YF Life 萬通保險

First Policy No.: 第一份保單編號：								
Second Policy No.: 第二份保單編號：								

Cashless Hospitalization Service Pre-Approval Form 出院免找數服務評估申請書 (C09)

Name of Insured : 受保人姓名 :	Name of Policy Owner : 保單持有人姓名 :
ID Card No. of Insured : 受保人身份證號碼 :	Insured's Present Occupation: 受保人現時職業:

Important Notes 重要事項:

1) Please complete and submit this form to us *at least 4 working days prior to the planned admission (*at least 5 working days for non-Hong Kong / non-Macau hospitals). All parts must be completed before YF Life Insurance International Ltd.("the Company") will process the application. The Company have absolute right to approve or reject any Cashless Hospitalization Service.
請於計劃入院日期前*最少四個工作天遞交申請(*非香港／澳門醫院，最少五個工作天)。本評估申請書所有部份必須填妥。萬通保險國際有限公司("本公司")有絕對決定權批核或拒絕任何出院免找數服務申請。

2) The approval of the Cashless Hospitalization Service is no way constitute an admission of liability. The Company will have claims assessment based on the relevant claim form, medical documents. The claim decisions will be made subject to the terms, conditions and provisions of the policy.
批核此出院免找數服務並不表示本公司承認是次賠償責任。本公司會於受保人出院後根據相關索償申請書、醫療文件進行賠償審核。賠償決定會因應保單條件、情況及保單條款所約束。

PART I : CLAIMANT'S STATEMENT 第一部份 : 索償人聲明

1. If hospitalization / surgery is due to accident, please provide: 若因意外受傷而住院/接受手術，請詳述：

1a. Date of accident: 發生是次意外的日期	1a. _____/_____/_____ MM 月 DD 日 CCYY 年
1b. Place and cause of the accident: 意外發生的地點及詳情	1b. _____
1c. Which part(s) of the body was injured: 受傷的身體部位	1c. _____
1d. Had the accident been reported to police? If yes, please attach police report and / or police statement. 曾否就是次意外報警? 若有，請提供警署報告副本及／或口供紙	1d. ☐ No 沒有報警 ☐ Yes 有報警

2. If hospitalization / surgery is due to sickness, please provide: 若因患病而住院/接受手術，請詳述：

2a. Signs and symptoms: 病徵及病狀	2a. _____
2b. Since when have these signs / symptoms first appeared? 初次呈現病徵/病狀的日期	2b. _____/_____/_____ MM 月 DD 日 CCYY 年

3. Consultation information 診治詳情：

3a. Date/ Doctor name and address of the first consultation for this accident / sickness or related condition: 此意外/疾病或相關情況的首次診治日期／醫生名稱及地址	3a. _____/_____/_____ MM 月 DD 日 CCYY 年 Name and address of Doctor 醫生名稱及地址 _____
3b. Please provide all doctors' information who were consulted for this accident / sickness or related condition. 請列出所有曾診治此意外/疾病或相關情況的醫生資料	3b. Name of the Doctor 醫院名稱 Address of the doctor 醫生地址
3c. Name and address of Insured's usual medical attendant: 受保人的家庭醫生名稱及地址	3c. Name and address of Insured's usual medical attendant: 受保人的家庭醫生名稱及地址
3d. Except for this claimed condition, the details of the last medical consultation: 除是次索償的情況外，上一次曾就診的詳情	3d. Date of consultation : _____ / _____ / _____ 求診日期 MM 月 DD 日 CCYY 年 Cause of consultation : 求診原因 _____ Name and address of the doctor : 醫生名稱及地址 _____

Signed by Policy Owner 保單持有人簽署 X _____

4. Declaration and Authorization 聲明及授權：

PERSONAL INFORMATION COLLECTION STATEMENT

I/We understand and agree my/our personal information (including a record of my/our image or voice by whatever means and my/our health information) collected by or held by YF Life Insurance International Ltd ("the Company") may be used for the purposes of: (1) approving, evaluating or processing my/our insurance application/policy service request; (2) administering, maintaining or reinsuring my/our policies; (3) adjudicating my/our claims, or conducting any investigation or analysis of my/our claims; (4) data matching; 5) investigation or prevention of crime; or (6) fulfilling legal or regulatory requirements. I/We understand and agree that failure to provide any information requested by the Company may result in the Company not being able to process my/our insurance application/policy service request.

