MACAU
INSURANCE COMPANY
澳門保險

MediGroup Insurance Plan 團體醫療計劃

OUT-PATIENT CLAIM FORM 門診索償申請表

(Internal Use Only 此欄由本公司填寫)	Claim No. 索償編號	Date Received 接收日期

Name of Employer / Policyholder 僱主／團體名稱	Policy No. 保單編號

Name of Insured Employee / Member 受保僱員／成員姓名	Certificate / Staff No. 受保證明書／職員編號	Daytime Contact No. 日間聯絡電話

Name of Patient if other than Insured Employee / Member 病人姓名，如與受保僱員／成員非同一人	Relationship to Insured Employee / Member 與受保僱員／成員之關係 ☐ Spouse 配偶 ☐ Child 子女 ☐ Others 其他	No. of bills/statements/receipts attached 附上之門診賬單／結單／收據數目

Note

1) This form and relevant original medical receipts must be submitted to MIC within 90 days from the date of consultation.
2) Claim payment will be subject to the terms and conditions set out in the corresponding Master Policy.
3) Incomplete form or omission of required information may cause delay in processing.

注意

1) 於診治後九十天內，索償人士必須將此申請表連同有關正式收據提交予本公司處理，逾期無效。
2) 一切賠償款項將根據有關主保單上的條文計算。
3) 若此申請表未完全填妥或未有提供足夠理賠資料，賠償處理可能會被延誤。

Declaration & Authorization

I/We hereby declare and agree that any personal information collected or held by Macau Insurance Company Limited ("the Company") (whether contained in this claim application or otherwise obtained) is provided and may be held, used, and disclosed by the Company to individuals/organizations associated with the Company or any selected third party (within or outside of Macau, including reinsurance and claims investigation companies and industry associations/federations) for the purposes of processing this application and providing subsequent services, and data matching, and to communicate with me/us for such purposes. I/We understand that I/we have the right to obtain access to and to request correction of any personal information held by the Company concerning me/us (and my/our dependants, if any). I/We also hereby irrevocably authorize:

a) any organization, institution, or individual that has any record or knowledge of my/the Insured(s)'s health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to the Company such information. This authorization shall bind my/the Insured(s)'s successors and assigns and remain valid notwithstanding my/the Insured(s)'s death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.
b) the Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate my/the Insured(s)'s health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.

聲明及授權書

本人／我們現聲明並同意，澳門保險股份有限公司（"貴公司"）可保留、使用或透露貴公司所收集或保留之任何有關本人／我們的個人資料（在此申請書所載或從其他途徑取得），給予貴公司有關的人士／機構或任何被選定的機構（在本澳或海外的，包括再保險及賠償調查公司，及有關的行業協會／聯會），用作處理本申請及提供其後的服務，及資料核對等用途，及因此等用途與本人／我們聯絡。本人／我們明白到本人／我們有權向貴公司查閱及申請改正所有與本人／我們（及受本人／我們受供養人，如適用）的個人資料。本人／我們不可撤回地授權：

a) 任何知悉或擁有本人／被保人之健康狀況及病歷或任何治療或諮詢記錄及曾為或將為本人／被保人診治之機構、組織或人士，向貴公司透露有關資料。即使本人／被保人死亡或喪失能力，此授權書仍然存有法律效力，而本人／被保人之繼承人及轉讓人亦會受此授權書約束。此授權書之正本與副本同屬有效。
b) 貴公司或任何其認可之驗身醫生或化驗所，替本人／被保人進行所需之醫療評估及測試，並對本人／被保人之健康狀況進行審核及評估，作為處理本申請及其後與之有關的賠償事宜。此等化驗包括，但並不限於膽固醇及有關之血脂肪、糖尿病、腎或肝功能失常、愛滋病或感染人體免疫力缺乏症病毒、免疫系統失常或體內藥物、毒品、尼古丁及其他代謝產物之含量等化驗。

Signature of Claimant (18 years of age & over) 索償人（十八歲或以上）簽署	Signature of Insured Employee / Member 受保僱員／成員簽署	Date Signed 簽署日期

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