請掃二條碼登入客戶專頁，隨時提交索償申請及查閱進度。
https://cs.chinalife.com.hk

中國人壽 CHINA LIFE 海外

住院賠償申請表 HOSPITALIZATION CLAIM FORM

保單持有人姓名 Name of Policyholder	受保人姓名 Name of Insured	保單編號 Policy No.

受保人身份證/ 護照號碼 I.D. / Passport No. of Insured

特別指示 Special instruction （請勾選 Please select）

☐ 是次索償先於上述個人保單處理，餘額再於本公司的團體保單 (保單號碼_____) 索償。This claim will be processed under above Individual policy first, the balance will be claimed under our Company Group policy.

☐ 是次索償先於本公司的團體保單 (保單號碼 _____) 處理，餘額再於上述個人保單索償。 This claim will be processed under our Company Group policy first, the balance will be claimed under above Individual policy.

保險中介資料 INSURANCE INTERMEDIARY INFORMATION

保險中介名稱 Name of Insurance Intermediary

保險中介編號 Insurance Intermediary Code

聯絡電話 Contact No.

重要須知 IMPORTANT NOTE

- 請以正楷填寫本申請表。任何資料如有更改，受保人/保單持有人/索償人必須在更改的位置簽署作實。Please complete this form in BLOCK LETTERS. All amendments should be endorsed by the Insured / Policyholder / Claimant in full signature.
- 本申請表中所用之「本公司」或「貴公司」之表述指中國人壽保險(海外)股份有限公司。The expressions “the Company” or “our Company” used in this form refers to China Life Insurance (Overseas) Company Limited.
- 本申請表第一部分必須由受保人/保單持有人/索償人填寫，並需於出院後三十天內連同有關之單據及出院證明書之正本呈交本公司。Part I of this form must be completed by Insured/Policyholder/Claimant and returned to the Company within 30 days from date of discharge with original receipts and discharge note.
- 如受保人為十八歲或以上，受保人及保單持有人必須親自填寫及簽署本申請表，如受保人為十八歲以下，本申請表應由保單持有人及受保人之家長或合法監護人填寫及簽署。如受保人/保單持有人因傷殘不能書寫，其直系親屬可代為填寫本申請表及簽字，並提供關係證明及醫生證明。If the insured is at or above age 18, the Insured and policyholder must complete and sign this form by his or her good self. If the insured is under age 18, this form should be completed and signed by policyholder and the insured's parent/ legal guardian. In the event that the Insured/ policyholder is physically incapacitated and prevented from signing, this form may be completed and signed by an immediate family member with relevant relationship proof and physician's statement provided.
- 若受保人/保單持有人/索償人以圖章蓋印簽署，必須由一位見證人予以見證。見證人之個人資料只會用於處理本索償申請及核實和確認本申請表簽署人的身份之用。If the Insured/Policyholder/Claimant uses a signature stamp, it must be witnessed by a witness. The personal particulars of the witness will only be used for the purpose of processing this claim and verifying and confirming the identity of the signatory of this form.
- 受保人/保單持有人/索償人之簽署必須與本公司之紀錄相同。The signature of the Insured / Policyholder / Claimant must be the same as the Company’s record.
- 保險中介人或銀行營業員收到本申請表並不代表本公司已收到。Receipt of this form by your Insurance Intermediary or bank officer does not constitute receipt by the Company.
- 如有任何查詢，請與 閣下的保險中介人聯絡或致電本公司客戶服務熱線(853) 2859 5519 查詢。填妥的表格及所需文件請寄往澳門新口岸宋玉生廣場 263 號中土大廈 22 樓 A、B、K-P 座。If you have any queries, please feel free to contact your insurance intermediary or our Customer Service Hotline at (853) 2859 5519 for details. Completed form(s) and required document(s) should be sent to China Life Insurance (Overseas) Co. Ltd., Alameda Dr. Carlos D’ Assumpção No. 263, 22 Andar A, B, K-P, Edif. China Civil Plaza, Macau.
- 本公司有權隨時更新此申請表，並接受或拒絕未符合本公司要求的申請表。請登入本公司網站 www.chinalife.com.mo 瀏覽及下載最新版本。The Company has the right to update this form from time to time and to accept or to reject the form if the Company's requirements are not fulfilled. Please visit our website www.chinalife.com.mo to view and download the latest version of the form.
- 如中英文版本有任何抵觸或不符之處，概以中文本為準。If there is any discrepancy or inconsistency between the English version and the Chinese version of this form, the Chinese version shall prevail.

