

HOSPITALIZATION CLAIM FORM 住院賠償申請表
PART I (To be completed by Insured/Policyowner) 第一部份 (由受保人/保單持有人填寫)

Policy No. 保單編號	Name of Insured 受保人姓名 Identity Document No.: 身份證明文件號碼	Age 年齡 Sex 性別	<input type="checkbox"/> New Claim 首次索償 <input type="checkbox"/> Further Claim 再度索償 <input type="checkbox"/> Pending Claim 待決賠償 <input type="checkbox"/> Review/Appeal 重批/覆核
Contact Phone No. 電話號碼	Name of Sales Personnel 保險顧問姓名	Code of Sales Personnel 保險顧問編號	Claim No. (For office use only) 賠償號碼 (公司專用)

A. If Hospitalization was due to an ACCIDENT, please complete questions 1-4 如因意外受傷入院, 請填寫問題1至4

1. a. Date, Time & Location of Accident 意外發生日期、時間及地點 Date of Accident _____ (DD日/MM月/YYYY年) 意外日期 Time 時間 _____ /AM上午 _____ PM下午 Location 地點 _____	2. Did you report to the police? 有否報警? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 有, Police Station 警署名稱 : Ref. No. 檔案編號
b. Where and how did the accident happen? (Describe activities engaged if applicable) 意外如何發生及事發地點? (請形容當時進行之活動,如適用)	3. Present occupation (if more than one, state all) and exact nature of occupational duties 現職(若有兼職請列明) 職位及職責
c. Part(s) of body injured and type of injury 受傷部位及傷勢	4. Name and address of business or employer 公司或僱主名稱及地址
d. Date Returned to work 復職日期 _____ (DD日/MM月/YYYY年) OR 或 e. Expected Date of Returning to work 預計復職日期 _____ (DD日/MM月/YYYY年)	

B. If Hospitalization was due to an ILLNESS, please complete questions 5 and 6 如因病人入院, 請填寫問題5至6

5. a. Signs and symptoms 病徵及病狀 b. For this episode, when did these symptoms first appear? 就是次病況而言, 何時出現首次徵狀? _____ (DD日/MM月/YYYY年) c. Other than this episode, have you had any similar/ related past history? 除此次病況外, 閣下以往有否類似或相關病歷? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide details 有, 請提供有關詳情: Consultation Date _____ Name & address of Physician/ Hospital _____ Diagnosis 就診日期 _____ 醫生/醫院名稱及地址 _____ 診斷結果 (DD日/MM月/YYYY年)	6. a. Name and address of the Physician/ Hospital who have treated for this illness 曾因此病況就診之醫生/醫院名稱及地址 Consultation Date _____ Name & address of Physician/ Hospital 就診日期 _____ 醫生/醫院名稱及地址 (DD日/MM月/YYYY年) b. Please provide details of your usual attending Physician/ Hospital. 請提供閣下慣常就診之醫生/醫院名稱 Name & address of Physician/ Hospital _____ Contact Phone No. 醫生/醫院名稱及地址 _____ 聯絡電話
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C. HOSPITALIZATION AND CONSULTATION DETAILS 住院及診治詳情

7. a. Name of Hospital 醫院名稱 b. Date of Admission 入院日期 _____ (DD日/MM月/YYYY年) Date of Discharge 出院日期 _____ (DD日/MM月/YYYY年) c. Admission period in Intensive Care Unit (if applicable) 入住深切治療部日期 (如適用) From 由 _____ to 至 _____ DD日/MM月/YYYY年 d. Have you taken any home leave during the hospital confinement? 閣下有否於住院期間請假外出? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please state the date and time of your home leave. 如有, 請列明外出之日期及時間	8. The Physician first consulted for this illness/ accident 首次就診之醫生資料 Name and address of the Physician 醫生名稱及地址 _____ Consultation date 求診日期 _____ (DD日/MM月/YYYY年) 9. The Physician who referred the insured to hospital 建議/轉介入院之醫生資料 Name and address of the Referral Physician 轉介醫生名稱及地址 _____ Referral date 轉介日期 _____ (DD日/MM月/YYYY年)
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D. CONCURRENT CLAIMS 同期之索償

10. Did you apply for compensation from other insurers/ organization for the same event? 閣下有否就此事向其他保險公司/機構申請索償?

No 否 Yes, please provide details 有, 請提供有關詳情:

