FALCON
Falcon Insurance Company (Hong Kong) Limited
富勤保險(香港)有限公司

AAA MediCare
特級醫保有限公司

AAA MEDICARE – HOSPITALIZATION & SURGICAL CLAIM FORM

INSTRUCTIONS 填寫指示：

1. This Form is to be completed by the Insured Member, the Attending Physician and Surgeon.
   此表格必須由受保人、主診醫生及外科醫生填寫。
2. If the claimant is the Insured member, please complete Part 1 - item 2 only and leave item 3 blank. If the claimant is the Dependant, complete both item 2 and 3.
   如賠償申請人乃受保人，只需填寫第一部份之項目2。如賠償申請人乃家屬，請填寫項目2和3。
3. Written notice of hospital confinement should be submitted within 20 days from the commencement of such confinement.
   請於住院日起計20日內遞交住院之書面通知。
4. Original itemized bills and receipts and this Form must be submitted within 90 days from the date discharged from hospital.
   請於出院日起計90日內將正本詳列之賬單及收據連同賠償表格一起遞交。
5. This Form must be fully completed and signed and the information supplied on all bills and receipts should be clearly stated. Otherwise, documents submitted will be returned for verification or other necessary actions.
   此表格必須祥盡填寫生由受保人簽署。賬單及收據所列之資料必須清楚明確，否則所遞交之文件會被退回查前。
6. Documents returned must be re-submitted within 90 days of incurring such expenses. Otherwise, such claim will be declined.
   被退回之文件必須於費用支出後90日內再次遞交，否則此賠償申請將不獲受理。
7. No benefit is payable for items and conditions listed under 'EXCLUSIONS' in the Policy.
   在保單之「不受保障範圍」內之項目將不在賠償之列。

Part 1 - To be completed by the Insured Member 第一部份 — 由受保人填寫

1a. Policy No. 保單號碼	b. Policyholder 保單持有人名稱		
2a. Ref. No. 參照號碼	b. Name of Insured Member 受保人姓名 Surname 姓 Other name 名		
3a. Ref. No. 參照號碼	b. Name of Claimant (if not Insured Member) 賠償申請人姓名（如與受保人不同） Surname 姓 Other name 名	c. Relationship 關係	d. Occupation 職業
4. Date admitted to Hospital 入院日期	5. If hospitalization was the result of an accident, please describe when, where and how the accident happened? 如因意外入院，請敘述時間、地點及發生過程。		

6. If confinement is due to childbirth, please complete: 如因分娩住院，請填此欄：

Name of Child 子女姓名	Date of Birth 出生日期

7. Has the Claimant had any prior treatment for the same or closely interrelated cause? If yes, please complete:
   賠償申請人以前曾否接受過同樣或相關原因之治療？如「有」，請填此欄：

Date admitted/Treated 入院 / 治療日期	Date discharged 出院日期	Cause 原因	Name & address of Doctor 醫生姓名及地址	Name and address of Hospital 醫院名稱及地址

8a. Are you making any other insurance or compensation claim as a result of this hospitalization? 你有否因這次入院而申請其他保險賠償或補償？ ☐ Yes 有 Result 結果： ☐ No 無	b. Name of Insurance Company / Type of Compensation 保險公司名稱 / 補償類別

1) I hereby declare that the foregoing statements, including any statement attached, are true, correct and complete to the best of my knowledge and belief.

2) **Personal Information Collection Statement**
The information you provide to **Falcon Insurance Company (Hong Kong) Ltd.** is collected to enable the company to carry on insurance business and may be used for the purpose of (i) any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or service; (ii) any claim or investigation or analysis of such claim; and (iii) exercising any right of subrogation. The information may be transferred to (i) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claim or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; (ii) 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 (iii) any members of the "Federation" by the "Federation" for any of the above or related purposes. Moreover, **Falcon Insurance Company (Hong Kong) Ltd.** is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance industry. You have the right to obtain access to and to request correction of any personal information concerning yourself held by **Falcon Insurance Company (Hong Kong) Ltd.** Requests for such access can be made to our compliance officer (36/F., The Lee Gardens, 33 Hysan Avenue, Causeway Bay, Hong Kong. Tel: 2232 2888 Fax: 2232 2799).

