中國交銀保險有限公司
China BOCOM Insurance Co.,Ltd.

保險公司填寫 For Office Use
Claim Ref. No.
Received Date

Insurance Claim Form (Part I)
保險索償申請書(第一部份)

To be completed by the Policyholder/Insured Person 由保單持有人/受保人填寫

Important note :

1. This form is to be filled by the Policyholder/Insured Person. Please do not sign on blank form and use the same signature as policy record.
2. No fees, commission or charges of whatever nature are payable to Authorized Agents or Employees of the Company in respect of this claim.
3. To enable us to process your claim promptly, please answer all questions in this form as fully and accurate as you can.
4. Please submit a copy of the identification document of the Insured Person &/or Insured Dependent, unless submitted before, together with this form.
5. This claim application will be processed by our authorized third party claims administrators

1. 此申請表應由受保人/受保家屬填寫。請勿在空白申請書上簽署，而簽名式樣須與保單的記錄相符。
2. 有關本索償，客戶無需支付任何手續費、佣金或其他任何性質的費用予本公司的獲授權代理或其他僱員。
3. 請回答此申請書上的所有問題，以供我們批核 閣下的索償申請。
4. 如在之前未有遞交保單持有人/受保人的身份證明文件，請隨此申請表一併遞交。
5. 這保險索償申請書之理賠程序將通過我們的授權聲明的第三者管理員進行處理。

In-Patient Pre-Authorization Claim 住院預先授權申請 ☐	In-Patient Claim 住院索償 ☐	Out-Patient Claim 門診索償 ☐	Dental Claim 牙科索償 ☐

Policy Information 保單資料	
Policy number 保單編號	Full name of Policyholder 保單持有人姓名
Insured Person's Details 受保人資料	
Full name of Insured Person 受保人姓名	Date of birth 出生日期 (dd/mm/yyyy)(日/月/年)
HKID Card / Passport No. 香港身份證/護照號碼	Gender 性別 Male 男 ☐ Female 女 ☐
Email Address 電郵地址	Contact number 聯絡電話

Are you making any other claims as a result of this treatment? No 不是 ☐ Yes 是 ☐
(Please provide claims settlement advice from other insurer, if applicable)
有關此次治療，閣下是否有申請其他保險賠償？(請提供其他保險公司之賠償結算通知，如適用)

Name of Insurance Company 保險公司名稱: _____ Policy No 保單號碼: _____

☐ Return original receipt after claim processing, if yes, please「 √ 」the box and **attach with a copy of this Claim Form and Receipts / Documents** (Please note: Original receipts will not be returned if the claim was fully reimbursed unless return original receipt is requested for other purpose, please state the reason)
如欲索回醫生收據正本，請在空格內填上「 √ 」號，並**附上此索償申請書及收據/文件影印本一份**(請注意:如申請已獲全數賠償，正本收據將不獲退回。除非本收據需用作其他用途，請注明原因)

Settlement method (Not Applicable for In-Patient Pre-Authorization claim)
付款方法 (不適用於住院預先授權申請)

Note:
*** The payment is in Hong Kong Currency**
*** The settlement amount can make payable to the choice of the Policyholder or the Insured Person provided that the Insured Person's age is above 18 years old.**
*** For Autopay Settlement Method**
1.1 : Please ensure the bank account holder is either the Policyholder or the Insured Person with age is above 18 years old.
1.2 : Please ensure the bank account holder is the Policyholder if the Insured Person's age is below 18 years old.
注意:
*** 賠償金額必須為港幣**
*** 賠償金額可選擇給付予保單持有人或已年滿十八口或以上之受保人。**
*** 如選擇自動轉賬方法**

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1.1 : 銀行戶口持有人必須為保單持有人或已年滿十八歲或以上之受保人
1.2 : 若受保人未滿十八歲，銀行戶口持有人必須為保單持有人

☐ By Cheque 支票 ********** ☐ Policyholder 保單持有人 / ☐ Insured Person 受保人
☐ By Autopay 自動轉賬

Name of bank account holder 銀行戶口持有人姓名

_____

Name of bank in Hong Kong 香港的銀行名稱

_____

Bank No. 銀行號碼 ☐☐☐ - Branch No. 分行號碼 ☐☐☐ - Account No. 戶口號碼 ☐☐☐☐☐☐☐☐

Area of Treatment 接受治療之地區			
Country of treatment : **接受治療之地區**	Asia 亞洲 ☐	USA 美國 ☐	Others; please state 其它；請註明 ☐ _____