I/We understand and agree my/our personal information collected by or held by the Company may be transferred or disclosed by the Company to any of the following persons (whether within or outside Hong Kong) for the purposes as specified above or to governmental/regulatory bodies (whether within or outside Hong Kong) for them to carry out their governmental/regulatory functions: (1) YF Life group companies and their associated/affiliated companies; (2) financial institutions, insurance companies, intermediaries and reinsurers; (3) claims investigation companies or any companies/persons necessary for claims assessment/investigation; (4) industry associations/federations and their members; (5) governmental/regulatory bodies and law enforcement agencies; (6) crime prevention organisations and their members/participants; and (7) service providers and selected persons which are under a duty of confidentiality to the Company.

I/We understand that I/we have the right to access to, and to correct, any of my/our personal information held by the Company by writing to the Personal Data Protection Officer of the Company. (Address : 27/F, YF Life Tower, 33 Lockhart Road, Wanchai, Hong Kong (applicable to policies issued in Hong Kong) or Avenida Doutor Mario Soares No. 320, Finance and IT Center of Macau, 8 Andar A, Macau (applicable to policies issued in Macau)). The Company may charge a reasonable fee for the processing of such request.

DECLARATION

I/We, the undersigned, hereby declare that all information deposed hereinabove, whether they are written by me/us or not, is true and complete to the best of my/our knowledge and belief and I/we have not withheld any material information connected with this claim. I/We also have read and understood the Personal Information Collection Statement stated above. I/We provide the information herein on a voluntary basis. However, I/we understand that failure to provide information as per the Company request may result in the Company being unable to process with this application. This application form and all other documents submitted to the Company for this claim shall be the property of the Company, and will be non-returnable under all circumstances.

The submission of this form and / or the issuance of letter of guarantee by the Company is in no way constitute of liability.

For the Company to assess, provide, and to communicate with me / us the Cashless Hospitalization Service, I / We understand and agree that my / our personal data collected and held by the Company may be used, stored, transferred and disclosed (whether within or outside Hong Kong) to such individuals / organizations associated with the Company and the Cashless Hospitalization Service. These include any third party service provider and their healthcare network which is involved in providing the Cashless Hospitalization Service.

I/We understand that the Company will not be responsible for any act, negligence or failure to act on the party of any third party service provider which is involved the provision of the Cashless Hospitalization Service.

In the event that the Company has settled any charges not covered in the policy or which exceeds the Insured's eligible benefit limit, the Company shall have the right to deduct any of such charges from the credit card as specified below. However, if the Company cannot collect such shortfall due to insufficient credit available in the credit card account or for any other reason whatsoever, the Company shall have the right to setoff the shortfall amounts against the amount due or payable to me/us/the Insured from this Policy and/or any policy issued by the Company of which I/we/the Insured am/are/is the Policy Owner(s), Assignee(s) or payee(s) including but not limited to any death benefit, policy benefits or return of premium (for whatever reason).

AUTHORIZATION

I/We hereby on behalf of myself/ourselves irrevocably authorize (1) any individual or organization (including but not limited to my/our employer, registered medical practitioner, hospital, clinic, insurance company, bank, police, governmental department, public or private institution) that has any record, statement, information of mine/us (whether medical or otherwise) to release, disclose or transfer all the information to the Company or its representatives for the purposes of assessing and processing any insurance claim. (2) The Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and/or tests to evaluate my/our health status in related to this claim. I/We hereby acknowledge that (1) this authorization shall be binding on my/our successors and assignees and remain valid and subsisting notwithstanding my/our death or incapacity for whatever reasons; (2) A photocopy of this authorization shall be as valid as its original. I/We hereby grant my/our consent to the Company to collect, use and transfer the above health information in accordance with the Personal Information Collection Statement.

