閩 信 保 險 有 限 公 司
MIN XIN INSURANCE COMPANY LIMITED
(A WHOLLY-OWNED SUBSIDIARY OF MIN XIN HOLDINGS LIMITED)

香港總行 Head Office ：香港中環紅棉路8號東昌大廈17樓
17/F., Fairmont House, 8 Cotton Tree Drive, Central, Hong Kong
電話Tel: (852) 2826 3660 傳真Fax: (852) 3020 5063
電郵E-mail: cs@mxic.com.hk

澳門分行 Macau Branch ：澳門南灣湖景大馬路810號財神商業中心6樓E座
Avenida Panorâmica do Lago Nam Van, no. 810, Edif. Fortune Business Centre, 6.˚andar E, Macau
電話Tel: (853) 2888 3876 傳真Fax: (853) 2830 5600
電郵E-mail: macaucs@mxic.com.hk

索償申請表請電郵至
claims@mxic.com.hk
或傳真： 3020 5063

OVERSEAS HELPER INSURANCE - HOSPITALIZATION CLAIM FORM
海外家傭保險 - 住院索償申請表

請閣下於受保人出院後30天內填妥本表格並連同下列所需文件一併交回。 本公司會保留權利在需要時要求閣下提供額外之有關索償資料及文件。 發出此索償申請表不代表本公司已承認賠償責任。
Completed claim form must be given to the Company within 30 days from discharge of hospital together with the following supporting documents. We reserve our right request additional information / documents when needed. The issue of this claim form is not an admission of liability on the part of our Company.

1. 收據正本必須有病人姓名，住院日期，診斷結果，主診醫生簽署，醫院蓋章及醫生轉介信
   Original medical receipt (s) with patient name, hospitalization date, diagnosis, signature and stamp of attending physician and referral letter
2. 由主診醫生填妥附頁之証明文件及醫療報告。
   Completed Certificate of Medical Attendant and Medical report.

注意：所有醫療報告或証明，需由申索人自費提供。
Noted: Any documentary proof and/or other reports shall be furnished at the expenses of the Claimant.

Part I – To be Completed by the Insured (Employee) 第一部份 - 由保戶（僱主）填寫

INSURED (EMPLOYER) 保戶（僱主）:

Policy No.: _____
保單號碼
Name of Insured: _____ Contact Telephone No.: _____
保戶姓名 聯絡電話號碼
Correspondence Address: _____
通訊地址

INSURED PERSON (OVERSEAS HELPER EMPLOYEE) 受保人（海外家傭僱員）:

Name of Insured Person: _____
受保人姓名
HKID/ Passport No. of Insured Person: _____
受保人香港身份證/ 護照號碼

CLAIM INFORMATION 索償資料 :

Diagnosis / Nature of sickness: _____
病因 / 疾病性質

Total number of day(s) of in-patient: _____ Total claim amount (pls. specify the currency): _____
總留院日數 總索償金額 (請註明幣值)

Date of previous episode of the same condition before? If any, pls. specify the date: _____
過往是否曾出現同樣徵狀? 如有，請註明

Have you applied for medical claims in other insurance company for this event/ accident? If yes, pls. specify. ☐
閣下有否就是次的事故/ 意外同時向其他保險公司提出索償醫療費用? 如有，請註明

Name of insurer: _____
保險公司名稱

Items 項目	Descriptions 明細	Claim Amount 索償金額 HKD/ MOP/ RMB/ Others 港幣/ 澳門幣/ 人民幣/ 其他
(A)	Room Board & General Nursing Fee 病房及一般醫護服務費	
(B)	Hospital Special Services Charge / Miscellaneous 醫院特別服務收費 / 雜項	
(C)	Surgery Costs 手術費	
(D)	In-Hospital Doctor's Call Charge 院內醫生巡房費	
(E)	In-Hospital Specialist Consultation Fee 院內專科醫生巡房費	
(F)	Anaesthetist Fee 麻醉師費	
(G)	Operating Theatre Fee 手術室費	
(H)	Others (please specify) 其他 (請註明)	

☐ Please "✓" the box for return of certified true copy of original invoice(s) & receipt(s) after claim processing.
如欲索回醫生發出的正式認證副本發票及收據，請在空格內加上"✓"號。

