NOW HEALTH INTERNATIONAL

全球保理賠申請表
WorldCare claim form

第一部分 ：會員與病人資料
Section 1 : Member and Patient Information

投保人姓名：**Planholder's** name: **您好嗎大家當時節奏感興趣閑置有點兒**	保險計劃編號：**Plan** number:
病人姓名：Patient's name:	會員編號：Membership number:
出生日期（日/月/年）：Date of birth (dd/mm/yyyy): / /	
電郵地址：Email address:	電話號碼：Telephone number:
醫生就診/診斷原因： – 列出病症或醫療問題如腹部疼痛/腳部出現皮疹/眼部感染 Reason for doctor visit/diagnosis: – specify symptoms or medical problem e.g. abdominal pain/rash on foot/eye infection	
治療所在國家： Country where **Treatment** took place:	治療日期（日/月/年）： **Treatment** date (dd/mm/yyyy): / /
發生索賠時的幣種： Currency claim incurred in:	被保險人希望在賠償中使用的貨幣： Currency you would like your claim reimbursed in:
索賠總金額： Total claimed amount:	
服務類型：門診 **Out-Patient** ☐ 日間留院 **Day-Patient** ☐ 住院 **In-Patient** ☐ Type of service:	服務類型：牙科 Dental ☐ 生育 Maternity ☐ 眼科 Optical ☐ 例行體檢 Routine check up ☐ Type of service:
主治醫生：牙醫 Dentist ☐ 醫生 **Medical Practitioner** ☐ 專科醫生 **Specialist** ☐ 其他 Other ☐ 請説明：Please specify: Attending physician:	
是否因事故/損傷而索賠？是 Yes ☐ 否 No ☐ 如果是，請附上完整醫療資料。事故/損傷日期（日/月/年）：/ / Is this claim due to **Accident**/injury? If yes, include complete medical information. Date of **Accident**/injury (dd/mm/yyyy):	

第三方保險人 **Third party insurers**

如果部分費用可由第三方進行賠償，（例如索賠的醫療狀況或損傷與相關的人員或機構有關）請提供詳情：
If some of the costs are recoverable from a third party (for example, if the **Benefits You** are claiming relate to a **Medical Condition** or injury caused by a person or organisation, or if **You** have cover on another insurance policy for this claim), please provide details:

第二部分：支付詳情
Section 2: Payment details

請支付：被保險人 **Planholder** ☐ 醫療機構 Provider ☐ Please pay:		
請選擇支付類型：銀行轉賬 Bank transfer ☐ 支票 Cheque ☐ Please choose payment type:		
1. 銀行轉賬 — 請填寫所有詳情以進行銀行轉賬支付。* Bank transfer – please complete all details to enable bank transfer payments.*		
賬户/收款人姓名： Account/payee name:	支付貨幣： Payment currency:	
銀行名稱： Bank name:	銀行代碼： Bank code:	分行代碼： Branch code:
分行地址： Branch address:		
國際銀行賬號或賬户號碼： IBAN or account no.:	匯款路由代碼 （如Swift或sort代碼） Routing code (e.g. Swift or sort code):	
其他任何相關的信息：(例如：當地銀行代碼) Any other relevant information: (e.g. Local bank code)		
2. 支票**：收款人姓名 Cheque**: Payee name		
支票郵寄地址： Cheque mailing address:		
收款人電話號碼： Payee's telephone number:		

* 我們確保所有的銀行費用由我們支付；然而在某些情況，您的當地銀行將向您收取服務費用，請與您的當地銀行核實服務費收取情況。
** 如果您需要通過支票支付，請注意支票將會以普通郵寄發送。
* **We** endeavour to ensure that all bank charges are paid by **Us**; however on occasions **You** may incur a charge levied by **Your** own bank, over which **We** have no control.
** If **You** require payment via cheque, please note that this will be sent to **You** in the post, and may take some time to be received.

本人已經閱讀第四部分中的聲明及授權。本人同意並明白該聲明及授權，任何索賠都應符合本人的保險計劃的條款及條件。
I have read the declaration and authorisation in Section 4. I agree to the declaration and authorisation and understand that any claim for **Benefit** is in accordance with the terms and conditions of **Our Plan**.

本人同意並附上第四部份的的聲明及授權 。
I will enclose Section 4 if anthorisation has been limited by me where available.

