宏利
Manulife

團體醫療索償表格
Group Medical Claim Form

☐ 門診索償 OUTPATIENT CLAIM ☐ 牙科索償 DENTAL CLAIM

由受保人填寫 To be completed by Insured Member (必須填寫 Must be provided)

僱主名稱
Employer Name: HK FEDERATION OF EDUCATION WORKERS LTD

團體保單編號
Group Policy No.: 317454-0011-3

僱員英文姓名
Employee English Name (In Full):

保險証編號
Certificate No.:

病人英文姓名
Patient English Name (In Full)

家屬編號（如適用）
Dependent No. (If applicable) :

☐ **正本收據將不獲發還。如需取回收據的核實副本，請於方格內加上 "✓"。**
Original receipt will not be returned. Please "✓" this box for return of certified true copy of receipt.

A. 門診索償 OUTPATIENT CLAIM

診症 / 治療日期 Date(s) of Consultation /Treatment (日 / 月 / 年) (DD / MM / YY)	費用 Amount Charged	診症類別（必須已列於保單的保障範圍內） Type of Treatment (Should be covered under the policy) * 請圈出合適類別 Please circle the appropriate type	病人自行聲明病症 Self Declaration of Diagnosis 只適用於醫管局轄下的醫院門診部或政府門診 (私家及中醫症除外) For Claims Incurred at Outpatient Dept. under Hospital Authority / Government Clinics Only (Except for private and chinese medicine case)
1.		* GP / SP / CMP / Others:	病症 Diagnosis
2.		* GP / SP / CMP / Others:	病症 Diagnosis
3.		* GP / SP / CMP / Others:	病症 Diagnosis
4.		* GP / SP / CMP / Others:	病症 Diagnosis

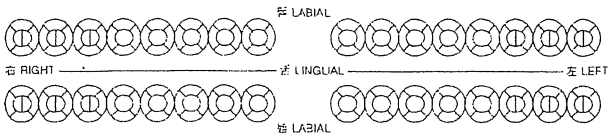
* GP = 普通科 General Practitioner SP = 專科 Specialist CMP = 中醫 Chinese Medical Practitioner
其他 Others = 物理治療 Physiotherapist / 脊醫 Chiropractor / X光 X-ray / 化驗 Lab tests / 例行檢查 Routine Checkup / 住院前之診症 Pre-hospitalisation consultation / 住院後之診症 Post-hospitalisation consultation / 等 etc

B. 牙科索償 DENTAL CLAIM

遞交牙科索償前，請確保閣下之保單有提供牙科保障。Please ensure you are covered under the dental benefit before submitting dental claims.

須確保治療項目,費用及日期清楚列明於收據上。
Please ensure particulars and amount charged with date clearly marked on the receipt.

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 right chart.