Insurance Company/ Organization 保險公司/機構 Policy No. 保單號碼 Benefit(s) to Claim 索償類別 Result/ Status 結果/狀況

E. PAYMENT INSTRUCTION 付款指示

(If payment instruction is not specified or information is not clear, HKD cheque will be issued 如沒有註明方式或資料不清晰, 將以港幣支票支付)

By Autopay 自動轉賬

Current Direct Debit Authorization bank account in the company record; or
現時本公司紀錄之自動轉賬戶口; 或

Specified HKD bank account below
以下指定之港幣銀行戶口

Bank No. 銀行號碼	Branch No. 分行號碼	Account No. 戶口號碼
<input type="text"/>	<input type="text"/>	<input type="text"/>

Notes:

- Bank account holder name must be the same as **Policyowner's** name.
- Please provide account holder's bank account proof which shows account holder name and account number.
- Autopay is only applicable to banks in Hong Kong and the payment will be paid in Hong Kong Dollar.
- If the autopay is rejected by your bank, the respective claim payment will be paid by cheque.

注意事項:

- 銀行賬戶持有人姓名必須與**保單持有人**姓名相同。
- 請提供賬戶持有人的銀行賬戶證明, 而該證明須列有銀行賬戶持有人姓名及銀行賬號。
- 自動轉賬只適用於香港銀行及款項將以港幣支付。
- 若自動轉賬不成功, 本公司將以港幣支票支付相關之賠償款項。

By cheque 支票 (If no cheque currency is selected, HKD cheque will be issued 若沒有選擇支票貨幣, 將以港幣支票支付。)

Cheque currency 支票貨幣

Hong Kong Dollar 港幣 Policy Currency 保單貨幣

F. DOCUMENT CHECKLIST 所需文件指引

Please ✓ below to indicate the documents submitted with this claim form. 請於下表以“✓”號表示連同以賠償申請表遞交的文件:

Document Type 文件類別	Hospital & Surgical Benefit 住院保障	Hospital Cash Benefit 住院現金保障
<input type="checkbox"/> Copy of identity document of the insured & Policyowner 受保人及保單持有人之身份證明文件副本	✓	✓
<input type="checkbox"/> Claim Form Part I (Completed by the Policyowner) 賠償申請表第一部份 (由保單持有人填寫)	✓	✓
<input type="checkbox"/> Claim Form Part II (Completed by the insured's Attending Physician) 賠償申請表第二部份 (由受保人之主診醫生填寫)	✓	✓
<input type="checkbox"/> Hospital Receipt(s) and Statement(s) of Charges 醫院收據及收費單 (費用明細表)	✓ (Original) (正本)	✓ (Copy) (副本)
<input type="checkbox"/> Copy of Discharge Summary/ Discharge Slip 出院總結/ 出院紙副本	✓	✓
<input type="checkbox"/> Copy of Laboratory / X-ray/ CT scan/ MRI/ Pathological Report(s) 化驗/X-光/電腦掃描/磁力共振/病理檢驗報告副本	✓	✓
<input type="checkbox"/> Copy of Admission Note, Discharge Summary, Discharge Certificate, Daily Medical Record & Temperature Sheet of hospital in Mainland China 中國內地醫院之病案首頁、入院紀錄、出院總結、每日醫囑單及體溫表副本	✓	✓
<input type="checkbox"/> Copy of Referral letter by Registered Doctor /Hospital 註冊醫生/醫院轉介信副本	✓	✓
<input type="checkbox"/> Copy of Compensation Breakdown from other insurer/ Party 其他保險公司或機構之賠償細算表	✓	#
✓ Required Documents 基本文件 # Optional Documents 附加文件		
** The Company may request for the submission of extra information/ documents on case by case basis** 本公司可能會按個別個案情況要求遞交額外資料/文件		

DECLARATION AND AUTHORIZATION 聲明及授權

DECLARATION - I/WE HEREBY DECLARE AND AGREE that:

- (1) all statements and answers to all questions in relation to the above claims whether or not written by my/our own hand are to the best of my/our knowledge and belief complete and true;
- (2) Personal Information Collection Statement ("PICS") as below.

AUTHORIZATION

I/WE HEREBY AUTHORIZE (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organization, institution, or person, that has any records or knowledge of me/us and who has attended or may hereafter attend myself/ourselves to disclose such information to Tahoe Life Insurance Company Limited ("Tahoe Life"); (2) Tahoe Life or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ourselves in relation to this claim. This authorization shall bind my/our successors and assignees and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

I/We declare and agree that I/we have the full authority from and consent to make the above authorizations.