保單編號 Policy No.										

第一部份 – 索償資料 (由受保人/保單持有人/索償人填寫)
PART I – PARTICULARS OF CLAIM (To be completed by Insured/Policyholder/Claimant)

A. 受保人資料 PARTICULARS OF INSURED

1 受保人年齡及性別 Age and Sex of Insured_____ 聯絡電話 Contact Phone No. _____

B. 一般資料 GENERAL INFORMATION

1 **索償保障類別 Benefit(s) to claim** ☐ 住院醫療 Hospital Benefit ☐ 住院入息 Hospital Income

2 **索償申請類別 Type of claim** ☐ 首次索償 New Claim ☐ 再度索償 Further Claim ☐ 待決賠案 Pending Claim ☐ 重批/覆核 Review / Appeal

3 **閣下有否因同一事故曾/將會向其他保險公司索償？如是，請提供該保險公司名稱及保單號碼。Did/Will you make a claim against any other insurance company for the same incident? If yes, please indicate the name of insurance company and policy no..** ☐ 是 Yes ☐ 否 No

保險公司名稱 Name of Insurance Company

保單號碼 Policy No.

4 **是否申請退回收據的核實副本 Request return of certified true copy receipt(s)** ☐ 是 Yes ☐ 否 No

5 **受保人現職職位及職責(若多於一種職業,請列明所有職位及職責) Position and duties of Insured's present occupation (if more than one, please state all)**

6 **受保人公司或僱主名稱及地址 Name and address of Insured's business or employer**

C. 因意外住院 FOR HOSPITALIZATION DUE TO ACCIDENT

1 **意外發生日期及時間 Date and time of the accident**

年 Year	月 Month	日 Day	時 Hour	分 Minute	上午/下午 AM/PM

2 **意外發生地點及經過 Location and details of the accident**

3 **請詳述意外受傷部位及受傷情況 Please describe the part(s) of body injured and the extent of injury in details**

4 **閣下有否報警？如有，請提供右面所需的資料 Did you report to the police? If yes, please provide information on the right**

☐ 是 Yes ☐ 否 No

警署地點 Police Station

檔案編號 Case Reference No.

註：請附上警察報告/交通意外報告/口供紙/酒精測試報告影印本。
Remarks: Please attach a photocopy of the Police Report / Traffic Accident Report / Police Statement / Alcohol Test Report.

D. 因疾病住院 FOR HOSPITALIZATION DUE TO ILLNESS

1 **請描述病徵 / 病狀 Please describe the symptoms**

2 **首次就診前該等病徵/症狀已存在多久？How long has the Insured been experiencing these symptoms prior to first consultation?**

保單編號 Policy No.										

E. 治療詳情 TREATMENT DETAILS

1 初診醫生/醫院的資料 The physician/hospital first consulted for this injury or illness.

年 Year | 月 Month | 日 Day | 醫生/醫院名稱 Name of physician/hospital

醫生/醫院地址 Address of physician/hospital

2 建議入院的醫生資料 / 其他曾診治此病或過往同類病況的醫生資料 The doctor who referred the insured to hospital / other doctors seen for this or similar past condition

年 Year | 月 Month | 日 Day | 醫生/醫院名稱 Name of physician/hospital

醫生/醫院地址 Address of physician/hospital

3 入院日期 Date of admission | **出院日期 Date of discharge**

年 Year | 月 Month | 日 Day | 年 Year | 月 Month | 日 Day

4 受保人有否於住院期間請假外出？如有，請列明外出及返回之日期及時間。 Has the Insured taken any home leave during the hospital confinement? If yes, please state the starting and ending date and time. ☐ 有 Yes ☐ 沒有 No

	年 Year	月 Month	日 Day	時 Hour	分 Minute	上午/下午 AM/PM
外出日期及時間 Starting date and time						
返回日期及時間 Ending Date and Time						

5 若就診之註冊醫生/醫療服務提供者與受保人/保單持有人/索償人/保險中介人有任何關係，請列明之。Is there any relationship between the Registered Medical Practitioner / Medical Services Provider and the Insured /Policyholder /Claimant / Insurance Intermediary? If so, please state the relationship.

F. 領款方式(請選擇一種理賠支付方式) PAYMENT METHOD (Please select only one of the settlement options)

1 自動入賬申請 Direct Credit Application

☐ **已登記的「付款銀行賬戶」Registered Payment Bank Account**

此服務只適用於本公司指定的澳門開立銀行賬戶，並於本公司已完成及成功辦理登記的指定銀行賬戶。The service is only applicable to a bank account set up in Macau designated bank by the company and the bank account which registration is completed successfully in the company.

