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

收集個人資料聲明
Personal Information Collection Statement

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入院前索償評估表格 Pre-hospitalisation Claim Assessment Form

請以英文正楷填寫此表格，並於接受治療或入院前最少 3 個工作天以傳真或電郵方式遞交此表格至藍十字（亞太）保險有限公司（「藍十字」）。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 return it to **Blue Cross (Asia-Pacific) Insurance Limited ("Blue Cross")** by fax or email at least 3 working days prior to receiving treatment or hospitalisation. Subject to the eligibility of the Insured (Patient), an assessment of the estimated eligible claim amounts under the policy will be provided by Blue Cross.

(I) 保單持有人 / 受保人（病人）資料 Details of Policyholder/Insured (Patient)

由保單持有人或受保人（病人）填寫 To be completed by the Policyholder or the Insured (Patient)

保單持有人姓名 Name of Policyholder	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)	聯絡電話 Contact Telephone No.	請選擇其中一項回覆方法 Please select either one for our reply ☐ 電郵 Email 地址 Address _____ ☐ 傳真 Fax 號碼 No. _____

(II) 治療詳情及評估 Treatment Details and Assessment

	治療詳情由受保人（病人）填寫 Treatment Details to be completed by Insured (Patient)	評估由藍十字填寫 Note 1 Assessment to be completed by Blue Cross Note 1	
診斷 Diagnosis		保障生效日期（日 / 月 / 年） Coverage Effective Date (DD/MM/YY)	
入院日期 Date of Admission	日 / 月 / 年 DD/MM/YY		
醫院名稱 Name of Hospital		保單貨幣 Policy Currency (HK$/US$)	
病房級別 Level of Accommodation	預計入住的病房級別 Intended Level of Accommodation ☐ 私家房 Private ☐ 半私家房 Semi-private ☐ 普通房 Ward ☐ 日間 / 診所手術 Day Case/Clinical	可享有的病房級別 Entitled Level of Accommodation ☐ 私家房 Private ☐ 半私家房 Semi-private ☐ 普通房 Ward $ 每日 Per day	
將進行之手術 / 治療 Surgical Procedure(s) / Treatment(s) to be performed	手術名稱（如適用）Name of Surgery (if applicable) 1. _____ 2. _____ 預算醫療費用（如適用） Estimated Medical Expenses (if applicable)	❖ 處理中的索償申請並未於此評估中反映。 Claim in progress is not reflected in this estimation. ❖ 詳情請參閱保障利益表及手術表（如適用）。 Please refer to the Schedule of Benefits and the Surgical Schedule for details (if applicable). 估計可賠償金額（每宗傷病） Estimated Eligible Amounts (per Disability)	
a. 外科醫生費用 Surgeon's Fee	HK$	$	$
b. 麻醉科醫生費用 Anaesthetist's Fee	HK$	$	$
c. 手術室費用 Operating Theatre Charge	HK$	$	$
d. 醫生巡房費用 Physician's Hospital Visit	HK$ 每日 Per day	$ 每日 Per day	$
e. 醫院雜項費用 Miscellaneous Hospital Charges	HK$	$	$
備註 Remarks		授權人簽署 Authorised Signature	日期（日 / 月 / 年） Date (DD/MM/YY)

Note1 此表格之可賠償金額之評估及其他與此評估有關之口頭或書面通訊是根據保單內住院及手術保障所計算，只供客戶參考之用，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。如此評估與最終理賠有任何差異，均以最終理賠為準。Assessment of the estimated eligible claim amounts in this form and any other communication in relation to this assessment, whether verbal or written, are computed based on Hospital and Surgical Benefits of insurance policy and are solely for customers' reference, actual eligible claim amounts will be subject to the final claim decision. All benefits payable are subject to the terms and conditions and the full list of policy exclusions. Should there be any discrepancy between this assessment and the final claim decision, the final claim decision shall prevail.

(III) 聲明及授權 Declaration and Authorisation

本人 / 我們謹此聲明並同意：(1) 本人 / 我們明白發出或填妥此評估表格並不代表藍十字確認責任或保證賠償。(2) 本人 / 我們已閱讀及明白隨本表格附上的收集個人資料聲明。**I/WE HEREBY DECLARE AND AGREE**: (1) I/We understand that the issuance or completion of this form does not constitute admission of liability or guarantee payment of the claim on behalf of Blue Cross. (2) I/We have read and understood the Personal Information Collection Statement as accompanied with this form.

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