



團體醫療索償表格
Group Medical Claim Form

門診索償 OUTPATIENT CLAIM 牙科索償 DENTAL CLAIM

由受保人填寫 To be completed by Insured Member (必須填寫 Must be provided)

僱主名稱
Employer Name: _____

僱員英文姓名
Employee English Name (In Full): _____ 團體保單編號
Group Policy No.: _____

病人英文姓名
Patient English Name (In Full) _____ 保險証編號
Certificate No.: _____

正本收據將不獲發還。如需取回收據的核實副本，請於方格內加上“√”。
Original receipt will not be returned. Please "√" this box for return of certified true copy of receipt.

如此次索償曾於其他保險公司處理，請附上該保險公司的賠償通知書。
If this claim was processed by another insurer before, please attach Payment Advice issued by the earlier insurer(s).

A. 門診索償 OUTPATIENT CLAIM (請參閱注意事項 (2) Refer Point (2) of Notes)

診症 / 治療日期 Date(s) of Consultation/Treatment (日 / 月 / 年) (DD/MM/YY)	費用 Amount Charged	診症類別 (必須已列於保單的保障範圍內) Type of Treatment (Should be covered under the policy) * 請圈出合適類別 Please circle the appropriate type	病人自行聲明病症 Self Declaration of Diagnosis 適用於香港政府門診 (但不包括私家病人或中醫診所)，亦適用於澳門鏡湖醫院及澳門鏡湖醫院的門診。 Applicable to HK govt clinics (but not for private patients or Chinese medicine visits), as well as Macau UST Hospital & Macau Kiang Wu Hospital outpatient clinics.	已附上 收據 <input type="checkbox"/> Original receipt attached <input type="checkbox"/>
1.		* GP / SP / CMP / Others: _____	病症 Diagnosis	<input type="checkbox"/>
2.		* GP / SP / CMP / Others: _____	病症 Diagnosis	<input type="checkbox"/>
3.		* GP / SP / CMP / Others: _____	病症 Diagnosis	<input type="checkbox"/>
4.		* GP / SP / CMP / Others: _____	病症 Diagnosis	<input type="checkbox"/>

* GP = 普通科 General Practitioner SP = 專科 Specialist CMP = 中醫 Chinese Medical Practitioner
其他 Others = 物理治療 Physiotherapist / 脊醫 Chiropractor / X光 X-ray / 化驗 Lab tests / 例行檢查 Routine Checkup / 住院前之診症 Pre-hospitalisation consultation / 住院後之診症 Post-hospitalisation consultation / 等 etc

B. 牙科索償 DENTAL CLAIM
遞交牙科索償前，請確保閣下之保單有提供牙科保障。 Please ensure you are covered under the dental benefit before submitting dental claims.

若閣下的牙科保障是以每顆牙齒計算，請牙醫在收據上註明治療之牙齒號碼及該項收費或填寫以下圖表。
For dental benefit is on PER TOOTH basis, please invite dentist to state the "tooth number" and its charges on receipt or fill in below tooth chart:

右 RIGHT 舌 LINGUAL 左 LEFT

唇 LABIAL 唇 LABIAL

牙醫簽署及診所印章 簽署日期
Signature of Dentist and Clinic Chop Date Signed

C. 聲明及授權書 DECLARATION AND AUTHORIZATION

本人明白，同意並謹此聲明：
I hereby DECLARED, UNDERSTOOD and AGREED that:

