

香港太古城英皇道 1111 號太古城中心第 1 期 13 樓  
13/F, Cityplaza One, 1111 King's Road, Taikoo Shing, Hong Kong  
電話 Tel: 2160 8800 傳真 Fax: 2866 0785

「中銀集團人壽保險有限公司」以下簡稱：「本公司」或「貴司」  
BOC Group Life Assurance Company Limited referred to hereinafter as “the Company”

保險中介人姓名  
Name of Insurance Intermediary \_\_\_\_\_

分行及員工編碼  
Branch Code & Staff No. \_\_\_\_\_

聯絡電話  
Contact Tel No. \_\_\_\_\_

只供內部使用 Internal Use Only

參考編號 Ref. No.:

甲部- 由保單權益人/受保人填寫 Part I - To be completed by Policy Owner/Insured:

保單編號 Policy No.	受保人姓名 Name of Insured	受保人身份證號碼 Insured ID No.	受保人年齡/性別 Insured Age/Sex
保單權益人聯絡電話 Policy Owner Contact Tel No.		保單權益人電郵地址 Policy Owner Email Address	

個人資料收集聲明 PERSONAL INFORMATION COLLECTION STATEMENT

在中銀集團人壽保險有限公司(“中銀人壽”),保護我們客戶個人資料對我們很重要。作為一個提供保險產品及服務的機構,收集及運用客戶個人資料是我們日常商業運作的基本工作。如客戶希望了解中銀人壽的私隱政策的詳情,歡迎透過以下網址 <http://www.boclife.com.hk/tc/others/privacy-policy.html> 閱讀有關文件。

中銀人壽將透過收集閣下的個人資料,包括但不限於保單編號、受保人姓名、身份證號碼、年齡/性別、聯絡電話及電郵地址等,作可賠償金額估算之用。若未能提供該等資料,可能會導致中銀人壽無法提供上述用途。中銀人壽不會將閣下的個人資料轉移給第三方作及不會將之使用於可賠償金額估算以外之其他用途,包括但不限於直接促銷。有關個人資料將根據中銀人壽之保留期準則予以保存。

任何資料當事人有權(a) 查核本公司是否持有他的資料及要求查閱該等資料;(b) 要求本公司改正任何有關他的不準確的資料;及(c) 查明本公司對於資料的政策及慣例和獲告知本公司持有的個人資料種類。

任何關於查閱或改正資料,或索取關於資料政策及慣例或所持有的資料種類的要求,應向下列人士提出:

中銀集團人壽保險有限公司  
資料保障主任

中銀集團人壽保險有限公司

香港太古城英皇道 1111 號  
太古城中心第 1 期 13 樓  
傳真:(852) 2522 1219

At BOC Group Life Assurance Company Limited (“BOC Life”), the protection of personal information of our customers is important to us. As a provider of insurance products and services, the collection and use of the personal information of our customers is fundamental to our daily business operations.

If you wish to understand BOC Life’s Privacy Policy in detail, you may visit relevant document using the hyperlink below <http://www.boclife.com.hk/en/others/privacy-policy.html>.

BOC Life will collect your personal data, including but not limited to policy no., the name of Insured, ID no., age/sex, contact tel. no. and email address, for the purpose of estimating the claimable amount. Failure to supply such data may result in BOC Life being unable to provide the aforesaid purpose. BOC Life will not transfer your personal data to 3<sup>rd</sup> party and will not use it on any purpose other than estimating the claimable amount, including but not limited to direct marketing. The personal data will be retained according to the retention policy of BOC Life.

Any data subject has the right (a) to check whether the Company holds data about him and to request access to such data; (b) to require the Company to correct any data relating to him which is inaccurate; and (c) to ascertain the Company’s policies and practices in relation to data and to be informed of the kind of personal data held by the Company.

The person to whom requests for access to data or correction of data or for information regarding policies and practices and kinds of data held are to be addressed is as follow: -

BOC Group Life Assurance Company Limited  
The Data Protection Officer

BOC Group Life Assurance Company Limited

13/F, Cityplaza One, 1111 King's Road, Taikoo Shing, Hong Kong  
Facsimile: (852) 2522 1219

聲明 DECLARATION

本人知悉 (1) 此可賠償金額估算只供參考並無法律效力,並不構成最終賠償責任;(2) 賠償將根據所有其後遞交的必要證明文件,並按保單條款及細則和保單年度內的保障限額作決定;(3) 最終的賠償金額及自付費用會根據醫療服務提供者發出的發票或收據中所列明的實際帳目和分項收費計算;(4) 可賠償金額估算的結果,會因接受醫療服務的地域、醫療服務提供者及病房級別作出調整和限制。