If you are claiming for treatment received outside your area of cover, please answer the following questions:
倘若受保人於覆蓋地區範圍以外接受治療，請填寫下列問題

(1) The reason for being abroad:
前往該國家或地區之原因 _____

(2) Date of departure and return to own area of cover:
逗留該國家或地區之日期
From 由 _____ (dd/mm/yyyy)(日/月/年) To 至 _____ (dd/mm/yyyy)(日/月/年)

Pre-Authorization Claim ONLY 預先授權申請專用 **(Please complete the Insurance Medical Claim Form Part II by the attending medical practitioner** **請提交由主診醫生填寫之保險索償申請書第二部份)**	
Date of symptoms first noticed 病徵首次出現日期	Name of medical practitioner and address 醫生之姓名及地址
First consultation date 首次求診日期	Signs and symptoms 病徵及病狀

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In-Patient Claim ONLY (Not applicable to In-Patient Pre-authorization Claim)
住院索償專用(不適用於住院預先授權申請)

(Please complete the Insurance Medical Claim Form Part II by the attending medical practitioner
請提交由主診醫生填寫之保險索償申請書第二部份)

1) If caused by illness 若由疾病導致	**2) If due to accident 若由意外導致**
Date of symptoms first noticed 病徵首次出現日期 First consultation date 首次求診日期 Signs and symptoms 病徵及病狀	Date & time 日期及時間 Place 地點 Accident details (where and how does it happen) 意外詳情(何地及如何發生)

3) Hospitalisation Details 住院詳情

Date of admission 入院日期 Date of discharge 出院日期	Diagnosis & date of diagnosis 診斷及診斷日期	Name and address of medical practitioner / hospital 醫生/醫院名稱及地址

Out-Patient Claim ONLY 門診索償專用

				Type of Claims (Please "√" the appropriate box) 索賠類型 (請在適當的空格打"√")				
	Consulta-tion Date 求診日期	Symptom onset date 發病日期	Diagnosis 診斷	GP/SP Medicine 普通科醫生/專科醫生 藥物	Labotaory test/MRI/CT/ PET/Ultrasound 化驗測試/電腦掃描/ 磁力共震造影/正電子掃描/ 超聲波	Physiotherapy/ Chriopractor / Osteopathy * Referral letter is required 物理治療/脊醫/整骨療法 *需提供轉介信	Chinese Practitioner / Acu-puncture / Home-opathy 中醫/針灸/順勢療法	Amount Claimed 索償金額
1.								
2.								
3.								
4.								
5.								

Dental Claim ONLY 牙科索償專用

Routine dental care
例行牙科檢查 Yes 是 ☐ No 否 ☐

Date of consultation 求診日期 : _____ (dd/mm/yyyy)(日/月/年)	***This question does not apply to routine dental care claim 這個問題並不適用於常規牙科護理索賠*** Symptom onset date or Date of Accident 病徵出現日期或意外日期 : _____ (dd/mm/yyyy)(日/月/年)

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***** ***This question does not apply to routine dental care claim 這個問題並不適用於常規牙科護理索賠***

Signs and symptoms / Accident details (where and how does it happen)
病徵及病狀 / 意外詳情（何地及如何發生）

Guidelines for document submission 遞交索償申請所須文件指引

Please「 √ 」against the documents you have submitted together with this claim form. We will notify you if we need to obtain extra information from you or from other parties to assess your claim. As the time required for obtaining the information varies, the processing time of your claim will likely take longer time.
請於連同索償表格遞交文件之方格口加上「 √ 」號。如需要閣下或其他機構提供進一步資料作閣下之索償申請, 本公司將會通知閣下。由於收集有關之資料時間有異, 閣下之索償申請時間有可能因此而延長。