- 本人於本表格所提供的一切資料為本人所知的全部及為真確無誤。
All information provided by me in this form is complete and true to the best of my knowledge and belief.
- 本人授權任何醫生、醫學界執業人士、醫院、診所或其他與醫療有關的機構、保險公司或其他組織、機關或人士，將其所有關於本人及受保家屬的記錄或健康狀況資料，提供予宏利。此授權書是不可撤銷的，即使本人去世，此授權仍然生效。此授權書的影印本將與正本同樣有效。
I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my dependent to provide to Manulife any such information. Such authorization shall survive me and shall be irrevocable. A photocopy of this authorization shall be as valid as the original.
- Information collected from me and in respect of me and/or my dependent (including but not limited to claims history) can enable Manulife to carry on its insurance/financial business and may be:
 - used by Manulife or its associated companies for the purpose of (a) approving and administering the policy or any alterations, cancellation or renewal of it; (b) underwriting and any claims or analysis of it; (c) statistical or actuarial research of Manulife, Manulife's associated companies or the insurance/financial industry; (d) processing my application, investigating and settling claims and detecting and preventing fraud (whether or not relating to the policy issued in respect of this application); and/or
 - transferred to (a) any related company or other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business or any regulatory bodies, association or federation of insurance companies that exists or is formed from time to time; (b) any person/organization to fulfill any of the above purposes and/or for the purpose of data verification by way of matching procedures or otherwise; and/or reinsurance of the policy; (c) health care professionals, hospitals, accountants, legal advisors, employers; (d) organisations that consolidate claims and underwriting information for the insurance industry, fraud prevention organisations, other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information.
- 所有資料處理過程或會涉及資料轉移至香港特別行政區/澳門特別行政區及以外地區。
All data processes may involve a transfer of information to places either within or outside the Hong Kong Special Administrative Region/Macau Special Administrative Region.
- 本人同意宏利將有關本人提供的所有資料傳回給保單持有人 (即僱主) / 受保僱員 (如適用)。本人已向所有受保家屬取得授權 (如適用)，可(a)向宏利提供其資料；及(b)將所有其提供的資料傳回給保單持有人 (即僱主) 和本人。本人亦明白本表格內提供的資料是讓宏利作處理本人索償之用。
I agree Manulife to transfer back all supplied information from me to the policyholder (i.e. the Employer)/ insured employee (where applicable). I have obtained the necessary authorization from my dependent to (a) supply their information to Manulife; and (b) transfer back all supplied information from them to the policyholder (i.e. the Employer) and me if my dependent (if applicable) is to be covered. I also understand that the information requested in this form is required in order for Manulife to process this claims.
- 本人有權以書面通知宏利僱員福利部之個人資料主任，要求索閱及更改個人資料 (如需要)。
By writing to the Privacy Officer of Manulife - Employee Benefits, I can request access to and correction of my personal data (if appropriate).
- 宏利可按於《有關〈個人資料 (私隱) 條例〉的客戶通知》(“通知”) (適用於香港保單) / 《宏利個人資料收集聲明》(“聲明”) (適用於澳門保單) (如適用) 所述，處理有關資料。假如本人未有細閱該通知/聲明 (如適用)，本人可從本人的宏利中介人或透過宏利網址www.manulife.com.hk取得該通知/聲明 (如適用)。
All information may be treated by Manulife in the same manner as mentioned in the "Notice to Customers relating to the Personal Data (Privacy) Ordinance" ("Notice") (for Hong Kong policy) / Manulife Personal Information Collection Statement ("Statement") (for Macau policy) (where applicable). In case I have not read the Notice/Statement (where applicable) before, I can obtain such Notice / Statement (where applicable) from my Manulife's intermediary or through Manulife's website at www.manulife.com.hk
- 本人明白並同意宏利有權要求受保人，因資料不確而退回已賠償之金額。
Manulife has the right to reverse/claim back any incorrect payment caused by incorrect information provided by me.
- 本人已經細讀及明白此“團體醫療索償表格”之所有資料及內容；包括背頁所提供之索償指引及一般不受保項目。
I have read and understood the information and content provided in this entire "Group Medical Claim Form", including the Claims Instructions and General Exclusions provided overleaf.

病人/受保僱員簽署 (如病人不足18歲，則須受保僱員簽署)
Patient's/Insured Employee's Signature (For patient whose age is below 18, insured employee's signature is required)

日期 (日 / 月 / 年)
Date (DD / MM / YY)

→ 請參閱續頁 Please turn to next page

注意事項：

- 1 提交之索償表格，正本單據，收條及發票需列明
 - ✓ 診症 / 治療日期
 - ✓ 病者姓名
 - ✓ 病症
 - ✓ 各項收費（如診金、藥費、化驗費等）並由主診醫生蓋章及簽署。
- 2 請覆查收據上之病症名稱。非明確之病症名稱，如醫療疾病 / 外科病況等，都不足以作理賠評估。
- 3 如在海外求醫，請提交各項收費服務、病症、病者姓名等之中文 / 英文翻譯本。
- 4 請填妥及簽署此表格，並於診症 / 治療後三個月內遞交至貴公司人事部或有關負責人或以下宏利地址。
- 5 如門診收據費用是HK\$1,200或以下，索償一旦經由網站<https://www.claimsimple.hk>提交後，除非收到宏利通知，不需要提交該索償文件之正本。
- 6 如您的團體保單已採用電子提示服務及受保僱員亦已於宏利登記電郵地址，我們在完成索償申請後會發出電子提示至此指定的電郵地址。受保僱員請使用宏利戶口號碼及私人密碼，登入www.manulife.com.hk e-GLH網上服務查詢索償詳情及閱覽索償賠款通知。
- 7 請登入www.manulife.com.hk開啟你的個人賬戶即可查詢您的索償資料及福利賠償表。

Notes:

