Please read the following carefully before you retrieve, print or complete this form.
在索取、列印或填寫表格前， 請閣下先詳閱下文。

Disclaimer

Any form downloaded/printed via any electronic media provided by Chow Tai Fook Life Insurance Company Limited ("CTF Life") (e.g. corporate website, interactive voice response system) is done at your own discretion and risk. CTF Life is not responsible for any printing error that results from the form download/printing and any loss or damage howsoever caused as a result of such printing error. In the event that there is any printing error in the downloaded/printed form, CTF Life may require you to fill in a correct form before starting to process your application.

For forms downloaded from the Internet (the "Internet Printed Form"), upon completing and signing the Internet Printed Form, you shall be deemed to have read and understood the contents of the form displayed on computer screen (the "Displayed Form") which shall prevail in case there is any inconsistency, contradiction or difference of whatever kind between the Displayed Form and the Internet Printed Form and have agreed to all provisions contained therein and to have agreed and undertaken not to raise any objection whatsoever in connection with any inconsistency, contradiction of difference of whatever kind between the Displayed Form and the Internet Printed Form.

CTF Life reserves the right to update the forms from time to time as it sees fit and also reserves the right to accept or reject the form submitted by you.

免責聲明

閣下凡透過周大福人壽保險有限公司 [周大福人壽] 之電子收發渠道 [如公司網站、互動語音回應系統] 下載或列印任何表格，應自行考慮及衡量需承擔之風險。周大福人壽概不負責任何因下載或列印表格所引致的列印錯誤及其可能導致之任何損失或毀壞。若閣下提交之下載或列印表格有任何列印錯誤，周大福人壽有可能在處理閣下的申請前要求閣下填寫一份正確之表格。

當閣下填寫及簽署由網站下載之表格 [互聯網列印表格] ，則被視作閣下已詳閱及明白電腦螢幕上出現之表格 [閱覽表格] 之內容，並同意表格內之所有條文。如該閱覽表格與互聯網列印表格出現任何不符、矛盾或分歧時，閣下同意並承諾不會提出任何異議。如閱覽表格與互聯網列印表格出現任何不符、矛盾或分歧時，概以閱覽表格為準。

周大福人壽有權隨時在認為適當情況下更新表格內容，並保留接受或拒絕閣下遞交之申請表格的權利。

預先保障審核安排服務申請書
Pre-Authorization Arrangement Service Application Form

CTF Life 周大福人壽

如何申請預先保障審核安排服務?
How to apply for Pre-Authorization Arrangement Service?

當確定需要住院或進行日間手術時，請根據情況進行以下步驟:
Once confinement or day-surgery needs are confirmed, please follow the instructions according to the applicable situation:

