MassMutual FINANCIAL GROUP℠

| First Policy No.: 第一份保單編號： | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Second Policy No.: 第二份保單編號： | | | | | | | | |

# HOSPITAL BENEFIT CLAIM FORM 住院保障索償申請書 (C02)

| Name of Insured : 受保人姓名 ： | Name of Policy Owner : 保單持有人姓名 ： |
|---|---|
| ID Card No. of Insured : 受保人身份證號碼 ： | ☐ Hospital & Surgical Benefit 住院醫療保障 / Hospital & Surgical Plus 住院醫療多重保 ☐ Hospital Income Benefit 住院現金津貼 ☐ Extra Cancer Benefit 額外癌症多重保 ☐ Others 其他 |

The issue of this form is in no way constitute an admission of liability. During the claim process, no fee, commission or charge of whatever nature shall be paid to the employees or Consultants of MassMutual Asia Limited ("the Company"). All parts must be completed before we will process the claim. In the event of the claim involving any payment to be made by the Company, the Policy Owner / Insured / Assignee must provide valid documentation proofs (such as identity document and address proof) to the satisfaction of the Company for the Company to conduct due diligence pursuant to the Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance, Cap.615.

發出此申請書並不表示美國萬通保險亞洲有限公司("本公司")已承認是次賠償責任。在此索償過程中，索償人無需支付任何費用予本公司之僱員或顧問。本索償申請書所有部份必須填妥。於處理任何索償而涉及本公司需要付款予客戶的情況下，有關之保單持有人 / 受保人 / 承讓人必須提交符合本公司要求之有效証明文件(例如其身份證明及地址證明)，讓本公司能按照於「打擊洗錢及恐怖分子資金籌集(金融機構)條例」第 615 章所載進行客戶盡職審查。

## PART I : CLAIMANT'S STATEMENT 第一部份 ： 索償人聲明

**1. Occupation 職業：**

| | |
|---|---|
| 1a. Insured's Present Occupation: 受保人現時職業 | 1a. _____ |
| 1b. Name and Address of Employer: 僱主名稱及地址 | 1b. _____ |

**2. If hospitalization / surgery was due to accident, please provide: 若因意外受傷而住院/接受手術，請詳述：**

| | |
|---|---|
| 2a. Date of accident: 發生是次意外的日期 | 2a. ____ / ____ / ____ MM 月 DD 日 CCYY 年 |
| 2b. Place and cause of the accident: 意外發生的地點及詳情 | 2b. _____ |
| 2c. Which part(s) of the body was injured: 受傷的身體部位 | 2c. _____ |
| 2d. Had the accident been reported to police? If yes, please attach police report or provide the name of the police station, the file number and vehicle number. 曾否就是次意外報警? 若有，請提供警署報告副本或警署名稱、檔案號碼及車牌號碼 | 2d. ☐ No 沒有報警 ☐ Yes 有報警 Police Station : 報案警署名稱 File No. : 檔案號碼 Vehicle number : 車牌號碼 |

**3. If hospitalization / surgery was due to sickness, please provide: 若因患病而住院/接受手術，請詳述：**

| | |
|---|---|
| 3a. Signs and symptoms: 病徵及病狀 | 3a. _____ |
| 3b. Since when have these signs / symptoms first appeared? 初次呈現病徵/病狀的日期 | 3b. ____ / ____ / ____ MM 月 DD 日 CCYY 年 |

