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

OUTPATIENT MEDICAL CLAIM FORM 門診醫療賠償表格

Policy No. 保單號碼	Policyholder 保單持有人名稱

Insured Member 受保人		Claimant (if not Insured Member) 賠償申請人（如與受保人不同）		
Ref. No. 參照號碼	Surname 姓 Other Name 名	Ref. No. 參照號碼	Surname 姓 Other Name 名	Relationship 關係

No. 編號	Date of Claim 賠償日期 (in chronological order) 按時間次序排列 Day 日	Month 月	Year 年	Expenses Incurred 費用 Dollars 元	Cents 角	Benefit Claimed (Please '✓') 福利賠償申請 （請用'✓'） Consultation 門診	Chinese Herbalist/ Bonesetter 中醫/ 跌打	Specialist Consultation 專科門診	Physiotherapy/ Chiropractor 物理/ 脊醫治療	Lab. Test 化驗	Pres. Medicine 處方藥	Dental 牙科

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 (6/F., DCH Commercial Centre, No.25 Westlands Road, Quarry 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，以上所述一切是根據本人所知所信正確填寫，並爲完全和真確。

2) **收集個人資料聲明**

閣下提供的資料，爲**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。該等資料可能移轉予：(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協會或聯會或類同組織〔「聯會」〕，以達到任何上述或有關目的，或以便「聯會」執行其監管職能，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賦予「聯會」的職能；及 (iii) 或透過「聯會」移轉予任何「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(香港鰂魚涌華蘭路 25 號大昌行商業中心 6 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、機構或人仕作爲有關之用途。

4) **授權**

a) 本人謹此授權/謹此代表賠償申請人授權* (i) 任何擁有本人/賠償申請人*的醫療記錄或資料之醫生、醫院、診所、保險公司、政府部門或其他機構及人仕，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*身故或喪失行爲能力後仍然有效。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 _____

* 本賠償表格之中文譯本只供參考之用，如有爭議，應以英文原義爲準。

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香 港鰂魚 涌
海 澤 街 28 號
東港中心1007 室

INSTRUCTIONS 填寫指示：

1. This form is only for 1 claimant and can accommodate 6 claims only. Separate forms must be used for different claimants (Member/Spouse/Child). 此表格只適用於一位賠償申請人及其 6 項賠償申請。不同的賠償申請人（受保人/配偶/子女）需分開表格填寫。

2. If the claimant is the Insured Member, please complete the column of 'Insured Member' only and leave 'Claimant (if not Insured Member)' blank. If the claimant is the Dependant, complete both columns. In both cases, this Form is to be completed by the Insured Member. 如賠償申請人乃受保人，只需填寫「受保人」一欄。如賠償申請人乃家屬，請填寫「受保人」及 「賠償申請人（如與受保人不同）」兩欄。此表格在上述兩種情況下均由受保人填寫。

3. Original receipt of each claim bearing the following information must be submitted: (a) Date of Treatment; (b) Name of Patient; (c) Amount of Charge; (d) Diagnosis; (e) Attending Physician's signature and Official Stamp and (f) Name of the Clinic/Laboratory/ Hospital. 每一項賠償申請所需之收條正本必須載有以下的資料： (a) 診症日期； (b) 病者姓名； (c) 收費； (d) 診斷症狀； (e) 主診醫生簽署及蓋章； (f) 診所、化驗所或醫院之名稱。

4. For Laboratory Test, Specialist Consultation, Physiotherapy/Chiropractor and Prescribed Medicines claims, the Attending Physician's recommendation must be attached. 所有化驗、專科門診、物理/ 脊醫治療及處方藥之賠償申請均需附有主診醫生之轉介信。

5. This Form must be submitted within 90 days of incurring such expenses. Otherwise, claims will not be approved. 請於費用支出後 90 日內遞交此表格，否則此賠償申請將不獲受理。

6. This Form must be fully completed and signed and the information supplied on all receipts should be clearly stated. Otherwise, documents submitted will be returned for verification or other necessary actions. 此表格必須詳盡填寫並由受保人簽署。收據所載之資料必須清楚明確，否則所遞交之文件會被退回查對。

7. Documents returned must be re-submitted within 90 days of incurring such expenses. Otherwise, such claims 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。

8. No benefit is payable for items and conditions listed under 'EXCLUSIONS' in the Policy. 在保單之「不受保障範圍」內之項目不在賠償之列。