1A OR 或	**經網絡特選專科醫生轉介：**適用於「周大福人壽」醫療產品 登入「周大福人壽」於醫生搜尋中選擇所需之網絡特選專科醫生 ，直接打電話給醫生預約症。如果您有任何疑問，你可以致電周大福人壽客戶服務熱線：(852) 2866 8898（按 3） 注意事項： 「網絡特選專科醫生」為聯合醫務專業管理有限公司 “UMP” 網絡下的指定醫院或醫療服務機構。您可以不時向周大福人壽保險有限公司(「周大福人壽」) 要求索取一份最新的網絡醫院及醫生名單。 當確定需要住院或進行日間手術時，網絡特選專科醫生會協助填寫本地住院預先保障審核安排服務申請書(「表格」) 的第三部份。 **When network doctor referral is needed:** Login to “CTF Life” and select Doctor Search, select the doctor and call directly for the first consultation, if you have any queries, please contact the CTF Life Customer Hotline : (852) 2866 8898 (Press 3) “Appointed Network Specialist” refers to the doctors within the designated hospital or healthcare provider under the network of UMP Professional Management Limited (“UMP”). You may request from Chow Tai Fook Life Insurance Company Limited (“CTF Life”) for an updated list of the Appointed Network Hospital and Specialist from time to time. Once confinement or day-surgery needs are confirmed, the appointed network specialist would complete Part III of this Inpatient Pre-Authorization Arrangement Service Application Form (the “Form”).
1B	**經非網絡特選專科醫生轉介，**直接到閣下之指定醫生處求診。只適用於「醫世保」、「裕醫保」、「御醫保特級」及「世逸」 當確定需要住院或進行日間手術時，請確保受保人的主診醫生正確填寫表格的第三部份。 **When no doctor referral is needed,** consult the doctor of your choice directly. This service only applicable for MediPro, MediGold, MediGold Plus & MediChamp. Once confinement or day-surgery needs are confirmed, please ensure the attending doctor of the insured completes Part III of the form.
2	受保人或保單持有人需填妥表格的第一及第二部份。並於受保人住院或進行日間手術前最少四個工作天將表格遞交予 UMP。 Insured/ Policy Holder shall complete Part I and II of the form and send the form to UMP at least 4 working days prior to the insured’s confinement or day surgery.
3	如您的申請成功 UMP 將向有關醫院或醫療機構發出「住院或日間手術付款保證書」並將確認信發送到您的電子郵件。If your application is successful UMP will issue a “Letter of Guarantee” to the relevant medical provider and send the confirmation letter to your email. *請注意：如醫療費用不超過我們據此表格批准之金額，於受保人完成日間手術後，網絡日間手術中心會將單據(「單據」) 直接交給我們。在理賠手續辦妥後，您將會收到周大福人壽發出的賠償通知書。如有差額(定義見下文)及/或有每年自付額，周大福人壽將於賠償通知書發出後的 14 天內從您於表格的第二部份授權的信用卡帳戶中收取差額及/或自付額，如有。 *Please note: If the medical expenses do not exceed the amount we have approved under this Form, then upon the insured’s completion of the day surgery, the Network Day case centre will send the invoice (the “Invoice”) directly to us. You will receive a claims statement after the claim is processed. If there is any Shortfall (as defined below) &/or any balance of annual deductibles, CTF Life will arrange for settlement of the Shortfall including the balance of deductibles by debiting from the credit card you have authorized in Part II of the Form within 14 days after the claims statement is dispatched.

預先保障審核安排服務之條款及條件：
Terms and Conditions for Pre-Authorization Arrangement Service:

i) 預先保障審核安排服務不適用於以下醫療費用：
No Pre-Authorization Arrangement Service will be provided for medical expenses that are:
   a) 超出我們就此表格所批准的金額的費用，或
   in excess of the amount we have approved under this Form, or
   b) 您的保單（「該保單」）內介定之保單生效日期或復效日（以後者為準）後的首一百八十日內產生的費用；或
   incurred within the first 180 days after the Policy Effective Date as defined in your insurance policy (the “Policy”) or the date of reinstatement (whichever is later); or
   c) 不符合醫療必要或合理及慣常費用定義之費用；或
   the expense which does not meet the definition of Medically Necessary or Reasonable and Customary Charges; or
   d) 過去預先保障審核安排服務下之逾期差額（如有）；或
   overdue shortfall from previous Pre-Authorization Arrangement (if any) ; or
   e) 未在表格上申報之手術費用；或
   the surgical expense which has not yet been declared on the Form; or
   f) 不受該保單保障的費用。
   not covered by the Policy.

ii) 由於我們是根據對醫學療程的估計批核您的預先保障審核安排服務申請；故此，該批核並不代表我們對您的索償的所有項目均已批核或將會批核。我們保留權利在審閱單據後拒絕您的索償，並追回我們已付但不在該保單的保障範圍內的醫療費用（「差額」），以及應繳付之每年自付額（如有）。
Since our approval of your application for Pre-Authorization Arrangement Service is based on an estimation of the course of medical treatment, that approval does not mean that we have approved or will approve all items of your claim. We reserve the right to reject your claim upon evaluation of the Invoice, and recoup the part of the medical expenses which we have paid but is not covered by the Policy (the “Shortfall”) & payable annual deductibles (if any).

iii) 您須要提供醫療詳情，並授權周大福人壽由您的信用卡戶口收取差額，以及應繳付之每年自付額（如有）。
You will be required to provide details of medical treatment and authorize CTF Life to collect the Shortfall & payable annual deductibles (if any) from your credit card account.

iv) 周大福人壽對預先保障審核安排服務引起的一切事項擁有唯一及絕對決定權。
CTF Life has the sole and absolute discretion in relation to all matters arising from the Pre-Authorization Arrangement Service.

v) 周大福人壽保留終止或變更預先保障審核安排服務的權利而無須另行通知。
CTF Life reserves the right to terminate or vary the Pre-Authorization Arrangement Service in our sole discretion without further notice.