- 1 Submit Claim Form, Original receipts, bill and invoice showing
 - ✓ date of consultation / treatment
 - ✓ patient's full name
 - ✓ diagnosis
 - ✓ breakdown charges (consultation fee, medication, laboratory fee, etc) with doctor's stamp and signature.
- 2 Please check again the diagnosis written on receipt. Non-specific diagnosis, for example, medical illness / surgical condition is insufficient to determine the claim eligibility.
- 3 For overseas doctor's visits, please provide translation to English / Chinese on each item, diagnosis, patient name, etc.
- 4 Send this completed and signed form to your Human Resource Department or plan administrator or Manulife at address below within 3 months from date of consultation / treatment.
- 5 For outpatient's receipt amount at HKD1,200 or below, once the claim submitted via <https://www.claimsimple.hk>, there is no need to submit hardcopy document unless notice from Manulife.
- 6 If your Group Policy has already subscribed e-Alert services and insured employee has registered his/her email address, an e-Alert will be sent to the designated email address upon claim processed. Please use your Manulife Customer Number (MCN) & PIN to check claim result and view Payment Advice via e-GLH Online Service at <http://www.manulife.com.hk>.
- 7 Please login www.manulife.com.hk to initiate your personal account to check your claims result and benefit schedule.

想知更多有關門診 / 牙醫索償，請掃描
To know more about outpatient / dental
claims submission, please connect



一般不受保項目：

本公司將不會對下列各項開支作出任何賠償，於保障表內特別註明則除外：

- 1 與受保人因疾病或受傷而須接受之治療或診斷無關之定期身體健康檢查或檢驗，或並非必須之醫療服務。
- 2 先天性異常、有關不育之治療、絕育手術。
- 3 牙科護理及治療。惟保單有提供牙科保障除外。
- 4 整容手術、視力糾正及助聽器，及有關處方。受保人於受保期間因意外受傷而必須接受之治療則除外。
- 5 分娩（包括剖腹產子或因懷孕引致的狀況）。
- 6 直接或間接由於不論宣戰與否之任何戰爭、與戰爭有關之行動、暴動、叛亂或民眾騷動導致之受傷或疾病。
- 7 預防疫苗注射。
- 8 藥物及酒精治療。
- 9 精神障礙或心理治療。
- 10 受保人自殺、試圖自殺或蓄意自我傷害而招致之任何費用。
- 11 後天免疫缺乏症（愛滋病）及與後天免疫缺乏症有關之併發症。
- 12 受保前已存在之狀況。
- 13 勞工保償、保險公司或其他醫療保障計劃，已獲得賠償之醫療費用。

General Exclusions:

The Company shall not reimburse expenses incurred as a result of the following unless specified in the valid Benefit Schedule:

- 1 Routine physical examinations, health check-ups or tests not incidental to treatment or diagnosis of an insured sickness or injury or any treatment which is not medically necessary unless otherwise provided for in the Clinical Benefits Schedule.
- 2 Congenital anomalies, infertility, sterilization.
- 3 Dental care and treatment unless otherwise provided for in the Dental Benefit Schedule.
- 4 Cosmetic surgery, treatment on refractive errors or hearing aids except as necessitated by injuries wholly occurring during the period of insurance.
- 5 Childbirth (including surgical delivery or pregnancy related).
- 6 Injury or sickness arising directly or indirectly from war or any act of war, declared or undeclared, riots, insurrection, or civil commotion.
- 7 Vaccination and immunization injections.
- 8 Drug addiction or alcoholic treatment.
- 9 Treatment of functional disorders of the mind and psychological treatment.
- 10 Suicide, attempted suicide or intentionally self-inflicted injury, whether sane or insane.
- 11 Treatment of Human Immunodeficiency Virus (AIDS) or ARC (AIDS-related Complex).
- 12 Pre-Existing Conditions.
- 13 Expenses that have been recoverable from Employees' Compensation Law, any government or public programmes of medical benefits', other group or individual insurance.

以上各項並未全數列出所有不受保項目，詳情請參閱有關保障條款。

This is not a comprehensive list of Exclusions, please refer to the specific Benefit Provision for details.

Please return the completed form and original receipts to 請將填妥的表格連同收據正本交：
For Hong Kong policy - Employee Benefits, Manulife (International) Limited, P.O. Box 70302, Kowloon Central Post Office.
For Macau policy - Manulife (International) Limited, Macau Administration Office, Avenida De Almeida Ribeiro No. 61, Circle Square, 14 andar A, Macau.
適用於香港保單 - 九龍中央郵政局郵政信箱70302號宏利人壽保險(國際)有限公司僱員福利部。
適用於澳門保單 - 澳門新馬路61號永光廣場14樓A宏利人壽保險(國際)有限公司澳門分行行政部。

本表格之中文譯本只供參考用途，若與英文版本有異，一概以英文版本為準。
The Chinese version of this form is for reference only. In the event of discrepancies between the Chinese and English versions, the English version shall prevail.