



信諾委任卓健醫療服務有限公司(卓健)為信諾醫療保系列之服務商,其服務包括處理索償事務。如有關任何索償事項查詢,請致電卓健提供之信諾醫療保專線。
電話:(852) 8203 2202 傳真:(852) 2534 0223 請郵寄已填妥之索償表格及有關之醫療收據正本至香港上環德輔道303號4樓卓健醫療服務有限公司卓健醫療理賠部(MAT)。
Quality HealthCare Medical Services Limited (QHMS) is a service provider appointed by CIGNA to provide services for CIGNA HealthFirst Medical Series, including the administration of claims.
Please call the QHMS managed CIGNA HealthFirst Hotlines for any claim related enquiry. Tel: (852) 8203 2202 Fax: (852) 2534 0223
Please mail your completed claim form and related original medical receipts to QHMS Claims Department (Medical Affairs Team), Quality HealthCare Medical Services Limited, 4/F 303 Des Voeux Road Central, Sheung Wan, Hong Kong.

第一部份 - 請由受保人填寫,如受保人未滿18歲,則由保單持有人填寫(請連同住院/醫療費用單據一併交回)
Part I - To be completed by insured or policyholder if insured is below 18 years old (Please attach hospital / medical expense receipts with this form)

1. 個人資料 Personal Particulars

保單持有人姓名 英文 _____ 中文 _____ 保單編號
Name of Policyholder Eng _____ Chin _____ Policy No. _____

受保人姓名 英文 _____ 中文 _____
Name of Insured Eng _____ Chin _____

受保人香港身份證號碼 _____ 年齡 _____ 性別 男 女 _____ 日間聯絡電話
HK Identity Card No. of Insured _____ Age _____ Sex _____ M / F _____ Daytime Contact Telephone No. _____

現任僱主名稱 _____ 受僱職位
Name of Current Employer _____ Position Held _____

現任僱主地址 _____ 公司電話
Address of Current Employer _____ Tel No. _____

所有索償通知將會郵寄至閣下在本公司記錄之通訊地址。
All claim communication will be mailed to your correspondence address as per our company record.

2. 付款指示 Payment Instruction

- i. Direct Account Transfer in HKD 以港元直接轉數至自動轉賬戶口:
(Only applicable to savings/current account for payment collection for this policy of which Payor and Policyholder are the same person.
只適用於儲蓄/來往賬戶以作直接付款的保單,而付款人與保單持有人必須為同一人。)
- ii. Cheque Delivery 支票傳遞方式:
By surface mail to correspondence address 以平郵寄至通訊地址
- Note: 注意: If no payment instruction is assigned, HKD cheque will be issued and sent by surface mail to policy address. 如無任何付款或支票指示,將會發出港元支票並以平郵寄至保單地址。

3. 求診資料 Consultation Information

請提供詳細求診資料以便處理索償 Please provide detailed consultation information to facilitate the claim processing:

3.1 是次求診/住院 This consultation/hospital confinement:

- i. 求診原因(請提供詳情) Reasons of this consultation (provide details as appropriate):
• 由疾病/意外所致。請提供診斷 Due to illness/accident. Please provide the diagnosis: _____
• 如屬意外導致,請提供意外詳情
For accident, please provide the circumstances of the incident: _____
- ii. 您何時首次發現上述病徵 _____ (年/月/日) iii. 初診日期 _____ (年/月/日)
When did you first aware of the manifestation of such symptoms? (YY/MM/DD) Date of first consultation: (YY/MM/DD)
- iv. 醫院/診所/醫生名稱 _____
Name of Hospital / Clinic / Doctor _____
- v. 求診日期 _____ (年/月/日)
Consultation period: From _____ to _____ (YY/MM/DD)
- vi. 您過去曾就是次疾病/意外所就診之醫生名稱 _____
Name of doctor(s) consulted for this illness / accident in the past: _____
- 3.2 過去因該病求診紀錄 Previous related consultation history:
- i. 首次求診之病徵 _____
What was the sign / symptom in the first consultation? _____
- ii. 初診日期 _____ (年/月/日) iii. 其後因該病徵覆診/再診之日期 _____ (年/月/日)
Date of first consultation: (YY/MM/DD) Subsequent consultation dates of this sign / symptom: (YY/MM/DD)
- 3.3 請列出閣下過去慣常求診的醫生/家庭醫生之名稱及地址
Please provide the name and address of your usual/family doctor: _____

4. 其他資料 Others

請問除本公司外,受保人有否投保於其他保險公司?如有,請列明:

Do you have other insurance coverage If so, please state:

保險公司名稱 _____ 投保種類 _____ (Life/Medical/CI/Disability) 保單編號 _____ 保單生效日期 _____
Name of Insurer _____ Type of Coverage _____ Policy Number _____ Policy Effective Date _____

5. 聲明及授權 Declaration & Authorization

(請由受保人簽署,如受保人未滿18歲,則由保單持有人簽署 To be signed by insured. If insured is below 18 years old, please sign by Policyholder)

本人謹此聲明上述一切陳述,不論是否本人親手所寫,均屬正確無訛,並為吾所知所信之全部。本人同意任何蓄意欺騙或隱瞞將構成法律責任並導致保單失效。

本人同意信諾收集或持有本人之個人資料,不論是否由此申請書或其他途徑取得,並可能提供、轉移或披露予任何持有有關於本人或上述受保人記錄或資料之香港或海外醫生、醫院、藥劑師、保險公司、警署、僱主、或其他機構發放有本人或上述投保人之病歷、病情預後、治療、醫假、或在職、離職詳情、或在其他保障下可獲之保障額、索償金等資料,作為處理、調查和索賠分析或評估。

I hereby declare all the statements to all questions above, whether or not written by my own hand are to the best of my knowledge and belief complete and true. I agree that any concealment or misstatement as regards to amount or otherwise, in connection with this claim may result in prosecution and the policy shall become void.