**4. Hospitalization / Surgery 住院 / 手術詳情：**

| | |
|---|---|
| 4a. Date of first consultation for this claimed accident / sickness or related sickness: 此索償意外/疾病或相關疾病的首次診治日期 | 4a. ____ / ____ / ____ MM 月 DD 日 CCYY 年 |
| 4b. Name and address of the Attending Doctor first consulted for this claimed accident / sickness or related condition: 就此索償意外/疾病首次求診之醫生名稱及地址 | 4b. |
| 4c. Regarding the current hospitalization / surgery, please give the period of hospitalization / date of surgery, name of the hospital and name of the attending doctor(s). 就是次入院/手術，請列出留院期/手術日期、醫院名稱及主診醫生姓名 | 4c. ____ / ____ / ____ MM 月 DD 日 CCYY 年 To 至 ____ / ____ / ____ MM 月 DD 日 CCYY 年 Name of the hospital 醫院名稱 Name of the attending doctor 主診醫生姓名 |
| 4d. Did the Insured take any home leave during the hospital confinement? 受保人在住院期間曾否請假離開醫院 | 4d. ☐ No 無 ☐ Yes 有 (from 由 _____ MM/DD/CCYY 月/日/年 to 至 _____ MM/DD/CCYY 月/日/年) Reason(s) 原因 |

☐ Request for Return of Original Receipts / Documents 申請退回正本收據/文件

Signed by Policy Owner 保單持有人簽署 X _____

**5. Past Consultation / Hospitalization Details 過往的就診 / 住院詳情：**

| | |
|---|---|
| 5a. Name and address of Insured's usual medical attendant:<br>受保人的家庭醫生名稱及地址 | 5a. |
| 5b. Except for this claimed condition, the details of the last medical consultation:<br>除是次索償的情況外，上一次曾就診的詳情 | 5b. Date of consultation: _____ / _____ / _____<br>求診日期 MM 月 DD 日 CCYY 年<br>Cause of consultation :<br>求診原因<br>Name and address of the doctor :<br>醫生名稱及地址 |
| 5c. Except for this claimed condition, the details of the last hospitalization:<br>除是次索償的住院 / 手術外，上一次住院的詳情 | 5c. Date of hospitalization 住院日期:<br>_____ / _____ / _____ to _____ / _____ / _____<br>MM 月 DD 日 CCYY 年 至 MM 月 DD 日 CCYY 年<br>Diagnosis :<br>診斷<br>Doctor and hospital information :<br>醫院及醫生資料 |

**6. Others 其他：**

| | |
|---|---|
| 6. As a result of the hospitalization / surgery, has the Insured apply for compensation from other insurance company / organization? If yes, please give details.<br>受保人有否就是次住院/手術向其他保險公司申請任何類型的賠償? 若有，請詳細說明。 | 6. ☐ No 無 ☐ Yes 有<br>Name of company / organization 公司名稱 Policy No./Reference No.保單號碼/參考編號 |

**PERSONAL INFORMATION COLLECTION STATEMENT**

I/We understand and agree my/our personal information (including a record of my/our image or voice by whatever means and my/our health information) collected by or held by MassMutual Asia Limited ("the Company") may be used for the purposes of: (1) approving, evaluating or processing my/our insurance application/policy service request; (2) administering, maintaining or reinsuring my/our policies; (3) adjudicating my/our claims, or conducting any investigation or analysis of my/our claims; or (4) data matching. I/We understand and agree that failure to provide any information requested by the Company may result in the Company not being able to process my/our insurance application/policy service request.

I/We understand and agree my/our personal information collected by or held by the Company may be transferred or disclosed by the Company to any of the following persons (whether within or outside Hong Kong) for the purposes as specified above or to governmental/regulatory bodies (whether within or outside Hong Kong) for them to carry out their governmental/regulatory functions: (1) MassMutual group companies and their associated/affiliated companies; (2) financial institutions, insurance companies, intermediaries and reinsurers; (3) claims investigation companies or any companies/persons necessary for claims assessment/investigation; (4) industry associations/federations and their members; (5) governmental/regulatory bodies and law enforcement agencies; and (6) service providers and selected persons which are under a duty of confidentiality to the Company.

I/We understand that I/we have the right to access to, and to correct, any of my/our personal information held by the Company by writing to our Personal Data Protection Officer. (Address : 27/F, MassMutual Tower, 33 Lockhart Road, Wanchai, Hong Kong or Avenida Praia Grande No. 517, Edificio Comercial Nam Tung 16-E2, Macau). The Company may charge a reasonable fee for the processing of such request.

