中国平安 PING AN
保险·银行·投资

中國平安保險(香港)有限公司
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醫療保險 – 住院及手術 MEDICAL INSURANCE – HOSPITALIZATION & SURGICAL

甲部 – 由病人填寫
PART I – TO BE COMPLETED BY THE PATIENT

本表格適用於任何醫院或門診手術賠償
This form is applicable to both inpatient and outpatient surgical claim

保單持有人姓名 Name of Policy Holder	電話／手機號碼／電子郵箱 Tel./Mobile Phone/E-mail Address:
僱員／成員姓名 Name of Employee/ Member (For Group insurance policy only)	保單號碼 Policy No.:
保戶號碼（倘適用） Insured No./ Certificate No. (If applicable)	
病人姓名 Name of Patient	身份証號碼 I.D. Card No.
職業 Occupation	出生日期 Date of Birth / 性別 Sex. ☐ 男 M ☐ 女 F

與保單持有人關係
Relationship to the Policy Holder
☐ 本人 Self ☐ 配偶 Spouse ☐ 子女 Child
☐ 僱員／成員 Staff / Member ☐ 僱員／成員家屬 Dependent

(1) 閣下是否曾因同一病況而接受治療？
Have you had any prior treatment for this or related conditions? ☐ 沒有 No ☐ 有 Yes

醫生姓名
Doctor's Name _____

地址
Address _____

_____

日期
Date(s) _____

(2) 有關此次住院／手術，閣下有否申請其他保險賠償？
Are you making any other insurance claim as a result of this hospitalization / surgery? ☐ 沒有 No ☐ 有 Yes

保險公司名稱
Name of Insurance Company _____

保單號碼
Policy No. _____

(3) 此次住院／手術是否由於一宗意外引致？
Was the hospitalization / surgery a result of an accident? ☐ 不是 No ☐ 是 Yes

日期
Date _____ 時間
Time _____ 地點
Place _____

經過
Brief Description _____

聲明及授權書 DECLARATION & AUTHORIZATION

本人現聲明上述所填報的資料正確無訛。
本人茲授權持有本人健康或任何資料之醫院、醫生、保險公司或機構，可以將部份或全部有關本人傷勢之病歷、診斷報告及藥方等資料給予中國平安保險香港)有限公司或其代理人，此授權書之影印本與正本具同等效力。
I hereby declare that the above information given is true and correct.
I further authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish to CHINA PING AN INSURANCE (HONG KONG) CO., LTD. or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation prescription or treatment and copies of all hospital or medical record. A Photostat copy of this authorization shall be considered as effective and valid as the original.

日期 Date: _____ 病人簽署 Signature of Patient _____

乙部 – 由主診醫生填寫，所需費用由索償人自行承擔
PART II – TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANTS OWN EXPENSE.

(1) 病人姓名
Name of Patient

(2) 住院
Hospitalization

醫院名稱
Name of hospital _____

入院日期
Date of Admission _____ 出院日期
Date of Discharge _____

(3) 手術
Surgical Procedure

手術日期
Date of operation _____ 手術名稱
Name of the procedure _____

性質
Nature _____

_____

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

(5) 診療
Diagnosis of conditions

(6) 出院摘要(治療及以後治療計劃，包括診查辦法、結果、併發症及跟進計劃)
Brief discharge summary: (including treatments, investigation procedures, results, and/or any complication and follow up plan)

(7) 首次出現病徵日期或意外發生日期
Date of the accident occurred or symptom first appeared.

(8) 病人首次求診日期
Date of first consultation for this condition or related illness.

(9) 據閣下所知，病人以前曾否患有同類病況?
To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? ☐ 沒有 NO ☐ 有 YES

請說明何時及當時情況
Please state dates and describe _____

_____

(10)病人是否經其他醫生轉介?
Is the patient referred by another doctor? ☐ 沒有 NO ☐ 有 YES

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

_____

_____
主診/專科醫生的姓名 (資歷)
Name of Attending Physician/ Specialist (with qualifications)

_____
地址 Address

_____
電話 Telephone

_____
主診/專科醫生的姓名 (資歷)
Name of Attending Physician/ Specialist (with qualifications)

_____
日期 Date