Claim Procedures 索償程序

Claims Procedure – Hospitalization & Surgical (Pay & Claim)
索償程序 – 住院及手術 (先付款，後索償)

(1) Need to pay when discharge
出院時先繳交費用
(2) Obtain all *official receipts* and medical report 向醫院索取所有正本收據及醫療報告
(3) Let the attending doctor to *complete Part II of the hospitalization claim form*
要求醫生填寫索償表格的第二部份
(4) For government hospital claim, the completion of Part II of the hospitalization claim form can be exempted but the discharge summary is needed.
如入住政府醫院，出院時醫生無需填寫索償申請表的第二部份，但需向醫生索取出院証明書

(1)Complete Hospitalization and Day Care Treatment Claim Form – Part I
完成住院及日症治療索償表格第一部份

Within 90 days after discharge from hospital
出院後 90 天內

Blue Cross 藍十字
An AIA Company 友邦保險成員公司

Submit the completed claim form together with all Original Hospital bills and breakdown list of expenses and receipts

遞交所有醫院正本收據及已填好的索償申請表

Claim will be settled by autopay or cheque ***within 8 – 10 working days*** if all information is completed and settlement form will be sent to each member thereafter.
賠償會在收到所有所需文件後起計 8 – 10 個工作天內，索償款項會轉帳到你的銀行戶口或以支票賠償予受保成員

Claims Procedure – Hospitalization & Surgical (Pay & Claim)
索償程序 – 住院及手術 (先付款，後索償)

Important 重要事項

- For confinement in the general ward of government hospital in Hong Kong, please attach the original receipts issued by the hospital together with a copy of **discharge summary**. If no diagnosis is provided by the doctor, the insured (patient) is required to supplement the exact diagnosis on the abovementioned documents and confirm with a signatory.
  若入住香港政府醫院的普通病房，請提供由政府醫院發出的收據正本及**出院撮要副本**。若醫生未註明病症名稱，受保人 (病人) 須於上述文件上補充確實的病症名稱並簽署確認。

- Expense related to clinical / day surgery and the associated histopathology can be covered under Hospitalization Benefit (only covered under Hospital Special Services (Hospital Expenses) / Surgical Benefit / Anaesthetist's Fee / Operation Theatre, if the benefit is applicable) where admission is not necessary. If the medical expenses for day surgery exceeds the Basic Hospitalization Benefit, the balance can be reimbursed under Supplementary Major Medical Benefits (if applicable).

  日間簡單手術或在診所進行的簡單手術及相關的病理化驗，無需入院進行均可獲得住院福利賠償 (只包括醫院雜項費 / 手術費 / 麻醉師費 / 手術室費，如有相關福利)。如在門診進行之手術超出基本住院福利保障金額，餘額亦可於附加重症醫療保障中獲得賠償 (如有相關福利)。

- Diagnostic Advanced Imaging (CT, MRI & PET scan) will be covered under Hospital Special Services (Hospital Expenses) and admission is not necessary.
  先進診斷掃描 (如磁力共振、電腦掃描及正電子掃描) 可於日間化驗及診斷中心進行亦可獲得醫院雜項費賠償，無需入院進行。

- Both Target Therapy, Chemotherapy, Radiotherapy and Renal Dialysis Expenses (with or without hospital confinement) are covered under Hospital Special Services Charges benefit and exceeded amount can be reimbursed under SMM benefit
  所有住院或門診之標靶治療, 化療, 電療 及洗腎費用均可當作住院雜費賠償及可於基本住院保障的住院雜費耗用後，在附加重症醫療保障中獲得賠償。

- Surgical Supplies is covered under Hospital Special Services Charges
  手術所需用品均可當作住院雜費賠償

- Expenses for obtaining medical report will not be reimbursed.
  索取醫療報告之費用將不獲賠償。

Claims Procedure – Hospitalization & Surgical (Pay & Claim)
索償程序 – 住院及手術 (先付款，後索償)

Must be filled in by attending physician 由主診醫生填寫

Completed by insured member 由受保人填寫


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An AIA Company

HOSPITALISATION & SURGICAL CLAIM FORM
住院及手術索償申請表

Enjoy Speedy Claim Submission via eClaim in 3 simple steps
1. Input claim details
2. Upload the scanned copies/photos of receipt
3. Confirm

