NAVIGATOR
Insurance Brokers Ltd.
Unit 8E, Golden Sun Centre, 223 Wing Lok St, Sheung Wan, Hong Kong
Tel : +852 2530 2530 | Fax : +852 2530 2535
Email : crew@navigator-insurance.com | www.navigator-insurance.com

HK NOV 2012

AXA redefining / standards

Policy Number 保單編號

Global Elite Health Plan
寰宇特選醫療計劃

Medical Claim Form (Out-Patient)
門診索償申請表

Part I – To be completed by the Insured/Policyowner
必須由被保人/保單持有人填寫

Important note :
1. This form is to be filled by the Insured/Policyowner. Please do not sign on blank form and use the same signature as policy record.
2. No fees, commission or charges of whatever nature are payable to Financial consultant or Employees of the Company in respect of this claim.
3. To enable us to process your claim promptly, please answer all questions in this form as fully and accurate as you can.
4. Please submit a copy of the identification document of the Insured and/or Policyowner, unless submitted before, together with this form.

重要事項 :
1. 此申請表應由被保人/保單持有人。請勿在空白申請表上簽署，而簽名式樣須與保單的記錄相符。
2. 有關本索償，客戶無需支付任何手續費、佣金或其他任何性質的費用予本公司的理財顧問或其他僱員。
3. 請回答此申請表上的所有問題，以供我們批核閣下的索償申請。
4. 如在之前未有遞交被保人及/或保單持有人的身份證明文件，請隨此申請表一併遞交。

Financial consultant's code:
理財顧問編號:

Financial consultant's name:
理財顧問姓名:

Financial consultant's contact no.:
理財顧問聯絡號碼:

"The company"
"本公司" 或 "貴公司":

AXA China Region Insurance Company (Bermuda) Limited (incorporated in Bermuda with limited liability)
安盛保險(百慕達)有限公司 (於百慕達註冊成立的有限公司)

AXA China Region Insurance Company Limited
安盛金融有限公司

1. Details of insured 被保人資料

Full name of insured 被保人姓名

Gender 性別

National ID/Passport No 身份證/護照號碼

Date of birth 出生日期 (dd/mm/yyyy)(日/月/年)

Contact number 聯絡電話

Email address 電郵地址

2. Settlement method 付款方法*

☐ By Cheque 支票
(To be drawn in Hong Kong 於香港兌現)

☐ Pay to Insured 付予被保人 ☐ Pay to Policyowner 付予保單持有人

☐ HKD 港幣 ☐ Policy Currency 保單貨幣

☐ By Autopay 自動轉賬
Name of bank account holder 銀行戶口持有人姓名

Name of bank in Hong Kong 香港的銀行名稱

Bank account number 銀行戶口號碼

Note:
* Settlement Method
1. The settlement amount will pay to the Insured or Policyowner.
2. The settlement amount will pay to the Insured, except:
   (a) Insured is below age 18, OR
   (b) Insured do not have any bank account.
3. The settlement amount will be in policy currency, unless specified.

注意:
* 付款方法
1. 賠償金額會付予給被保人或保單持有人。
2. 賠償金額會付予給被保人，除非:
   (a) 被保人未滿十八歲，或
   (b) 被保人並未擁有任何銀行戶口。
3. 除非另行說明，賠償金額會以保單貨幣支付。

3. Guidelines for document submission
遞交索償申請所須文件指引

Please tick against the documents you have submitted together with this claim form. We will notify you or your financial consultant if we need to obtain extra information from you or from other parties to assess your claim. As the time required for obtaining the information varies, the processing time of your claim will likely take longer time.