I understand that (1) this claimable amount remains an estimates without legally binding and do not constitute a liability; (2) the claim decision will depend on the submission of all supporting documents as required for claim assessment in accordance with the policy terms and conditions and benefit entitlement in the Policy Year; (3) the final claimable amounts and out-of-pocket expenses will be subject to the actual bill amounts and breakdowns as stated in the invoices or receipts issued by healthcare services providers; (4) the claimable amount estimate is subject to benefit reduction or limitation in relation to the regions where the eligible medical services are incurred, the choice of healthcare services provider or the choice of higher ward class.

本人謹此代表本人/受保人及其他在此賠償申請表提及之人士(“相關人士”)聲明及同意 (1) 上述一切陳述及問題的所有答案,不論是否本人親手所寫,就本人所知所信,均為事實之全部並確實無訛; (2) 本人/我們已收受、閱讀及完全明白載於本文件的個人資料收集聲明,及同意相關人士的任何個人資料只用作可賠償金額估算之用途及貴公司將不會把該等個人資料提供給第三方作為非可賠償金額估算之用途。

本人聲明及同意已獲相關人士授權及同意本人作出上述聲明及同意。

I HEREBY DECLARE AND AGREE on behalf of myself/the insured and other persons referred to in this claim form (“Relevant Persons”) that (1) all statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true; and (2) I/We have received, read and fully understood the Personal Information Collection Statement contained in this document, and agree that any personal data of the Relevant Persons may be used for the purposes for Claimable Amount Estimation processing and the Company may not provide the personal data to any third parties for non-Claimable Amount Estimation purposes.

I declare and agree that I have the full authority from and consent of the Relevant Persons to make the above declarations and agreements.

保單權益人簽署  
Signature of Policy Owner

姓名  
Name in Block Letter

身份證號碼  
ID No.

日期  
Date

受保人簽署  
Signature of Insured

姓名  
Name in Block Letter

身份證號碼  
ID No.

日期  
Date

乙部 - 由主診醫生填寫，所需費用由保單權益人自行承擔 Part II -To be completed by attending physician at the claimant's own expenses		
病人姓名 Name of Patient	年齡/性別 Age / Sex	身份證號碼 ID No.
首次出現病徵日期 First Symptom Date: _____(年/月/日 YY/MM/DD)		
初診日期 First Consultation Date: _____(年/月/日 YY/MM/DD)		
病徵詳情 Symptoms Details: _____		
最終診斷 Final Diagnosis : _____		
預計入院日期/接受手術日期 Expected Admission Date/Surgery Date: _____(年/月/日 YY/MM/DD)		
醫療機構名稱 Name of Services Provider: _____		
建議之手術/治療 Surgery/Treatment Required: _____		
預算醫院收費 (由主診醫生根據醫院提供的收費資料填寫) Estimated Hospital Charges (To be completed by attending physician based on the charge information provided by hospital)		
1. 住宿 Room Charges: \$ _____ x _____ 日 day(s) _____ 至 To _____ (年/月/日 YY/MM/DD) (年/月/日 YY/MM/DD)		
2. 手術室及相關物料費用 Operating Theatre and Associated Material Charges : \$ _____		
3. 診斷/檢測程序費用 Diagnostic Test/Investigation Charges: \$ _____		
4. 其他醫院收費 Other Hospital Charges: \$ _____		
總計 Total: \$ _____		
預算醫生費用 (由主診醫生填寫) Estimated Doctor's Fee (To be completed by attending physician)		
1. 主診醫生巡房費 Attending Doctor's Visit Fee: \$ _____ x _____ 日 day(s) _____ 至 To _____ (年/月/日 YY/MM/DD) (年/月/日 YY/MM/DD)		
2. 外科醫生費 Surgeon's Fee: \$ _____		
3. 麻醉科醫生費 Anaesthetist's Fee: \$ _____		
4. 其他專科醫生診費(請註明) Other Specialist's Consultation Fee (Please Specify): \$ _____		
5. 其他項目及收費 Other Items and Charges: \$ _____		
總計 Total: \$ _____		
專業意見 Professional Comment		
病人是否因其他原因，直接或間接引致或加劇有關之受傷/病症? Was the patient's injury/ illness directly or indirectly caused or aggravated by other factors?		
<div><div><input type="checkbox"/> 是 YES 請在適當位置劃上剔號並提供詳情 Please tick where it is appropriate and give details:</div><div><div><input type="checkbox"/> 酒精/ 麻醉劑/ 藥品中毒 Intoxication by alcohol/ narcotics/ drug</div><div><input type="checkbox"/> 不育/ 絕育 Infertility/ sterilization</div><div><input type="checkbox"/> 妊娠/ 分娩/ 流產/ 人工流產 Pregnancy/ childbirth/ miscarriage/ abortion</div><div><input type="checkbox"/> 康復/ 療養 Convalescence/ custodial/ rest care</div><div><input type="checkbox"/> 參與危險性運動/ 活動 Hazardous sport/ activity</div><div><input type="checkbox"/> 自殺或自致之傷害 Suicide/ self- inflicted injury</div><div><input type="checkbox"/> 美容或整形手術 Cosmetic or plastic surgery</div><div><input type="checkbox"/> 精神病治療/ 精神病/ 精神分裂或錯亂 Psychiatric treatment/ mental or nervous disease or disorder</div><div><input type="checkbox"/> 其他 Others _____</div></div><div><div><input type="checkbox"/> 先天性情況 Congenital condition</div><div><input type="checkbox"/> 視力矯正 Corrective aids or treatment of refractive errors</div><div><input type="checkbox"/> 一般身體檢查 General health check</div><div><input type="checkbox"/> 睡眠不寧引致失調 Sleep disturbance disorders</div><div><input type="checkbox"/> 愛滋病/ 與愛滋病相關的併發症 AIDS/ AIDS related complex disease</div><div><input type="checkbox"/> 性病/ 由性接觸感染的疾病 Venereal disease/ sexually transmitted disease</div></div></div>		
<input type="checkbox"/> 否 NO		
主診醫生之聲明 Physician Declaration		
本人已向病人/親屬/獲授權人士解釋上述預算費用，並徵得同意。 I have explained to the patient/next-of-kin/authorized person details of the above estimated charges and have sought his/her agreement.		
主診醫生姓名 Name of Attending Physician	主診醫生簽署(蓋印)Signature of Physician(with chop)	日期 Date