Claim Notes

Claim Instructions

Part I 甲部 – To be completed by the Insured (Patient) 由受保人（病人）填寫

Declaration and Authorisation 聲明及授權書

Blue Cross (Asia-Pacific) Insurance Limited 藍十字（亞太）保險有限公司
www.bluecross.com.hk


Part II – To be completed by the attending physician/surgeon at the claimant's own expenses
乙部 – 由主診醫生／外科醫生填寫，所需費用由索償人自行承擔

1. Clinical History 求診記錄

2. Details of Hospitalisation 住院詳情

3. Professional Comment 專業意見

4. Others 其他

Claims Procedure – Outpatient (Panel Service)
索償程序 – 門診 (網絡服務)

Using Blue Cross Healthcare Card 使用藍十字醫療卡

1) Present the "Blue Cross Healthcare Card" to the receptionist of the appointed clinic. You will then be asked to sign the voucher.
出示您的「藍十字醫療卡」予指定診所的接待處，並簽署有關收據。

2) If the charges for medical treatment are ineligible, you will be notified and be required to pay the amount.
若該診費不合資格，您將會接獲通知以便支付有關差額。

- **General Physician and medication**
  (Receive not more than 3 days basic medication)
  普通科醫生診症和藥費 (可獲不多於三天的基本藥物)

- **Specialist Physician and medication**
  (Receive the basic medication)
  專科醫生診症和藥費 (可獲基本藥物)

- **Chinese Heralist 中醫門診**
  (Receive not more than 2 packs of basic Chinese medicines 可獲不多於兩劑的基本中草藥)

- **Bone-setting 中醫跌打**
- **Acupuncture 中醫針灸**
- **Physiotherapy 物理治療**

Network Service Providers 網絡服務供應商	
QHMS	Humphrey & Partners
EC Healthcare	Medinet
Dr. Vio & Partners	Raffles Medical Group
Dr. Jones Fok & Asso.	U Care
HMMP	DOC Net
Mediconcen	UMP Professional

Claims Procedure – Outpatient / Dental
索償程序 – 門診 / 牙科 (先付款，後索償)

(1) Need to pay first after consultation
診症後先繳交費用

(2) Obtain original receipt which must show: Patient's Name, Date of Consultation, Diagnosis, Doctor's stamp & signature and amount of breakdown of laboratory/consultation charges.
向醫生索取正本收據，收據上必須有你的姓名、診症日期、病症名稱、醫生簽名和蓋印及該次診症所收的費用詳列表

Complete the
Outpatient Claim Form / Dental Claim Form
填寫門診索償申請表 或
牙科索償申請表

Within 90 days after consultation
診症後 90 天內

Blue Cross 藍十字
An AIA Company 友邦保險成員公司

(1) Submit the completed claim form together with all original receipt
遞交所有正本收據及已填好的索償申請表
(2) For the Chinese Herbalist consultation, the List of Medicine Prescription is required 中醫索償申請必須一同遞交中草藥處方紙
(3) Referral letter is required for X-ray / Lab test
申請X光 / 化驗的開支索償，必須連同轉介信一同遞交。

Claim will be settled by autopay or cheque ***within 7 – 10 working days*** if all information is completed and settlement form will be sent to each member thereafter.
賠償會在收到所有所需文件後起計 7 – 10 個工作天內，索償款項會轉帳到你的銀行戶口或以支票賠償予受保成員

Claims Procedure – Outpatient
索償程序 – 門診

Important 重要事項

- For outpatient visits in government hospital/ clinic, please attach the original receipts together with a copy of **medical certificate/ sick leave certificate with specified diagnosis or discharge summary**. If no diagnosis is provided by the doctor, the insured (patient) is required to supplement the exact diagnosis on the abovementioned documents and confirm with a signatory.
  請附上由政府門診發出的收據正本及**附有病症名稱的醫療證明書/ 病假證明書或出院撮要副本**。若醫生未有註明病症名稱，受保人（病人）須於上述文件上補充確實的病症名稱並簽署確認。

- Max. one visit per day for each Out-patient benefit
  每一項門診 福利每日只可申請索償一次

- If you request for the return of your original receipts for the second claims from another insurance company, please indicate on the claim form.
  如你需要我們在處理完成你的賠償申請後退回所有收據，請於索償申請表上聲明。