病人簽名（被保險人/投保人）： Patient's signature (**Insured/Main Applicant**):	日期（日/月/年）： **Date** (dd/mm/yyyy): / /

第三部分：醫療資料，日間留院或住院治療金額高於500美元的索賠（由負責治療病人的醫生填寫）
Section 3: Medical information, Day-Patient and In-Patient claims over USD 500
(to be completed by the doctor responsible for the patient's **Treatment**)

病症： **Medical Condition**:	診斷ICD10代碼（如適用）： Diagnosis ICD10 code: (if applicable)
基本病因詳情： Details of any underlying cause:	
病人首次就醫的具體時間？（日/月/年） When did the patient first see a doctor? (dd/mm/yyyy) / /	
治療/藥物詳情： Details of **Treatment**/medication:	
手術詳情（如有）： Details of operation (if any):	
	診療程序代碼（如適用）： Procedure code: (if applicable)
醫院詳情（如適用）： **Hospital** details (if applicable):	治療日期（日/月/年）： **Treatment** date (dd/mm/yyyy): / /
姓名： Name:	
地址： Address:	
入院日期（日/月/年）： Admission date (dd/mm/yyyy): / /	出院日期（日/月/年）： Discharge date (dd/mm/yyyy): / /

醫生聲明：
Medical Practitioner Declaration:
謹此聲明，本人是病人的醫生，就本人所知及所信，所填資料均正確無誤。
I declare that I am the patient's **Medical Practitioner**, and that the particulars given are, to the best of my knowledge, true and correct.

姓名（正楷填寫）： Print name:	官方印章： Official stamp:
簽名： Signature:	
日期（日/月/年）： Date (dd/mm/yyyy): / /	

若被保險人的保險計劃包含住院現金津貼：如果病人在醫院渡過了一整夜而無需付費，請附上醫院提供的確認函，並加蓋醫院印章。
門診直付網絡：保險人有可能會與相關醫院商議直接付款。請在治療前致電保險人的客户服務團隊予以安排，號碼為 +852 2279 7310。
If **Your Plan** includes a hospital cash **Benefit**: If the patient stayed in **Hospital** overnight without charge please include confirmation from the **Hospital** including the **Hospital** stamp.
Direct Billing: It may be possible for **Us** to arrange direct settlement with the **Hospital** involved. Please call **Our** Customer Service team before **Treatment** to arrange this on +852 2279 7310.

第四部分：聲明及授權
Section 4: Declaration and authorisation

個人資料（私隱）條例

我們以及您的承保人將在審核您的理賠申請的過程中，收集有關您的若干數據。該等數據將用以處理理賠申請。這些數據可能為上述用途交給承保人、醫生、醫療機構及理賠管理人，包括在香港特別行政區外的該等人士。任何分包管理您的保險計劃的第三方亦需承擔相同的保密責任，包括在香港特別行政區外的該等人士。除上述者外，您的姓名及聯繫數據將不會向其他組織披露。

我們可能需要從您平常就診的醫生處獲得醫療報告。如果我們需要這麼做，此條例會賦予您特定權利，且會在下文列明。如果您希望：

1. 您可以拒絕表示同意，但如果您這樣做的話，我們可能無法受理您的索賠。
2. 您可以在報告送達我們之前要求查看報告。如果您表示同意，我們將直接聯繫您的醫生並要求查看該報告。如果您希望查看報告，請刪去聲明中的“否”字，我們將據此通知醫生。然後醫生就不會將報告發給我們，直到：
   i) 您已經查看報告並表示同意，或
   ii) 我們要求報告後已經過去21天，且醫生還沒有收到您的回覆

重要備註：我們越快收到報告，受理您索賠的速度就越快。

3. 查看報告後，您可以拒絕表示同意 — 這同樣可能影響到我們受理您的理賠申請。
4. 如果您不同意，您可以要求醫生修改報告。如果醫生拒絕，您可以要求他（她）附上聲明，表明您對於報告的看法。
5. 您還可以要求醫生讓您查看最近六個月內提供給我們的所有報告。

重要備註：您的醫生有權就提供報告副本向您收費（以支付成本）。這筆費用未包括在您的保險計劃中。

您的醫生可能會拒絕讓您查看您的報告，前提是他（她）認為這會對您的身體或精神健康造成嚴重損害、或表明醫生對您的看法、或可能透露曾提供您的相關信息的他人的身份，雖然此人並非保健專業人士，但卻與您的護理工作有關。

在這種情況下，您有權查看報告的其餘部分。如果這會影響到整個報告，您的醫生必須事先取得您的同意才能將報告發給我們。

重要備註：這牽涉到香港法律，且在您所居住的國家或地區，同時情況可能會有所不同。

時康國際集團旗下公司就提供的國際醫療保險產品也許會就您可能有興趣的其他國際醫療保險產品及服務通過信函、短信或電子郵件與您聯繫。如您不希望我們如此行事，請勾選本方框 □。

