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

關愛一生及康健保醫療保險計劃 - 可賠償金額估算申請表
ICARE MEDICAL INSURANCE PLAN / HEALTH GUARD HOSPITAL CARE BENEFIT PLAN - APPLICATION FORM FOR CLAIMABLE AMOUNT ESTIMATE

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

保險中介人資料 INSURANCE INTERMEDIARY INFORMATION

保險中介人姓名 Name of Insurance Intermediary

保險中介人編號 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/主診醫生必須在更改的位置簽署作實。Please complete this form in BLOCK LETTERS. All amendments should be countersigned by the Insured / Policyholder / Claimant/Attending Physician 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.
- 請受保人/保單持有人/索償人填妥此表格第一部份，及主診醫生填妥第二部份，並於入院/手術前**最少 7 個工作天**，以傳真(853) 2878 7287 或電郵 pos_mo@chinalife.com.hk 方式遞交至業務管理部。Please complete Part 1 on the following form by the Insured / Policyholder / Claimant and Part 2 by the Attending Physician and send to Claims Department by fax (853) 2878 7287 or email to pos_mo@chinalife.com.hk **at least 7 working days** prior to admission to hospital/surgery.
- 請注意該可賠償金額估算結果僅供參考，並不構成本公司最終賠償責任。賠償將根據所有其後遞交的必要理賠證明文件，並按保單條款及細則和保單年度內的保障限額作決定。最終的賠償金額及自付費用會根據醫院或診所發出的正式收據中所列明的實際帳目和分項收費計算。Please note that the claimable amount estimate is just for reference and will not constitute our final liability. Claim decision will depend on the submission of all supporting documents as required for claim assessment in accordance with the policy terms and conditions and benefit entitlement in the Policy Year. The final claimable amounts and out-of-pocket expenses will be subject to the actual bill amounts and breakdowns as stated in the official receipts issued by hospital or clinic.
- 可賠償金額估算的結果，會因接受醫療服務的地域或較高病房級別作出調整和限制。該估算只根據受保人保單之保障限額計算。任何未批核理賠個案或任何不保事項均未有計算在估算內。The claimable amount estimate is subject to benefit reduction or limitation in relation to the regions where the eligible medical services are incurred or the choice of higher ward class. The claimable amount estimate is based on the benefit limit of the Insured's policy. Any pending claim yet to be approved or any exclusion will not be taken into account for this estimation.
- 本公司將以電郵/郵寄可賠償金額估算的申請結果至閣下在我們公司註冊的電郵地址/#通訊地址#(只適用於未有電郵地址)。The Company will deliver the result of the Claimable Amount Estimate Application to your email address/#correspondence address" (only applicable if email address is not available) registered in our Company.
- 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 the age of 18, the Insured and Policyholder must complete and sign this form by his or her good self. If the insured is under the age of 18, this form should be completed and signed by the Policyholder and the insured's 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 application 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.
- 閣下的保險中介人收到本申請表並不代表本公司已收到。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。Receipt of this form by your Insurance Intermediary does not constitute receipt by the Company. If you have any queries, please feel free to contact your insurance intermediary or our Customer Service Hotline at (852) 3999 5519 for details.
- 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.										

第一部分 – 聲明 (由受保人/保單持有人/索償人填寫)
PART I - DECLARATION (To be completed by the Insured / Policyholder / Claimant)

A. 保單持有人資料 (必須填寫) PARTICULAR OF POLICYHOLDER (COMPULSORY)

1 手提電話 Mobile phone no. *

2 電郵地址 Email Address *

* 以上所提供的手提電話及電郵地址只作可賠償金額估算申請之用，如資料與本公司現有記錄不符，概以公司記錄為準。The above mobile phone no. and email address provided will only be used for Claimable Amount Estimate Application. If there is any discrepancy between the above information and Company's record, the Company's record shall prevail.

B. 收集個人資料聲明 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.

C. 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。

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

	受保人 Insured			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.

第二部分 - 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 STATEMENT (To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)

A. 病人資料 Particulars of Patient

1 病人姓名 Name of Patient　　年齡及性別 Age and Sex

2 身份證/ 護照號碼 I.D. Card / Passport No.

3 病人首次求診日 Patient first Consultation Date　年 Year　月 Month　日 Day

4 醫院/診所名稱 Name of Hospital /Clinic

5 醫院/診所地址 Address of Hospital /Clinic

6 預計入院/手術日期 Expected Date of Admission/Surgery　年 Year　月 Month　日 Day

7 病人家庭醫生姓名 Patient's Family Doctor Name

8 預計留院日數 Estimated length of stay

9 住院病房級別或日間中心 Class of Ward / Day case　☐ 日間中心 / 診所 Day Centre/Clinic　☐ 私家 Private　☐ 半私家 Semi-Private　☐ 大房 Ward

B. 疾病/受傷詳情及有關資料 ILLNESS / INJURY DETAILS AND RELATED INFORMATION

1 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.

2 發病日期 Onset date of the symptoms/conditions　年 Year　月 Month　日 Day

3 診斷 Diagnosis　　國際疾病分類編碼 ICD 10 Code

4 是次入院/治療是否醫療需要？ Is the hospitalization/treatment medically necessary?　☐ 是 Yes　☐ 否 No

如是，請詳述。If "Yes", please give details.

5 根據你的評估及意見，病人就是次的病況，是否可以單從門診設施中接受適當的治療？ Given the condition of the patient, is it possible to provide this treatment on an outpatient basis?

☐ 是 Yes　☐ 否 No　如不可以，請提供原因: If "No", please explain

6 是次病況是否為復發性/慢性? Is the condition recurrent / chronic?　☐ 是 Yes　☐ 否 No

如"是"，請提供首次發病日期 If "Yes", please provide the onset date:

年 Year　月 Month　日 Day

7 如是次住院/治療由意外事故引起，請提供以下詳情：If this hospitalization/treatment was caused by an accident, please provide details below:

事故發生日期 Accident Date:　年 Year　月 Month　日 Day

原因 Cause:

受傷位置及受傷程度 Part of body injured & extent of injury:

8 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 physician.　☐ 是 Yes　☐ 否 No

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

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C. 治療詳情及預計費用 TREATMENT DETAILS AND COST ESTIMATION

(預計費用只作參考，最終收費視乎病人實際接受的治療、程序及服務而定) (The estimated charges are for reference only. Final payments are subject to charges incurred from treatment, procedures and services performed)

1 治療計劃或手術名稱 Treatment plan or Surgical procedure name (請提供每項手術名稱 Please provide the name of each surgery)

麻醉 Anesthesia

☐ 全身麻醉 G.A. ☐ 局部麻醉 L.A. ☐ 監測麻醉 M.A.C

2 建議之化驗 / 影像檢查 / 其他診斷性檢查及接受該等檢查的原因。Please list out any Lab tests/Imaging/other diagnostic investigations required for this hospitalization and reasons for the same.

3 是次提供的治療、治療程序、檢測是否為尚未能確定成效或屬實驗性質或仍在試驗階段的治療? Has the treatment, procedure or test not yet been established as being effective or is experimental or is in trial stage?

☐ 是 Yes ☐ 否 No

如是，請詳述並提供原因 Please provide details:

4 治療預計費用 Cost estimation of treatment:

住房及膳食費 Room and board	MOP / HKD		每日 Per Day
主診醫生巡房費 Attending physician's Visit Fee	MOP / HKD		每日 Per Day
外科醫生費(請列出明細；如有) Surgeon's Fee (with breakdown; if any)	MOP / HKD		
麻醉師費用(請列出明細；如有) Anaesthetist's Fee(with breakdown; if any)	MOP / HKD		
手術室費用 Operating Theatre Fee	MOP / HKD		
雜項開支費 Miscellaneous Charges	MOP / HKD		
其他費用(例如專科醫生費及其他) Other Expenses (e.g. specialist fee etc.)	MOP / HKD		
入院前及出院後之門診護理 Pre and post hospitalization outpatient follow up	MOP / HKD		
預計總費用 Total estimate fee	MOP / HKD		

D. 主診醫生資料及聲明 ATTENDING PHYSICIAN'S PARTICULARS AND DECLARATION

本人謹此聲明，就本人所知所信，上述由本人提供的資料均為事實之全部，並確實無訛。本人已向病人解釋上述預算費用，並徵得其同意。I HEREBY DECLARE that all the information provided by me in this form is true and correct to the best of my knowledge and belief. I have explained to the patient the details of the above estimated charges and have sought his / her agreement.

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