- ☐ 1. Claims form which is to be completed fully (original)
  已填妥的索償申請書(正本)
- ☐ 2. Itemized Detailed Bill with Cost Breakdown (original/certified copy)
  詳細分項列明的費用明細（正本/核證副本）
- ☐ 3. Original receipt issued by the hospital or service providers
  醫院或服務提供者發出之正本收據
- ☐ 4. Result of the diagnostic test (original/certified copy of Laboratory result, X-Ray/MRI etc) (where applicable)
  診斷測試結果（化驗結果、X 光、磁力共震造影等正本/核證副本）（如適用）
- ☐ 5. Prescription upon discharge (original/certified copy) (where applicable)
  出院時處方（正本 / 核證副本）（如適用）
- ☐ 6. Hospital discharge summary (where applicable)
  出院報告(如適用)
- ☐ 7. Medical reports associated to the medical condition (where applicable)
  病症有關聯的醫療報告(如適用)

If you have any questions regarding this form or any other aspects of the coverage, please contact our Customer Representatives at (852) 2862 0186 and please quote your policy number to facilitate your enquiry.
若閣下對本申請書或其他保單相關事宜有任何疑問，請致電 (852) 2862 0186 聯絡我們的客戶服務代表，並請供閣下的保單編號以便利查詢。

Claims must be submitted along with all supporting documents within 90 days from date of service.
索償申請須於接受診治後 90 天內，連同所有證明文件一併呈交。

Send this claim form together with all supporting documents to our authorized claims administrator at Unit 1015-1018, 10/F., Tower 1, Millennium City 1, 388 Kwun Tong Road, Kwun Tong, Hong Kong
請將此申請書與所有證明文件發送至我司的獲授權理賠管理人，地址為：香港九龍觀塘道 388 號創紀之城第一期 10 樓 1015-1018 室.

Declaration and authorization 聲明及授權

I HEREBY DECLARE AND AGREE on behalf of myself and other persons referred to in this application form (hereinafter referred to as "Relevant Persons", "We", "Our" or "Us") (for the avoidance of doubt, the expressions of "Relevant Persons", "We", "Our" or "Us" include myself and such other persons) that (1) all statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true; (2) the Company is not bound by and is not required to rely on any statement which I may have made to any person if not written or printed here; (3) any information and personal data of the Relevant Persons collected, compiled or held by the Company or its authorized claims administrators from time to time (whether contained in this application or otherwise), may be used, stored, processed, transferred or disclosed to and/or shared with other parties pursuant to the scope of use as mentioned under below PERSONAL INFORMATION COLLECTION STATEMENT ("PICS"). If I/We fail to provide any information requested in this application form, it may result in the Company's inability to accept or process this application.

I HEREBY AUTHORIZE on behalf of the Relevant Persons that (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution or person, that has any records or knowledge of me/the Relevant Persons and/or who has attended or may hereafter attend to me/the Relevant Persons to disclose such information to the Company or its authorized claims administrators as the Company or its authorized claims administrators may request; (2) the Company &/or its authorized claims administrators or any of their appointed medical examiners, paramedical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/the Relevant Persons in relation to this application and any claim arising therefrom. A photocopy of this authorization shall be as valid as the original.

I HEREBY DECLARE AND AGREE that I have the full authority from and consent of the Relevant Persons to make the above declarations, agreements and authorizations.

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本人謹此代表本人及其他在此申請表提及之人士（下稱「相關人士」或「我們」）（為免存疑，「相關人士」或「我們」指包括本人及此申請書提及之其他人士）聲明及同意(1)上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所信，均為事實全部並確實無訛；(2)本人對任何人所作出的任何聲明，如沒有在此申請書上填寫或印出，貴公司不須受其約束；(3)貴公司或其獲授權理賠管理人可以根據下列收集個人資口的聲明口列明之範圍使用、儲存、處理、轉移或披露及／或分享貴公司所不時收集、編輯或持有之任何相關人士的個人資料(不論是否此申請書所載或從其他途徑所取得)。
如我們不能提供任何此申請所需的資料，貴公司或不能接受或處理此申請。

本人謹此代表相關人士授權(1)任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、或其他組織、機構或人士，凡知道或持有任何有關本人/相關人士之記錄，及/曾診驗或可能將會診驗本人/相關人士者，均可應貴公司或其獲授權理賠管理人要求將該等資料提供給貴公司或其獲授權理賠管理人；(2)貴公司及/或其獲授權理賠管理人或任何其指定之驗身醫生、醫療人員或化驗所，可就此申請或任何與此有關之賠償申請替本人/相關人士進行所需之醫療評估及測試，作為審核本人/相關人士之健康狀況。此授權書的影印本與正本均有同等效力。

