FALCON

Falcon Insurance Company (Hong Kong) Limited
富勤保險(香港)有限公司

A FAIRFAX Company

WIN HELPER OUTPATIENT CLAIM FORM 家傭門診醫療索償表格

Claim Notes

1. This Form is applicable to outpatient claim.
2. **Each Claim Form is for one Claimant (Patient) only.**
3. This Form must be submitted within 30 days of incurring such expenses.

Claim Procedures

1. Attach the **Original** receipt(s) issued by the doctor or certified true copy of receipt(s) issued by other insurers (if applicable). Each receipt **MUST** state the following information:
   - ■ Full name of patient ■ Date of consultation / Date of treatment ■ Diagnosis
   - ■ Breakdown of charges ■ Doctor's signature and official stamp ■ Name of Clinic/Hospital
2. For outpatient visits in public hospital/clinic, please attach the original receipts together with a copy of medical certificate / sick leave certificate with specified diagnosis or discharge summary. If no diagnosis is provided by the doctor, the Claimant (Patient) is required to supplement the exact diagnosis (e.g. Hypertension) on the abovementioned documents and confirm with a signatory.
3. **Complete and sign this Form.**
4. Provide copy of claim settlement advice from other insurers, if applicable.
5. Please tick the appropriate box if certified true copy of receipt is required. Falcon Insurance Company (Hong Kong) Limited will retain the original receipt for record purpose.

索償注意事項

1. 此索償表格適用於門診索償。
2. **每張索償表格只限一名索償人(病人)。**
3. 請於費用支出後 30 日內遞交此索償表格。

索償程序

1. 附上由醫生簽發的收據**正本**或由其他保險公司發出的收據核實副本 (如適用)。每張收據**必須**列明以下資料：
   - ■ 病人姓名 ■ 診症日期 / 治療日期 ■ 病症名稱 ■ 收費項目說明
   - ■ 醫生簽署及蓋章 ■ 診所或醫院之名稱
2. 請附上由政府醫院或門診發出的收據正本及附有病症名稱的醫療證明書 / 病假證明書或出院撮要副本。若醫生未有註明病症名稱，索償人(病人)須於上述文件上補充確實的病症名稱 (例如：高血壓) 並簽署確認。
3. **填妥此索償表格及簽署。**
4. 如適用，請提供其他保險公司之賠償結算通知書副本。
5. 如需索取收據之核實副本，請於適當空格內畫上✓號。收據正本將存檔於富勤保險(香港)有限公司。

Policy No. 保單號碼	Policyholder Name 保單持有人名稱

Insured Person 受保人

Name 姓名 Surname 姓 Other Name 名	Type of Personal Identification Document and Number 身份證明文件類別及號碼 (Please tick the appropriate box 請於適當方格內畫上✓號) □ HKID Card No. 香港身份證號碼 □ Passport No. 護照號碼

No. 編號	Date of Treatment 診治日期 (DD/MM/YY)	Amount Incurred 索償金額	Type of Claim (Please✓) 索償類別 (請用✓)		
			GP's Consultation 普通科醫生診症	Dental 牙科	Others (Please specify) 其它(請註明)

Post-hospitalization follow up visit 出院後之跟進覆診 □ Yes 是 □ No 否

Date of hospitalization 住院日期： From 由 __________________(DD/MM/YY) to 至 __________________(DD/MM/YY)

□ Return certified true copy of receipt(s) after claim processing. 如欲索回收據之核實副本，請於方格內填上✓號。