聲明 - 本人/我們謹聲明並同意：

- (1) 不論是否由本人/我們親手書寫，所有與上列索償有關的陳述及所有問題的答案均按本人所知及所信均屬完整及真確；
- (2) 下列「個人資料收集聲明」。

授權

本人/我們謹此授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構或其他機構、組織或人士，凡知道或持有任何有關本人/我們之紀錄者、及/或曾診驗或可能將會診驗本人/我們者，均可將該等資料提供給泰禾人壽保險有限公司（「泰禾人壽」）；(2) 泰禾人壽或任何其他指定之醫生或化驗所，可就此賠償申請替本人/我們進行所需之醫療評估及測試，作為審核本人/我們之健康狀況。此授權對本人/我們之繼承人及受讓人具約束力；即使死亡或無行為能力時，此授權仍具效力。本授權書的影印本與正本均有同等效力。本人/我們聲明本人/我們有權及同意作出上述授權。

Personal Information Collection Statement ("PICS") 個人資料收集聲明

1. Purpose: Among the personal data collected from you to Tahoe Life Insurance Company Limited/ Tahoe Insurance Services Limited ("Company"), it is collected for the purpose of: (i) processing, administering, implementing and effecting the requests indicated in this document or any documents that you may submit to the Company from time to time; (ii) providing all services related to this document and the Policy, including promoting or improving such services or related services by the Company or its subsidiaries and affiliates; (iii) communicating with you in relation to the administrative purposes; (iv) investigating, processing and paying claims made under your insurance policy; (v) co-operating with any investigation and meeting any disclosure requirements imposed by any legal, regulatory, governmental, tax, law enforcement or other authorities, or self-regulatory or industry bodies within or outside Hong Kong Special Administrative Region ("HKSAR"); (vi) transferring your Personal Data to any federation or similar organization of insurance companies ("Federation") and any members of the Federation to carry out its regulatory functions and/or in the interest of insurance industry or any members; (vii) statistical or actuarial research; (viii) other ancillary purposes which are directly related to the purposes set above.

For using the personal data provided by you for promotional / marketing purposes, please refer to the section titled "Use of Personal Data in Direct Marketing". The failure of providing the Personal Data by you may result in the Company being unable to provide products and services, assess your policy application, process claims under insurance policies issued by the Company, or process any other requests, enquiries, or complaints from you.

2. Transfer: Personal data provided by you to the Company will be kept in confidential but it may be transferred to parties mentioned below for purposes set above: (i) any related company(ies), including subsidiaries or affiliates of the Company; (ii) any other unrelated company carrying on insurance, provisional trustee of mandatory provident fund or reinsurance related business; (iii) financial services intermediaries that are authorized by the Company for the distribution of products and services provided by the Company; (iv) a claims, investigation or other services provider providing services relevant to your insurance policies; (v) relevant industry association and federation that exists or is formed from time to time; (vi) any person (including agents, contractors or third party service providers) who provides administrative, telecommunications, computer, payment, data processing or other services in connection with the operation of the Company's business and provision of products and services to you; (vii) any legal, regulatory, governmental, tax, law enforcement or other authorities, or self-regulatory or industry bodies within or outside HKSAR; (viii) any third party in connection with a transfer or potential transfer of all or part of the business of the Company that some of the transferees may be located within or outside of HKSAR; (ix) your insurance agents, intermediaries or referrers.

3. Access: You have the right to ascertain what type of personal data the Company holds, whether the Company holds your personal data and, if so, the right to request access to and to request correction of any personal data concerning you held by the Company. Such request can be made to the Data Protection Officer of the Company at 15/F, Cityplaza One, 1111 King's Road, Taikoo Shing, Hong Kong. The Company has the right to charge a reasonable fee for processing a request to access your personal data access request.

Use of Personal Data in Direct Marketing

Apart from the aforementioned purposes, the Company may use your personal data including name, contact details, products and services portfolio information, transaction pattern and behavior, financial background and demographic data for direct marketing by mail, fax, email, telephone or SMS that may include the following classes of services, products and subjects: (a) insurance, financial and related services and products; (b) reward, loyalty or privileges programmes and related services and products; and (c) services and products offered by the Company's co-branding partners (the names of such co-branding partners can be found in the application form(s) and/or advertising leaflet(s)/poster(s) for the relevant services and products, as the case may be). Your personal data may also be provided to third party providers of financial, insurance, medical/health, call centre, marketing or research services, rewards, loyalty or privileges program services and/or related services for their use in direct marketing.