Claims Procedure – Outpatient
索償程序 – 門診

Completed by insured member
由受保人填寫

Blue Cross 藍十字
An AIA Company 友邦保險成員公司

收集個人資料聲明 Personal Information Collection Statement
聯絡我們 Contact Us

OUTPATIENT CLAIM FORM 門診索償申請表

Download Now 立即下載
Blue Cross HK App

Enjoy Speedy Claim Submission via eClaim in 3 simple steps
1. Input claim details
2. Upload the scanned copies/photos of receipt
3. Confirm

透過電子索償平台簡單 3 步遞交索償申請
1. 輸入索償資料
2. 上載收據之掃描副本 / 相片
3. 確認

Claim Notes
1. This form is applicable to outpatient claim. Each claim form is for one Insured (Patient) only.
2. You can find the Policy number and Insured number on Blue Cross Certificate of Insurance or Blue Cross Healthcare Card, you may also visit www.bluecross.com.hk/supercare to view account information after logging in.
3. Please print this claim form on A4 size paper and send it together with the original receipts to Medical Claims Department of Blue Cross (Asia-Pacific) Insurance Limited ("The Company") within 90 days from treatment date. The Company's Personal Information Collection Statement as accompanied with this form is for your reference and retention, please do not return it along with your claim application.
4. The Company is entitled to request for your provision of further information and documents or completion of other specific claim forms.

Claim Instructions
1. Attach the original receipts issued by the doctor or certified true copy of receipts issued by other insurers (if applicable). Each receipt MUST state the following information:
   - Full name of patient
   - Date of consultation/Date of treatment
   - Diagnosis
   - Breakdown of charges
   - Doctor's signature and official stamp
2. For outpatient visits in government hospital/clinic, please attach the original receipts together with a copy of medical certificate/sick leave certificate with specified diagnosis or discharge summary. If no diagnosis is provided by the doctor, the insured (patient) is required to supplement the exact diagnosis (e.g. Hypertension) on the above mentioned documents and confirm with a signature.
3. If laboratory tests/X-rays are necessary, please attach the doctor's referral letter unless it is waived.
4. For treatment of Chinese Medicine Practitioner, please attach the original receipts and prescription.
5. Complete and sign this form.
6. Provide copy of claim settlement advice from other insurers, if applicable.
7. Original receipt will not be returned once submitted. Please tick the appropriate box if certified true copy of receipt is required.

索償注意事項
1. 此申請表適用於門診索償，**每名受保人（病人）須獨立填寫申請表**。
2. 您可於藍十字保險證明書或藍十字醫療卡上查看保單號碼及受保人號碼，您亦可登入 www.bluecross.com.hk/supercare 查閱帳戶資料。
3. 請以 A4 紙打印此索償申請表，並於治療後 90 天內，連同收據正本一併交回藍十字（亞太）保險有限公司（「本公司」）醫療保險索賠部。隨本申請表附上的收集個人資料聲明，是供閣下參閱及保留之用，請無需於遞交索償申請時退回。
4. 本公司有權要求閣下提供更多資料及文件或填寫其他專用索償表格。

索償申請指示
1. 附上由醫生簽發的收據**正本**或由其他保險公司發出的收據核實副本（如適用）。每張收據**必須**列明以下資料：
   - 病人姓名
   - 診症日期 / 治療日期
   - 病症名稱
   - 收費項目說明
   - 醫生簽署及蓋章
2. 請附上由政府醫院或門診發出的收據正本及附有病症名稱的醫療證明書 / 病假證明書或出院重要副本，若醫生未有註明病症名稱，受保人（病人）須於上述文件上補充該實的病症名稱（例如：高血壓）並簽署確認。
3. 除已獲豁免外，如須提交化驗或 X 光診斷，請附上醫生轉介信。
4. 如屬中醫治療，請附上收據正本及中醫處方正本。
5. 填妥此申請表及簽署。
6. 如適用，請提供其他保險公司之賠償結算通知書副本。
7. 一經遞交之收據正本將不獲發還，如需索取收據之核實副本，請於適當空格內畫上「✓」號。