您可隨時聯繫我們，選擇停止接收由我們發出的任何市場營銷信息。時康國際集團旗下公司的聯繫方式和個人資料（私隱）條例的相關資料可在www.now-health.com登錄下載。

聲明

特此聲明，本人是病人/病人的監護人*（如果病人小於 16 歲）（*請刪去不適用者）。

本人希望獲取索賠賠償，並聲明就本人所知及所信，所提供資料均真實、正確及完整，即使並非本人親筆書寫。

本人明白，本人為欺詐或企圖欺詐時康國際而提供錯誤、不完整或有誤導性的事實或數據屬違法。懲罰包括監禁、罰款、拒絕承保、保費損失或保費增加、取消賠償及法定損害賠償。

本人同意上述資料保障聲明，並明白該索賠申請應符合時康國際保險計劃的條款及條件。

由於本人已閱讀根據個人資料（隱私）條例告知本人權利方面的聲明，並同意時康國際必要時可從醫生處查閱醫療報告，所以時康國際可以處理我的索賠要求。

本人（不）*希望在醫療報告送達時康國際之前查看醫療報告。*如果您希望查看報告，請刪除“不”字。

本人謹同意授權治療過本人或向本人提供過建議的任何醫生和/或醫院向時康國際提供其可能要求的與該索賠相關的任何資料。

填妥並由病人與醫生簽名後（當需要時），請將此表及隨附的發票和付款收據寄回至時康國際（亞太）有限公司，香港北角電氣道183號友邦廣場15樓1501-03，09室。

Data Privacy

We and **Your Underwriters** will collect certain information about **You** in the course of considering **Your** claim. This information will be processed for the purposes of administering claims. **You**r information may be passed to **Underwriters, Medical Practitioners,** Medical Assistance Companies and Claims Administrators for these purposes, including those located outside the HKSAR. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those located outside the HKSAR. **Your** name and contact details will not be disclosed to other organisations (except as stated above).

It may be necessary to obtain a medical report from **Your** usual Doctor/ **Medical Practitioner** for this claim. If **We** need to do this, **You** have specific rights and they are set out below. If **You** wish:

1. **You** can refuse to give **Your** consent – but if **You** do **We** may be unable to deal with **Your** claim.
2. **You** can ask to see the report before it is sent to **Us**. If **You** give **Your** consent, **We** will be able to contact **Your** Doctor direct for a report. If **You** wish to see it, delete the word "NOT" in the declaration and **We** will inform the Doctor accordingly. Then the Doctor will not send it to **Us** until:
   i) **You** have seen the report and approved it; or
   ii) 21 days have passed since **We** requested the report and the Doctor has not heard from **You**.

Important note: **The sooner We receive the report, the sooner We can deal with Your claim.**

3. Having seen the report, **You** can refuse **Your** consent – again this may affect **Our** ability to deal with **Your** claim.
4. **You** may ask the Doctor to change the report if **You** disagree with it. If (s) he refuses, **You** can require him/her to attach a statement of **Your** views to the report.
5. **You** may also ask the Doctor to let **You** see all reports supplied to **Us** within the last six months.

Important note: Your Doctor is entitled to charge You for supplying You with a copy of the report (to cover cost). This is not covered by Your Plan.

Your Doctor may refuse to let **You** see **Your** report if (s)he feels it will do serious harm to **Your** physical or mental health, or it will indicate the Doctor's intentions in respect of **You**, or it may reveal the identity of another person who has supplied information about **You** who is not a health professional but is involved in **Your** care.

In such cases **You** will be entitled to see the remainder of the report. If this affects the entire report, **Your** Doctor must obtain **Your** consent before (s)he sends it to **Us**.

Important note: This relates to Hong Kong law and may differ in the country in which You reside.

Now Health International group companies providing IPMI products may contact **You** by letter, SMS or email with details of other IPMI or related products and services which may be of interest to **You**. If **You** do not wish this to happen please tick this box □.

You may opt out of future marketing by contacting **Us** at any time. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com.

Declaration

I hereby declare that I am the patient/patient's guardian*(if the patient is under 16 years of age) (*please cross out if not applicable).

I wish to claim **Benefit** and declare the information I have given is, to the best of my knowledge, true, correct and complete even if it is not in my own handwriting.

I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information (misrepresentations) to Now Health International for the purpose of defrauding or attempting to defraud Now Health International or the **Underwriters**. Penalties may include imprisonment, fines, denial of coverage, loss of or increase in premium, loss of **Benefits** and legal damages.