Before using your personal data for the purposes of direct marketing conducted by the Company or any third parties indicated in this section, the Company must obtain your consent and only after your consent is received by the Company, the Company may use or provide your personal data for direct marketing purpose.

You may, in future, withdraw your consent to the use of your personal data by the Company and any third parties on direct marketing purposes. Such request can be made to the Data Protection Officer of the Company at 15/F, Cityplaza One, 1111 King's Road, Taikoo Shing, Hong Kong and the Company shall cease to use your personal data for direct marketing purposes.

Amendment to the PICS

The Company reserves the right at anytime, with or without notice, amends this PICS which will be found in our website or in writing to notify you how the Company will collect, use and transfers your personal data. Should there be any amendment to this PICS in the future, such amendment will become effective with immediate effect.

1. 目的：泰禾人壽保險有限公司/泰禾保險服務有限公司（「本公司」）就向閣下收集之個人資料（「個人資料」）乃為以下目的使用：**(i)** 處理、管理、落實及實行閣下提交予本公司的本文件或不時提交的任何其他文件中所表明的申請；**(ii)** 提供與本文件和本保單相關的一切服務，包括推廣或改善本公司或其關聯公司提供的有關本次申請的服務或相關服務；**(iii)** 就行政目的與閣下聯絡；**(iv)** 調查、處理及繳付閣下保單的理賠申請；**(v)** 依照在香港特別行政區境內或境外任何法律、監管、政府、稅務、執法或其他機關，或自律監管機構或行業組織的要求，配合調查及作出披露；**(vi)** 將閣下的個人資料發送給任何保險公司聯會或類似組織（「聯會」）以及聯會的任何成員，以供其履行其監管職能及/或為保險行業或聯會的任何成員的合理利益所需的其他職能；**(vii)** 統計或精算研究；**(viii)** 其他直接與以上目的相關的用途；

就本公司使用閣下提供的個人資料作宣傳或市場推廣用途，請參閱「使用個人資料作直接促銷用途」一節。未能提供所需的個人資料可能導致本公司無法為閣下提供產品及服務、評估閣下的保單申請、處理保單索償、或處理任何閣下提出的要求、查詢或投訴。

2. 轉移：閣下提供的個人資料將保密處理，惟會因以上第1條所述之目的將此等資料轉移給以下各方：**(i)** 本公司的任何成員公司，包括附屬公司及聯屬公司；**(ii)** 任何其他從事保險、強制性公積金暫行受託人或再保險相關業務的非本公司成員公司；**(iii)** 獲本公司授權以分銷本公司所提供之產品及服務的金融服務中介團體；**(iv)** 提供與閣下的保單有關的索償、調查或其他服務的提供者；**(v)** 現有或不時成立的相關行業協會及聯會；**(vi)** 向閣下提供與本公司產品及服務有關的行政、電訊、電腦、付款、數據處理或其他服務的任何人士（包括代理商、承包商或第三方服務提供者）；**(vii)** 於香港境內或境外任何法律、監管、政府、稅務、執法或其他機關，或自律監管機構或行業組織；**(viii)** 與本公司業務的轉讓或擬議轉讓有關的任何第三方，當中部分受讓方或位於香港境內或境外；**(ix)** 閣下的保險代理人或中介人或介紹人。

3. 查閱：閣下有權查明本公司持有個人資料的類別、本公司是否持有閣下的個人資料，如持有，閣下有權要求查閱本公司持有涉及閣下的個人資料以及要求對該等資料作出更正。閣下可向本公司的資料保障主任提出要求，地址為香港太古城英皇道1111號太古城中心一座15樓。本公司有權為處理閣下的個人資料查閱要求而收取合理費用。