To be completed by the Insured (Patient) 由受保人（病人）填寫 – Part 1/2 部分
（or his/her parent if the Insured is aged below 18 若受保人之年齡在 18 歲以下，請由其家長填寫）

To avoid delay in processing your claim due to incomplete information, please complete all the below information in English BLOCK letters.
為免因資料不全而延遲處理閣下之索償申請，請以英文正楷填妥下列所有資料。

Name of Policyholder/Employer 保單持有人姓名 / 僱主名稱	Policy No. 保單號碼	Staff No. (if applicable) 職員編號（如適用）
Name of Employee in English (if applicable) 僱員之英文姓名（如適用）	Employee's Insured No. (if applicable) 僱員之受保人號碼（如適用）	HKID Card No. 香港身份證號碼
Name of Insured (Patient) in English 受保人（病人）之英文姓名	Patient's Insured No. (must be provided) 病人之受保人號碼（必須提供）	HKID Card No. 香港身份證號碼

☐ Original receipt will not be returned once submitted. Please put a "✓" in this box for request of certified true copy of receipt for other insurance claims.
一經遞交之收據正本將不獲發還，如需索取收據之核實副本辦理其他保險索償，請於方格內畫上「✓」號。

Please fill in the nature of claim and breakdown of charges 請填寫索償性質及各項收費

No. 序號	Date of Consultation/ Treatment 診症 / 治療日期 (DD/MM/YY 日 / 月 / 年)	Nature of Claim (please put a "✓" in the appropriate box) 索償性質（請於適當方格內畫上「✓」號） General Practitioner's Consultation 普通科醫生診症	Specialist's Consultation* 專科醫生診症*	Chinese Medicine Practitioner Treatment# 中醫治療#	Diagnostic X-rays and Lab Tests* X光診斷及化驗*	Prescribed Medicine and Drugs** 處方藥物**	Others (please specify, e.g. Physiotherapy*, Chiropractic*, Routine Check-up, etc.) 其他（請註明，如：物理治療*、骨格治療*、常規健康檢查等）	If Post-hospitalisation/Surgical follow up visit, please specify the date of Hospitalisation/Surgery 如住院 / 手術後的覆診，請註明住院 / 手術日期 (DD/MM/YY 日/月/年)	Total amount indicated on the receipts (please specify currency) 收據總金額（請列明貨幣）
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

*Doctor's referral letter is required unless it is waived 除已獲豁免外，必須連同醫生轉介信遞交
#Chinese Medicine prescription is required (if applicable) 必須連同中醫處方遞交（如適用）
**Doctor's prescription is required unless it is waived 除已獲豁免外，必須連同醫生處方遞交

Blue Cross (Asia-Pacific) Insurance Limited 藍十字（亞太）保險有限公司
www.bluecross.com.hk

MC037/02.2023

To be completed by the Insured (Patient) 由受保人（病人）填寫 – Part 2/2 部分

Have you ever made any other insurance or compensation claim(s) resulting from this treatment? 有關此次治療，閣下有否曾經申請其他保險 / 賠償？ ☐ Yes 是 ☐ No 否

Are you going to make any other insurance or compensation claim(s) resulting from this treatment? 有關此次治療，閣下是否將會申請其他保險 / 賠償？ ☐ Yes 是 ☐ No 否

If yes, please provide 如是請提供

(i) Name of Insurance Company 保險公司名稱 _____ (ii) Policy No. 保單號碼 _____

(iii) Type of Insurance Product 保險產品類別 (applicable to Insured under Caring Medical Protection Plus 只適用於「醫安心精選」醫療保險計劃之受保人)
☐ Group Medical Insurance 團體醫療保險 / ☐ Individual Medical Insurance 個人醫療保險 / ☐ Others 其他

If treatment is due to pregnancy, please give expected date of delivery. 若治療是因懷孕引致，請提供預產日期。Claims will be processed after the delivery of baby and the submission date of documentary proof will be extended to 60 days from the date of delivery (applicable to those members with Maternity Benefits) 索償申請會於分娩後處理，遞交證明文件之期限將延長至由嬰兒出生日起計60天內（適用於附有產科保障的成員）。 _____ (DD/MM/YY 日 / 月 / 年)

Declaration and Authorisation 聲明及授權書

1. I/We have obtained all necessary authorisation from my/our dependents (if applicable) to supply their information to Blue Cross (Asia-Pacific) Insurance Limited ("the Company") or its authorised representative if my/our dependents are parties to the claim request(s). I/We also understand that the information requested in this form is required in order for the Company to process these claims.
2. I/We hereby authorise any hospital, physician, medical practitioner, medically related service provider, insurance company, person, party and/or authority that has any records or is holding any information of the insured person or me/us to disclose to the Company or its authorised representative, any and all information with respect to the insured person's or my/our loss, disability, claim history, medical history, police statement made and the like for the purpose of assessing the insured person's or my/our claim request(s). A photocopy of this authorisation shall have the same effect as the original.
3. I/We hereby declare that all the above information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief. I/We have not withheld any material information and acknowledge that failure to supply true and accurate answers to this request or inform the Company of all material information may render the Company unable to accept or process this request and all rights to recover under the Policy shall be forfeited. I/We understand that the issuance or completion of this application does not constitute admission of liability or guarantee payment of the claim on behalf of the Company.
4. I/We confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form.
5. I/we agree and understand that the claims' information (including but not limited to submitted medical records) may be disclosed to the Employee's Insured.

1. 如本人 / 我們之家屬為賠償申請之一方，本人 / 我們已向家屬取得一切所需授權（如適用），向藍十字（亞太）保險有限公司（「貴公司」）或其授權代表提供其個人資料，本人 / 我們亦明白本表內所提供的資料是讓貴公司作處理本人 / 我們索償之用。
2. 本人 / 我們謹此授權任何持有受保人或本人 / 我們之任何記錄或資料的醫院、醫生、醫學界執業人士、與醫療有關的服務供應商、保險公司、有關人士、機構、及 / 或有關當局，向貴公司或其授權代表提供任何或所有有關受保人或本人 / 我們之損失、傷害、殘廢記錄、病歷、口供或任何相關資料作評估受保人或本人 / 我們的賠償申請之用途。此授權書之正本及副本皆具同等效力。
3. 本人 / 我們謹此聲明，上述所有問題的答案包括所有資料及細節均是準確無誤、真實及為事實之全部，並且是盡本人 / 我們所知及所信而作答的。本人 / 我們並沒有隱瞞任何重要資料及確認如未能提供真實及準確無誤之資料或通知貴公司任何有關此賠償申請之重要資料，將可能導致貴公司不能接受或處理此索償申請及喪失所有追討保單權益之權利。本人 / 我們明白發出或填妥此賠償表格並不代表貴公司確認責任或保證賠償。
4. 本人 / 我們確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。
5. 本人 / 我們同意並理解，索償的資料（包括但不限於已提交的醫療記錄）可能會提供給僱員之受保人。

Signature of Insured (Patient) 受保人（病人）簽署 _____ Date 日期 (DD/MM/YY 日 / 月 / 年) _____

In the event of the patient aged below 18, this form should be signed by his/her parent. 倘若病人之年齡在 18 歲以下，本申請表須由其家長簽署。

Claims Procedure – Dental Treatment
索償程序 – 牙科治療

Completed by Dentist 由主診牙科醫生填寫

Completed by insured member 由受保人填寫

Blue Cross 藍十字
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收集個人資料聲明 Personal Information Collection Statement

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DENTAL TREATMENT CLAIM FORM 牙科治療索償申請表

Enjoy Speedy Claim Submission via eClaim in 3 simple steps
1. Input claim details
2. Upload the scanned copies/photos of receipt
3. Confirm

透過電子索償平台簡單 3 步遞交索償申請
1. 輸入索償資料
2. 上載收據之掃描副本 / 相片
3. 確認

Download now 立即下載
Blue Cross HK App

Claim Notes
1. This form is applicable to dental treatment claim. **Each claim form is for one insured only.**
2. You can find the Policy number and Insured number on Blue Cross Certificate of Insurance or Blue Cross Healthcare Card, you may also visit www.bluecross.com.hk/supercare to view account information after logging in.
3. Please print this claim form on A4 size paper and send it together with the original receipts to Medical Claims Department of Blue Cross (Asia-Pacific) Insurance Limited ("The Company") within 90 days from dental treatment completion date. The Company's Personal Information Collection Statement as accompanied with this form is for your reference and retention, please do not return it along with your claim application.
4. The Company is entitled to request for your provision of further information and documents or completion of other specific claim forms.

Claim Instructions
1. Attach the **original** receipts issued by the dentist or certified true copy of receipts issued by other insurers (if applicable). Each receipt **MUST** state the following information:
   - Full name of patient/insured
   - Date of treatment
   - Breakdown of charges
   - Dentist's signature and official stamp
2. Complete and sign this form.
3. Provide copy of claim settlement advice from other insurers, if applicable.
4. Original receipt will not be returned once submitted. Please tick the appropriate box if certified true copy of receipt is required.

索償注意事項
1. 此申請表適用於牙科治療索償。**每名受保人須填立填寫申請表。**
2. 您可於藍十字保險證明書或藍十字醫療卡上查看保單號碼及受保人號碼，您亦可登入 www.bluecross.com.hk/supercare 查閱帳戶資料。
3. 請以 A4 紙打印此索償申請表，並於完成牙科治療後 90 天內，連同收據正本一併交回藍十字（亞太）保險有限公司（「本公司」）醫療保險理賠部，隨本申請表附上的收集個人資料聲明，是供閣下參閱及保留之用，請無需於提交索償申請時退回。
4. 本公司有權要求閣下提供更多資料及文件或填寫其他專用索償表格。

索償申請指示
1. 附上由牙科醫生簽發的收據**正本**或由其他保險公司發出的收據核實副本（如適用）。每張收據**必須**列明以下資料：
   - 病人／受保人姓名
   - 治療日期
   - 收費項目說明
   - 牙科醫生簽署及蓋章
2. 填妥此申請表及簽署。
3. 如適用，請提供其他保險公司之賠償結算通知書副本。
4. 一經遞交之收據正本將不獲發還。如需索取收據之核實副本，請於適當空格內畫上「✓」號。

Part I 甲部 – To be completed by the Insured (Patient) 由受保人（病人）填寫 – Part 1/2 部分

（or his/her parent if the Insured is aged below 18 若受保人之年齡在 18 歲以下，請由其家長填寫）

To avoid delay in processing your claim due to incomplete information, please complete all the below information in English BLOCK letters.
為免因資料不全而延遲處理閣下之索償申請，請以英文正楷填妥下列所有資料。

Name of Policyholder/Employer 保單持有人姓名 / 僱主名稱	Policy No. 保單號碼	Staff No. (if applicable) 職員編號（如適用）
Name of Employee in English (if applicable) 僱員之英文姓名（如適用）	Employee's Insured No. (if applicable) 僱員之受保人號碼（如適用）	HKID Card No. 香港身份證號碼
Name of Insured (Patient) in English 受保人（病人）之英文姓名	Patient's Insured No. (must be provided) 病人之受保人號碼（必須提供）	HKID Card No. 香港身份證號碼

☐ Original receipt will not be returned once submitted. Please put a "✓" in this box for request of certified true copy of receipt for other insurance claims.
一經遞交之收據正本將不獲發還。如需索取收據之核實副本辦理其他保險索償，請於方格內畫上「✓」號。

Declaration and Authorisation 聲明及授權書

1. I/We have obtained all necessary authorisation from my/our dependents (if applicable) to supply their information to Blue Cross (Asia-Pacific) Insurance Limited ("the Company") or its authorised representative if my/our dependents are parties to the claim request(s). I/We also understand that the information requested in this form is required in order for the Company to process these claims.
2. I/We hereby authorise any hospital, physician, medical practitioner, medically related service provider, insurance company, person, party and/or authority that has any records or is holding any information of the insured person or me/us to disclose to the Company or its authorised representative, any and all information with respect to the insured person's or my/our loss, disability, claim history, medical history, police statement made and the like for the purpose of assessing the insured person's or my/our claim request(s). A photocopy of this authorisation shall have the same effect as the original.
3. I/We hereby declare that all the above information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief. I/We have not withheld any material information and acknowledge that failure to supply true and accurate answers to this request or inform the Company of all material information may render the Company unable to accept or process this request and all rights to recover under the Policy shall be forfeited. I/We understand that the issuance or completion of this application does not constitute admission of liability or guarantee payment of the claim on behalf of the Company.
4. I/We confirm having read and understood the Company's Personal Information Collection Statement as accompanied with this form.
5. I/we agree and understand that the claims' information (including but not limited to submitted medical records) may be disclosed to the Employee's Insured.