預先保障審核安排服務申請書
Pre-Authorization Service Application Form

CTF Life 周大福人壽

保單號碼 Policy Number	
保險代理 / 經紀姓名 Name of Agent / Broker	
保險代理 / 經紀編號 Code of Agent / Broker	
電話 Telephone No.	

重要事項 IMPORTANT NOTICE

如果您已完成在線預先批核登記， 請提供登記成功簡訊中出現的預先批核參考號碼。
If you had completed the online Pre-authorization Registration, please provide the Pre-authorization reference no. that appeared in the SMS for successful registration.

如果您已完成在線預先批核登記，您可以跳過填寫以下表格的第一部分，直接簽署第二頁的聲明及授權書。
If you had completed the online Pre-authorization Registration, you could skip filling Part I below, and just sign under Declaration and Authorization in page 2.

如有任何疑問，請聯絡我們的 **24 小時熱線 2866 8898（按 3 字）** If you have any question, please contact our **24 hours hotline 2866 8898 (press 3)**

請於填寫此表格前細閱「如何申請住院預先保障審核安排服務」的部份。請填妥此表格並於住院或進行日間手術前最少四個工作天，以傳真(852) 3468 2603 或電郵 CTFLife.PA@ump.com.hk 方式遞交予聯合專業管理有限公司。Please read the section on "How to apply for Inpatient Pre-Authorization Arrangement Service?" and the Terms and Conditions for Pre-Authorization Arrangement Service before completing this Form. Please send the completed Form to Chow Tai Fook Life Insurance Company Limited by fax (852) 3468 2603 or e-mail CTFLife.PA@ump.com.hk at least 4 working days prior to confinement or day surgery.

第一部份-由受保人或保單持有人填寫

Part I - To be completed by Insured / Policy Owner

A. 受保人及保單持有人個人資料 Personal Particulars of the Insured and Policy Owner

1. 保單持有人姓名 Name of Policy Owner		2. 受保人姓名 Name of Insured	3. 受保人身份證 / 護照號碼 Insured's ID / Passport No.
4. 受保人年齡 Age of Insured	5. 受保人性別 Sex of Insured	6. 保單持有人電話號碼 Telephone No. of Policy Owner	7. 保單持有人電郵地址 E-mail Address of Policy Owner

請根據是次住院或日間手術之原因填寫 B 或 C 部分 Please fill in part B or C according to the reason of confinement or day surgery

B. 如住院或日間手術是疾病引致 If Confinement or Day Surgery is due to Illness

1. 住院或進行日間手術前有何等徵狀？ What are the symptoms presented before confinement or day surgery?	2. 首次就診之前，受保人有此等徵狀已多久？ How long has the Insured been having these symptoms before the first consultation?

3. 何時因此等徵狀而首次求診 (日/月/年)？
When did the first consultation for these symptoms (DD/MM/YY) take place?

4. 就診詳細情況及其他資料 Details of Consultation and Other Information

a. 首次就該疾病或受傷診治受保人的醫生的名稱和地址： Name and address of the doctor who first treated the insured for the injury or the illness:	b. 建議受保人入院的醫生的名稱和地址: Name and address of the doctor who referred the insured to hospital:	c. 過往就同樣病症曾向其求診的醫生名稱和地址: Name and address of doctors consulted in the past for similar condition:

C. 如住院或日間手術是意外引致 If Confinement or Day Surgery is due to Accident

1. a. 意外日期 (日/月/年)： Date of accident (DD/MM/YY): b. 意外發生的時間： Time of accident: c. 意外發生的地點： Place of accident:	2. a. 意外如何發生？ How did the accident happen? b. 有否報警？ Has the accident been reported to the police? ☐ 否 No ☐ 有 Yes c. 如有， 請附上口供紙或警察報告影印本 If yes, please attach a photocopy of the witness statement or police report
3. 身體的哪些部位受傷？ Which parts of the body were injured?	4. 受傷程度如何？ What was the extent of the injury?

