中銀集團保險有限公司
BANK OF CHINA GROUP INSURANCE COMPANY LIMITED

索償編號 (公司專用)
*Claim No. (for office use)*

# 團體醫療保險 *Group Medical Insurance* – 牙科索賠申請書 *Dental Claim Form*

投保單位 *Policyholder Name :* _____ 保單號碼 *Policyholder Number :* _____

受保員工姓名 *Name of Employee:* _____ 所屬部門 *Department :* _____ 受保員工編號 *Insured No. :* _____

索償人姓名 **(如不是受保員工)** *Name of Claimant (IF NOT EMPLOYEE)* _____ 身份證號碼 *HKID No. :* _____ 與受保員工關係 *Relationship :* _____

**個人醫療保險（如適用）** For Individual Policy (if applicable) 如索償人在中銀集團保險有限公司已購買個人醫療保單並需要在此個人單下作索償，請提供保單編號或者在下方空格內畫上「✓」號。If the claimant has individual medical insurance policy with BOCGI and would like to make a claim under that policy as well, please provide the policy number or tick the box below.

☐ 在我的中銀集團保險個人保單編號_____下作出索償 File a claim under my BOCGI Individual Policy number

敬請注意一般情況下有關索償會先在團體醫療保單下賠付(如擁有團體保單及適用者)，如賠償不足並符合條款規定的部份會應閣下的填報要求在個人單下再作賠付。如果閣下未能在此申請書內填寫個人單的編號，將視為閣下只須在團體保單內賠付。Please note that generally your loss will be assessed under group policy first and the balance will be settled under your individual policy (if applicable) according to the policy terms and conditions. If you leave this session blank, this claim will only be proceeded under your group policy.

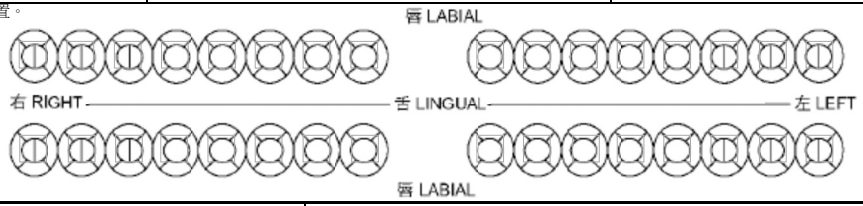
## *須由應診牙醫填寫。To be completed by your attending dentist*

*如需退回正本收據，請加"✓"。Please "✓" for return original receipts* ☐

*牙科診治或服務是否因意外導致？Is dental treatment or services as a result of accident?*

| 序號 *No.* | 日期 *Date* | 牙齒編號 *Tooth No.* | 治療項目 Particulars | 收據金額 Amount Incurred |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

請於右圖註明病人接受治療的牙齒或口腔位置。
Please mark teeth treated or area of oral treatment on the following chart.




*牙醫簽署及診所印章*
*Signature of Dentist and Clinic Chop*

*簽署日期 Date Signed*

***授權***

本人現授權任何西醫、醫院、診所、保險公司及其他人士，均可向**中銀集團保險有限公司**提供本人或本人家屬之健康情況、傷病資料及病歷記錄，作為審核有關醫療保險索賠之用。本授權書之影印本與正本有同等效力。

**聲明**

1、本人聲明上述所填報之資料均屬真實無訛，本人清楚明白如上述資料有誤或不實，可能導致本人或本人家屬的保障無效。

2、本人明白本人提供的資料，為　貴公司提供保險業務所需，並可能使用於下列目的：

- 任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期；
- 任何索償，或該等索償的調查或分析；
- 行使任何代位權；及

可能移轉予：

- 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；
- 現存或不時成立的任何保險公司協會或聯會或類同組織（『聯會』），以達到任何上述或有關目的，或以便『聯會』執行其監管職能，或其他基於保險業或任何『聯會』會員的利益而不時在合理要求下賦予『聯會』的職能；及
- 或透過『聯會』移轉予任何『聯會』的會員，以達到任何上述或有關目的。

此外，本人在此授權**中銀集團保險有限公司**可向『聯會』從保險業內收集的資料中查閱及/或核對本人任何資料。

本人有權查閱及要求更正由**中銀集團保險有限**公司持有有關本人的個人資料。如有需要，可向**中銀集團保險有限公司**辦公室提出（電話：28670888，傳真：25221705）。