本人謹此聲明及同意已獲相關人士授權及同意本人作出以上聲明、協議及授權。

In the event the Insurance claims application consisting of personal information, such application will not be processed unless this personal information collection statement is duly read and signed by the Policyholder/Insured Person. (effective from 1st April, 2013)

PERSONAL INFORMATION COLLECTION STATEMENT ("PICS")

COLLECTION AND USE OF PERSONAL DATA

China BOCOM Insurance Co., Ltd. (hereafter called "**the Company**") may use the personal data collects from you (whether contained in this application or otherwise) for the purposes of

(i) investigating, processing and paying claims made under your insurance policy;
(ii) collecting deductibles for claim settlement and/or any outstanding amounts from you;
(iii) conducting market research for statistical or other purposes;
(iv) matching any data held which relates to you from time to time for any of the purposes listed herein;
(v) conducting identity and/or credit checks and/or debt collection;
(vi) carrying out other services in connection with the operation of the Company's business;
(vii) contacting you for any of the above purposes;
(viii) other ancillary purposes which are directly related to the above purposes; and
(ix) complying with applicable laws, regulations or any industry codes or guidelines.

Personal data will be collected only for lawful and relevant purposes and all practicable steps will be taken to ensure that personal data held by the Company is accurate. The Company will take all practicable steps to ensure security of the personal data and to avoid unauthorized or accidental access, erasure or other use.

The Company may disclose your personal data for the above purposes to the following classes of transferees:

(a) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist the Company to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers, bank for executing direct debit payment and data processors);
(b) in the event of a claim, loss adjudicators, claims investigators and medical advisors;
(c) in the event of default, debt collectors and recovery agents;
(d) insurance reference bureaus or credit reference bureaus;
(e) reinsurers and reinsurance brokers;

(f) your insurance broker (if you have one);
(g) our legal and professional advisors;
(h) our related companies;
(i) the Hong Kong Federation of Insurers (or any similar association of insurance companies) and its members;
(j) the Insurance Claims Complaints Bureau and similar industry bodies; and
(k) government agencies and authorities as required or permitted by law.

The Company may also use and disclose your personal data otherwise with your consent.

"Related companies" in this form means the holding company of the China BOCOM Insurance Co., Ltd (Bank of Communications Co., Ltd.) which includes branches, subsidiaries, representative offices and/or any corporations or legal entity under the effective management control by the Bank of Communications Co., Ltd. and/or any subsidiaries and/or representative offices of China BOCOM Insurance Co., Ltd, wherever situated.

DIRECT MARKETING

Unless with your consent, the Company MAY NOT use any extra information obtained under this form for any direct marketing purpose except for those information obtained from you before for processing the insurance application. In the event you ***DO NOT WISH*** the Company and/or its affiliated companies to use your personal data in direct marketing and receive the direct marketing materials, you may inform us in writing to the address in the section on **"ACCESS AND CORRECTION OF PERSONAL DATA".** The Company shall, without charge to you, ensure that you are not included in future direct marketing activities.

ACCESS AND CORRECTION OF PERSONAL DATA:

Under the Personal Data (Privacy) Ordinance (Cap. 486) ("PDPO"), you have the right to ascertain whether the Company holds your personal data, to obtain a copy of the data, and to correct any data that is inaccurate. You may also request the Company to inform you of the type of personal data held by it. Requests for access and correction or for information regarding policies and practices and kinds of data held by the Company should be addressed in writing to: **Data Privacy Officer of China BOCOM Insurance Co., Ltd. 18/F., Fairmont House, 8 Cotton Tree Drive, Central, Hong Kong.**

保單持有人/受保人必須閱讀及簽署此收集個人資料聲明後有關的索償申請將會被處理(2013 年 4 月 1 日起生效)

收集個人資料的聲明

收集及使用個人資料

中國交銀保險有限公司（下稱"本公司"） 可能會使用客戶提供的個人資料(不論是否此表格所載或從其他途徑所取得)作以下用途：

(i) 調查、處理及支付 閣下保單有關的索償；

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(ii) 向 閣下收取自負額及欠款；
(iii) 為統計或其他目的進行市場研究；
(iv) 不時就本條款所列的任何目的核對所持有的與 閣下有關的任何資料；
(v) 進行身份和／或信用核查和／或債務追收；
(vi) 開展與本公司業務經營有關的其他服務；
(vii) 就以上用途聯絡 閣下；
(viii) 其它與上述用途有直接關係的附帶用途；及
(ix) 遵循適用法律，條列及業內守則及指引。