DECLARATION AND AUTHORIZATION 聲明及授權 :

本人/吾等在此聲明本人/吾等已盡一切能力保證上述各節均屬實情，及在此次意外中，本人/吾等並無得到其他保險賠償.
本人/吾等亦同意，如以上或將來提供之資料有虛假成分或有隱瞞，此保險單將被作廢，而一切索償權利亦將喪失。
I/We declare that, to the best of my/our knowledge, the above statements are true and correct and I/We have no other insurance policy indemnifying me/us in respect of this accident. I/We hereby further agree if I/We have made or shall make any false statement or concealment, the Policy shall be void and all rights of recovery under the Policy shall be forfeited.

本人/吾等現授權**閩信保險有限公司 (**「**本公司**」**)** 由現存或不時成立的任何保險公司的協會或聯會或類同組織 (以下簡稱「聯會」) 從保險業內收集的資料中查閱及/或核對本人/吾等之任何資料。
I/we hereby authorize **Min Xin Insurance Company Limited ("Company")** to obtain access to and/or to verify any of my/our data with information collected by any association, federation or similar organization of insurance companies the exists or is formed from time to time (the "Federation") from the insurance industry.

本人/吾等授權持有本人/吾等投保資料，索償紀錄或任何有關資料之一方，包括但不限於警方及政府機構，保險公司等任何有關人士或組織，可以將部份或全部有關本人是次或相關事件等資料提供**貴公司**或其代理人。
I/We hereby further authorize any parties, including but not limited to police and government authorities, insurance companies etc. who are in possession of my insurance proposal information, claim information or any related information to release part or all of the information about the subject or related incidents of injury, loss or damage to the **Company** or its agents.

個人資料收集聲明 PERSONAL INFORMATION COLLECTION STATEMENT

由**本公司**收集所得或持有閣下之個人資料(該等資料可能在此表格提供或從其他途徑得到)可被用於**強制性**用途，如閣下不能提供有關個人資料，**本公司**將不能向閣下提供服務。
Your personal information collected or held by the **Company (**whether contained in this Application or otherwise obtained) may be used for below **obligatory purposes**. Failure to supply the required information may result in the **Company** unable to provide services to customers.

閣下提供的資料，為**本公司**提供業務所需，並可能使用於下列目的 :
The information you provide to the **Company** is collected to enable the **Company** to carry on insurance business and may be used for the purpose of:

- 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 ;
  any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or service;
- 任何索償、訴訟或該等索償的調查或分析 ;
  any claim, action and/or proceedings or investigation or analysis of such claim; and
- 行使任何代位權 ; 及
  exercising any right of subrogation; and

可能轉移予 :
may be transferred to:

- 任何有關的公司，或任何其他從事與保險或再保險有關的公司，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 ;
  any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service providers providing services relevant to insurance business for any of the above or related purposes;
- 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
- 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
- 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。
  any members of the "Federation" by the "Federation" for any of the above or related purposes.

閣下有權查閱及要求更正由**本公司**持有有關閣下的個人資料，如有需要，請以書面向**本公司**個人資料保護主任提出。
You have the right to obtain access to and to request correction of your personal information held by the **Company** by request in writing to Personal Data Protection Officer of the **Company**.
根據私隱條例，**本公司**有權收取合理費用，藉以處理任何資料的查閱要求。
In accordance with the Ordinance, the **Company** has the right to charge a reasonable fee for processing any data access request.
此授權書之影印本亦屬有效。
A photocopy of this authorization shall be considered as effective and valid as the original.

保戶簽署 (如屬公司請印章) Signature of Insured (with Company chop if applicable) 日期 Date:	受保人簽署 Signature of Insured Person 日期 Date:

閩 信 保 險 有 限 公 司
MIN XIN INSURANCE COMPANY LIMITED
(A WHOLLY-OWNED SUBSIDIARY OF MIN XIN HOLDINGS LIMITED)

香港總行 Head Office ：香港中環紅棉路8號東昌大廈17樓
17/F., Fairmont House, 8 Cotton Tree Drive, Central, Hong Kong
電話Tel: (852) 2826 3660 傳真Fax: (852) 3020 5063
電郵E-mail: cs@mxic.com.hk