使用個人資料作直接促銷用途

除了以上所述的用途，本公司擬把閣下的個人資料包括姓名、聯絡資料、產品及服務組合資料、交易模式及行為、財務背景及人口統計數據透過郵寄、傳真、電郵、電話及短訊形式用於直接促銷，當中包括以下的服務、產品和類別：**(a)** 保險、財務及相關服務及產品；**(b)** 獎賞、年資獎勵或優惠計劃及相關服務和產品；**(c)** 本公司的聯名合作夥伴提供之服務和產品（有關服務和產品的申請表/宣傳單張/海報上會提供聯名合作夥伴的名稱，視屬何情況而定）；閣下的個人資料可提供予第三方金融機構、保險公司、醫療機構、電話服務公司、市場營銷或研究服務、獎賞、年資獎勵及優惠計劃服務及/或相關服務作直接促銷。使用閣下的個人資料進行本公司或任何第三方直接促銷前，本公司必須得到閣下的同意及只有在本公司收到閣下的同意後，本公司才可使用或提供閣下的個人資料作直接促銷用途。閣下將來可以撤回閣下對個人資料作本公司及第三方直接促銷用途的同意書。這項要求可向本公司的資料保障主任提出，地址為香港太古城英皇道1111號太古城中心一座15樓。此後，本公司須停止使用閣下的個人資料作直接促銷之用。

個人資料收集聲明的修訂

本公司保留權利可隨時且在無須通知的情況下，修訂本個人資料收集聲明，本公司亦可在本公司的網站或以書面形式知會閣下，閣下因而能得悉本公司如何收集閣下的個人資料、如何使用該資料及轉移該資料的情況。任何有關修訂將在刊登後即時生效。

Signature of Policyowner 保單持有人簽名 _____

Signature of Insured (Age 18 or above) 受保人簽名（年滿18歲或以上） _____

Date (DD/MM/YY) 日期（日/月/年） _____

Name 姓名 _____

Name 姓名 _____

Identity Document No. 身份證明文件號碼 _____

Identity Document No. 身份證明文件號碼 _____

Relationship to the Insured 與受保人關係 _____

Part II (To be completed by the Attending Physician at Claimant's expense)

第二部份 (須由主診醫生填寫。所需費用由索償人自行承擔。)

Name of Patient 病人姓名	Age 年齡	Sex 性別	Identity Document No.: 身份證明文件號碼	Admission Date 入院日期: Discharge Date 出院日期: (DD日/MM月/YYYY年)
<p>1. a. Had the patient been staying in Intensive Care Unit? 病人有否入住深切治療部?</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, 有, from 由 _____ to _____ (DD日/MM月/YYYY年)</p> <p>b. Had the patient taken any home leave during the said hospitalization period? 在上述住院期間, 病人有否請假離院?</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please state the date, time and reason 有, 請列出日期、時間及原因</p>			<p>2 a. Date on which the patient first consulted you for this illness or injury? 就是次病症或意外, 病人首次向閣下求診的日期?</p> <p>_____ (DD日/MM月/YYYY年)</p> <p>b. What were the signs & symptoms the patient complained at the first consultation? 病人在首次求診時, 有何病徵及病狀出現?</p> <p>c. Date of accident OR signs & symptoms first appeared before the first consultation? 意外日期或首次求診前已出現病徵及病狀之日期</p> <p>Since 從 _____ (DD日/MM月/YYYY年) OR Existed 已存在 for _____ day(s) 日 _____ month(s) 月 _____ year(s) 年</p> <p>d. If the hospitalization is due to accident, please provide the accident details and injured areas: 若是次住院因意外引致, 請提供意外經過及受傷部位。</p> <p>e. If the hospitalization is due to illness, please state whether it is a recurrent condition? 若是次住院因疾病引致, 是次病況是否為復發性疾病?</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 Date of FIRST occurrence 首次出現日期: _____ (DD日/MM月/YYYY年)</p>	
<p>3. a. Are you the patient's usual Physician? 閣下是否病人慣常求診的醫生?</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, medical records date back to 是, 醫療紀錄可追溯至: _____ (DD日/MM月/YYYY年)</p> <p>b. Was the patient referred to you by another Physician? 病人是否經由其他醫生轉介予閣下?</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, name and address of Referral Physician 是, 轉介醫生名稱及地址:</p> <p>c. For this episode, had the patient previously been seen by other Physician(s) for these symptom(s)? 就此病症而言, 病人之前有否就有關之病況向其他醫生求診?</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, on _____ by _____ 有, 在(DD日/MM月/YYYY年) (Name and Address of Doctor) 醫生姓名及地址</p> <p>d. Did you refer the patient to another Physician/ Hospital? 閣下有否轉介病人予其他醫生/醫院?</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes, please provide name & address of the Physician/ Hospital and the referral reason 有, 請提供醫生/醫院名稱、地址及轉介原因</p>			<p>4. a. Final diagnosis 最後診斷</p> <p>b. What is/ are the underlying cause(s) for final diagnosis? 引致上述最後診斷的病因</p> <p>c. When was the patient informed of the diagnosis? By whom? 病人何時被告知該診斷? 由哪位醫生告知?</p> <p>d. Surgery performed with dates and surgeon's name 手術名稱、進行日期及有關外科醫生姓名</p> <p>e. Summary of medical treatment given and tests performed with results 請總結有關治療及檢驗結果</p>	
<p>5. a. The prognosis of the condition 癒後情況:</p> <p><input type="checkbox"/> Good 良好 <input type="checkbox"/> Fair 一般 <input type="checkbox"/> Poor 甚差</p> <p>b. Any possibility of having a relapse 有否復發的可能?</p> <p><input type="checkbox"/> No 否 <input type="checkbox"/> Yes 有</p>			<p>6. Was the patient's injury / illness directly or indirectly due to or aggravated by the following? 病人是否因以下之原因, 直接或間接引致或加劇有關之受傷/病症?</p> <p><input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Yes, please tick where appropriate and provide details 是, 請在適當位置劃上剔號及提供詳情</p> <p><input type="checkbox"/> alcoholism/drug abuse 酗酒/濫用藥物</p> <p><input type="checkbox"/> AIDS or AIDS related complex disease 後天免疫力缺乏症(愛滋病)或與後天免疫力缺乏症有關之疾病</p> <p><input type="checkbox"/> venereal disease, sexually transmitted diseases 性病或經由性接觸感染之疾病</p> <p><input type="checkbox"/> congenital or birth defects 先天性症狀或由出生時導致之缺陷</p> <p><input type="checkbox"/> emotional, mental, nervous disorders 情緒, 精神或神經病</p> <p><input type="checkbox"/> pregnancy/childbirth/infertility, sterilization 懷孕/分娩/不育或絕育</p> <p><input type="checkbox"/> engaging in hazardous sport/activity 參與危險性之運動/活動</p> <p><input type="checkbox"/> cosmetic or plastic surgery 美容或整形手術</p> <p><input type="checkbox"/> rehabilitation or convalescence 康復或療養</p> <p><input type="checkbox"/> Others, please specify 其他, 請說明:</p>	