請於連同索償表格遞交文件之方格內加上剔號。如需要閣下或其他機構提供進一步資料作閣下之索償申請,本公司將會通知閣下或閣下之理財顧問。由於收集有關之資料時間有異,閣下之索償申請時間有可能因此而延長。

☐ 1. Claims form which is to be completed fully (original) 已填妥的索償申請表(正本)
☐ 2. Itemized Detailed Bill with Cost Breakdown (original/certified copy) 詳細分項列明的費用明細 (正本/核證副本)
☐ 3. Result of the diagnostic test (Laboratory result, X-Ray/MRI etc- original/certified copy) (where applicable) 診斷測試結果 (化驗結果、X光、磁力共震造影等正本/核證副本) (如適用)
☐ 4. Prescription (original/certified copy) (where applicable) 處方(正本/核證副本) (如適用)

Note:

Please submit copies of the identification document of the Policyowner and the Insured, unless submitted before, together with this form. This is in accordance with the Guidance Note on Prevention of Money Laundering and Terrorist Financing issued by the Office of the Commissioner of Insurance which requires that copies of the identification document of customers should be collected no later than the time of payout for identification and verification.

注意:

如在之前未有遞交身份證明文件,請隨此申請表一併遞交保單持有人及被保人的身份證明文件副本。根據保險業監理處發出的「防止洗黑錢及恐怖分子籌資活動指引」,保險公司必須在不遲於付款時收集客戶的身份證明文件副本以作核實用途。

4. About the consultation 有關求診

To be completed by insured/policyowner for claims below HKD4,000/USD500
港幣4,000/美元500 以下的索償申請必須由被保人/保單持有人填寫

Name of clinic
診所名稱

Date of consultation
求診日期 (dd/mm/yyyy)(日/月/年)

Diagnosis
診斷

Date of Previous Consultation (for similar condition)
先前求診日期 (有關相同情況) (dd/mm/yyyy)(日/月/年)

Amount Claimed
索償金額

Symptoms of Insured /Policyowner relating to this consultation 被保人或保單持有人是次求診的病徵

Details of Treatment given/Name of Medicine Prescribed 治療詳情或處方藥物名稱
(E.g. Injections, ECG, Laboratory test, X-ray, Minor Surgery. Please provide the test report(s) if any)
(如注射、心電圖、化驗結果、X光、小型手術。如有，請提供測試報告)

Have you ever had the same or similar conditions/symptoms in the past 5 years? If yes, please elaborate.
過去五年曾否患有同類病況？如有，請詳細說明。

If you have any questions regarding this form or any other aspects of the coverage, please contact our Global Elite Customer Service at (852) 3723 3008 quoting your policy numbers.

Claims must be submitted along with all supporting documents within 90 days from date of service. Send this claim form together with all supporting documents to Global Elite Customer Service at Room 702, 101 King's Road, North Point, Hong Kong.

若閣下對本申請表格或其他保單相關事宜有任何疑問，請致電 (852) 3723 3008 聯絡我們的寰宇特選客戶服務，並提供閣下的保單編號。

索償申請須於接受診治後 90 天內，連同所有證明文件一併呈交。請將此申請表與所有證明文件發送至 寰宇特選客戶服務，地址為：香港北角英皇道 101 號 702 室。

5. Declaration and authorisation 聲明及授權

I HEREBY DECLARE AND AGREE on behalf of myself and other persons referred to in this application/form (hereinafter referred to as "Relevant Persons", "We", "Our" or "Us") (for the avoidance of doubt, the expressions "Relevant Persons", "We", "Our" or "Us" include myself and such other persons) that (1) all statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true; (2) the Company is not bound by and is not required to rely on any statement which I may have made to any person if not written or printed here; (3) any information and personal data of the Relevant Persons collected, compiled or held by the Company from time to time (whether contained in this application or otherwise), may be used, stored, processed, transferred or disclosed to and/or shared with individuals, entities and/or organisations associated with the Company, reinsurance companies, claims investigation companies, industry associations or federations, fund management companies, financial institutions, government authorities and/or the Company's appointed service providers, in each case whether within or outside of Hong Kong, for the purpose of: (i) processing and evaluating this application and any other application for insurance or policy change / service; (ii) providing subsequent services to Us including but not limited to administering the policies issued or direct marketing of insurance and/or other financial products or services and data matching; (iii) evaluating Our potential financial needs; (iv) conducting market research for statistical or other purposes; (v) marketing other financial services and/or products to Us; (vi) complying with the laws of any applicable jurisdiction; and/or (vii) other services in connection with the operation of the Company's business; (4) I/We understand that I/We have the right to obtain access to and to request correction of my/Our personal data held or controlled by the Company. A reasonable fee may be charged for processing any data access request. If I/We do not wish to receive direct marketing information or materials, I/We will notify the Company in a written form specified by the Company. All such requests shall be addressed to the Head of Customer Service of the Company at 16/F, Tower One, Times Square, 1 Matheson Street, Causeway Bay, Hong Kong. If We fail to provide any information requested in this application / form, it may result in the Company's inability to accept or process this application.