個人資料收集聲明

本人/我們明白及同意萬通保險國際有限公司("貴公司")所收集或持有本人/我們的個人資料(包括任何形式的肖像、聲音及與健康有關的資料)可能會被用於下列目的：(1) 批核、評審及處理本人/我們之投保計劃申請/保單服務要求；(2) 就本人/我們之保單提供行政、持續或再保險的服務；(3) 評核本人/我們索償，或就本人/我們之索償進行調查或分析；(4) 資料核對；(5) 偵測或防止罪行；或(6) 符合法律或合規要求。本人/我們明白及同意必須提供貴公司所需的個人資料，否則，貴公司將不能處理本人/我們之投保申請或就本人/我們之保單提供服務。

本人/我們明白及同意貴公司可能為達到上述目的或讓政府/監管機構(不論在香港或海外)執行其職務而向以下任何一方(不論在香港或海外)轉移或透露由貴公司收集或持有屬於本人/我們的個人資料：(1) 萬通保險集團成員公司及其關聯或相關公司；(2) 金融機構、保險公司、中介人或再保險公司；(3) 賠償調查公司及所需有關評核索償之公司及/或人士；(4) 行業組織/聯會及其成員；(5) 政府部門或監管機構和執法機構；(6) 防犯罪組織及其會員/參與者；及 (7) 與貴公司有保密協議的服務提供者及其他人士。

本人/我們明白本人/我們有權查閱和更改任何由貴公司持有屬於本人/我們的個人資料。如有需要，本人/我們可與貴公司的資料保護主任提出有關要求、並以書面方式呈交(地址：香港灣仔駱克道 33 號萬通保險大廈 27 樓(適用於香港簽發的保單) 或澳門蘇亞利斯博士大馬路 320 號澳門財富中心 8 樓 A 座(適用於澳門簽發的保單))。處理上述要求時，貴公司可能會收取合理費用。

聲明

本人/我們，即下方簽署者，謹此聲明上述披露之一切資料，不論是否由本人/我們手寫，就本人/我們等所深知及確信均屬完整並真確無訛。本人/我們就此索償申請並無隱瞞任何重要資料。本人/我們等亦已閱讀及明白上述的個人資料收集聲明。本人/我們在此提供的資料均屬自願。若未能依據貴公司要求提供資料，本人/我們明白會導致貴公司不能處理此申請。此評估申請書及一切其他文件在遞交給貴公司後便會成為貴公司的財產。在任何情況下均不會獲得退回。

收妥此申請書及/或發出保證書並不表示本公司已承認是次賠償責任。

本人/我們明白為評估本申請、處理本出院免找數服務、及與本人/我們溝通以進行出院免找數服務，貴公司所收集或持有本人/我們的個人資料可能被使用、儲存、轉移或透露予任何處理出院免找數服務的貴公司有關聯人士或機構(不論在香港或海外)，包括第三方服務提供者及其醫療網絡團隊。

本人/我們明白貴公司不會就第三方服務提供者任何行為、疏忽或失實承擔任何責任。

若貴公司曾為本人/我們/受保人支付任何不在受保障範圍內的費用，或支付超出有關保障限額的費用時，貴公司將有權從以下指定的信用卡中扣除任何相關的金額。若貴公司因有關信用卡戶口的信用額不足，或不論任何其他原因以至未能收取該筆差額，貴公司將有權把應收款項從此保單，及/或任何由貴公司簽發並以本人/我們/受保人作爲保單持有人、承讓人或作為此等款項的收款人的保單所獲支付予本人/我們/受保人的金額中抵銷扣除，包括但不限於任何身故賠償、保單利益或保費退還(不論何種原因)。

授權書

本人/我們現授權(1) 任何擁有本人/我們等任何記錄、供詞、資料(不論是否醫學資料)之人士或機構(包括但不限於本人/我們的僱主、註冊醫生、醫院、診所、保險公司、銀行、警察、政府部門、公共或私營機構)向貴公司或其代表發放、披露或轉交任何與評核及處理保險索償申請有關的資料。(2) 貴公司或任何由貴公司指定的醫務人員或化驗所可就此索償對本人/我們等進行有需要之醫療評估及測試，以審核本人/我們的健康狀況。本人/我們現確認 (1) 此授權書對本人/我們之繼承人及受讓人具有約束力，即使本人/我們死亡或無行為能力(不論任何原因)，此授權書仍然生效及具效力；(2) 本授權書之副本與正本具有同等效力。本人/我們謹此授權貴公司可按「個人資料收集聲明」的規定收集、使用及轉移上述有關本人/我們健康方面的資料。

Signature of Consultant 顧問簽署	Signature of Policy Owner 保單持有人簽署	Signature of Insured 受保人簽署 (only if age is over 18 若年齡超過 18 歲)
Name and Code of Consultant 顧問姓名及編號	Name of Policy Owner 保單持有人姓名	Name of Insured 受保人姓名
Date 日期	Policy Owner's ID No. 保單持有人身份證號碼	Insured's ID No. 受保人身份證號碼

5. Credit Card Authorization (this section must be completed) 信用卡授權書 (必須填寫此部份)：

If the amount paid by YF Life Insurance International Ltd. ("the Company") to the hospital exceeds the eligible claims arising from this hospitalization, this form authorizes the Company to collect the shortfall amount from the following credit card account.