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

簽署日期
Date Signed

C. 聲明及授權書 DECLARATION AND AUTHORIZATION

本人明白，同意並謹此聲明：

1. 本人於本表格所提供的一切資料為本人所知的全部及為真確無誤。
2. 本人授權任何醫生、醫學界執業人士、醫院、診所或其他與醫療有關的機構、保險公司或其他組織、機關或人士，將其所有關於本人及受保家屬的記錄或健康狀況資料，提供予宏利。此授權書是不可撤銷的，即使本人去世，此授權仍然生效。此授權書的影印本將與正本同樣有效。
3. 從本人收集及關於本人及/或受保家屬的資料，旨在確保宏利的保險或金融業務得以順利進作，而該等資料可供
   i) 宏利或其聯營公司作以下用途：(a)批核及管理本保單，或其後進行任何修訂、取消保單或續保事宜；(b)核保、分析及處理賠償申請；(c)供宏利、聯營公司或保險/金融業作統計或精算研究用途；及/或
   ii) 轉交予(a)任何有關連公司；其他從事與保險或再保險有關業務之公司；或中介人、提供理賠、調查或其他保險業相關服務之供應商或現時已存在或日後組成之監管機構、保險公司聯會或組織；(b)任何人士/機構以作上述用途及/或以配對或其他方法核實資料；與及安排再保險。
   所有資料處理過程或會涉及資料移轉至香港特別行政區及以外地區。
4. 本人同意宏利將有關由本人提供的所有資料傳回給保單持有人（即僱主）/受保僱員（如適用）。本人已向所有受保家屬取得授權（如適用），可(a)向宏利提供其資料；及(b)將所有其提供的資料傳回給保單持有人（即僱主）和本人。本人亦明白本表格內提供的資料是誤宏利作處理本人索償之用。
5. 本人有權以書面通知宏利僱員福利部之個人資料主任，要求索閱及更改個人資料（如需要）。
6. 宏利可按於《有關（個人資料（私隱）條例）的客戶通知》（「通知」）/《宏利個人資料收集聲明（「聲明」）（如適用）所述，處理有關資料假如本人未有細閱該通知/聲明（如適用），本人可從本人的宏利中介人或透過宏利網址www.manulife.com.hk取得該通知/聲明（如適用）。
7. 本人明白並同意宏利有權要求受保人，因資料不確而退回已賠償之金額。
8. 本人已經細讀及明白此「團體醫療索償表格」之所有資料及內容；包括背頁所提供之索償指引及一般不受保項目。

I hereby DECLARED, UNDERSTOOD and AGREED that:

1. All information provided by me in this form is complete and true to the best of my knowledge and belief.
2. I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my dependent to provide to Manulife any such information. Such authorization shall survive me and shall be irrevocable. A photocopy of this authorization shall be as valid as the original.
3. Information collected from me and in respect of me and/or my dependent can enable Manulife to carry on its insurance/financial business and may be:
   i) used by Manulife or its associated companies for the purpose of (a) approving and administering the policy or any alterations, cancellation or renewal of it; (b) underwriting and any claims or analysis of it; (c) statistical or actuarial research of Manulife, Manulife's associated companies or the insurance/financial industry; and/or
   ii) transferred to (a) any related company or 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 or any regulatory bodies, association or federation of insurance companies that exists or is formed from time to time; (b) any person/organization to fulfill any of the above purposes and/or for the purpose of data verification by way of matching procedures or otherwise; and/or reinsurance of the policy.
   All data processes may involve a transfer of information to places either within or outside the Hong Kong Special Administrative Region.
4. I agree Manulife to transfer back all supplied information from me to the policyholder (i.e. the Employer)/ the insured employee (where applicable). I have obtained the necessary authorization from my dependent to (a) supply their information to Manulife; and (b) transfer back all supplied information from them to the policyholder (i.e. the Employer) and me if my dependent (if applicable) is to be covered. I also understand that the information requested in this form is required in order for Manulife to process this claims.
5. By writing to the Privacy Officer of Manulife - Employee Benefits, I can request access to and correction of my personal data (if appropriate).
6. All information may be treated by Manulife in the same manner as mentioned in the "Notice to Customers relating to the Personal Data (Privacy) Ordinance" ("Notice") / Manulife Personal Information Collection Statement ("Statement") (where applicable). In case I have not read the Notice / Statement (where applicable) before, I can obtain such Notice / Statement (where applicable) from my Manulife's intermediary or through Manulife's website at www.manulife.com.hk.
7. Manulife has the right to reverse / claim back any incorrect payment caused by incorrect information provided by me.
8. I have read and understood the information and content provided in this entire 'Group Medical Claim Form", including the Claims Instructions and General Exclusions provided overleaf.

FEDERATION OF EDUCATION WORKERS HONG KONG LIMITED
香港教育工作者聯會有限公司

病者/受保僱員簽署（如病者不足18歲，則須受保僱員簽署 Patient's signature is required）
Patient's/Insured Employee's Signature (For patient whose age is below 18, insured employee's signature is required)

日期（日 / 月 / 年）
Date (DD / MM / YY)

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ISO 9001
Certified to Manulife Employee Benefits