I HEREBY AUTHORISE on behalf of the Relevant Persons that (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of me/the Relevant Persons and/or who has attended or may hereafter attend to me/the Relevant Persons to disclose such information to the Company as the Company may request; (2) the Company or any of its appointed medical examiners, paramedical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/the Relevant Persons in relation to this application and any claim arising therefrom; (3) the Company to give either the Hong Kong Federation of Insurers or other parties, as required for proper administration of the Code of Practice for Life Insurance Replacement, a copy of the Customer Protection Declaration and any related records or information. This authorisation shall bind the successors and assignees of the Relevant Persons and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.

I HEREBY DECLARE AND AGREE that I have the full authority from and consent of the Relevant Persons to make the above declarations, agreements and authorisations.

本人謹此代表本人及其他在此申請表提及之人士（下稱「相關人士」 或 「我們」）(為免存疑，「相關人士」或「我們」指包括本人及此申請書提及之其他人士) 聲明及同意 (1) 上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所信，均為事實全部並確實無訛；(2) 本人對任何人所作出的任何聲明，如沒有在此申請書上填寫或印出，貴公司不須受其約束；(3) 貴公司可以使用、儲存、處理、轉移或披露及／或分享貴公司所不時收集、編輯或持有之任何相關人士的個人資料(不論是否此申請書所載或從其他途徑所取得)予任何不論在本港境內或境外與貴公司聯繫之個別人士、獨立個體及／或機構、再保公司、理賠調查公司、業內組織或聯會、基金管理公司、財務機構、政府機關及／或貴公司指定之服務供應商作以下用途： (i)審核及評估此申請及任何其他投保申請或保單更改／服務申請；(ii) 向相關人士提供隨後的服務，其包括但不限於已繕發保單之管理，或保險及／或其他金融產品或服務之直接市場推廣及資料核對用途；(iii) 分析相關人士的財務需要； (iv) 進行市場研究統計或其他用途； (v) 向相關人士推廣其他金融服務及 / 或產品；(vi) 為遵守任何適用的司法管轄權之法律； 及 / 或 (vii)提供與貴公司業務運作相關的其他服務；(4) 本人／我們明白本人／我們有權就貴公司持有或管理我們各自的個人資料提出查閱及修正的要求。貴公司可就處理任何查閱資料的要求收取合理費用。如本人／我們不願意接收直接市場推廣資訊或資料，本人／我們將會以貴公司指定書面形式通知貴公司。所有有關要求必須致函香港銅鑼灣勿地臣街1號時代廣場1座16樓向客戶服務主管提出。如我們不能提供任何此申請所需的資料，貴公司或不能接受或處理此申請。

本人謹此代表相關人士授權(1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、或其他組織、機構或人士，凡知道或持有任何有關本人 / 相關人士之記錄，及 / 或曾診驗或可能將會診驗本人 / 相關人士者，均可應貴公司要求將該等資料提供給貴公司；(2) 貴公司或任何其指定之驗身醫生、醫療人員或化驗所，可就此申請或任何與此有關之賠償申請替本人 / 相關人士進行所需之醫療評估及測試，作為審核本人 /相關人士之健康狀況；(3) 貴公司於有需要時，向香港保險業聯會或其他執行壽險轉保守則的機構，提供客戶保障聲明書副本，以及其他有關紀錄或資料。此授權對相關人士之繼承人及受讓人具有約束力；即使相關人士死亡或無行為能力時，此授權仍具效力。此授權書的影印本與正本均有同等效力。