5. 就診詳細情況及其他資料
Details of Consultation and Other Information

a. 首次就該疾病或受傷診治受保人的醫生的名稱和地址： Name and address of the doctor who first treated the insured for the injury or the illness:	b. 建議受保人入院的醫生的名稱和地址: Name and address of the doctor who referred the insured to hospital:	c. 過往就同樣病症曾向其求診的醫生名稱和地址: Name and address of doctors consulted in the past for similar condition:

預先保障審核安排服務申請書
Pre-Authorization Service Application Form

CTF Life 周大福人壽

第二部份-由受保人或保單持有人填寫
Part II - To be completed by Insured / Policy Owner

A. 收取差額及/或應繳付之每年自付額之信用卡授權書 Credit Card Authorization Form for Shortfall &/or Payable Annual Deductibles (if any) Collection

如周大福人壽向醫院支付的費用超出該保單的保障範圍，此授權書將授權周大福人壽從以下的信用卡帳戶收取差額及/或應繳付之每年自付額〈如有〉。信用持卡人必須為此保單之投保人或會員。周大福人壽將於信用卡保留港幣 50,000 元，直至整個理賠程序完結為止。周大福人壽將於收取差額的十四天前向保單持有人發出差額付款通知書。(請注意，就香港客戶而言，我們會接受 VISA, MASTER CARD 及 American Express)
In the event that the Company has settled any charges not covered by the Policy, this Part authorizes CTF Life to collect the Shortfall &/or payable annual deductibles (if any) by debiting from the following credit card account. The credit cardholder must be the Subscriber or the Member of this policy. CTF Life will hold HKD 50,000 from the credit limit of this credit card account until the claim assessment is fully completed. The shortfall notification will be sent to Policy Owner 14 days prior to collection. (Please note that for Hong Kong customers, Visa Card, Master Card and American Express Card are acceptable)

信用卡付款授權書 Credit Card debit authorization (此部分必須填寫 this section must be completed)

持卡人姓名 Cardholder's Name:	持卡人身份證 / 護照號碼 Cardholder I.D. Card/Passport No.:	持卡人與受保人的關係 Relationship with Policyowner/Insured:
信用卡號碼 Credit Card Account No.:	信用卡到期日 Credit Card Expiry Date:	

本人授權及指示周大福人壽如本第二部份上文所述，從本人的信用卡戶口的信用額保留港幣 50,000 元及從其扣除差額及/或應繳付之每年自付額
I hereby authorize and direct CTF Life to hold HKD 50,000 from the credit limit of and debit the Shortfall &/or payable annual deductibles (if any) from my credit card account as detailed above in this Part II.

持卡人簽署 Cardholder's Signature: 日期(日/月/年) Date (DD/MM/YY):	聯絡電話 Contact no.:

B. 住院醫療諮詢服務 " Inpatient Advice" service preference:
住院醫療諮詢服務將提供予經醫生確診而需要住院進行治療的受保人。這是為受保人提供的增值服務，可就有關確診的疾病得到進一步意見。
住院醫療諮詢服務可以下列不同形式進行及由不同國家醫生提供，請選擇其中 1 項：
Inpatient Advice service would be provided to insured who have an inpatient recommendation regarding the diagnosis made by a medical doctor. This is a value-added service for the insured to obtain extra information about the diagnosis in different forms and provided by doctors of different countries listed below. Please choose ONE item from the below options:

☐ 不需要住院醫療諮詢服務 No Inpatient Advice service needed	☐ 需要香港住院醫療諮詢服務，In-patient Medical Advice service needed 1. ☐專科醫生診症 Specialist consultation 2. ☐書面報告 Written report 3. ☐遠程視訊諮詢 Tele-consultation

如選擇使用住院醫療諮詢服務，本人將授權聯合專業管理有限公司('UMP') 收集本人之醫療報告及住院建議作醫療轉介用途。所收集的資料絕對保密，及在諮詢服務完成後三個月內銷毀。一切資料由授權人自願提供並自行選擇最終治療決定。聯合專業管理有限公司並不會為任何治療決定、過程及其治療結果負上責任。
By choosing to use the Inpatient Advice service, I hereby authorize UMP Professional Management Limited ('UMP') to collect my medical reports and materials relevant to the inpatient recommendation for referral purpose. Information collected will be kept confidential and would be destroyed after 3 months upon completion of the service. All information is provided voluntarily and all treatment decisions are made by the authorizer.