本公司僅將為合法和相關的目的收集個人資料，並將採取一切切實可行的步驟，確保本公司所持個人資料的準確性。本公司將採取一切切實可行的步驟，確保個人資料的安全性，及避免發生未經授權或者因意外而擅自取得、刪除或另行使用個人資料的情況。

本公司亦可因應上述用途披露 閣下的個人資料予下列各方：
(a) 就上述用途，向本公司提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問（包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商、執行直接付款方式繳付保費之銀行及數據處理服務商）；
(b) 處理索賠個案的理賠師、理賠調查員及醫療顧問；
(c) 追討欠款的收數公司或索償代理；
(d) 保險資料服務公司及信貸資料服務公司；
(e) 再保公司及再保經紀；
(f) 閣下的保險經紀（若有）；
(g) 本公司的法律及專業業務顧問；
(h) 本公司的關連公司；
(i) 香港保險業聯會（或同類的保險公司聯會）及其會員；
(j) 保險索償投訴局及同類的保險業機構；
(k) 法例要求或許可的政府機關。
經 閣下同意，本公司可能會以其它方式使用及披露 閣下的個人資料。

"關連公司" 是指本公司的控股公司『交通銀行股份有限公司』其中亦包括交通銀行股份有限公司屬下之分行、附屬公司及代表處及/或任何被交通銀行股份有限公司在管理上控制的公司及/或中國交銀保險有限公司的附屬公司及代表處，不論其所在地。

直銷促銷
若非經閣下同意，本公司不可能使用閣下在索償申請書中提供的額外聯絡資料用作任何直接促銷用途。這並不包括早前在投保申請處理時提供的資料。若閣下***不願意***本公司及與本公司關聯的公司使用及將閣下的個人資料提供予其他人士作任何形式的直接促銷用途。請閣下請發信至下文"**個人資料的查閱和更正**"部份所列的地址通知本公司。本公司會在不收取任何費用的情況下確保不會將 閣下納入日後的直接促銷活動中。

個人資料的查閱和更正
根據條例，閣下有權查明本公司是否持有閣下的個人資料，獲取該資料的副本，以及更正任何不準確的資料。閣下還可以要求本公司告知閣下本公司所持個人資料的種類。查閱和更正的要求，或有關獲取政策、常規及本公司所持的資料種類的資料，均應以書面形式發送至：**中國交銀保險有限公司位於香港中環紅棉路8號東昌大廈18樓個人資料保護主任收。**

Name of Claimant 索償人姓名	**Signature of Claimant 索償人簽署**	**Signature date 簽署日期**
HKIDCard/Passport No. 香港身份證/護照號碼	**Nationality 國籍**	**Relationship to Insured Person 與受保人關係**
Email Address 電郵地址		**Contact number 聯絡電話**

Note : Claimant refers to Policyholder or Insured Person or the person who filed a claim against the company
注意 ： 索償人指保單持有人或 受 保人或向本公司索償的人士

Note: Please submit copies of the identification document of the Policyholder and the Insured Person, unless submitted before, together with this form. This is in accordance with the Guidance Note on Prevention of Money Laundering and Terrorist Financing issued by the Office of the Commissioner of Insurance which requires that copies of the identification document of customers should be collected no later than the time of payout for identification and verification.
注意：如在之前未有遞交身份證明文件，請隨此申請書一併遞交保單持有人及受保人的身份證明文件副本。根據保險業監理處發出的「防止洗黑錢及恐怖分子籌資活動指引」，
保險公司必須在不遲於付款時收集客口的身份證明文件副本以作核實用途。

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Insurance Claim Form (Part II) (In-Patient and Pre-authorization claim ONLY)
保險索償申請書(第二部份) (住院及預先授權申請專用)

To be completed by the Attending Physician 由主診醫生填寫

Patient's details 病人資料	
Full name of Insured Person 受保人姓名	Date of birth 出生日期 (dd/mm/yyyy)(日/月/年)
HKID Card / Passport No. 香港身份證/護照號碼	Gender 性別 Male 男 ☐ Female 女 ☐