The credit card holder must be the Policy Owner or the Insured or with direct relationship with the Policy Owner or the Insured e.g. spouse or parent. The credit card should be valid for at least 6 months from the date of admission. The Company will hold HK$5,000 from the credit limit of this credit card account. The shortfall notification will be sent to the Policy Owner 14 days prior to the collection. (Visa Card and Master Card are accepted. The transaction will be processed in Hong Kong dollars. For credit card issued outside Hong Kong, the amount will be subject to exchange rate fluctuations and charges. For details, please refer to the card issuer.)

如萬通保險國際有限公司("本公司")直接向醫院支付的費用超出是次住院就合資格保障應支付的賠償額，此授權書將授權本公司從以下信用卡戶口收取有關差額。

信用卡持卡人必須為此保單之保單持有人或受保人，或與保單持有人或受保人有直接關係，如配偶或父母。信用卡有效期必須由入院起計至少六個月。本公司將於信用卡保留 5,000 港元的信用額。本公司將於收取差額費用十四天前發出差額付款通知書通知保單持有人有關差額詳情。(接受 VISA 及 MASTER，交易將以港幣結算，如使用非香港發行的信用卡，付款金額將受到匯率波動和費用的影響，請聯絡發卡銀行了解詳情。)

Credit Card Authorization Form 信用卡付款授權書

Cardholder's Name 信用卡持卡人姓名	
Relationship with the Policy Owner/ Insured 與保單持有人 / 受保人關係	
Credit Card Account No. 信用卡號碼	☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐
Credit Card Expiry Date 信用卡到期日	☐☐ / ☐☐☐☐ MM 月 CCYY 年

I hereby authorize and direct YF Life Insurance International Ltd. to hold HK$5,000 credit limit and debit the outstanding shortfall due from my credit card account.
本人特此授權及指示萬通保險國際有限公司從本人之信用卡戶口保留 5,000 港元的信用額及扣除到期之差額費用。

Signature of Cardholder 信用卡持卡人簽署	Signature of Policy Owner 保單持有人簽署	Date 日期

PART II : ATTENDING PHYSICIAN'S STATEMENT 第二部份 ： 醫生報告

Note : 1) Please make sure that the report below is duly completed by the Attending Doctor of the Insured before it is submitted to the Claims Department.
2) The Insured/claimant will be responsible for any fee for the completion of this report.

注意 ： 1) 以下報告在交予理賠部前必須由主診醫生填寫。
2) 受保人/索償人須負責因填寫下列報告所需支付的一切費用。

Name of patient : 病者姓名 _____ ID Number : 身份證號碼 _____

(1) Details of hospitalization 住院資料

Name of hospital : 醫院名稱 _____ Room Class: 病房級別 ☐ Ward 普通病房 ☐ Semi-private 半私家 ☐ Private 私家

Planned Date of admission : 預計入院日期 _____ / _____ / _____ (MM 月 / DD 日 / CCYY 年)

Expected length of Confinement : 預計住院日數 _____ Day(s) 日

(2) Chief complaints of the patient relating to this hospitalization : 病者住院的主要原因 _____

(3) a) Signs and symptoms presented : 出現的病徵及病狀 _____

b) Date of the accident occurred or symptom first appeared : 意外發生日期或初次呈現病徵的日期 _____ / _____ / _____ (MM 月 / DD 日 / CCYY 年)

c) Diagnosis : 診斷 _____ Date of diagnosis: 診斷日期 _____ / _____ / _____ (MM 月 / DD 日 / CCYY 年)

d) Date of first consultation for this injury / sickness or related sickness : 此受傷/疾病或相關疾病的首次就診日期 _____ / _____ / _____ (MM 月 / DD 日 / CCYY 年)

e) Name and address of the doctor who referred the patient to you: 轉介病者給你的醫生姓名及地址 ： _____

f) Is the disability related to the following? 此疾病是否由下列之情況而引致或與下列任何情況相關?

