MACAU
INSURANCE COMPANY
澳門保險

MediGroup Insurance Plan 團體醫療計劃

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

Applicable to both in-patient and out-patient surgical claims 住院或門診手術索償適用

(Internal Use Only 此欄由本公司填寫)	Claim No. 索償編號	Date Received 接收日期

PART 1 - TO BE COMPLETED BY THE PATIENT 甲部 – 由病人填寫

Name of Employer / Policyholder 僱主／團體名稱	Policy No. 保單編號
Name of Employee / Member 僱員／成員姓名	
Certificate / Staff No.證明書／職員編號	Daytime Contact No. 日間聯絡電話

Name of Patient 病人姓名			I.D. Card No.身份證號碼
Occupation 職業	Date of Birth 出生日期	日 D　月 M　年 Y	Gender 性別 ☐ M 男 ☐ F 女

Relationship to the Employee / Member 與僱員／成員之關係 ☐ Self 本人 ☐ Spouse 配偶 ☐ Child 子女 ☐ Others 其他

1 Have you / the claimant had any prior treatment for this or related conditions 閣下／索償申請人有否曾經因同一病況而接受治療？

☐ NO 沒有 ☐ YES 有 Name of Doctor 醫生姓名 _____

Address 地址 _____

Date(s)日期 _____

2 Are you / the claimant making any other insurance claim as a result of this hospitalization / surgery 有關此次住院／手術，閣下／索償申請人有否申請其他保險賠償？

☐ NO 沒有 ☐ YES 有 Name of Insurance Company 保險公司名稱 _____ Policy No. 保單號碼 _____

3 Was the hospitalization / surgery a result of an accident 此次住院／手術是否由於一宗意外引致？

☐ NO 不是 ☐ YES 是 Accident Date 意外日期 _____ Time 時間 _____ Place 地點 _____

Brief Description 經過 _____

_____

Note

1) This form and relevant original medical receipts must be submitted to MIC within 30 days from the date of discharge from hospital. Otherwise, the claim shall be declined for reimbursement.
2) Claim payment will be subject to the terms and conditions set out in the corresponding Master Policy.
3) Incomplete form or omission of required information may cause delay in processing.

注意

1) 在出院後三十天內，索償人士必須將此申請表連同有關正式收據提交予本公司處理，逾期無效。
2) 一切賠償款項將根據有關主保單上的條文計算。
3) 若此申請表未完全填妥或未有提供足夠理賠資料，賠償處理可能會被延誤。

Declaration & Authorization

I/We hereby declare and agree that any personal information collected or held by Macau Insurance Company Limited ("the Company") (whether contained in this claim application or otherwise obtained) is provided and may be held, used, and disclosed by the Company to individuals/organizations associated with the Company or any selected third party (within or outside of Macau, including reinsurance and claims investigation companies and industry associations/federations) for the purposes of processing this application and providing subsequent services, and data matching, and to communicate with me/us for such purposes. I/We understand that I/we have the right to obtain access to and to request correction of any personal information held by the Company concerning me/us (and my/our dependants, if any). I/We also hereby irrevocably authorize:

a) any organization, institution, or individual that has any record or knowledge of my health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to the Company such information. This authorization shall bind my successors and assigns and remain valid notwithstanding my death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.
b) the Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate my health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.

聲明及授權書

本人／我們現聲明並同意，澳門保險股份有限公司（"貴公司"）可保留、使用或透露貴公司所收集或保留之任何有關本人／我們的個人資料（在此申請書所載或從其他途徑取得），給予貴公司有關的人士／機構或任何被選定的機構（在本澳或海外的，包括再保險及賠償調查公司，及有關的行業協會／聯會），用作處理本申請及提供其後的服務，及資料核對等用途，及因此等用途與本人／我們聯絡。本人／我們明白到本人／我們有權向貴公司查閱及申請改正所有與本人／我們（及受本人／我們受供養人，如適用）的個人資料。本人／我們不可撤回地授權：

a) 任何知悉或擁有本人之健康狀況及病歷或任何治療或諮詢記錄及曾為或將為本人診治之機構、組織或人士，向貴公司透露有關資料。即使本人死亡或喪失能力，此授權書仍然存有法律效力，而本人之繼承人及轉讓人亦會受此授權書約束。此授權書之正本與副本同屬有效。
b) 貴公司或任何其認可之驗身醫生或化驗所，替本人進行所需之醫療評估及測試，並對本人之健康狀況進行審核及評估，作為處理本申請及其後與之有關的賠償事宜。此等化驗包括，但並不限於膽固醇及有關之血脂肪、糖尿病、腎或肝功能失常、愛滋病或感染人體免疫力缺乏症病毒、免疫系統失常或體內藥物、毒品、尼古丁及其他代謝產物之含量等化驗。

Signature of Claimant (18 years of age & over) 索償人（十八歲或以上）簽署	Signature of Employee / Member 僱員／成員簽署	Date Signed 簽署日期

掃碼 網上遞交
Scan QR code to submit online

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www.mic.com.mo

PART 2 - TO BE COMPLETED BY THE SURGEON OR ATTENDING PHYSICIAN 乙部 – 由主診醫生填寫

Name of Patient 病人姓名

Name of Hospital 醫院名稱

Admission Date 入院日期	D 日	M 月	Y 年	Discharged Date 出院日期	D 日	M 月	Y 年

1a Please give chief complaint / diagnosis for this hospitalization 住院期間主要病狀／診斷

_____

_____

1b Describe the type of treatment / surgical procedure given to the patient 病人所接受的治療／手術

_____

_____

2 When were the symptoms first presented or when did the accident happen 首次出現病徵或意外發生的時間?

_____

3a When was the first consultation for this treatment / sickness 此項治療／疾病的首次就醫時間?

_____

3b Has the patient received continuous treatment related to this sickness since then 病人其後有否就同一疾病繼續接受治療?

_____

4 If hospitalization was due to accident, please state how it happened 倘因意外引致住院，請闡述事發經過

_____

_____

5 Was the patient referred to you by another doctor 病人是否經由其他醫生轉介？

☐ No 否 ☐ Yes 是 Doctor's Name 醫生姓名 _____

Address 地址 _____

6a Have you treated the patient for this or related sickness before 以前曾否為該病人就同一或相關疾病進行治療?

☐ No 否 ☐ Yes 是 Details 詳情 _____

6b Was the condition a recurrent episode / a chronic disease? If YES, state the date of first attack 該狀況是否經常出現或為長期病患？ 如"是"，請註明首次出現的日期

☐ No 否 ☐ Yes 是 Details 詳情 _____

7 If the treatment is due to pregnancy, please give the date of conception 倘因懷孕引發治療，請註明受孕日期 D 日 M 月 Y 年

8a Is the hospitalization / treatment medically necessary 該次住院／治療是否有醫學上的必要？

☐ No 否 ☐ Yes 是 Details 詳情 _____

8b For the average patient, what is the usual duration of hospitalization for this sickness 就一般情況而言，該疾病需要住院多少天？

_____

8c Is it possible to provide this treatment on an outpatient basis 該疾病是否可改以門診方式治理？

☐ No 否 ☐ Yes 是 Details 詳情 _____

9 Did any complications arise during hospitalization 病人在住院期間有否出現併發症狀？

☐ No 否 ☐ Yes 是 Details 詳情 _____

Other remarks 其他備註

Name of Attending Physician / Specialist (with qualifications) 主診／專科醫生姓名 (及資歷)	Address 地址
	Telephone 電話
Signature of Attending Physician / Specialist 主診／專科醫生簽名	Date 日期