收集個人資料聲明 Personal Information Collection Statement

本人 / 我們確認本人 / 我們已閱讀及明白周大福人壽保險有限公司（以下簡稱 "周大福人壽" ）之個人資料收集聲明（"該聲明"）。本人 / 我們聲明及同意貴公司可根據該聲明所述的任何目的收集及 / 或持有、使用及/或披露/分享任何個人資料（不論是否從此表格或以其他方式獲得）。本人 / 我們明白本人 / 我們必須於此表格提供所須資料，否則貴公司將可能無法執行該聲明之目的及 / 或向本人 / 我們提供產品或服務。本人 / 我們確認及同意本人 / 我們的個人資料可能披露/共享給該聲明所指明的第三方; 執法機構; 保險業就現有資料而對所提供的資料作出分析和檢查而使用的數據庫或登記冊作出於該聲明所述的任何目的。本人/我們明白該聲明的最新版本可於周大福人壽的網址下載：www.cftlife.com.hk，及可向貴公司索取。

I /We confirm that I/we have read and understood Chow Tai Fook Life Insurance Company Limited ("CTF Life")'s Personal Information Collection Statement ("PICS"). I/We declare and agree that any personal data CTF Life may collect and/or hold, use and/or disclose/share with (whether contained in this form or otherwise obtained) in accordance with the Purposes as set out in the PICS. I/We understand that if I/we do not provide the required personal data, CTF Life may not be able to perform the Purposes and/or provide products or services to me/us. I/We acknowledge and agree that my/our personal data may be disclosed/shared with specified parties in the PICS; law enforcement authorities; databases or registers used by the insurance industry to analyse and check information provided against existing information for any of the Purposes stated in the PICS. I/We understand the updated version of the PICS is available for download from CTF Life's website: www.ctflife.com.hk, and will be made available upon request.

預先保障審核安排服務申請書
Pre-Authorization Service Application Form

CTF Life
周大福人壽

聲明及授權書 （由保單持有人及受保人簽署，如受保人未滿*18*歲，則由其家長或合法監護人簽署） 。
Declaration and Authorization *(To be signed by the policyowner and insured OR to be signed by the insured's parent / legal guardian if the insured is under the age of 18).*

本人/我們聲明上述一切陳述及對問題的所有答案均為事實之全部，並確實無訛。
I/We declare that the above statements and answers made by me/us are true, accurate and complete.
本人/我們茲授權凡知道或擁有任何有關本人或受保人記錄的僱主、任何註冊西醫、醫院、診所、保險公司、其他機構或人士，均可將該等資料提供給周大福人壽保險有限公司。即使本人或受保人死亡或喪失能力，此授權書仍然有效，所有本人及受保人之繼承人及承讓人亦會受此授權書約束。本授權書的影印本與正本具有同等效力。
I/We hereby authorize any employer, any registered medical practitioner, hospital, clinic, insurance company or other institution or person, that has any records or knowledge of me or the Insured named to give such information to Chow Tai Fook Life Insurance Company Limited. This authorization shall bind the successors and assignees of me/the Insured and remain valid notwithstanding the death or incapacity of me/the Insured. A photocopy of this authorization shall be as valid as the original.

本人 / 我們明白及同意I/We understand and agree that:

1) 遞交此住院預先保障審核安排服務申請書或由貴公司簽發付款保證信均不得被詮釋為等同於貴公司承擔賠償責任。
Neither submission of this Inpatient Pre-Authorization Arrangement Service Application Form nor the issuance of letter of guarantee by the Company shall be construed as admission of liability on the part of the Company.

2) 若貴公司曾支付任何不在該保單的受保障範圍內的費用〈如: 應繳付之每年自付額〉，貴公司將從第二部份指定的信用卡中扣除差額。若貴公司因任何原因包括但不限於有關信用卡戶口的信用額不足，以至未能收取該筆差額，貴公司將有權把差額從貴公司據該保單及/或任何由貴公司簽發的保單所應支付予該保單的保單持有人的任何金額中抵銷扣除，包括但不限於任何身故賠償(在法律允許的範圍內)、紅利或保費退還(不論任何原因)，不論該保單的保單持有人本來是否將以一份保單的擁有人的身份有權獲得該等金額。
In the event that the Company has settled any charges not covered by the Policy, i.e. any payable annual deductibles, the Company shall deduct the Shortfall from the credit card as specified in Part II. However, if collection of the Shortfall is unsuccessful due to any reasons including but not limited to insufficient funds in the credit card account, the Company shall have the right to offset the Shortfall against any amount due or payable to the Policy Owner from the Policy and /or any policy issued by the Company including but not limited to any death benefit (to the extent it is permissible by law), dividends or return of premium (for whatever reason), irrespective of whether the Policy Owner is otherwise entitled to receive that amount in the capacity of a policy owner.