**DECLARATION**

I/We, the undersigned, hereby declare that all information deposed hereinabove, whether they are written by me/us or not, is true and complete to the best of my/our knowledge and belief and I/we have not withheld any material information connected with this claim. I/We also have read and understood the Personal Information Collection Statement stated above. I/We provide the information herein on a voluntary basis. However, I/we understand that failure to provide information as per the Company request may result in the Company being unable to process with this claim. This claim form and all other documents submitted to the Company for this claim shall be the property of the Company, and will be non-returnable under all circumstances.

If there is any subsequent change to the information provided, I/we undertake to notify the Company as soon as possible.

I/ We hereby agree and authorize the Company, according to the Insurance (Levy) Regulation, to deduct (1) corresponding levy on unpaid premium (if any); and (2) outstanding levy of the policy(ies) (if any) from the claim payment of the policy(ies) payable to me/ us. The levy will be remitted to the Insurance Authority by the Company. (Applicable to policy issued in Hong Kong)

**AUTHORIZATION**

I/We hereby on behalf of myself/ourselves irrevocably authorize (1) any individual or organization (including but not limited to my/our employer, registered medical practitioner, hospital, clinic, insurance company, bank, police, governmental department, public or private institution) that has any record, statement, information of mine/us (whether medical or otherwise) to release, disclose or transfer all the information to the Company or its representatives for the purposes of assessing and processing any insurance claim. (2) The Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and/or tests to evaluate my/our health status in related to this claim. I/We hereby acknowledge that (1) this authorization shall be binding on my/our successors and assignees and remain valid and subsisting notwithstanding my/our death or incapacity for whatever reasons; (2) A photocopy of this authorization shall be as valid as its original. I/We hereby grant my/our consent to the Company to collect, use and transfer the above health information in accordance with the Personal Information Collection Statement.

**個人資料收集聲明**

本人/我們明白及同意美國萬通保險亞洲有限公司("貴公司")所收集或持有本人/我們的個人資料(包括任何形式的肖像、聲音及與健康有關的資料)可能會被用於下列目的：(1) 批核、評審及處理本人/我們之投保計劃申請/保單服務要求；(2) 就本人/我們之保單提供行政、持續或再保險的服務；(3) 評核本人/我們索償，或就本人/我們之索償進行調查或分析；或(4) 資料核對。本人/我們明白及同意必須提供貴公司所需的個人資料，否則，貴公司將不能處理本人/我們之投保申請或就本人/我們之保單提供服務。

本人/我們明白及同意貴公司可能為達到上述目的或讓政府/監管機構(不論在香港或海外)執行其職務而向以下任何一方(不論在香港或海外)轉移或透露由貴公司收集或持有屬於本人/我們的個人資料：(1) MassMutual 集團成員公司及其關聯或相關公司；(2) 金融機構、保險公司、中介人或再保險公司；(3) 賠償調查公司及所需有關評核索償之公司及/或人士; (4) 行業組織/聯會及其成員；(5) 政府部門或監管機構和執法機構；及 (6) 與貴公司有保密協議的服務提供者及其他人士。

本人/我們明白本人/我們有權查閱和更改任何由貴公司持有屬於本人/我們的個人資料。如有需要，本人/我們可與貴公司的資料保護主任提出有關要求、並以書面方式呈交(地址：香港灣仔駱克道 33 號美國萬通大廈 27 樓或澳門南灣大馬路 517 號南通商業大廈 16 樓 E2 室)。處理上述要求時，貴公司可能會收取合理費用。

**聲明**

本人/我們，即下方簽署者，謹此聲明上述披露之一切資料，不論是否由本人/我們手寫，就本人/我們等所深知及確信均屬完整並真確無訛。本人/我們就此索償申請並無隱瞞任何重要資料。本人/我們等亦已閱讀及明白上述的個人資料收集聲明。本人/我們在此提供的資料均屬自願。若未能依據貴公司要求提供資料，本人/我們明白會導致貴公司不能處理此索償。此索償申請書及一切其他文件在遞交給貴公司後便會成為貴公司的財產。在任何情況下均不會獲得退回。

