無憂出院免找數服務申請表
Cashless Facility for Hospitalization Application Form

查詢熱線 Enquiry Hotline (853) 8988 6060

申請書編號 Application No. (只供內部填寫 For internal use only)

請填妥此表格並於入院前最少四個工作天，以電郵方式（support@hmg.com.hk）遞交予富衛人壽保險（澳門）股份有限公司（「公司」或「富衛」）。如被保險人獲成功安排優質高效理賠程序，富衛將為被保險人提供「無憂出院免找數服務」。

Please complete this form and send to FWD Life Insurance Company (Macau) Limited (the "Company" or "FWD") by email (support@hmg.com.hk) at least 4 working days prior to the hospitalization. If Efficient and Seamless Resolution is successfully arranged for the Insured, FWD would provide Cashless Facility to the Insured.

甲部（由被保險人 / 投保人填寫） Part I (To be completed by Insured / Policyowener)

A. 被保險人資料 Insured's Particulars

保單編號 Policy No.	投保人姓名 Name of Policyowner	被保險人姓名 Name of Insured	身份証號碼 / 護照號碼 I.D. No. / Passport No.
聯絡電話 Contact Phone No.		電郵地址 E-mail Address	

B. 住院詳情 Details of Hospitalization

因意外導致住院，請填寫以下第1至3及6題。For Hospitalization due to Accident, please complete questions 1 to3 and 6 below.
因疾病導致住院，請填寫以下第4至6題。For Hospitalization due to illness, please complete 4 to 6 below.

1. 意外在何時及何地發生？ When and where did the accident occur?
2. 意外發生經過？ How did the accident occur?
3. 受傷部位（如左足踝）及傷勢 Part of body injured (e.g. Left ankle etc.) and type of injury
4. 請描述被保險人之病徵及病狀 Give a brief description of Insured's symptoms
5. 在被保險人首次就診前，該等病徵已存在多久？How long had he/she been experiencing these symptoms prior to the first consultation?

6. 請填報診治詳情 Give details of consultations	日期（日 / 月 / 年） Date (DD/MM/YYYY)	醫生 / 醫院名稱及地址 Name(s) and Address of Doctor / Hospital
(a) 首次診治的醫生資料 The doctor first consulted for this illness	(a)	
(b) 建議入院的醫生資料 The doctor who referred the Insured to hospital	(b)	
(c) 曾診治此病 / 意外的其他醫生資料 All other doctors consulted during this illness / accident	(c)	
(d) 過往曾診治同類病況的醫生資料 Doctor seen for any similar condition in the past	(d)	

C. 聲明及授權 Declaration and Authorization

本人謹此聲明並同意：
1. 我謹在此聲明及同意以上之資料是完全及正確，並就此問卷之內容成為本人保單之一部份。
2. 由公司收集及持有本人或被保險人（如有不同）的任何個人資料，可使用、儲存、透露及轉予（無論本澳或海外）公司有關聯的人仕或機構團體，包括第三方服務提供者及其醫療網絡團隊、再保公司、賠償調查員、保險業協會 / 聯盟及追收欠款公司，以作為(i)承保及評估本申請；(ii)提供有關本申請的所有服務；以及(iii)因上述目的與本人或被保險人（如有不同）聯絡。
3. 本人明白，本人或被保險人（如有不同）有權要求查閱及於查閱後有權要求更正（如適當時），公司所持有之有關本人或被保險人（如有不同）的任何個人資料，或獲得任何拒絕查閱的理由；本人亦明白公司有權就處理任何查閱資料的要求，收取合理費用。〔注意：任何查閱及更正要求可以書面方式寄往澳門商業大馬路301-355號財神商業中心12樓賠償部收。〕

I HEREBY DECLARE AND AGREE THAT:
1. The above particulars and answers are complete and true, and this questionnaire will form part of the contract of the desired insurance on my life. I also authorize the Company to obtain, if necessary, confidential reports from any doctor/hospital that I have referred above.
2. Any personal data of myself or the Insured (if different) collected and held by the Company may be used, stored, disclosed and transferred (whether within or outside Macau) to such individuals/organizations associated with the Company and this Cashless Facility Service (the "Service'). These include any third party service provider and it's healthcare network team which is involved in providing this Service, reinsurers, claims investigators, industry associations/ federations and debt collectors for the purposes of (i) assess and evaluate this application; (ii) provide all services related to this application; and (iii) communicating with me or the Insured (if different) for such purpose.
3. I understand that I have or the Insured (if different) has the right to request access to and to request correction (if appropriate) of any personal information concerning myself or the Insured (if different) held by the Company or be given reasons for any refusal of access. I also understand that the Company has the right to charge a reasonable fee for process of any access. [Note: Any request for access or correction can be made in writing and addressed to the Claims Department at 12/F, Fortuna Business Centre, No. 301-355, Av. Comercial De Macau, Macau.]

本人在此授權或代表被保險人（如有不同）授權：
1. 當有需要時，富衛人壽保險(澳門)股份有限公司（「公司」）可要求持有或瞭解本人或被保險人（如有不同）的健康及醫療紀錄；或任何治療或忠告或曾向其求診或以後向其求診之任何註冊醫生、醫院、診所、保險公司，政府機構或其他團體透露有關被保險人資料。
2. 公司或公司許可的醫療人員底化驗所，就本賠償申請，進行必要的醫學評估及測試，以評估本人或被保險人的健康狀況。
3. 若貴公司曾為本人 / 我們 / 受保人支付任何不在受保範圍內的費用，或支付超出有關保障限額的費用時，貴公司將有權向本人 / 我們 / 受保人收取該筆差額。若貴公司因不論任何其他原因以至未能收取該筆差額，貴公司將有權（法律允許的範圍內）把應收款項從此或任何本人於貴公司持有之其他保單的金額中抵銷扣除，包括但不限於任何身故賠償、股息、紅利或保費退還（不論何種原因）。