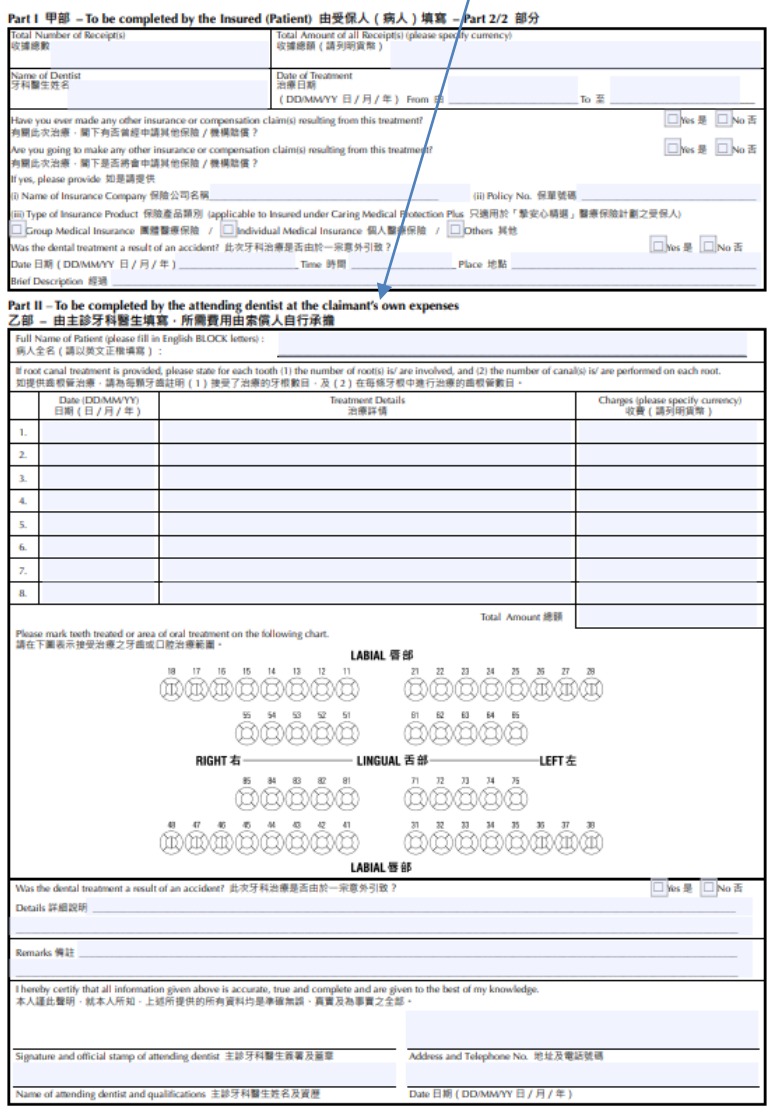
1. 如本人／我們之家屬為賠償申請之一方，本人／我們已向家屬取得一切所需授權（如適用），向藍十字（亞太）保險有限公司（「貴公司」）或其授權代表提供其個人資料，本人／我們亦明白本表內所提供的資料是讓貴公司作處理本人／我們索償之用。
2. 本人／我們謹此授權任何持有受保人或本人／我們之任何記錄或資料的醫院、醫生、醫學界執業人士、與醫療有關的服務供應商、保險公司、有關人士、機構、及／或有關當局，向貴公司或其授權代表提供任何或所有有關受保人或本人／我們之損失、殘疾、索償記錄、病歷、口供或任何相關資料作評估受保人或本人／我們的賠償申請之用途。此授權書之正本及副本皆具同等效力。
3. 本人／我們謹此聲明，上述所有問題的答案和填寫的所有資料及細節均是準確無誤、真實及為事實之全部，並且是盡本人／我們所知及所信而作答的。本人／我們並沒有隱瞞任何重要資料及確認如未能提供真實及準確無誤之資料或通知貴公司任何有關此賠償申請之重要資料，將可能導致貴公司不能接受或處理此索償申請及喪失所有施行保單權益之權利。本人／我們明白發出或填妥此賠償表格並不代表貴公司確認責任或保證賠償。
4. 本人／我們確認已閱讀及明白隨本表格附上有關貴公司的收集個人資料聲明。
5. 本人／我們同意並理解，索償的資料（包括但不限於已提交的醫療記錄）可能會提供給僱員之受保人。