In-Patient Claim ONLY (Not applicable to In-Patient Pre-authorization claim) 住院索償專用 (不適用於住院預先授權申請)	
Date the patient first consulted you for the condition 有關是次疾病病人首次求診日期 _____ (dd/mm/yyyy)(日/月/年)	
Symptoms presented during the first consultation and the duration of symptoms 首次求診的病徵及病徵出現時期	
Name and address of doctor who has referred this patient to you 轉介醫生之姓名及地址	
Name of Hospital 醫院名稱	Diagnosis 診斷
Date of admission 入院日期 _____ (dd/mm/yyyy)(日/月/年)	Date of discharge 出院日期 _____ (dd/mm/yyyy)(日/月/年)
Chief reason to this hospital admission 是次入住醫院的原因	
Date of operation 手術日期 _____ (dd/mm/yyyy)(日/月/年)	Type of Surgical Procedure 手術類別
Brief discharge summary (including treatment, investigation procedures, results, and/or any complications and follow up plans) 出院撮要 (包括治療、診查程序、結果、併發症及/或跟進計劃)	
Did the patient take any home leave during the hospital confinement 病人有否於住院期間離院？ Yes有 ☐ No否 ☐	
If yes, please specify the reason for home leave 如有，請註明住院期間離院的原因	Period of home leave 離院時段
Further treatment plan: 治療計劃	
If claim is related to pregnancy, is pregnancy conceived from natural conception? 若因分娩提出索償，請問懷孕成因是否由於人工受孕而形成 Yes有 ☐ No否 ☐	

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Pre-Authorization Claim ONLY　預先授權申請專用

Date the patient first consulted you for the condition
有關是次疾病病人首次求診日期

_____
(dd/mm/yyyy)(日/月/年)

Symptoms presented during the first consultation and the duration
首次求診的病徵及出現時期

Name and address of doctor who has referred this patient to you
轉介醫生之姓名及地址

Name of Hospital **醫院名稱**	Diagnosis **診斷**
Date of operation 手術日期 _____ (dd/mm/yyyy)(日/月/年)	Type of Surgical Procedure 手術類別
Estimated length of treatment (in days): **預計治療所需時間（日）**	Treatment plan: **治療計劃**

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Room type 房間類別: Room charge per night 每晚房租: Total estimated room & all hospital charges: 預計病房及醫院收費合共	Estimated cost for treating doctor (i+ii): 預計醫生之收費 i. Daily visit estimated cost: 預計每日巡房費 ii. Surgery estimated cost: 預計手術收費 Estimated cost for anesthetist: 預計麻醉師收費 Total estimated cost for treating doctor/ surgeon & anesthetist: 預計醫生麻醉師收費合共

Please answer the following questions (Applicable to both In-Patient Claim and Pre-authorization Claim) **請必須回答下列提問: (適用於住院索償及預先授權申請)**		
Was the above medical condition caused by any of the following condition 上述之醫療情況是否由以下情況引起?		
1. Congenital anomaly 先天性異常	Yes 是☐ No 否☐	If answer is "Yes", please state details 如是，請提供詳細資料:
2. Self inflicted 自我傷殘	Yes 是☐ No 否☐	
3. Psychiatric condition 精神病	Yes 是☐ No 否☐	
4. Influence of alcohol, drug or intoxicant 受酒精藥物影響	Yes 是☐ No 否☐	
5. Obesity, weight reduction or weight improvement 體重因素	Yes 是☐ No 否☐	
6. Pregnancy, childbirth caesarian section, abortion or miscarriage 懷孕、分娩、墮胎或流產	Yes 是☐ No 否☐	
7. Treatment related to infertility 治療不育	Yes 是☐ No 否☐	

Medical practitioner declaration and agreement 聲明及授權	
I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his/her condition. I declare and agree to make the declaration on this claim form. 本人謹此聲明曾為病人作出診治，以上填報的各項資料乃本人基於以上的情況而提供意見。本人謹此聲明及同意上述一切陳述及問題的所有答案均為事實之全部並確實無訛。	
Name of medical practitioner 醫生姓名	Contact Tel. No. & Mailing address 聯絡電話及地址
Qualification 醫學資格	Specialty 專業資格
Signature of medical practitioner 醫生簽署	Date 日期

重設表格　遞交表格

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