☐ Drugs or alcohol abuse / dependency 藥物酒精濫用/依賴
☐ Congenital deformities or anomalies 先天性畸形或反常
☐ Obesity, weight control 過度肥胖/控制體重
☐ Suicide or self-infliction 自殺或自傷身體
☐ Recurrent episode or a chronic disease? If yes, date of first attack: _____ / _____ / _____ (MM 月 / DD 日 / CCYY 年) 舊病復發或慢性疾病? 如是，首次發病日期
☐ Mental disorder, psychiatric conditions, behavioral problems or personality disorder 精神紊亂、心理或精神疾病、行為問題或人格障礙
☐ Pregnancy, abortion, childbirth or miscarriage 懷孕、墮胎、生育或小產
☐ Cosmetic or plastic surgery 美容或整形外科手術

If yes, please give details: 如是，請提供詳情 : _____

g) To the best of your judgment or knowledge, has the patient ever had the same or similar sickness or symptoms relating thereto? 據你判斷或所知，病者曾否患有以上疾病或呈現相似的病徵?

☐ No. 否 ☐ Yes. 是 Please state when and what was it : 請列明何時染病及疾病名稱 ： _____

h) Is the patient having any treatments or taking medicines? 病人現在是否接受任何治療或服用藥物？ ☐ No 否 ☐ Yes 是

Please provide details (including onset date, doctor's name, diagnosis, name of medicine, etc). 請提供詳情（包括病發日期，應診醫生姓名，診斷，藥名等）

_____

(4) Please advise the tests/imaging/other diagnostic investigation required during the hospitalization, why? 住院其間建議之化驗/影像檢查/其他診斷性檢查及接受該等檢查的原因。

_____

a) Were the medical test(s) and equipment for the procedure available only in hospital? 該檢查及手術所需的設備是否僅在醫院才有? ☐ No 否 ☐ Yes 是

b) Is it possible that the treatments / investigations / procedure of the patient be managed on an out-patient basis/at day surgery centre? 病者之治療/檢查/醫療程序是否可在門診/日間手術中心進行?

☐ No, please provide reason(s): 否 請提供原因 _____

☐ Yes, please give reason(s) for this hospitalization: 是 請提供住院原因 _____

Signature of the attending physician / specialist (with chop) :
主診醫生簽署及蓋章

Name of Patient
病者姓名 : _____

ID Number
身份證號碼 : _____

(5) Surgery / treatment required :
建議手術/治療 _____

Anaesthesia 麻醉 ☐ General 全身麻醉 ☐ Local 局部麻醉 ☐ MAC 監護麻醉管理

For surgery under Monitored Anaesthesia Care, please specify the reason for hospital stay.
如手術在監護麻醉下進行，請註明住院原因。

_____

(6) Estimated hospitalization charges 預算住院費用

Estimated Daily Doctor's Round Fee
預算每日醫生巡房費: $_____ x _____ 日
days(s)

Estimated Surgeon Fee
預算手術費: $_____

Estimated Anaesthetist Fee
預算麻醉科醫生費: $_____

Estimated Operation Theatre Fee
預算手術室費: $_____

Estimated Hospital Expenses Fee
預算醫院費用 $_____

Estimated Total fee of this Hospitalization:
預算是次住院總費用

(7) a) Date of the first consultation for this patient (Not limited to this claimed injury/sickness):
病者首次就診日期 (不限於此索償受傷/疾病)

_____

b) Are you the patient's usual medical attendant?
閣下是否病者家庭醫生

☐ No, please advise the name(s) of the patient's usual medical attendant: _____
否，請提供病者家庭醫生的姓名

☐ Yes.
是。

c) Are you a member of the patient's immediate family or living regularly with the patient?
閣下是否病者之直屬家庭成員或與病者慣常居住的人士?

☐ No. 否。 ☐ Yes, details : 是，詳情 _____

I hereby certify that I have personally attended the above-named Patient and that all the information provided by me in this form is true and correct to the best of my knowledge and belief.
本人謹此聲明本人曾提供治療予上述病者。就本人所知所信，上述由本人提供的資料均為事實之全部，並確實無訛。

Signature of the attending physician / specialist 主診醫生簽署

Address & Telephone No. 地址及電話號碼

Date 日期

Name of the attending physician / specialist 主診醫生姓名

Hospital specialty/Unit/Department 醫院專科 / 單位 / 部門

Qualification(s) 專業資格

Hospital / doctor's name chop 醫院 / 醫生之蓋章