I agree to the data protection declaration above and understand that cover is provided in accordance with the terms and conditions of Now Health International **Plan**.

I have read the statement notifying me of my rights under the Personal Data (Privacy) Ordinance and consent to Now Health International seeking medical reports if needed from my **Medical Practitioner**, so Now Health International can deal with my claim for **Benefit**.

I do (NOT)* wish to see the medical report before it is sent to Now Health International. *Delete the word NOT if you wish to see the report.

I hereby consent to authorise any doctor and/or **Hospital** who has treated or advised me to provide Now Health International with any information they may require in connection with this claim.

When completed and signed by the patient and **Medical Practitioner** (when appropriate), please return this form and the accompanying invoices and payment receipts to: Now Health International (Asia Pacific) Limited, Units 1501-3 & 9, 15/F, AIA Tower, 183 Electric Road, North Point, Hong Kong.

重要信息：

請使用正楷字體填寫本理賠申請表，並於首次治療日期後六個月內提交給保險人（除非條件不允許）。

如果被保險人的門診醫生費用或日間留院和住院治療索賠總金額（每名被保險人於每個保險期間的每個醫療狀況）少於美元500，被保險人只需填寫第一部分和第二部分，並在向保險人提交理賠申請表時附上被保險人的就診收據。被保險人可以將理賠申請表和收據掃描及電郵至AsiaPacService@now-health.com或傳真至 +852 2279 7330。請保留原有文件的副本，保險人可能會要求被保險人提供該類副本。

如果被保險人的日間留院或住院治療索賠總金額（每名被保險人於每個保險期間的每個醫療狀況）超過美元500，請確認第三部分由醫生填寫。保險人還必須查看收據副本、診斷報告和出院報告（如果被保險人曾經是日間留院或住院病人）。此外，您可以將理賠申請表、收據、診斷報告和出院報告掃描及電郵至AsiaPacService@now-health.com或傳真至+852 2279 7330。請保留原有文件的副本，我們可能會要求您提供該類副本。

被保險人可以在被保險人的網上安全組合區隨時在線跟蹤理賠的進度。請使用被保險人的用户名和密碼登入www.now-health.com。

如果被保險人對該表格或保險的其它方面有任何疑問，請致電 +852 2279 7310 或電郵至AsiaPacService@now-health.com。

Important information:

Please complete the claim form in BLOCK CAPITALS and submit it to **Us** within six months of the initial **Treatment** date (unless this is not reasonably possible).

For all **Out-Patient Treatment** and if the total amount **You** are claiming (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) for **In-Patient** or **Day-Patient Treatment** is less than USD 500, **You** only need to complete Sections 1 and 2 and include a copy of **Your** receipt when **You** send **Us Your** claim form. **You** can scan **Your** claim form and receipt and email it to AsiaPacService@now-health.com or fax it to +852 2279 7330. Please keep a copy of the original documents in case they should be required by **Us**.

If the total amount **You** are claiming now or have claimed for **Day-Patient** and **In-Patient**, (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is over USD 500, please ensure Section 3 is completed by the treating **Medical Practitioner**. **We** must also see receipts, diagnostic reports and discharge reports (if **You** have been a **Day-Patient** or **In-Patient**) for claims over this amount. **You** can scan **Your** claim form and receipts/diagnostic reports/ discharge reports and email them to AsiaPacService@now-health.com or fax them to +852 2279 7330. Please keep a copy of the original documents in case they should be required by **Us**.

You can track the progress of **Your** claim online at any time in **Your** online secure portfolio area. Log in at www.now-health.com using **Your** username and password.

If **You** have any questions about this form or any other aspect of **Your** cover, please call **Us** on +852 2279 7310 or email us at AsiaPacService@now-health.com.

在香港發佈的保險計劃由保險憑證中被指定的保險公司承保，
並委託時康國際（亞太）有限公司進行保單管理。

註冊地址：香港北角電氣道183號友邦廣場15樓1501-03，09室，保險代理登記號碼：10974559

Plans issued in Hong Kong are underwritten by the underwriter(s) as specified in the Certificate of Insurance and arranged by Now Health International (Asia Pacific) Limited.

Registered address: Units 1501-3 & 9, 15/F, AIA Tower, 183 Electric Road, North Point, Hong Kong.
Insurance Agent Registration Number: 10974559.

注意事項：本理賠申請表的中文譯本僅供參考，如有爭議，應以英文版本為準。
Note: The Chinese translation of the application form is for reference only, in case of any dispute, the English version shall prevail.

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