本人/我們明白若此預先保障審核安排服務申請書的中、英文兩個版本有任何抵觸或不相符之處，應以英文版本為準。
I/We understand that if there is any inconsistency or ambiguity between the English version and the Chinese version of this Pre-Authorization Arrangement Service Application Form, the English version shall prevail.

保單持有人簽署
Signature of Policy Owner : x _____

見証人簽署
Signature of Witness : x _____

保單持有人姓名 (大寫)
Name of Policy Owner (in block letters) : _____

見証人姓名 (大寫)
Name of Witness (in block letters) : _____

身份證 / 護照號碼
ID / Passport No. : _____

日期 (日/月/年)
Date (DD/MM/YY) : _____

日期 (日/月/年)
Date (DD/MM/YY) : _____

受保人簽署 (年齡十八歲或以上必須簽署)
Signature of Insured (whose age is 18 or above): x _____

If the insured is under the age of 18, please provide the following information:

受保人姓名 (大寫)
Name of Insured (in block letters) : _____

身份證 / 護照號碼
ID / Passport No. : _____

日期 (日/月/年)
Date (DD/MM/YY) : _____

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第三部份 - 由受保人的主診醫生填寫(費用由保單持有人支付)
Part III - To be completed by the Attending Doctor of the Insured (Cost to be borne by Policy Owner)

1. a. 病人姓名 Name of patient	b. 身份證/護照號碼 ID / Passport No.	c. 年齡/性別 Age / Sex	d. 職業 Occupation

醫療詳情 Medical Condition

1. 求診時之病徵或不適：
The symptoms/complaints on the date of the consultation:

原因Cause: ❒ 疾病 Illness ❒ 受傷Injury

2. 醫生預診是否於住院治療同一醫院進行？
Is the doctor's pre-consultation conducted at the same hospital as the inpatient treatment?
❒ 是 Yes ❒ 否No

3. 病徵或不適首次出現之日期 (日/月/年)：
Date on which symptoms/complaints first appeared (DD/MM/YY):

4. 診斷
Diagnosis

4. 國際疾病分類編號
ICD code

5. 首次診斷日期：
First consultation date:

6. 該情況是否以下其中之一(請選擇)？
Is this condition any one of the following (Please choose?)

- ❒ 慢性疾病之初次病發
first episode of a chronic illness?
- ❒ 慢性疾病的再次病發
recurrent episode of a chronic illness?
- ❒ 以上全部皆否
"No" to all of the above

如其中的項目為「是」，請提供該項的資料
If one of the above is "Yes", please give details:

7. 首次發病日期 (日/月/年)：
Onset of the first episode (DD/MM/YY) :

8. 有關疾病或受傷是否由以下因素導致?
Was such illness or injury caused by the following factors?

有 Yes	否 No	
❒	❒	自致傷害 (原因及經過) Self-inflicted injury (How it happened & underlying cause)
❒	❒	酗酒及濫用藥物 (酒類/藥物名稱、份量及飲食/服食多久) Drug abuse and Alcohol abuse (Name & dosage of drug/alcohol, quantity and duration of consumption)
❒	❒	退化性轉變 (發病日期及求診詳情) Degenerative changes (Onset date & consultation details)
❒	❒	先天性缺陷 (診斷、發病日期及求診詳情) Congenital anomalies (Diagnosis, date of onset & details of consultation)
❒	❒	過往受傷/疾病 (原因及求診詳情) Past injury or illness (Cause and details of consultation)
❒	❒	不育、絕育、懷孕、分娩或流產 (與疾病或受傷的關係及詳情) Infertility, Sterilization, Pregnancy, Childbirth or Miscarriage (How it related to the Illness or injury and details)
❒	❒	精神病(發病日期及求診詳情) Phychiatric condition (date of onset & details of consultation)
❒	❒	肥胖,體重控制(發病日期及求診詳情) Obesity, weight control (date of onset & details of consultation)

若「是」，請詳述。 If yes, please give details:

9a. 請列出受保人為此住院或日間手術需接受的全部化驗/診斷掃描/其他診斷性檢查及進行該等檢查的**原因**
Please list out all laboratory tests/diagnostic imaging/other diagnostic investigations required for this Confinement or Day Surgery and **reasons** for conducting the same.