7. a. Did the patient have the following PAST medical history/ habit? 病人過往有否以下病史／習慣？

No 否 Yes, please tick where appropriate and provide details 是，請在適當位置劃上剔號及提供詳情

asthma 哮喘 cardiac problem 心臟病 diabetes mellitus 糖尿病 drinking habit 飲酒習慣
 hepatitis B 乙型肝炎 hypertension 高血壓 unfavourable family history 家族病史 smoking habit 吸煙習慣
 previous operation 曾接受手術 drug addiction 濫用藥物 others, please specify details: 其他，請說明詳情：

b. By whom was the above PAST medical history first detected? Please provide the name and address of the Physician/Hospital.
請詳述首次診斷出上述病史之醫生姓名、地址／醫院名稱

c. Please provide first diagnosis date and treatment details of the above PAST medical history
請提供上述病史之首次診斷日期及治療詳情

d. Current prognosis of the above past medical history : Fully recovered 完全康復 On treatment 治療中
上述病史之預後情況

PLEASE COMPLETE IF HOSPITALIZATION WAS DUE TO ACCIDENT 因意外受傷入院請填寫此欄

8. a. Present Condition of injury 現時受傷情況

b. Patient's occupation and exact nature of occupational duties 病人之職業及職責

c. Bearing in mind the patient's occupation, in what way do you feel the injuries would /would not totally prevent the patient from working? Please specify.
以病人之職業而論，閣下認為此傷勢會否令病人完全不能工作？請列明原因

I/ We hereby declare that the information given on this form is true to the best of my/our knowledge and belief.

本人／我們現聲明此申請書上所填寫之資料皆為本人／我們所知及所信之事實。

Name of Physician 醫生姓名 _____

Qualification 資歷 _____

Hospital Name (if applicable) 醫院名稱 (如適用) _____

Telephone No. 電話號碼 _____

Signature & Hospital/Physician Chop 醫生簽署連同醫院/醫生蓋章 _____

Date 日期 _____ DD日/ _____ MM月/ _____ YY年