HSBCMIN

滙豐保險 HSBC Life

CLAIM FORM 索償表格

Hospital Cash Benefit Claim Form

住院現金保障索償表

HSBC Life (International) Limited, incorporated in Bermuda with limited liability (the "Company" or "HSBC Life")
滙豐人壽保險(國際)有限公司(註冊成立於百慕達之有限公司)(「本公司」或「滙豐保險」)

PLEASE SUBMIT THE FORM AND RELEVANT DOCUMENTS TO ONE OF THE AVAILABLE CHANNELS BELOW. 請將表格和相關文件用以下其中一種方式遞交。

- Scan the QR code on your right hand side to upload documents to" Document Upload Service" on HSBC website 您可以掃瞄右方的二維碼上載相關文件到滙豐網站上的「文件上載服務」; OR 或
- Mail to 18/F, Tower 1, HSBC Centre, 1 Sham Mong Road, Kowloon, Hong Kong 郵寄至香港九龍深旺道1號滙豐中心1座18樓; OR 或
- Submit to any HSBC Branch 可於任何滙豐分行遞交

WHAT HAPPENS NEXT 下一步

The process after you send in the claim form
提交此表後的流程

1. We'll let you know the outcome of this claim within 7 business days. 我們將在7個工作日內通知您此索償的結果。
2. If you have any questions about your claim, please call (852) 3128 0122. 如果您對索償有任何疑問，請致電(852) 3128 0122。

CLAIMS DOCUMENT CHECKLIST 索償文件清單

☐ Part I is fully completed & signed by the Policyholder/Claimant/Life Insured 索償表甲部經由保單持有人／索償人／受保人填寫並簽署
☐ Part II is fully completed & signed by the Attending Physician/Surgeon with chop (if admitted into a hospital under the Hospital Authority, please submit the Discharge Summary/Discharge Slip) 索償表乙部經由主診醫生／外科醫生填寫，簽署並蓋印(若入住醫管局轄下之醫院，請提供出院摘要副本／出院紙副本)
☐ Copy of receipt(s) of the medical expenses (including but not limited to deposit receipt) 醫療費用收據副本(包括但不限於按金收據)
☐ Copy of Histopathology, Laboratory Test Report, Endoscopic, Ultrasonogram, X-Ray, CT Scan, MRI, Diagnostic Written Report(s) and Operating theatre summary (if applicable) 病理學、化驗報告、內窺鏡、超聲波、X-光、電腦掃描、磁力共震、手術室摘要及診斷之書面報告副本(如適用)
☐ Copy of Policyholder & Insured's Identity Card 保單持有人及受保人之身份證明文件副本
☐ Copy of Bank Account Proof (applicable for Policyholder's sole or joint name bank account other than Policyholder's premium deduction account) 銀行戶口證明文件副本(適用於保單持有人之個人或聯名非保費轉賬戶口)

Applicable for Child Protection under HSBC Family Protector: 適用於滙家保兒童保障：
☐ Copy of Identity Card of Insured's Child 受保人子女之身份證副本
☐ Copy of Relationship Proof between Insured's Child & Insured 受保人子女與受保人之間關係證明文件副本
☐ Copy of Newborn Hospital Discharge Record or Medical Report and Child Birth Health Record of Insured's Child 受保人子女之初生嬰兒出院記錄或醫療紀錄及健康記錄

PART I – TO BE COMPLETED BY THE INSURED PERSON OR CLAIMANT IN ENGLISH OR CHINESE
甲部 – 由受保人或索償人以英文或中文填寫

DETAILS OF INSURED/INSURED'S CHILD 受保人／受保人子女資料

Policy No. 保單號碼	Name of Insured/Insured's Child 受保人／受保人子女姓名	I.D. Card/Passport No. 身份證／護照號碼
Contact Number 聯絡電話	Email Address 電郵地址	
Correspondence Address 通訊地址		

REASON FOR CLAIM 賠償原因

Diagnosis/Details of Accident 所患之病症／意外詳情	Date when symptoms first appeared / accident happened 病發／意外發生日期

PAYMENT INSTRUCTION 付款指示

☐ By Bank Account 經銀行戶口

☐ Transfer to the policyholder's premium deduction account (not applicable if the bank account is held by someone other than the policyholder's sole or joint name) 轉賬至保單持有人之保費轉帳戶口(不適用於非保單持有人之個人或聯名銀行戶口)

☐ Transfer to the Policyholder's sole or joint name bank account below 轉賬至以下保單持有人之個人或聯名銀行戶口

Bank Name and Branch 銀行及分行之名稱	Bank No. 銀行編號	Branch No. 分行編號	Account No. 賬戶號碼

Notes 註:
Please also submit adequate proof showing the full name and the bank account number of Policyholder's sole or joint name bank account (such as copy of bank book, ATM card, bank statement, etc.) to the company. If we do not receive the copy of the required document(s), the payment will be made by cheque payable to the Policyholder and mailed to the Policyholder's correspondence address. 請同時提交印保單持有人之個人或聯名戶口全名及銀行戶口號碼之充足證明(如銀行存摺或自動櫃員機卡或月結單副本等)。若您沒有提供上述所需文件，款項將以支票形式寄予保單持有人之通訊地址。

☐ By Cheque 以支票形式 (Mail to the Policyholder's correspondence address 寄往保單持有人之通訊地址)

☐ In policy currency (Only applicable for HKD/USD/CNY) 以保單貨幣付款(只適用於港幣／美元／人民幣) ☐ In HKD 以港幣付款

For your attention 請注意：
1. If policy has outstanding levy, The Company will deduct all of the outstanding levy from the claim payment. 如保單有逾期保費徵費，本公司會從賠償金額中扣除有關保單的保費徵費。
2. If the benefit payments are settled in currencies other than the policy currencies/currency of levy cap i.e. HKD as provided by the Insurance Authority, the benefit payments would be subject to the change according to the prevailing exchange rate of policy currencies/HKD to payment currencies to be determined by the Company from time to time. The fluctuation in exchange rates may have impact on the amount of payments. By choosing the payment currency(ies) other than policy currency, you are subject to the exchange rate risks. Exchange rate fluctuates from time to time. You may suffer a loss of your benefit values as a result of the exchange rate fluctuations. 如利益支付款項的貨幣不是以保單貨幣或保險業監管局訂定徵費上限的貨幣(即港幣)支付，該利益支付款項將會受本公司不時釐定的保單貨幣對支付貨幣／港幣的匯率而改變。匯率之波動會對款額構成影響。選擇非保單貨幣結算支付款項，您須承受匯率風險。匯率會不時波動，您可能因匯率之波動而損失部分的利益價值。
3. If the receiving bank account is a non-HSBC bank account, bank charges may incur which will be deducted from the amount payable by the said receiving bank and/or HSBC, if applicable. If you provide a bank account in currency different from the payment currency, the amount payable is subject to exchange rates difference. The Company will not be liable for any charges or loss due to payment settled via non-HSBC bank, currency exchange or rejection of transaction by the receiving bank as a result of incorrect bank account details. 如收款戶口非滙豐銀行之戶口，該銀行及／或滙豐銀行可於款項中收取服務費用，如適用。如您提供與利益支付款項的貨幣不同貨幣的戶口，請留意匯率的兑換差價。本公司將不會承擔任何因不同銀行或貨幣而導致被收取之費用或損失或因銀行戶口資料不乎而被拒絕轉賬之責任。
4. Unless otherwise specified, claim payment will be made according to the current payment instruction (if any) registered with the Company. 如無明確指示，賠償會按本公司的現有記錄轉賬(如有)。

DECLARATION AND AUTHORISATION 聲明及授權

I/we hereby certify that all the answers and statements given above are true and complete and that I/we have not withheld any information. 本人(等)在此聲明以上所提供的資料均屬正確無訛且並無缺漏。

I/we authorise any physician, hospital, clinic, insurance company or other individual organisation or government office that has any records or knowledge of me/us or my/our health, to disclose to HSBC Life (International) Limited or its representative any information relevant to this claim. This authority shall remain valid notwithstanding my death or incapacity and a copy of this authorisation shall be as effective and valid as the original. 本人(等)授權任何知道本人(等)健康情況及據知任何紀錄之醫生、醫院、診所、保險公司或其他私人、政府機構向滙豐人壽保險(國際)有限公司或其代表提供本人(等)之有關資料。此授權書於本人(等)死亡或喪失能力後依然生效。本授權書之影印本亦屬有效。

Personal Information Collection Statement (English)

By signing below, I/we confirm the above application and agree that the Company may use and disclose all personal data about me/us that the Company currently or subsequently hold for the purposes as set out in the Notice relating to the Personal Data (Privacy) Ordinance (which may otherwise be referred to as 'Personal Information Collection Statement'). I understand I can view such notice by scanning the QR code on your right hand side, or else I can request a copy by visiting my local HSBC Branch or by calling the Life Insurance Service Hotline: (852) 2583 8000. 本人(等)在下方簽署即確認上述申請，並同意貴公司可跟據本表格內有關個人資料(私隱)條例的通知書(也可稱為「個人資料收集聲明」)內列出的用途，使用及披露現時或其後持有有關本人(等)的所有個人資料。本人明白可以透過掃描右方的二維碼瀏覽該通知書，或可前往各滙豐分行或致電滙豐人壽保險服務熱線：(852) 2583 8000索取該通知書的副本。

個人資料收集聲明(中文)

SIGNATURE 簽署

Signature of Insured 受保人簽署

Name 姓名

I.D. Card/Passport No. 身份證／護照號碼

Date 日期

Signature of Policyholder 保單持有人簽署

Name 姓名

I.D. Card/Passport No. 身份證／護照號碼

Date 日期

INHK045R15 *(1123)* W

PART II – TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT'S OWN EXPENSES IN ENGLISH OR CHINESE
乙部–由主診醫生／外科醫生以英文或中文填寫，所需費用由索償人自行承擔

A. DETAILS OF INSURED PERSON (PATIENT) 受保人（病人）資料

1. Name of Insured Person (Patient) 受保人（病人）姓名

2. ID card/Passport no. 身份證／護照號碼

B. CLINICAL HISTORY 臨床病歷

3. (a) Date of first consultation 首次求診日期（DD 日／MM 月／YYYY 年）：

(b) Symptom(s)/chief complaint(s) presented onset date 出現病徵／主訴病徵日期（DD 日／MM 月／YYYY 年）：

4. How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前該病徵已存在多久？

C. ABOUT HOSPITALISATION 有關住院

5. (a) Name of hospital 醫院名稱

(b) Date of admission/treatment 入院／治療日期（DD 日／MM 月／YYYY 年）

(c) Date of discharge 出院日期（DD 日／MM 月／YYYY 年）

6. Final diagnosis at the time of discharge 出院時最後的診斷

7. Name of surgery/treatment 手術或治療名稱

D. PROFESSIONAL OPINION 專業意見

8. In your opinion, was the hospitalisation a result of recurrent episode/chronic illness or related to a previous condition? 您認為是次住院是因為復發性／長期疾病或之前的疾病／意外？ ☐ Yes 是 ☐ No 否

If yes, please provide date of the first episode and details. 如是，請提供首次發病日期及詳情

9. Was the condition due to or associated with the following? 上述情況是否與以下問題有關?

☐ Accidental bodily injury 意外身體受傷 ☐ Self-inflicted injury 自我傷害 ☐ Abuse of drugs or alcohol 濫用藥物或酒精
☐ Mental disorder 精神紊亂 ☐ Refractive error 屈光不正 ☐ Developmental condition 發育問題
☐ Infertility or sterilization 不育或絕育 ☐ Contraception 避孕 ☐ Treatment for cosmetic purpose 美容性質的治療
☐ Vaccination 疫苗接種 ☐ Pregnancy 懷孕 ☐ Congenital condition 先天性疾病／異常

E. DECLARATION AND AUTHORISATION 聲明及授權

I hereby declare and agree that all statements and answers to all questions are complete and true to the best of my knowledge and belief. 本人謹此聲明及同意上述一切陳述及問題的所有答案，就本人所知所信，均為事實全部並確實無訛。

Name of Attending Physician/ Surgeon (with qualifications) 主診／外科醫生姓名（資歷）	Address 地址	Contact Telephone No. 聯絡電話號碼

Signature and name chop of Attending Physician/Surgeon
主診／外科醫生簽名及蓋章

Date 日期
（DD日／MM月／YYYY年）

INHK045R15 *(1123)* W