## 中銀人壽標準自願醫保 BOC Life Standard VHIS

## 醫療費用賠償估算申請流程

## The Flow of Medical Expense Claimable Amount Estimation Application

請到中銀人壽網內 [www.boclif.com](http://www.boclif.com) 下載醫療費用賠償估算書或致電客戶服務熱線 2860 0655 查詢。

Please download the Medical Expense Claimable Amount Estimation Form at [www.boclif.com.hk](http://www.boclif.com.hk) or call BOC Life Customer Services Hotline at 2860 0655.



填妥醫療費用賠償估算書並於入院或接受日間手術前 5 個工作天遞交，亦可以傳真、電郵或郵遞至中銀人壽。

Complete the **Medical Expense Claimable Amount Estimation Form** and submit to us at least 5 working days prior to the hospital admission or performing Day Case Procedure. Please send to BOC Life by email/fax/mailling

傳真號碼 Fax no.: 2866 0785

電郵地址 E-mail.: [clm@boclif.com.hk](mailto:clm@boclif.com.hk)

郵寄地址 Address: 香港太古城英皇道 1111 號太古城中心第 1 期 13 樓  
13/F, Cityplaza One, 1111 King's Road, Taikoo Shing, Hong Kong



提交此申請後 3 個工作天內，本公司將以書面方式通知保單權益人有關之索償金額估算。  
We will inform the Policy Owner for the estimated payable claim amount in written within 3 working days from the submission of such request.

**重要提示 Important Notes:**

1. 此醫療費用賠償金額估算只供參考並無法律效力，並不構成最終賠償責任。  
This medical expense claimable amount remains an estimate without legally binding and do not constitute a liability.
2. 賠償將根據所有其後遞交的必要證明文件，並按保單條款及細則和保單年度內的保障限額作決定。  
Claim decision will depend on the submission of all supporting documents as required for claim assessment in accordance with the policy terms and conditions and benefit entitlement in the Policy Year.
3. 最終的賠償金額及自付費用會根據醫療服務提供者發出的發票或收據中所列明的實際帳目和分項收費計算。  
The final claimable amounts and out-of-pocket expenses will be subject to the actual bill amounts and breakdowns as stated in the invoices or receipts issued by healthcare services providers.
4. 可賠償金額估算的結果，會因接受醫療服務的地域、醫療服務提供者及病房級別作出調整和限制。  
The claimable amount estimate is subject to benefit reduction or limitation in relation to the regions where the eligible medical services are incurred, the choice of healthcare services provider or the choice of higher ward class.