☐ **指定銀行帳戶 Designated bank Account**

請提供賬戶證明文件，如印有賬戶持有人姓名/名稱及賬戶號碼的銀行卡/月結單/存摺。Please provide bank account document(s), such as bank card/monthly statement/ passbook with account holder name and account no.

至保單持有人/索償人於本公司指定的澳門開立銀行賬戶 To a bank account set up in Macau designated bank by the company held by the Policyholder/Claimant.

銀行名稱 Name of Bank | 銀行編號 Bank No. | 分行編號 Branch No. | 銀行賬戶號碼 Account No.

賬戶持有人姓名(中文) (必須為保單持有人/索償人)
Name of bank account holder (Chinese) (Policyholder/Claimant Only)

賬戶持有人姓名(英文) (必須為保單持有人/索償人)
Name of bank account holder (English) (Policyholder/Claimant Only)

本人/我們現申請以上理賠匯款方式領取金額，並同意銀行於匯款中扣除相關手續費 (如有)
I/We agree to apply the captioned Claims Remittance Service and bank charge would be deducted from the payment amount. (If applicable)

實際到賬時間會因應個別銀行而有差異，申請前請先向有關銀行查詢。The actual time to receive the payment may vary among banks. Please enquire to the bank before application.

倘未有足夠資料顯示銀行賬戶持有人為保單持有人/索償人或因故未能成功自動入賬，有關款項將以劃線支票形式發出。If there is insufficient information to identify the ownership of bank account belongs to Policyholder/Claimant or direct credit is failed for any reason, the payment will be issued by cheque.

保單編號 Policy No.										

F. 領款方式(請選擇一種理賠支付方式) (續) PAYMENT METHOD (Please select only one of the settlement options) (Continued)

2 本地銀行劃線支票 MACAU LOCAL CROSSED CHEQUE

賠款貨幣選擇 Preferred Settlement Currency

☐ 保單貨幣 Policy Currency ☐ 港元 (按中國人壽保險(海外)股份有限公司每月之固定兌換率計算)
Hong Kong Dollar (at monthly fixed rate of China Life Insurance (Overseas) Company)

☐ 親自到客戶服務中心提取 Collect Cheque at Customer Service Centre in person
(請保單持有人/索償人帶同身份證明文件親臨本公司的澳門客戶服務中心收取支票。) (The Policyholder/Claimant should collect the cheque at our Macau Customer Service Centre by presenting the identity document.)

☐ 授權第三者(代領人)領取 Pick up cheque in person by authorized person

代領人姓名 Name of authorized person	代領人聯絡電話 Contact no. of authorized person	代領人身份證明文件號碼 I.D. no. of authorized person

☐ 郵寄至保單登記的通訊地址 Mail to correspondence address registered in our Company

☐ 經保險中介轉遞 Deliver via Insurance Intermediary

☐ 經銀行營業員轉送 (請指定銀行分行及經辦人員) Deliver by bank officer (Please state the branch and bank officer)

銀行分行 Branch _____ 經辦人員 Bank Officer _____

3 其他領款方式 OTHER PAYMENT METHODS

☐ 抵付保費 (僅適用於同一保單持有人名下生效之保單，請指定保單號碼。) Offset the premium (only applicable to inforce policy under same Policyholder, please specify the policy no..)
保單號碼 Policy No.

4 其他方式 Other Methods

☐ 其他(請列明) Others (Please specify) _____

G. 索償所需文件清單 CLAIM DOCUMENT CHECKLIST

- ✓ 基本文件 Basic Documents；● 附加文件 Additional Documents；× 不適用 Not Applicable

索償所需文件(文件的核實副本可於本公司的客戶服務中心辦理) Claim Document (Documents can be certified at our Company's Customer Service Centre)	住院醫療 Hospital Benefit	住院入息 Hospital Income
☐ 由閣下填妥並簽署之本申請表第一部分 Part I of this form completed and signed by your good self	✓	✓
☐ 由主診醫生填寫並且簽署及蓋印之本申請表第二部份 Part II of this form completed and signed by attending physician with chop	✓	✓
☐ 載有明確診斷之出院紙/病假紙/醫生證明書(適用於香港醫院管理局轄下醫院之住院) Discharge slip/sick leave certificate/medical certificate with clear exact diagnosis (applicable to hospitalization in hospitals of the Hospital Authority of Hong Kong)	✓	✓
☐ 出院小結(適用於中國境內之住院) Discharge summary (applicable to hospitalization in Mainland China)	✓	✓
☐ 住院醫療收據正本及其帳單明細表 Original hospital receipt and statement of account	✓	✓ (只需副本) (Copy required only)
☐ 受保人身份證明文件之核實副本 The certified true copy of identity document of the Insured	✓	✓
☐ 投保人之身分證文件之核實副本 (受保人非投保人) The certified true copy of identity document of Policyholder (Insured is not Policyholder).	✓	✓
☐ 住院期間之診斷測試報告 (如：病理報告、驗血報告、正電子掃描/電腦掃描/磁力共振報告、心電圖報告、超聲波報告及 X 光報告等)Diagnosis report and test report during hospitalization (such as pathological report, blood test report, PET Scan/CT Scan/MRI report, ECG report, ultrasound report and X-ray report etc.)	●	●
☐ 其他保險公司或機構之賠償明細表 Settlement advice from other insurer/ party	●	×

保單編號 Policy No.										

H. 個人資料收集聲明 PERSONAL INFORMATION COLLECTION STATEMENT

本人/我們確認已閱讀及明白「中國人壽保險（海外）股份有限公司」的收集個人資料聲明。有關最新版本的收集個人資料聲明，可於 https://www.chinalife.com.mo/zh-hant/personal-information-collection-statement 下載或向中國人壽保險（海外）股份有限公司索取。

I/We confirm that I/we have read and understood the Personal Information Collection Statement ("PICS") of China Life Insurance (Overseas) Company Limited. For the latest version of the PICS, it can be downloaded from https://www.chinalife.com.mo/zh-hant/personal-information-collection-statement or is made available upon request.

I. 電子票據索償聲明 DECLARATION FOR ELECTRONIC RECEIPT

☐ 本人/我們，受保人/保單持有人/索償人謹此確認是次遞交之電子票據為唯一收據，相關診所醫院並沒有就是次求診收據曾經或重覆發出書面正本收據。I/We, the Insured/Policyholder/Claimant, confirm that the electronic receipt(s) submitted for this claim application is/ are the sole receipt(s). The clinic / hospital of this visit has not ever or repeatedly issued the original paper receipt(s) for the same visit. 本人/我們，受保人/保單持有人/索償人亦聲明及保證除貴公司外，就該住院或有關求診將獲賠付部份，並沒有向其他保險公司或機構進行重覆索償。I/We, the Insured/Policyholder/Claimant, declared and guarantee that apart from our company, I/we have not filed/ will not file the duplicate claims against other insurance companies or institutions concerning the amount to be claimed in your company for the said electronic receipt(s). 本人/我們，受保人/保單持有人/索償人承諾如上述聲明不正確，本人願意退還貴公司就該住院或有關求診之全部賠償，並承擔有關之一切法律責任。I/We, the Insured/Policyholder/Claimant, undertake that if the above statement is incorrect, I/we are willing to refund the full claim payment for the said receipt(s) to our company and bear all related legal liabilities.

J. 聲明及授權 DECLARATION AND AUTHORIZATION

授權 Authorization

本人/我們，受保人/保單持有人/索償人，代表本人/我們及尚未成年之受保人(如有)謹此授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、政府部門，或其他機構、組織或人士，凡知道或具有任何有關本人/我們/尚未成年之受保人之紀錄、認識或資料者，均可將該等資料提供、發放及轉交給中國人壽保險（海外）股份有限公司（以下簡稱「貴公司」）；(2) 貴公司或任何其指定之醫療/輔助醫療檢查員或化驗所，可就本索償申請替本人/我們/尚未成年之受保人進行所需之醫療評估及測試，作為審核本人/我們/尚未成年之受保人之健康狀況。此授權對本人/我們之繼承人及授讓人具有約束力；即使本人/我們死亡或無行為能力時，此授權書仍具效力。此授權書的影印本與正本均有同等效力。I/We, the Insured/Policyholder/Claimant, represent me/ us/ the Insured under 18 years old (if any) HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, government department, or other organization, institution or person, that is aware of or has any records, knowledge or information of me/us/the insured under 18 years old to disclose, release and transfer such information to the Company; (2) the Company or any of its appointed medical / para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ ourselves/ the insured under 18 years old in relation to this claim. This authorization shall bind the successors and assignees of me/us and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

聲明 Declaration

本人/我們，受保人/保單持有人/索償人，謹此聲明及同意(1)上述一切陳述及問題的所有答案，不論是否本人/我們親手所寫，就本人/我們所知所信，均為事實之全部並確實無訛；本人/我們明白倘未知任何一項是否重要，本人/我們均須將其事實在本申請表上說明；(2)本人/我們對任何人所作出之任何聲明，除在本申請表上填寫或印出及經 貴公司發表和批准外，貴公司不須受其約束。若相關人士不能提供任何本申請表所需的資料，貴公司可能因此不能審核及處理本索償申請。

I/We, the Insured/Policyholder/Claimant HEREBY DECLARE and AGREE that (1) all the foregoing statements and answers to all questions whether or not written by my/our own hand are to the best of my/our knowledge and belief complete and true; I/We also understand that in the event of doubt as to whether a fact is material, it should be disclosed here. (2) The Company is not bound by any statement which I/we may have made to any person unless it is written or printed here and is presented and approved by the Company. If any relevant persons fail to provide any information requested in this claim form, it may result in the Company's inability to process and deal with this claim.

K. 簽署(請勿在空白表格上簽署) SIGNATURE (Please DO NOT sign on BLANK form)

	受保人(年齡 18 歲或以上) Insured(whose age is 18 or above)			保單持有人 / 索償人* Policyholder / Claimant*			見證人 Witness		
簽署 Signature									
姓名 Name									
身份證/護照號碼 I.D. Card / Passport No.									
日期 Date	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day	年 Year	月 Month	日 Day
*索償人與受保人/保單持有人關係 *Relationship with Insured/Policyholder									

保單編號 Policy No.											

第二部份 – 主診醫生報告書 (由主診醫生填寫，所有費用由受保人/保單持有人/索償人自行承擔)
PART II – ATTENDING PHYSICIAN'S STATEMENT To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)

A. 病人資料 PARTICULARS OF PATIENT

病人姓名 Name of patient		病人年齡/性別 Age/sex of patient	/	病人身份證/護照號碼 I.D / Passport No. of patient	

B. 診治資料 CONSULTATION DETAILS

		年 Year	月 Month	日 Day
1	病人之醫療記錄可追溯至 We can trace the medical record of patient back to		/	/
2	首次出現病徵日期或意外發生日期 Date of the accident occurred or symptoms first appeared		/	/
3	病人首次有關此病症之求診日期 Date of first consultation for this condition or related illness		/	/

4 請詳細說明首次會診時之徵狀和病症 Please describe the symptoms and complaints at first consultation.

5 病人是否由其他醫生轉介？如是，請提供該醫生之姓名及地址 Is the patient referred by other physician? If yes, please give the name and address of the referring doctor. ☐ 是 Yes ☐ 否 No

轉介醫生姓名 Name of the referring doctor | 轉介醫生地址 Address of the referring doctor

6 診斷 Diagnosis | 國際疾病分類編碼 ICD 10 Code

C. 住院資料 HOSPITALIZATION DETAILS

1 醫院名稱 Name of hospital

	年 Year	月 Month	日 Day
入院日期 Date of admission		/	/
出院日期 Date of discharge		/	/
入住及離開深切治療部 Period in Intensive Care Unit			

2 手術資料 Surgical Procedure Details — 手術日期 Date of surgery: / /

手術名稱 Name of the Surgical Procedure | 醫療服務術語編碼 CPT Code

3 住院期間之治療、檢查及其結果、有否任何併發症及出院後之覆診或跟進計劃 Treatments, investigation procedures, results, and/or any complications during hospitalization and post-hospitalization follow up plan.

4 病人有否於住院期間請假外出？如有，請列明外出及返回之日期及時間。 Has the Insured taken an home leave during the hospital confinement? If yes, please state the starting and ending date and time. ☐ 有 Yes ☐ 沒有 No

	年 Year	月 Month	日 Day	時 Hour	分 Minute	上午/下午 AM/PM
外出日期及時間 Starting date and time						
返回日期及時間 Ending Date and Time						

保單編號 Policy No.										

D. 閣下之專業意見 PROFESSIONAL COMMENT

1 **是次檢查，治療及住院日數(如有) 是否與上述診斷有直接關係而且是醫療所需及由醫生建議?**
Were the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to the current diagnosis, and were medically necessary and recommended by you?

☐ 是 Yes ☐ 否 No

如否，請詳述. If No, please provide details (如: 是否由病人要求住院? E.g. Was the hospitalization requested by patient?)

2 **該檢查及手術可否在門診 / 日間手術中心進行? Can the medical test(s) and the operation procedure be done on an outpatient basis / at day surgery centre?**

☐ 是 Yes ☐ 否 No

如否，請註明臨床風險、須留院的醫院原因及詳述現時健康狀況 (合併症): If No, please indicate the clinical risk(s) , medical reason(s) for hospitalization and current Health Status (Co-morbidity) :

3 **手術是否必須在全身麻醉下進行? The surgery could only be performed under general anesthesia?**

☐ 是 Yes ☐ 否 No

如手術在監察下麻醉進行，請註明住院原因 For surgery under Monitored Anesthesia Care, please specify the reason for hospital stay.

4 **是次檢查，治療及住院是否緊急個案? Is it a case of emergency?**

☐ 是 Yes ☐ 否 No

如是，請詳述並提供原因 Please provide details:

5 **是次病症或受傷是否(1)復發個案，或(2)任何慢性疾病/ 嚴重疾病之併發症，或(3)與過往其他病況有關？如是，請提供有關診治日期及治療詳情。Is the condition (1) a recurrent episode or (2) a complication of any chronic illness/ major disease or (3) related to any previous conditions? If yes, please provide date of diagnosis and treatments details.**

☐ 是 Yes ☐ 否 No 診治日期 Date of diagnosis/treatments 年 Year _____ 月 Month _____ 日 Day _____

詳情(包括診斷/治療/檢查及結果) Details (including diagnosis/ treatments/ investigations and results)

6 **是項疾病之根本主因 What is the underlying cause of such illness?**

7 **病情預測及復發之可能 The prognosis of the condition and any possibility of having a relapse?**

8 **請選出與是項疾病有關之狀況。Is the illness associated with the following?**

☐ 先天性疾病 Congenital condition
☐ 自殘 Self-inflicted injury
☐ 不育或絕育 Infertility or sterilization
☐ 精神紊亂 Mental disorder
☐ 濫藥或酗酒 Abuse of drugs or alcohol
☐ 性病 Venereal disease
☐ 視力矯正 Corrective aids or treatment of refractive errors
☐ 康復/療養 Rehabilitation/ convalescence
☐ 整容或整形治療 Cosmetic or plastic surgery
☐ 發育異常 Develop-mental abnormality
☐ 參與危險性運動/活動 Hazardous sport / activity
☐ 遺傳性疾病 Hereditary condition
☐ 一般身體檢查/防疫注射 Body check vaccination & immunization injections
☐ 愛滋病或人體免疫缺損病毒感染 AIDS or HIV related illness
☐ 懷孕，請說明預產期 Pregnancy, please provide expected date of delivery
☐ 其他疾病，請說明 Other disease, please specify
☐ 以上皆否 None of the above

保單編號 Policy No.										

E. 其他醫療病史 OTHER MEDICAL HISTORY

1 請選出病人過往有否以下病症/習慣。Does the patient have any medical history or habit as indicated below?

☐ 哮喘 Asthma ☐ 心臟病 Cardiac problem ☐ 糖尿病 Diabetes Mellitus

☐ 乙型肝炎 Hepatitis B ☐ 高血壓 Hypertension ☐ 曾接受手術 Previous operation

☐ 濫藥 Drug abuse ☐ 家族性癌症 Family history of cancer ☐ 家族病史 Unfavorable family history

☐ 以上皆沒有 None ☐ 其他疾病，請說明 Other disease, please specify _____

2 該病人曾否因患上述疾病或其他嚴重疾病接受醫生或醫院治療 ？ 如有，請說明詳情。Had the patient previously been treated or hospitalized due to the above disease or other major disease? If so, please specify details.

☐ 有 Yes ☐ 沒有 No 診治日期 Date of diagnosis/treatments 年 Year _____ 月 Month _____ 日 Day _____

疾病 Disease

治療/住院詳情 Details of Treatment / Hospitalization

醫生姓名/醫院名稱 Name of Physician/Hospital

3 請提供飲酒/吸煙習慣詳情 Please provide details of drinking & smoking habit

每日用量 (支/包/樽/罐) Daily consumption (piece/ pack/ bottle/ can)

習慣始自 Drinking/ Smoking start date since 年 Year _____ 月 Month _____ 日 Day _____

F. 主診醫生資料 PARTICULARS OF ATTENDING PHYSICIAN

主診醫生姓名 Name of Attending physician		**資歷 Qualification**			
地址 Address		**聯絡電話 Contact No.**			
主診醫生簽署/醫院蓋章 Signature & Stamp of Attending Physician/ Hospital		**日期 Date**	年 Year	月 Month	日 Day