澳門分行 Macau Branch ：澳門南灣湖景大馬路810號財神商業中心6樓E座
Avenida Panorâmica do Lago Nam Van, no. 810, Edif. Fortune Business Centre, 6.˚andar E, Macau
電話Tel: (853) 2888 3876 傳真Fax: (853) 2830 5600
電郵E-mail: macaucs@mxic.com.hk

索償申請表請電郵至 claims@mxic.com.hk 或傳真: 3020 5063

ATTENDING PHYSICIAN'S STATEMENT
主診醫生陳述

Part II – To be Completed by the Attending Physician 第二部份 - 由主診醫生填寫

GENERAL ITEMS 一般項目 :

Name of Patient: _____ Hospital Name: _____
病人姓名 醫院名稱

Admission Date: _____ Discharge Date: _____
入院日期 出院日期

CLINCIAL HISTORY 門診病歷 :

Date of first consultation for this condition: _____
首次看診日期

Symptom(s)/ complaint(s) of the patient relating to this hospitalisation/ treatment/ investigation/ sickness:
病人就有關是次住院/ 接受治療/ 檢查之徵狀/ 疾病

_____

_____

_____

How long had the patient been experiencing these symptoms before the first consultation 病人之病徵於首次求診前出現了多久?

_____

_____

_____

Had the patient been previously treated or hospitalised for this disorders? Please provide details if known.
病人過去曾否就此病症需接受診治或入院治療? 如知悉，請提供詳情。

_____

_____

_____

HOSPITALISATION DETAILS 住院詳情 :

Final diagnosis: _____ Date of perform: _____
最後診斷 手術/ 治療日期

Please provide details of the hospitalisation and treatment that the patient underwent 請提供是次住院及相關治療詳情:

☐ Treatment 治療 ☐ Investigation 檢驗 ☐ Diagnostic Tests 診斷掃瞄

Operation procedure(s) performed: _____
手術名稱

Nature of operation procedure (please describe fully): _____
手術性質及過程 (請詳述)

Please give a brief discharge summary and relevant follow up/ recovery plan 請提供出院摘要及有關跟進/ 康復計劃:

Is patient still under your case for this condition? If "no", please give the date of your service terminated: _____
病人仍須因此病症需要你的醫護嗎? 若 "不需"，請填上服務終止日期 ☐ YES 需要 ☐ NO不需

Professional Comment 專業意見 :

In your professional opinion, was the patient hospitalised as a result of recurrent episode or a chronic illness or related to a previous complaint/ diagnosis. If "Yes", please provide date of the first episode and details.
根據你的專業意見，病人是否因長期疾病或慢性疾病或之前有關之病況而住院? 如"是" ，請提供首次患病之日期及詳情。

Was the condition due to or associated with the following? (Please tick the appropriate boxes)
病人的病況是否與下列情況有關? (請於適當空格加上"✓")

☐ Accident bodily injury 意外受傷
☐ Self-inflicted injury 自我傷害
☐ Abuse of drugs or alcohol 濫用藥物/酒精
☐ Mental or nervous disorder 精神紊亂
☐ Refractive error 視力問題
☐ Pregnancy 懷孕
☐ Infertility or sterilisation 不育或絕育
☐ Contraception 節育
☐ Vaccination 疫苗接種
☐ Treatment for cosmetic purpose 美容手術
☐ Congenital condition 先天性疾病
☐ Development condition 發展障礙
☐ Hereditary condition 遺傳性疾病
☐ General check-up 一般身體檢查
☐ None of above 以上皆不是

☐ Venereal disease, sexually transmitted disease or AIDS/ HIV related illness 性病、性傳染疾病或愛滋病/ 人類免疫缺乏病毒有關的疾病

DECLARATION AND AUTHORIZATION 聲明及授權 :

I hereby certify that all information given above is accurate and true to the best of my knowledge.
本人特此聲明，就上述資料依本人所知均正確無誤。

Name of attending physician & qualifications: _____ Telephone no.: _____
主診醫生姓名及認可資格 聯絡電話

Address of attending physician's clinic/ hospital: _____
主診醫生聯絡診所/ 醫院地址

_____

_____ _____

Authorised Signature and Chop of Hospital
醫院授權簽署及蓋章
Date日期:

Signature and Chop of Attending Physician
主診醫生簽署及蓋章
Date日期: