Long Term Medication – Hypertension Claim Form
長期藥物 — 高血壓索償表格

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如有關任何索償事項查詢，請致電客戶服務熱線（852）2560 1990。（請於選擇語言後按“4”以聯絡專責索償團隊）
For any claims related enquiry, please contact our Customer Service Hotline at (852) 2560 1990. (Please press "4" after language selection to contact the dedicated claim team)

☐ 首次索償 First claim ☐ 持續索償 Further claim

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。(請連同醫療費用單據一併寄回)
Part I – To be completed by insured or policyholder if insured is below 18 years old. (Please attach medical expense receipts with this form)

個人資料 Personal Particulars

Ref: _____ (for office use)

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

受保人姓名 Name of Insured 英文 Eng 姓 Family Name _____ 名 Given Name _____ 中文 Chin _____

受保人香港身份證號碼 HK Identity Card No. of Insured _____ 出生日期 Date of Birth _____ (YY / MM / DD) 年齡 Age _____ 性別 Sex 男 M / 女 F

日間聯絡電話 Daytime Contact Telephone No. _____ 電郵地址 E-mail Address _____

受保人之現任僱主名稱 Name of Current Employer of Insured _____ 受僱職位 Position Held _____

受保人之現任僱主地址 Address of Current Employer of Insured _____

公司電話 Tel No. _____

所有索償通知將會經我們的客戶平台通知或郵寄至閣下在本公司記錄之通訊地址。
All claim communication will be informed through our customer portal or mailed to your correspondence address as per our company record.

治療詳情 Treatments Details

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:

你何時首次發現高血壓病徵：
When did you first aware of the manifestation of Hypertension symptoms？_____ (YY / MM / DD)

你何時首次發現持續性高血壓，收縮血壓大於140毫米汞柱或舒張血壓大於90毫米汞柱?
When did you first aware the persistent high blood pressure of >140 mmHg systolic blood pressure or >90 mmHg diastolic blood pressure？_____ (YY / MM / DD)

首次求診日期：
Date of first consultation: _____ (YY / MM / DD)

醫院/診所/醫生名稱：
Name of Hospital / Clinic / Doctor: _____

求診日期： 由 From _____ (YY / MM / DD) 至 to _____ (YY / MM / DD)
Consultation period:

你何時開始每日服用抗高血壓藥物?
When did you first prescribe daily Anti-Hypertension Medication？_____ (YY / MM / DD)

求診期間，你有否中途停服抗高血壓藥物? 或是每天連續服藥?
Within the subject consultation period, have you stopped the taking of Anti-Hypertension Medication prescription for any time period?
Or you have prescribed the daily Anti-Hypertension Medication continuously?

☐ 是，我有每天連續服用抗高血壓藥物。
Yes, I have taken daily Anti-Hypertension Medication continuously.

☐ 否，我在以下時段停止服用抗高血壓藥物。 由 _____ (YY / MM / DD) 至 _____ (YY / MM / DD)
No, I have stopped the taking of Anti-Hypertension Medication in the period from to

請提供抗高血壓藥物名稱及每天服藥劑量。
Please provide the name and daily dosage of Anti-Hypertension Medication. _____

請列出過去慣常求診的醫生/家庭醫生之名稱、地址：
Please provide the name and address of your usual/family doctor:

初診日期：
Date of first consultation:

其他資料 Others

請問除本公司外，有否投保於其他保險公司？如有，請述：
Do you have other insurance coverage? If so, please state:

保險公司名稱 Name of Insurer _____ 投保種類 Type of Coverage _____ 保單編號 Policy Number _____ 保單生效日期 Policy Effective Date _____

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)

本人特此聲明一切陳述，不論是否本人親手所寫，就本人所知所言，均為正確無訛及完整。 本人茲授權任何醫生、醫院、藥房、保險公司、警察局、僱主、任何機構及人士，將已經存錄或準備存錄的本人/受保人之醫療、病歷及其他資料給予信諾環球人壽保險有限公司及信諾環球保險有限公司(統稱“信諾”）或其代表，作為評估或辦理此申請書或索償和售後服務/意見調查之用。為免任何疑問，本授權書對本人/受保人之繼承人、受讓人、遺囑執行人及遺產管理人均具有約束力。即使本人/受保人死亡或無行為能力，本授權仍具效力。本授權之副本及正本具同樣效力。本人謹此聲明及同意信諾收集或存錄有關之個人資料(無論載於本申請書內或從其他途徑所獲取的)，並可保留、使用、透露、及轉傳該等資料給任何有關公司/機構或被選定的團體(本港或海外，包括代表本人/受保人的保險中介人、再保公司、賠償調查公司及同業協會或聯會)，以辦理此申請書、索償及售後服務、資料核對，並作為知會本人/受保人之用。本人有權向貴公司查閱及要求更正任何已存錄之個人資料，而有關申請可向信諾個人資料保護專員提出。