若本人/我們所提供的資料有任何更改時，本人/我們確保盡快通知貴公司有關的更改。

本人/我們謹此同意及授權貴公司按《保險業(徵費)規例》從支付予本人/我們之賠償金額中扣除保單(1) 未繳保費的相關徵費(如適用)；及(2) 尚欠的徵費(如適用)，並由貴公司把徵費轉付至保險業監管局。(只適用於香港簽發之保單)

**授權書**

本人/我們現授權(1) 任何擁有本人/我們等任何記錄、供詞、資料(不論是否醫學資料)之人士或機構(包括但不限於本人/我們的僱主、註冊醫生、醫院、診所、保險公司、銀行、警察、政府部門、公共或私營機構)向貴公司或其代表發放、披露或轉交任何與評核及處理保險索償申請有關的資料。(2) 貴公司或任何由貴公司指定的醫務人員或化驗所可就此索償對本人/我們等進行有需要之醫療評估及測試，以審核本人/我們的健康狀況。本人/我們現確認 (1) 此授權書對本人/我們之繼承人及受讓人具有約束力，即使本人/我們死亡或無行為能力(不論任何原因)，此授權書仍然生效及具效力; (2) 本授權書之副本與正本具有同等效力。本人/我們謹此授權貴公司可按「個人資料收集聲明」的規定收集、使用及轉移上述有關本人/我們健康方面的資料。

| | | |
|---|---|---|
| Signature of Consultant 顧問簽署 | Signature of Policy Owner 保單持有人簽署 | Signature of Insured 受保人簽署<br>(only if age is over 18 若年齡超過 18 歲) |
| Name and Code of Consultant 顧問姓名及編號 | Name of Policy Owner 保單持有人姓名 | Name of Insured 受保人姓名 |
| Date 日期 | Policy Owner's ID No. 保單持有人身份證號碼 | Insured's ID No. 受保人身份證號碼 |

## PART II : ATTENDING PHYSICIAN'S STATEMENT　第二部份 ： 醫生報告

Note : 1) Please make sure that the report below is duly completed by the Attending Doctor of the Insured before it is submitted to the Claims Department.
2) The Insured/claimant will be responsible for any fee for the completion of this report.
注意 ： 1) 以下報告在交予理賠部前必須由主診醫生填寫。
2) 受保人/索償人須負責因填寫下列報告所需支付的一切費用。

(1) Name of patient : _____ ID Number : _____
病者姓名 身份證號碼

(2) Details of hospitalization 住院資料
Name of hospital : _____ Cause of hospitalization : _____
醫院名稱 入院原因
Date of admission : _____ / _____ / _____ Date of discharge : _____ / _____ / _____
入院日期 出院日期
MM 月 DD 日 CCYY 年 MM 月 DD 日 CCYY 年

(3) Surgical information 手術資料
Date of surgery : _____ / _____ / _____ Name of surgery : _____
手術日期 手術名稱
MM 月 DD 日 CCYY 年
Prescribed medicine or other treatment given : _____
已處方給病人服用的藥物或其他治療

(4) Chief complaints of the patient relating to this hospitalization/surgery : _____
病者住院/接受手術的主要原因

(5) Result of diagnosis : _____ Date of diagnosis : _____ / _____ / _____
診斷結果 診斷日期 MM 月 DD 日 CCYY 年

(6) a) Signs and symptoms presented : _____
出現的病徵及病狀
b) Date of the accident occurred or symptom first appeared : _____ / _____ / _____
意外發生日期或初次呈現病徵的日期 MM 月 DD 日 CCYY 年
c) Please provide the source of the above information : _____
請說明上述資料的來源
d) If the hospitalization / surgery was due to accident, please describe the cause of the accident:
若因意外受傷而住院/接受手術，請提供意外受傷的原因：
_____
e) Was there any evidence of a visible bruise or wound at the first consultation? If yes, please provide the details :
病者在第一次求診時，有否出現明顯瘀痕或傷口? 若有，請提供詳情。
_____

(7) a) Date of first consultation for this injury / sickness or related sickness : _____ / _____ / _____
此受傷/疾病或相關疾病的首次就診日期 ： MM 月 DD 日 CCYY 年
b) Name and address of the doctor who referred the patient to you:
轉介病者給你的醫生姓名及地址 ： _____