是次檢查及治療可否在門診處理,而無須在醫院進行?
Can the treatment and the medical test(s) be managed under an out-patient setting instead?
☐ 可以 Yes ☐ 不可以 No

若可以在門診處理,請說明病人住院的原因。
If "Yes", why was the patient admitted to hospital?

若不可以在門診處理,請詳述之。
If "No", please give details.

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9b. (若計劃住院) 就病人的病況，病人是否可以在門診進行所建議的治療/化驗/診斷掃描/其他診斷性檢查等？
(If confinement is contemplated) Given the condition of the patient, is it possible to provide the suggested treatment/laboratory test/diagnostic imaging/other diagnostic investigation etc. on an outpatient basis?

☐ 是 Yes ☐ 否 No

如「否」，請提供原因。 If "No", please explain.

10. 手術前/後診症 Pre/Post-Consultation

1. 手術前診症 Pre-Consultation 診金Fee: $_____(診症次數：一次 No. of consultation: 1 time)

2. 手術後診金 Post-Consultation 診金Fee: $_____(診症次數：一次 No. of consultation: 1 time)

11. 手術
Surgical Procedure

手術日期 (日/月/年)
Date of Operation (DD/MM/YY) : _____

手術名稱
Name of Operation : _____

外科醫生之姓名
Surgeon's name : _____

12. 麻醉 Anaesthesia: ☐ 全身麻醉 General Anaesthesia ☐ 局部麻醉 Local Aneasthesia

13 a.醫院名稱/日間手術中心：
Name of hospital / day surgery centre: _____

b. 預計入院日期 (日/月/年) ：_____
Estimated date of admission (DD/MM/YY) : _____ 預計住院日數 (日數) ：_____
Estimated length of stay (number of days) : _____
就你所知，該種情況/手術所需的住院日數為 ：_____
To the best of your knowledge, what is the usual length of stay for the similar condition and surgery? _____

住房級別: □ 普通病房 □ 半私家房 □ 標準私家房
Room Level: Ward Semi-Private Standard Private

14. 預計是次住院或進行日間手術下列各項費用 Estimated fee for the following items under this Confinement or Day Surgery:

a. 醫生費 Daily Attendance Fee :

b. 專科醫生費Specialist Fee:

c. 手術費 Surgical Fee:

d. 麻醉費 Anaesthetic Fee:

e. 藥物 medication fee:

f. 其他醫院費用 Other miscellaneous expenses

15. 請列出建議之化驗/影像檢查/其他診斷性檢查及接受該等檢查的原因。
Please list out any Lab tests / Imaging / other diagnostic investigations required for this hospitalisation and reasons for the same.

該等檢查是否僅在醫院可有? 若不可以,請詳述之。 Are the investigations available only in hospital? If "No", please give details.

該檢查及手術可否在門診 / 日間手術中心進行? Can the medical test(s) and the procedure be done on an outpatient basis/at day surgery centre?

16. 這是否緊急個案?
Is it a case of emergency?

□ 是 Yes □ 否 No

如是，請明確說明。If yes, please specify.

醫生聲明及簽署 Doctor's Declaration and Signature

本人謹此證明本人已親自為病人就上述之病症或受傷進行檢查，並確認以上提供的有關病人現時及過去的情況的資料就本人所知所信屬實。
I hereby certify that I have personally examined the patient and attended to his/her illness or injury, and that the information about his current and past condition as stated above is true to the best of my knowledge and belief.

主診醫生姓名 (專業資歷)
Name of Attending Doctor (with qualification)

簽署 (及印章)
Signature (with chop)

地址及電話號碼
Address & Phone No.

日期 (日/月/年)
Date (DD/MM/YY)