***Authorization***

*I act on behalf of myself and my dependents hereby authorize any medical practitioner, hospital, clinic, insurance company to disclose to the **Bank of China Group Insurance Co., Ltd.** all information concerning the above disability and any prior medical history for the purpose of proceeding the medical claim. A photostat of this authorization shall be as valid as the original.*

**Declaration**

1. *I hereby declare that the above statement and answers are true and correct. I understand that any misrepresentation of the above statement and answers will cause my/our claim invalid.*
2. *I understand that the information I provide to the Company is collected to enable the Company to carry on insurance business and may be used for the purpose or:*
   - *any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or services;*
   - *any claim or investigation or analysis of such claim; and*
   - *we may exercising any right of subrogation*

   *may be transferred to:*
   - *any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;*
   - *any association, federation or similar organization of insurance companies ("Federation") that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation and*
   - *any members of the "Federation" by the "Federation" for any of the above or related purposes.*

*Moreover, **Bank of China Group Insurance Co. Ltd**. is hereby authorized to obtain access to any/or to verify any of your data with the information collected by the Federation from the insurance industry.*

*I have the right to obtain access to and to request correction of any personal information concerning myself held by **Bank of China Group Insurance Co. Ltd**. Requests for such access can be made to our Administration Department (Tel:2867 0888 / Fax:2522 1705)*

**請看後頁賠償申請指示。**
**Please see overleaf for claim instructions.**

日期 *Date* _____　索償人簽署 *Signature of Claimant* _____　聯絡電話 Contact Number _____

## 團體醫療保險 *Group Medical Insurance* – 牙科索賠申請書 *Dental Claim Form*

***申請索償指示***

- 申請索償時必須提交正本收據，醫生轉介信(如適用)及連同有關資料呈交保險公司處理。 索償申請必須在診症日後90天內呈交。除非有特別要求，否則有關單據將不退還。
- 所有正本收據必須清楚列明以下資料，並須醫生蓋章簽署：
  - ✧ 病人姓名
  - ✧ 診症日期
  - ✧ 收費資料
  - ✧ 診斷及治療/手術名稱
- 專科、物理及脊醫治療(之索償需提供註冊西醫有效轉介信，轉介信有效期由簽發日起計有效一年(如適用)，每次索償均需提交推薦信副本； X光及化驗之轉介信則由簽發日起計有效90天。
- 有關索償中醫、針灸及跌打師需提供醫師姓名及登記註冊編號，及中醫則需提交處方副本。

**以下情況，索償申請將不獲辦理：**
- 索償申請於診症/治療日90天後遞交。
- 所需資料不足。

**填妥之索賠申請書連同附帶文件請交回：**

**中銀集團保險有限公司 – 健康保險部收**
**香港德輔道中71號**
**永安集團大廈九樓**
電話：3187 5100
傳真：2521 8672
網址：www.bocgroup.com/bocg-ins/

***Claims Instructions***

- Submit claim form with original receipt(s), referral letter (if applicable) and all supporting documents to the Insurance Company. Claims must be submitted to the Insurance Company within 90 days from incurred date / consultation. Receipt(s) will not be returned unless requested.
- All original receipts must indicate the following information and be signed / stamped by the attending doctor:
  - ✧ Patient's name
  - ✧ Consultation date
  - ✧ Breakdown of charges
  - ✧ Diagnosis and treatment/operation name
- Referral letter written by a registered Medical Practitioner is required for Specialist Consultation / Physiotherapy / Chiropractic Treatment (if applicable). Referral letter is valid for one year from date of issuance; copy of referral letter is required for each claim. Except for x-ray & laboratory;, referral letter is valid for 90 days from date of issuance.
- For Chinese herbalist, acupuncturist and bonesetter, please specify Chinese Medical Practitioner's name and registration number. For Chinese herbalist consultation, please attach copy of prescription sheet for reimbursement.

**No reimbursement of outpatient claims if:**
- Claim(s) submitted after 90 days date of consultation / visit
- Insufficient of required information

**Please send this completed claim form with attachment(s) to:**

**Bank of China Group Insurance Co. Ltd. – Health Insurance Dept.**
**9/F., Wing On House,**
**71 Des Voeux Road Central, Hong Kong**
Tel : 3187 5100
Fax : 2521 8672
Website : www.bocgroup.com/bocg-ins/