I consent that the personal information collected or held by the Company, whether contained in this application or otherwise obtained, is provided and may be transferred or disclosed to any physician, hospital, pharmacy, insurance company, police station, employer, or other organization, who has records or knowledge of myself or the insured, to release all information regarding medical history - prognosis treatment (including drug and alcohol abuse information), sick leave history, employment history, reason of employment termination, earnings or benefit payable under other insurance coverage within or outside Hong Kong for processing, investigation and claims analysis/assessment.

受保人/保單持有人簽署(如受保人未滿18歲) _____ 簽署日期 _____
Signature of Insured / Policyholder (if insured is below 18 years old) _____ Date Signed _____

受保人/保單持有人姓名(請以正楷書寫) _____ 受保人/保單持有人香港身份證號碼 _____
Name of Insured / Policyholder (in block) _____ HK Identity Card No. of Insured / Policyholder _____

病人姓名 _____ 香港身份證號碼 _____ 年齡 _____ 性別 _____
 Full name of Patient _____ HK Identity Card No. _____ Age _____ Sex _____

1. 求診資料 Consultation Information

診斷日期 由 _____ 至 _____
 Treatment Period from _____ to _____

1.1 病況診斷

Diagnosis of conditions

1.2 上述診斷期間曾接受之檢查、治療手術項目及結果:

Investigations, treatment, therapy, surgical procedures done and result during the above mentioned treatment period:

2. 有關上述病況之資料 History of Consultation

2.1 在是次求診日期前, 病人有否在台端執業之診所診治有關上述病況之紀錄? 如有, 病人始自何時求診?

Prior to this consultation, did patient first consult you for the related signs and symptoms? And when was the first consultation?

否 NO 有, 第一次求診日期始自 _____
 YES, the first consultation was since _____

2.2 病人在第一次求診之主要病徵為何?

What sign(s) and symptom(s) was/were the patient aware of at the first consultation?

2.3 如上述之徵狀是由意外所導致, 若上述之徵狀是由意外所導致, 請提供下列資料:

i) 意外發生日期 _____ 年 / 月 / 日 時間 _____ 地點 _____
 Accident Date _____ (YY/MM/DD) Time _____ Place of the accident happened _____

ii) 請詳述意外是如何發生。
 Please give the circumstances of the accident in details.

iii) 請問傷者在首次求診時, 受傷部位有否可見明顯外傷?
 Any external visible signs of bodily injury were revealed at the 1st consultation? Please give details.

2.4 據病人自述, 上述病徵在求診前出現多久?

According to the patient, for how long had such symptom(s) persisted before the first consultation? _____ (YY/MM/DD)

2.5 據你的診治, 在第一次求診時, 病徵已持續了

In your opinion, prior to the first consultation, such symptom(s) had persisted for _____ (YY/MM/DD)

2.6 病人是否由另一位醫生轉介台端作進一步治療? 如是, 請列出姓名:

Was the patient referred to you by another doctor for further management? If so, please state name of referral doctor:

否 NO 是, 該醫生為 _____ 轉介理由: _____
 YES, the name of referral doctor is _____ Reason of referral: _____

2.7 就上述病況, 病人有否住院?

Was hospitalization required for the abovementioned diagnosis?

是 YES 住院日期 由 _____ 至 _____ 住院原因 _____
 Hospitalization Period is from _____ to _____ Reason for this hospitalization: _____

否 NO 病人不需要住院接受治療
 The patient does not require to stay at hospital for treatment

2.8 如有轉介予專科診治, 請提供專科醫生之姓名及治療詳情:

If you have recommended the patient for specialist's opinion (other than attending Physician), please give specialist name and nature of treatment provided:

2.9 在住院期間, 病人有否請假外出?

During hospitalization period, did the patient have any home leave taken? 否 NO 有, 請假外出日期由 _____ 至 _____ 原因是 _____
 YES, the home leave period is from _____ to _____ Reason is _____

2.10 請指出上述病況是否與下列情況有關:

Please indicate if the medical condition and its subsequent treatment are associated with the followings:

是 YES	否 NO	先天性不正常情況、不育或絕育 Congenital anomalies, infertility or sterilization	是 YES	否 NO	牙科治療, 身體檢查 Dental care or General Check-up
是 YES	否 NO	受酒精或藥物影響 Under the influence of drugs or alcohol	是 YES	否 NO	休養、復康、療養或延續護理 Rest cure, rehabilitation, convalescence or extended care
是 YES	否 NO	不論在神智清醒與否下之自我傷殘或自殺行為 Self-inflicted injuries or suicidal attempt while sane or insane	是 YES	否 NO	心理、精神或神經科 Mental, psychiatric or nervous problems
是 YES	否 NO	懷孕或由此引發之病況 Pregnancy conditions or any related complications	是 YES	否 NO	美容 / 整形外科手術 Cosmetic / Plastic Surgery

醫生簽署 _____ 醫院 / 醫生蓋印 _____
 Signature of Physician _____ Hospital / Physician Stamp _____

醫生地址 _____ 簽署日期 _____
 Physician Name in Block _____ Date Signed _____

診所地址 _____
 Clinic Address of Physician _____