本人謹此聲明及同意已獲相關人士授權及同意本人作出以上聲明、協議及授權。

Name of claimant 索償人姓名

National ID/Passport No 身份證/護照號碼

Relationship to insured 與被保人關係

Signature of claimant 索償人簽署

Signature date 簽署日期

Mailing address/Contact tel no. 聯絡地址及電話

Name of financial consultation/witness
理財顧問/見証人姓名

Signature of financial consultant/witness
理財顧問/見証人簽署

Financial consultant code 理財顧問編號

Signature date 簽署日期

Note :

Claimant refers to Insured or Policyowner or the person who filed a claim against the company

注意：

索償人指被保人或保單持有人或向公司索償的人士

Part II – To be completed by the attending medical practitioner at the Insured or Policyowner's expense for claims above HKD4,000/USD500
索償表格第二部份 – 索償額為港幣4,000/美元500 以上必須由主診醫生填寫，費用由被保人或保單持有人支付

6. Known history with patient 病人求診資料

Date the patient first consulted you for condition related to this visit 首次相關病情的求診日期 (dd/mm/yyyy)(日/月/年)

Name and address of medical practitioner who has referred this patient to you for this injury or illness
轉介醫生之姓名及地址

7. About the consultation 有關診症

Name of clinic
診所名稱

Date of visit
求診日期 (dd/mm/yyyy)(日/月/年)

Date of previous visit
最近求診日期 (dd/mm/yyyy)(日/月/年)

Chief complaint of the patient relating to this visit 這次求診的最主要的病況

Has the patient ever had the same or similar conditions or symptoms in the past 5 years? If yes, please elaborate. 病人過去五年曾否患有同類病況？如有，請詳細說明。

Type of treatment or medicine prescribed (including treatment, investigation or procedures)
治療方法或藥物處方 (包括治療，診查或程序)

Was illness/injury related to the following condition 疾病/受傷是否由以下情況引起？

1. Congenital anomaly 先天性異常	☐ Yes是 ☐ No否	If answer is "Yes", please state details 如是，請提供詳細資料:
2. Self inflicted 自我傷殘	☐ Yes是 ☐ No否	
3. Psychiatric condition 精神病	☐ Yes是 ☐ No否	
4. Influence of alcohol, drug or intoxicant 受酒精藥物影響	☐ Yes是 ☐ No否	
5. Obesity, weight reduction or weight improvement 體重因素	☐ Yes是 ☐ No否	
6. Pregnancy, childbirth caesarian section, abortion or miscarriage 懷孕、分娩、墮胎或流產	☐ Yes是 ☐ No否	
7. Treatment related to infertility 治療不育	☐ Yes是 ☐ No否	

8. Further treatment plan or follow-up appointments
其他治療計劃或覆診

Please give details of any further treatment plan or follow-up appointments
請詳細列出其他治療計劃或覆診指示

9. Medical practitioner declaration and agreement
聲明及授權

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his/her condition. I declare and agree to make the declaration on this claim form.

本人謹此聲明曾為病人作出診治，以上填報的各項資料乃本人基於以上的情況而提供意見。本人謹此聲明及同意上述一切陳述及問題的所有答案均為事實之全部並確實無訛。

Name of medical practitioner 醫生名稱 | Qualification 醫學資格 | Specialty 專業資格

Contact Tel. No. & Mailing address 聯絡電話及地址

Signature of medical practitioner 醫生簽署 | Date 日期

(dd/mm/yyyy)(日/月/年)

NAVIGATOR
Insurance Brokers Ltd.
Unit 8E, Golden Sun Centre, 223 Wing Lok St, Sheung Wan, Hong Kong
Tel : +852 2530 2530 | Fax : +852 2530 2535
Email : crew@navigator-insurance.com | www.navigator-insurance.com