Blue Cross 藍十字
An AIA Company 友邦保險成員公司

預先評估網上服務
Pre-Assessment Online Service

收集個人資料聲明
Personal Information Collection Statement

本表格僅供網上平台申請使用
This form is for applications via online platform only

預先評估表格 Pre-Assessment Form

請以英文正楷填寫此表格並上傳至預先評估平台，收妥所有所需資料後，處理需時約4-7個工作天。於受保人（病人）符合資格的情況下，藍十字將為受保人（病人）就其保單保障範圍作可賠償金額之評估。

Please complete this form in BLOCK letters and upload to the Pre-Assessment platform. It should take around 4-7 working days once all necessary information is received. Subject to the eligibility of the Insured (Patient), as assessment of the estimated eligible claim amounts under the policy will be provided by Blue Cross.

甲部 - 由保單持有人及受保人(病人)填寫
Part I - To be completed by the Policyholder and the Insured (Patient)

保單號碼 Policy No.	受保人號碼(如適用) Insured No. (if applicable)
受保人(病人)姓名 Name of Insured (Patient)	

聲明及授權書
Declaration and Authorisation

本人謹此聲明並同意：

(1) 本人謹此授權任何持有受保人之任何記錄或資料的醫院、醫生、醫學界執業人士、與醫療有關的服務供應商、保險公司、有關人士、機構、及／或有關當局，向藍十字（亞太）保險有限公司（「藍十字」）或其授權代表提供任何或所有有關受保人之損失、損傷、賠償記錄、病歷、口供或任何相關資料作評估受保人的賠償申請之用途。

(2) 評估預算的可賠償金額，只供參考之用，實際賠償金額以最終理賠決定為準。所有保障項目只會在符合所有保單條款及細則及所有不保之事項的情況下支付。如有新的和額外的資料導致此評估與最終理賠有任何差異，包括部份或全數拒賠，均以最終理賠為準。

(3) 本人已閱讀及明白有關藍十字的收集個人資料聲明。

I HEREBY DECLARE AND AGREE THAT:

(1) Any hospital, physician, medical practitioner, medically related service provider, insurance company, person and/or authority that has any records or is holding any information of the insured person to disclose to Blue Cross (Asia-Pacific) Insurance Limited ("Blue Cross") or its authorised representative, any and all information with respect to the insured person's loss, disability, claim history, medical history, police statement made and the like for the purpose of assessing the insured person's claim request(s).

(2) The estimated eligible claim amounts in relation to this assessment is solely for customer reference. The actual eligible claim amounts will be subject to the final medical claim decision. All benefits payable are subject to the terms and conditions and the full list of policy exclusions. In case new and additional information is found leading to discrepancies between this assessment and the final claim decision, including a partial or complete rejection of the final assessment, the final claim decision shall prevail.

(3) I have read and understood the Personal Information Collection Statement of Blue Cross.

保單持有人／受保人(病人)簽署 Signature of the Policyholder/Insured (Patient)	受保人(病人)簽署(倘若受保人(病人)之年齡在18歲以下，本申請表須由其家長簽署) Signature of the Insured (Patient) (if Insured (Patient) is less than 18, signature of his/her parent is required)	日期(日／月／年) Date (DD/MM/YY)

乙部 - 由主診醫生／外科醫生填寫
Part II - To be completed by Attending Physician/Surgeon

主診醫生／外科醫生姓名 Name of Attending Doctor/Surgeon	醫生診所地址 Address of Doctor/Surgeon's Clinic
聯絡電話號碼 Contact Telephone No.	傳真號碼 Fax No.
醫院名稱 Name of Hospital	住房級別 Room Class ☐ 私家房 Private ☐ 半私家房 Semi-private ☐ 普通房 Ward ☐ 日間中心 Day Case ☐ 門診 Outpatient/Clinical
預計入院日期(日／月／年) Expected Date of Admission (DD/MM/YY)	預計住院日數 Expected Length of Confinement _____ 日 Day(s)

醫療詳情
Medical Condition

(1) 診斷及相關病徵
Diagnosis and associated signs and symptoms

(2) 相似病徵已存在多久（首次病發日期）？
How long have the similar symptoms and signs been existing (i.e. onset date)?

（日／月／年）
(DD/MM/YY)

(3) 病人首次向閣下求診的日期為何時？
When did the patient first consult you for this condition?

（日／月／年）
(DD/MM/YY)

(4) 是次住院是否與懷孕有關？
Is the hospitalisation related to pregnancy?

☐ 是 Yes ☐ 否 No

治療詳情
Treatment Details

將進行之手術／治療
Surgical procedure(s)/treatment(s) to be performed

將進行之化驗／影像檢查／其他診斷性檢查
Lab test(s)/imaging(s)/other diagnostic investigation(s) to be performed

將進行之麻醉方式
Type of anaesthesia to be performed ☐ 局部 Local ☐ 全身 General ☐ 監察麻醉 MAC ☐ 不需要 Not required

是此入院可於門診或日間中心進行？如答案是否，請説明原因。
Can the case be proceeded as outpatient or daycase? Please provide reason if the answer is No.

預算醫療費用 Estimated Medical Expenses

☐ 外科醫生費用 Surgeon's Fee HK$ _____

☐ 麻醉科醫生費用 Anaesthetist's Fee HK$ _____

☐ 手術室費用 Operating Theatre Charge HK$ _____

☐ 醫院雜項費用 Miscellaneous Hospital Charges HK$ _____

☐ 醫生巡房費用 Physician's Hospital Visit or Ward Round Fee HK$ _____

主診醫生／外科醫生簽署 Signature of Attending Doctor/Surgeon	日期（日／月／年） Date (DD/MM/YY)