Signature of Insured (Patient) 受保人（病人）簽署 | Date 日期（DD/MM/YY 日 / 月 / 年）

In the event of the Insured aged below 18, this form should be signed by his/her parent. 倘若受保人之年齡在 18 歲以下，本申請表須由其家長簽署。

Blue Cross (Asia-Pacific) Insurance Limited 藍十字（亞太）保險有限公司
www.bluecross.com.hk

MC032/02.2023



Part I 甲部 – To be completed by the Insured (Patient) 由受保人（病人）填寫 – Part 2/2 部分

Total Number of Receipt(s) 收據總數	Total Amount of all Receipt(s) (please specify currency) 收據總額（請列明貨幣）
Name of Dentist 牙科醫生姓名	Date of Treatment 治療日期 （DD/MM/YY 日 / 月 / 年） From 由 _____ To 至 _____

Have you ever made any other insurance or compensation claim(s) resulting from this treatment? 有關此次治療，閣下有否曾經申請其他保險 / 機構賠償？ ☐Yes 是 ☐No 否

Are you going to make any other insurance or compensation claim(s) resulting from this treatment? 有關此次治療，閣下是否將會申請其他保險 / 機構賠償？ ☐Yes 是 ☐No 否

If yes, please provide 如是請提供

(i) Name of Insurance Company 保險公司名稱 _____ (ii) Policy No. 保單號碼 _____

(iii) Type of Insurance Product 保險產品類別 (applicable to Insured under Caring Medical Protection Plus 只適用於「摯安心精選」醫療保險計劃之受保人)

☐ Group Medical Insurance 團體醫療保險 / ☐ Individual Medical Insurance 個人醫療保險 / ☐ Others 其他

Was the dental treatment a result of an accident? 此次牙科治療是否由於一宗意外引致？ ☐Yes 是 ☐No 否

Date 日期 (DD/MM/YY 日 / 月 / 年) _____ Time 時間 _____ Place 地點 _____

Brief Description 概要 _____

Part II – To be completed by the attending dentist at the claimant's own expenses
乙部 – 由主診牙科醫生填寫，所需費用由索償人自行承擔

Full Name of Patient (please fill in English BLOCK letters) :
病人全名（請以英文正楷填寫）：

If root canal treatment is provided, please state for each tooth (1) the number of root(s) is/ are involved, and (2) the number of canal(s) is/ are performed on each root.
如提供牙根管治療，請為每顆牙齒註明（1）接受了治療的牙根數目，及（2）在每條牙根中進行治療的管根管數目。

	Date (DD/MM/YY) 日期（日 / 月 / 年）	Treatment Details 治療詳情	Charges (please specify currency) 收費（請列明貨幣）
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
		Total Amount 總額	

Please mark teeth treated or area of oral treatment on the following chart.
請在下圖表示接受治療之牙齒或口腔治療範圍。

LABIAL 唇部
18 17 16 15 14 13 12 11 | 21 22 23 24 25 26 27 28
55 54 53 52 51 | 61 62 63 64 65
RIGHT 右 — LINGUAL 舌部 — LEFT 左
85 84 83 82 81 | 71 72 73 74 75
48 47 46 45 44 43 42 41 | 31 32 33 34 35 36 37 38
LABIAL 唇部

Was the dental treatment a result of an accident? 此次牙科治療是否由於一宗意外引致？ ☐Yes 是 ☐No 否

Details 詳細說明 _____

Remarks 備註 _____

I hereby certify that all information given above is accurate, true and complete and are given to the best of my knowledge.
本人謹此聲明，就本人所知，上述所提供的所有資料均是準確無誤、真實及為事實之全部。

Signature and official stamp of attending dentist 主診牙科醫生簽署及蓋章 | Address and Telephone No. 地址及電話號碼

Name of attending dentist and qualifications 主診牙科醫生姓名及資歷 | Date 日期 (DD/MM/YY 日 / 月 / 年)