Declaration and Authorization 聲明及授權書

1. I hereby declare that the foregoing statements, including any statement attached, are true, correct and complete to the best of my knowledge and belief. 本人謹在此聲明，以上所述一切是根據本人所知所信正確填寫，並為完全和真確。
2. Personal Information Collection Statement
   The information you provide to **Falcon Insurance Company (Hong Kong) Limited** ("the Company") is collected to enable the company to carry on insurance business and may be used for the purpose of (i) any insurance or financial related product or service or any alternations, variations, cancellation or renewal of such product or service; (ii) any claim or investigation or analysis of such claim; and (iii) exercising any right of subrogation. The information may be transferred to (i) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claim or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes; (ii) 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 (iii) any members of the "Federation" by the "Federation" for any of the above or related purposes. Moreover, the Company is hereby authorized to obtain access to and / or to verify any of your data with the information collected by the "Federation" from the insurance industry. You have the right to obtain access to and to request correction of any personal information concerning yourself held by the Company**.** Requests for such access can be made to our Data Protection Officer (Suites 307-11, 3/F, 12 Taikoo Wan Road, Taikoo Shing, Hong Kong Tel.: 2232 2888 Fax: 2232 2899).
   收集個人資料聲明
   閣下提供的資料，為**富勤保險(香港)有限公司**(「貴公司」)提供保險業務所需，並可能使用於下列目的：(i) 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；(ii) 任何索償，或該等索償的調查或分析；(iii) 行使任何代位權。該等資料可能移轉予：(i) 任何有關的公司，或任何其他從事與保險業務有關的公司，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；(ii) 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 (iii) 或透過 "聯會" 移轉予任何 "聯會" 的會員，以達到任何上述或有關目的。此外，在此授權貴公司由 "聯會" 從保險業內收集的資料中查閱及 / 或核對閣下任何資料。閣下有權查閱及要求更正由貴公司持有有關閣下的個人資料，如有需要，可向本公司資料保護主任 (香港太古城太古灣道 12 號太古城中心 3 樓 7-11 室 電話：2232 2888 傳真：2232 2899) 提出。
3. Consent & Authorization
   In accordance with the provisions of the Personal Data (Privacy) Ordinance of Hong Kong, I / and on behalf of the Claimant* consent, by signing below, that the personal information of me / the Claimant* provided by me / us* and held by the Company (whether contained herein or otherwise obtained) may be held, used, disclosed, released and transferred by the Company to the parties and for the purposes mentioned in the "Personal Information Collection Statement". I hereby authorize / and on behalf of the Claimant hereby authorize* (i) any doctor, hospital, clinic, or insurance company, government office or any organization or persons who has any records / knowledge / information of me / the Claimant* (whether medical or otherwise) to disclose, release or transfer to the Company or its representative such record, knowledge or information pertinent to the claim herein and / or the disability resulting from the said claim; (ii) the Company or any of its appointed medical / para-medical examiners or laboratories to perform necessary medical assessment and tests to evaluate the health status of me / the Claimant* in relation to (i) above. This authorization shall bind the successors and assignees of me / the Claimant* and remains valid notwithstanding death or incapacity. A photostatic copy of this authorization shall be as valid as the original. (*Delete where appropriate)
   同意及授權書
   根據香港個人資料(私隱)條例，就簽署此索償表格，本人/ 謹代表索償人*同意貴公司可持有或使用任何有關本人 / 索償人*之個人資料 (不論是否從此索償表格或其他途徑所得)，或將該等資料透露、發放或轉交予 "收集個人資料聲明" 內提及之組織、機構或人仕作為有關之用途。本人謹此授權 / 謹此代表索償人授權* (i) 任何擁有本人 / 索償人*的醫療記錄或資料之醫生、醫院、診所、保險公司、政府部門或其他機構及人仕，向貴公司或其代表透露及提供關於本人 / 索償人*之記錄或資料；(ii) 貴公司或其指定之醫護檢查人員或化驗所對本人 / 索償人*進行與 (i) 有關之身體檢查及化驗。此授權對本人 / 索償人*之繼承人及受讓人均有約束力，即使在本人 / 索償人*身故或喪生行為能力後仍然有效。此授權書之副本，與正本同樣有效。 (*請將不適用者刪除)

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Signature of Policyholder
保單持有人簽署

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Date 日期 (DD/MM/YY)

If there is any discrepancy between the English and Chinese versions, the English version shall apply and prevail.英文版本與中文版本之間如有任何歧異，均以英文版本為準。