以下資料：

Consulted Specialist's Name

該專科醫生的姓名：

Reason

原因：

(g) Brief medical summary to show treatments, investigations, result and/or any complications (**histo-pathologic report to be attached**)

請扼要地列舉病人於住院期間曾接受的治療、檢查、有關的結果及曾出現的併發症 (**連同病理報告副本**)：

(h) Was the condition due to or associated with the following (please circle the right answer)?

上述的傷病是否由於下列病症所引致 (請選擇有關病症)？

Sexually transmitted disease, pregnancy, infertility, sterilization, refractive error or correction of eyesight, cosmetic surgery, mental illness, emotional disorder, congenital condition or none of the above.

性病、懷孕、不育、絕育、視力不正常、美容手術、精神病、情緒失調、先天缺陷或其他。

I hereby certify that all information given above is accurate and true to the best of my knowledge.

本人現聲明上述所填報資料是據我所知及正確無訛。

Name of attending doctor (in full and in block letter)

主診醫生的姓名：

Address & Telephone No.

地址及電話號碼：

Signature of attending doctor with Practice/Hospital Stamp

主診醫生的簽名及其或醫院的印章：

Date

日期：

Day 日 / Month 月 / Year 年

When making a Hospital Insurance claim, return this Claim Form and original supporting documents to the company

申請「住院萬全保」賠償時，請將此份索償書填妥，連同有關證明文件之正本寄回本公司。

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。