I HEREBY AUTHORIZE AND AUTHORIZE ON BEHALF OF THE INSURED (if different):
1. Any registered practitioner, hospital, clinic, insurance company, government institution or other organization that has record or knowledge of my or the Insured's (if different) health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to FWD Life Insurance Company (Macau) Limited in relation to this claim.
2. The Company or any it's approved medical examiners or laboratories to perform necessary medical assessment and tests to evaluate my or the Insured's health status in relation to this claim.
3. In the event that the Company has settled any charges not covered by the policy or has made any payment over my/our/the Insured's eligible benefit limit of such policy, the Company shall have the right to collect such charges or amount overpaid from me/us/the Insured. If the Company cannot collect such shortfall due to any reason whatsoever, the Company shall have the right, to the extent permitted by law, to deduct or set off the shortfall amount against any benefit or amount due or payable to me/us/the Insured or any account value, credit balance or accumulations under such policy or any other insurance policy between me and the Company, including but not limited to any death benefit, dividend, bonus or return of premium (for whatever reason).

本人同時明白貴公司擁有隨時終止或更改此服務條款之最終權利而不需要另行通知，並且貴公司不會就第三方服務提供者及其醫療網絡團隊任何行為、疏忽或失實承擔任何責任。
I ALSO UNDERSTAND that the Company may terminate or vary the terms of the Service in its sole discretion without further notice, and that the Company will not be responsible for any act, negligence or failure to act on the party of any third party service provider and its healthcare network team which is involved the provision of this Service.

（注意:本授權對本人或被保險人的承繼人及轉讓人均有約束力，並且如法律上可行時，不論本人或被保險人死亡及失去行為能力，本授權仍然有效。本授權的影印本與正本同樣有效。）
(Note: This authorization shall bind my and the Insured's successors and assigns and remain valid notwithstanding my or the Insured's death or incapacity in so far as legally possible. A photocopy of this Authorization shall be as valid as the original.)

資料保護
公司已委任一位資料保護主任，處理有關閣下個人資料的任何書面查詢。如閣下對資料保護有任何查詢，請來信寄澳門商業大馬路301-355號財神商業中心12樓，富衛人壽保險(澳門)股份有限公司資料保護主任收。
Data Protection
The Company has appointed a Data Protection Officer to handle any enquiries relating to your personal information. If you would like to obtain a copy of the FWD Life Insurance Company (Macau) Limited Personal Data Policy and Practices, please write to the Corporate Data Protection Officer at 12/F, Fortuna Business Centre, No. 301-355, Av. Comercial De Macau, Macau.

日期（日 / 月 / 年） Date (DD/MM/YYYY)	簽署地 Place
投保人簽名 Signature of Policyowner	被保險人簽名 Signature of Insured

乙部（由被保險人之主診醫生填寫） Part II (To be completed by Attending Doctor of the Insured)

請在適當方格內填上「√」 Please tick "√" where appropriate

A. 診斷詳情 Diagnostic Details

病者姓名 Name of Patient	性別 Sex ☐ 男 Male ☐ 女 Female
是次就診之主訴 Chief Complaint of the Current Consultation	病徵出現日期（日 / 月 / 年） Onset Date of Symptoms
診斷 Diagnosis	是否慢性 / 復發疾病 Is it chronic / recurrent illness ☐ 是 Yes ☐ 否 No 首次病徵出現日期（日 / 月 / 年） First Onset Date (DD/MM/YYYY) _____
轉介 / 家庭醫生之姓名 Name of Referring Doctor / Usual Doctor （請提供轉介信 Please enclose referral letter）	

B. 治療詳情 Treatment Details

醫院名稱 Name of Hospital		住房級別 Room class ☐ 普通 Ward ☐ 半私家 Semi-Private ☐ 私家 Private	
預計入院日期（日 / 月 / 年） Estimated date of admission	預計住院日期（日 / 月 / 年） Estimated length of stay (number of days)	手術名稱 Name of surgery	麻醉 Anesthesia ☐ 局部麻醉 L.A. ☐ 全身麻醉 G.A.

此病是否與下列情況有關或因其引致？Was the medical condition caused by or related to the followings?

☐ 牙科治療或手術 dental treatment or surgery
☐ 先天性，遺傳性或發育異常 congenital, hereditary or developmental conditions
☐ 濫用藥物或酗酒 abuse of drugs or alcohol
☐ 妊娠，不育或絕育 pregnancy, infertility or sterilization
☐ 美容或外科整形手術 cosmetic or plastic surgery
☐ 精神紊亂，心理或精神疾病 mental, psychological or psychiatric conditions
☐ 企圖自殺或自殘 attempted suicide or self-inflicted injury
☐ 預防性治療或健康檢查 preventive treatment or health checks
☐ 治療過度肥胖或控制體重 Obesity or weight control

如是次住院目的為檢查，進行診斷掃描或一般日症手術，請說明住院之原因。 If hospitalization is arranged for scans, diagnostic testing or a procedure that is normally carried out in a day case, please explain why hospital confinement is necessary.	每日醫生巡房費用（港元） Attendance Fee per day (HK$)	手術費用（港元） Surgeon's Fee (HK$)	預計是次住院總費用（港元） Estimated Total Costs for this hospitalization (HK$)

醫生資料及簽署 Doctor's Particulars and Signature

醫生姓名（連帶資歷） Name of Doctor (with qualification)	電話號碼及地址 Telephone No. and Address
醫生簽名 Signature of Doctor	日期（日 / 月 / 年） Date (DD/MM/YYYY)