

保單編號 Policy Number

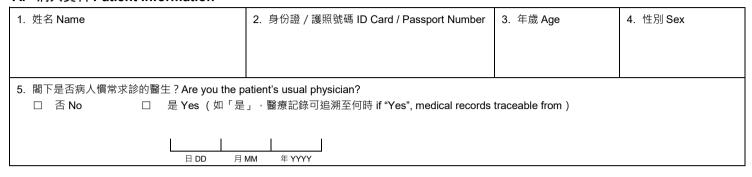
手術索償申請書 Surgical Claim Form

重要指示:請於適當空格內加「✓」號

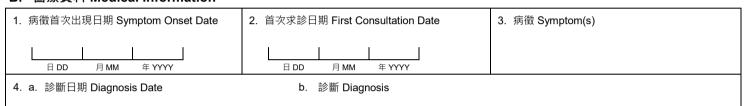
Important note: Please put "√" for the appropriate box

第二部分 PART II (由主診醫生填寫 to be completed by attending Physician)

A. 病人資料 Patient Information



B. 醫療資料 Medical Information



d. 從何處知悉 (請提供醫生/醫院名稱)

Informed by (please provide name of physician / hospital)

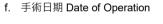


c. 病人首次知悉日期 Patient First Being Informed Date



∃ DD 是次疾病/意外之根本原因?請提供詳情

What was the underlying cause of the disease / accident? Please provide details



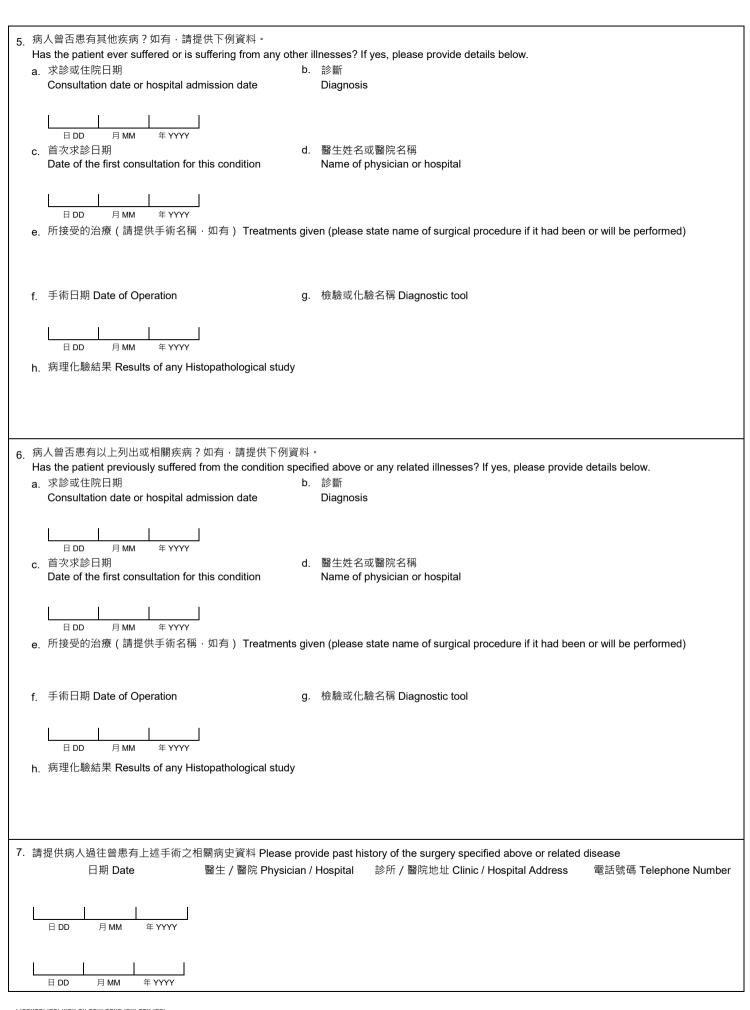
g. 手術名稱 Name of Procedure



- h. 手術性質 Nature of Surgery
- i. 是次手術是否醫療所需?請提供詳情 Was the surgery necessary? Please provide details
- 是否因繼發性或慢性疾病所引致或與以往的主訴/診斷有關?請提供詳情 Was the Medical Operation as result of recurrent episode or a chronic illness or related to previous complaint/diagnosis? Please provide details
- k 是否與先天性疾病有關?請提供詳情

Was the disease caused by any congenital related? Please provide details

I. 是否與愛滋病有關或受人體免疫力缺乏病毒(HIV)感染?請提供詳情 Was the disease caused by any HIV related or infection by any Human Immunodeficiency Virus (HIV)? Please provide details





8.	8. 請提供病人過往的健康紀錄資料 Please provide information of the past health history of the patient						
日期 Date		е	醫生 / 醫院 Physician / Hospital	診所 / 醫院地址 Clinic / Hospital Address	電話號碼 Telephone Number		
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	日 DD	月MM	年 YYYY				
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註:請附上病理學報告、內窺鏡報告、診斷性化驗/實驗室測試報告及/或手術室撮要副本
Note: Please attach copies of histopathology report, endoscopic report, diagnostic / laboratory tests report and/or operating theatre summary

醫生資料 Physician Information	
	醫生/醫院簽署及蓋章 Signature and Official Stamp of Physician / Hospital
	診所/醫院之地址 Address of Clinic / Hospital
電話號碼 Telephone Number	 日期(日 / 月 / 年) Date (DD/MM/YYYY)

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