(8) To the best of your judgment or knowledge, has the patient ever had the same or similar sickness or symptoms relating thereto?
據你判斷或所知，病者曾否患有以上疾病或呈現相似的病徵?
☐ No. 否 ☐ Yes. 是 Please state when and what was it : _____
請列明何時染病及疾病名稱 ：

(9) If you have referred the patient to other doctor(s) during the hospitalization, please provide details:
如你曾於此住院期間轉介客戶予其他醫生，請提供 ：
Name of Doctor : _____ Reason of Referral : _____
醫生名稱 轉介原因

(10) a) Medical history of the patient :
病者之病歷 ： _____
b) Onset date : _____ / _____ / _____
最初發病日期 MM 月 DD 日 CCYY 年
c) Please provide the source of the above information : _____
請說明上述資料的來源 ：

Signature of the attending physician / specialist (with chop) :
主診醫生簽署及蓋章

Name of Patient
病者姓名 : _____ ID Number
身份證號碼 : _____

(11) a) Was the condition a recurrent episode or a chronic disease?
上述之疾病是屬於舊病復發或慢性疾病?

☐ No. 否 ☐ Yes. 是 Please state details : 請提供詳細資料 _____

Date of first attack : 首次發病日期 _____

b) Was the symptom a secondary condition to other sickness?
以上病徵是否由其他疾病引起?

☐ No. 否 ☐ Yes. 是 Please state details : 請提供詳細資料 _____

(12) Is it possible that the treatments / investigations of the patient be managed on an out-patient basis?
病者之治療 / 檢查是否可在門診進行?

☐ No, please provide reason(s): 否 請提供原因 _____

☐ Yes, please give reason(s) for this hospitalization: 是 請提供住院原因 _____

(13) a) Date of the first consultation for this patient (Not limited to this claimed injury/sickness):
病者首次就診日期 (不限於此索償受傷/疾病) :

_____

b) Are you the patient's usual medical attendant?
閣下是否病者家庭醫生?

☐ No, please advise the name(s) of the patient's usual medical attendant: 否，請提供病者家庭醫生的姓名 _____

☐ Yes. 是。

c) Are you a member of the patient's immediate family or living regularly with the patient?
閣下是否病者之直屬家庭成員或與病者慣常居住的人士?

☐ No. 否。 ☐ Yes, details : 是，詳情 _____

(14) Was the sickness caused by or in any way associated with any conditions mentioned below? ☐ No. 否 ☐ Yes. 是
此疾病是否由下列之情況而引致或與下列任何情況相關?

If yes, please tick the appropriate box below : 如是，請在下列空格內加上✓號 :

☐ Influence of drugs or alcohol 受藥物或酒精影響
☐ Infertility or sterilization 不育或絕育
☐ Cosmetic or plastic surgery 美容或整形外科手術
☐ Congenital deformities or anomalies 先天性畸形或反常
☐ Suicide or self-infliction 自殺或自傷身體
☐ HIV or HIV-related conditions, AIDS 人體免疫能力缺乏症或其有關疾病、愛滋病
☐ Pregnancy, abortion, childbirth, miscarriage, prenatal care, postnatal care, etc. 懷孕、墮胎、生育、小產、產前或產後護理等
☐ Dental Care / surgery 牙科護理或手術

I hereby certify that I have personally attended the above-named Patient and that all the information provided by me in this form is true and correct to the best of my knowledge and belief.
本人謹此聲明本人曾提供治療予上述病者。就本人所知所信，上述由本人提供的資料均為事實之全部，並確實無訛。

Signature of the attending physician / specialist 主診醫生簽署 _____ Address & Telephone No. 地址及電話號碼 _____ Date 日期 _____

Name of the attending physician / specialist 主診醫生姓名 _____ Hospital specialty/Unit/Department 醫院專科 / 單位 / 部門 _____

Qualification(s) 專業資格 _____ Hospital / doctor's name chop 醫院 / 醫生之蓋章 _____