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, belief, complete and true. I authorize any medical practitioner, hospital, pharmacy, insurance company, police station, employer, or other organization or persons that have any records, medical history or knowledge of me and/or the insured, to release full particulars of such information to Cigna Worldwide Life Insurance Company Limited and Cigna Worldwide General Insurance Company Limited (collectively, "Cigna") or their appointed representatives/agents for the purposes of assessing or processing this application or claims and subsequent services/customer satisfaction survey. To avoid any uncertainty, this authorization shall bind all my/the insured's successors, assignees, executors and administrators and shall remain valid notwithstanding my/the insured's death or incapacity. A copy of this Declaration & Authorization shall be deemed to be valid as the original. I further agree that any personal information collected or held by Cigna (whether contained in this application or otherwise obtained) is provided and may be held, used, disclosed and transferred by Cigna to any related companies/organizations or any selected parties (within or outside Hong Kong, including insurance intermediary acting on my/the insured's behalf, reinsurance and claims investigation companies and industry associations/federations) for the purposes of processing this application or claims and providing subsequent services, data matching, and to communicate with me/the insured for such purposes. I have the right to obtain access and to request correction of any personal information held by Cigna. Such request can be made to Cigna's Data Protection Officer.

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

簽署日期
Date Signed _____

受保人／保單持有人姓名 (請以正楷書寫)
Name of Insured/Policyholder (in block) _____

受保人／保單持有人香港身份證號碼
HK Identity Card No. of Insured/Policyholder _____

第二部份 – 主診醫生報告 (此欄須由受保人之主診醫生填寫，而費用須由受保人負責)
Part II – Attending Physician Statement (To be completed by the insured's attending doctor at the insured's cost)

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

醫療資料 Treatments Details

診斷日期 由 Treatment Period from _____ 至 to _____

1. 病況診斷
   Diagnosis of conditions

   _____

   _____

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:

   _____

   _____

有關上述病況之資料 History of Consultation

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. 病人在第一次求診之主要病徵為何？
   According to the subject diagnosis, what sign(s) and symptom(s) was/were the patient aware of at the first consultation?

   _____

3. 又據病人自述，上述病徵在求診前出現多久？
   According to the patient, for how long had such symptoms(s) persisted before the first consultation?

   在第一次求診時，病徵已持續了 Prior to the first consultation, such symptom(s) had persisted for _____ 日 day(s) _____ 月 month(s) _____ 年 year(s)

4. 病人被確診為持續性高血壓，收縮血壓大於140毫米汞柱或舒張血壓大於90毫米汞柱，始自何時？
   When did the patient first diagnosed the persistent high blood pressure of >140 mmHg systolic blood pressure or >90 mmHg diastolic blood pressure?

   _____ (YY / MM / DD)

5. 病人何時首次服用抗高血壓藥物？
   When did the patient first prescribe daily Anti-Hypertension Medication? _____ (YY / MM / DD)

6. 請提供抗高血壓藥物名稱及每天服藥劑量。
   Please provide the name and daily dosage of the Anti-Hypertension Medication. _____

7. 由首次服用日期起，病人有否中途停服抗高血壓藥物？或是每天連續服藥至今？
   From the first prescription, have the patient stopped the taking of Anti-Hypertension Medication for any time period?
   Or the patient has prescribed the daily Anti-Hypertension Medication continuously up to now?

   ☐ 是，病人有每天連續服用抗高血壓藥物。
   Yes, the patient has taken Anti-Hypertension Medication continuously.

   ☐ 否，病人在以下時段停止服用抗高血壓藥物。由 _____ (YY / MM / DD) 至 _____ (YY / MM / DD)
   No, the patient has stopped the taking of Anti-Hypertension Medication in the period from _____ (YY / MM / DD) to _____ (YY / MM / DD)

8. 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 YES, the name of referral doctor is _____

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

醫生姓名 Physician Name _____ 簽署日期 Date Signed _____

診所地址 Clinic Address of Physician _____