3) **Consent**
In accordance with the provisions of the Personal Data (Privacy) Ordinance of Hong Kong, I/and on behalf of the Claimant* consent, by signing below, that the personal information of me/the Claimant* provided by me/us* and held by **Falcon Insurance Company (Hong Kong) Ltd.** (whether contained herein or otherwise obtained) may be held, used, disclosed, released and transferred by **Falcon Insurance Company (Hong Kong) Ltd.** to the parties and for the purposes mentioned in the "Personal Information Collection Statement".

4) **Authorization**
a) I hereby authorize/and on behalf of the Claimant hereby authorize* (i) any dentist, doctor, hospital, clinic, or insurance company, government office or any organization or persons who has any records/knowledge/information of me/the Claimant* (whether medical or otherwise) to disclose, release or transfer to **Falcon Insurance Company (Hong Kong) Ltd.** or its representative such record, knowledge or information pertinent to the claim herein and/or the disability resulting from the said claim; (ii) **Falcon Insurance Company (Hong Kong) Ltd.** or any of its appointed medical/para-medical examiners or laboratories to perform necessary oral examination, medical assessment and tests to evaluate the health status of me/the Claimant *in relation to (i) above.
b) This authorization shall bind the successors and assignees of me/the Claimant* and remains valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original.
*delete where appropriate.

1) 本人謹在此聲明，以上所述一切及根據本人所知所信正確填寫，並為完全和真確。

2) 收集個人資料聲明
閣下提供的資料，為**富勤保險(香港)有限公司**提供保險業務所需，並可能使用於下列目的：(i) 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；(ii) 任何索償，或該等索償的調查或分析；(iii) 行使任何代位權。該等資料可能被轉予：(i) 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；(ii) 現存或不時成立的任何保險公司賠會或聯會或類同組織（「聯會」），以達到任何上述或有關目的，或以使「聯會」執行其監管功能，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就予「聯會」的職能；及 (iii) 或透過「聯會」形轉予任何「聯會」的會員，以達到任何上述或有關目的。此外，在此授權**富勤保險(香港)有限公司**由「聯會」從保險業內收集的資料中查閱及/或核對閣下任何資料。閣下有權查閱及要求更正由**富勤保險(香港)有限公司**持有有關閣下的個人資料。如有需要，可向本公司監察主任(香港銅鑼灣希慎道33號利園36樓 電話：2232 2888 傳真：2232 2799) 提出。

3) 同意書
根據香港個人資料(私隱)條例，就簽署此賠償表格，本人同意/謹代表賠償申請人同意*富勤保險(香港)有限公司可持有或使用任何有關本人/賠償申請人*之個人資料(不論是否從此賠償表格或其他途徑所得)，或將該等資料透露、發放或轉交予「收集個人資料聲明」內提及之組織、機構或人士作為有關之用途。

4) 授權
a) 本人謹此授權/謹此代表賠償申請人授權*(i) 任何牙科醫生、醫生、醫院、診所、保險公司、政府部門或其他機構及人士，向**富勤保險(香港)有限公司**或其代表透露及提供關於本人/賠償申請人*之記錄或資料；(ii) **富勤保險(香港)有限公司**或其指定之醫護檢查人員或化驗所對本人/賠償申請人*進行與(i)有關之口腔檢查、身體檢查及化驗。
b) 此授權對本人/賠償申請人*之繼承人及受讓人均有約束力，即使在本人/賠償申請人*身故或喪失行為能力後仍然有效。此授權書之副本，與正本同樣有效。
*請將不適用者刪除

Date 日期 _____

Signature of Insured Member 受保人簽署 _____

Room 1007, Eastern Harbour Center,
No. 28 Hoi Chak Street,
Quarry Bay, Hong Kong

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Fax 傳真 : (852) 3160-4312
Website 網址 : www.aaamedicare.com

香港鰂魚涌
海澤街 28 號
東港中心 1007 室

Part 2 - To be completed by the Attending Physician 第二部份 — 由主診醫生填寫

1. Name of patient 病者姓名	2. Name of Hospital 醫院名稱	3. Date admitted 入院日期	Date discharged 出院日期

4. Complete diagnosis for hospitalization 住院之診斷	5. Cause, pathology & brief history of disability 病因、病理及簡略之病歷

6. When did the patient first consult you for this condition or other related symptoms? 病者何時因這種病症或其他有關病徵向你首次求診？	7. How long had the patient been experiencing such symptoms prior to this first consultation? 在首次求診前，病者經歷了該病徵有多久？

8. In your opinion, how long were these symptoms presented prior to this first consultation? Did you inform the patient of your opinion? 根據你的意見，在首次求診前，該病徵出現了多久？有否將你的意見通知病者？	9. Was the patient referred to you by another doctor? (No/Yes) If yes, please state the name of the doctor 病者是否由另一醫生轉介？（是/否）如「是」，請提供該醫生之姓名

10. Has the patient been hospitalized for the same or closely interrelated condition before?
If yes, please complete: 病者以往曾否因同樣或相關之病症而住院？如「有」，請填寫：

Date admitted 入院日期：	Name of Hospital 醫院名稱：
Date discharged 出院日期：	Cause 入院原因：
	Result 結果：

11. Is the condition due to or associated with the following? 上述情況是否因以下問題所致?

	Yes是	No否		Yes是	No否
(a) congenital anomalies ? 先天性缺陷	☐	☐	(f) AIDS,venereal disease or sexually transmitted disease ? 愛滋病、性病或因性接觸感染之疾病	☐	☐
(b) self-inflicted injury ? 自我傷害	☐	☐	(g) pregnancy, contraception, infertility or sterilization ? 懷孕、避孕、不育或絕育	☐	☐
(c) the influence of drugs or alcohol ? 酒精或藥物之影響	☐	☐	(h) refractive error or correction of eyesight ? 視力不正常	☐	☐
(d) mental or nervous disorder ? 精神或神經病	☐	☐	(i) routine medical check-up 一般身體檢查	☐	☐
(e) cosmetic or plastic surgery ? 美容或整形手術	☐	☐	(j) rest cure or sanitaria care ? 休養或療養	☐	☐

12. Have you recommended and secured the opinion or services of a specialist? 你曾否獲得專科醫生之意見或服務？ ☐ Yes 有 ☐ No 無 If yes, please give the name of the Specialist and the reason why his opinion or services are required. 如「有」，請提供該專科醫生之姓名及需要專科醫生意見或服務之理由。	13. In-hospital Doctor Visit Fees charged 醫生巡房收費 日數_____days 每日@_____ Total Fees 費用總額：

14. If confinement is due to childbirth 如因分娩住院

a. approximate date of commencement of pregnancy 懷孕開始之大概日期 Day日 Month月 Year年	b. it should be classified as a 分娩類別 ☐ Normal Delivery 順產 ☐ Miscarriage 流產 ☐ Caesarian Birth 剖腹生產

I hereby declare that I was the Attending Physician of the above-named patient during his/her hospital confinement, and that the answers given by me as above are full, complete and true to the best of my knowledge. 本人謹在此聲明，本人乃上述住院病者之主診醫生。以上所述一切是根據本人所知正確填寫，並為完全和真確。

Date 日期	Name, Qualifications & Address of Physician 主診醫生之姓名、資歷及地址	Physician's Signature & Official Stamp 主診醫生簽署及蓋章

Part 3 - To be completed by the Surgeon if operation was performed 第三部份 — 如需動手術，此欄由外科醫生填寫。

1. Name of Patient 病者姓名	2. Date of Operation 手術日期	3. Where performed 手術地點

4. Brief description of operating procedure performed 請簡略敘述手術進行之步驟

5. Surgical Fees charged 外科手術費用	6. Name of Anaesthetist & Qualifications 麻醉師姓名及資歷	7. Anaesthetist Fees charged 麻醉師費用

I hereby declare that the above patient had a surgical operation done by me, and that the answers given by me as above are complete and true to the best of my knowledge. 本人謹在此聲明，上述病者曾接受由本人負責之外科手術。以上所述一切是根據本人所知正確填寫，並為完全正確。

Date 日期	Name, Qualifications & Address of Surgeon 外科醫生之姓名、資歷及地址	Surgeon's Signature & Official Stamp 外科醫生簽署及蓋章

* 本賠償表格之中文譯本只供參考之用，如有爭議，應以英文原義為準。