Cancer (Reimbursement) Protection
癌症保障

Part A to B – to be completed by Insured Person
Part A to B – 由受保人填寫

Claim Form 索償申請書

Attention 注意:

How to submit a claim 如何遞交賠償申請

1. Fill in Cancer Claim Form by Insured Person 由受保人填寫癌症賠償申請書
2. Complete Cancer Medical Report by Attending Doctor 請主診醫生填寫癌症醫療報告
3. Submit original Claim Form and Medical Report together with all the necessary documents
   連同正本賠償申請書、醫生醫療報告和其他所需文件一併遞交
4. Send all required claim documents by mail to 5/F., 160 Des Voeux Road West, Sai Ying Pun, Hong Kong
   郵寄所需文件到香港西營盤德輔道西 160 號 5 樓

Claim Documents Checklist

1. Original Cancer Claim Form 正本癌症賠償申請書
2. Original Cancer Medical Report 正本癌症醫療報告
3. Copy of Insured Person's ID card 受保人的身份證副本
4. Other documents: -
   - Original Doctor and/or Hospital invoice and receipt 醫生或/及醫院簽發的醫療收費單及收據正本
   - Discharge Summary 出院摘要
   - Clinical Notes 臨床摘要
   - Histopathological report 病理報告
   - Laboratory tests report 化驗報告
   - Other Laboratory tests and imaging reports (if any) 其他化驗及造影報告 (如有): -
     - X-ray report X 光報告
     - Ultrasound report 超聲波報告
     - CT scan report 電腦掃描報告
     - MRI report 磁力共振報告
     - Positron emission tomography (PET) scan report 正電子掃描報告
     - Other imaging / scanning reports etc. 其他造影報告

Part A: Personal Information of the Patient 病人個人資料

Policy No. _____
保單號碼

□ Avo Top Cancer 安我常見癌症 □ Avo Female Cancer 安我女性癌症 □ Avo Male Caner 安我男性癌症

Name of Patient _____
病人姓名 (First name 名字) (Last name 姓氏)

HKID/Passport No. _____
香港身份證/護照號碼

Does the patient consume alcohol? □ Yes 有 Types 酒精類別 _____ Daily consumption unit 每日飲用量 _____ □ No 沒有

Part B: Patient's Declaration 病人聲明

1) Name the critical illness you are claiming for
申請賠償的危疾名稱

_____

2) Date of first consultation
首次求診日期

_____

3) Describe the symptoms from date of onset
詳述病發日起所患之病徵

_____

4) The name, address and contact phone no. of the doctor you first consulted for this illness
首次就此病而求診之醫生姓名，地址及聯絡電話

_____

5) How long have you been having these symptoms from the date of your first consultation i.e., around three months before first consultation?
閣下在首次求診日起，以上的病徵已存在多久？

_____

6) The name, address and contact phone no. of your regular doctor
閣下慣常求診之醫生姓名，地址及聯絡電話

_____

7) Please give below the details of any doctor(s) who have been consulted or the details of any hospitalization in connection with this illness
請提供曾診治此病的其他醫生或專科醫生資料

Name(s) and Address(es) of Doctor 姓名及地址	Consultation Date(s) 求診日期

Name of Hospital(s) 醫院名稱	Date of Admission 入院日期	Date of Discharge 出院日期

8) Have any of natural parents or siblings suffered from a similar or related illness? If "yes", please state
父母或兄弟姐妹中有否曾患有相同或有關之危疾？如"有"，請填寫下欄

Relationship of Relative 親屬關係	Nature of Illness 危疾類別	Date Illness Diagnosed 診斷日期

9) Are there any other hospitalization prior to this critical illness you are claiming for? If so, please give full details
閣下在患有是次申請賠償之疾病前是否患有其它疾病？如"有"，請把有關資料詳細填報

Name of Hospital (s) 醫院名稱	Date of Admission 入院日期	Date of Discharge 出院日期

10) Are you insured for similar benefits with any other Company? If "yes", please state
閣下是否在其它公司投保類似危疾保障？如"有"，請填寫下欄

Name of Insurer 投保公司名稱	Type of Benefit 投保類別	Amount of Benefit 投保金額	Policy Number 保單號碼

Continuous to Part C to F to be completed by Physician 繼續至由醫生填寫的 C 到 F 部分

Cancer Medical Report
Part C to F – to be completed by Physician
癌症醫療報告
Part C to F – 由醫生填寫

Part C: Consultation Details 診症詳情

Are you the patient's usual physician?

□ Yes, date on which the patient first consulted you

_____
(DD/MM/YYYY)

□ No, the referring doctor's name and address

_____
(Name)

_____

_____
(Address)

Date on which the patient first consulted you relating to this diagnosis

_____
(DD/MM/YYYY)

Symptom(s) or complaint(s) of the patient

_____

_____

_____

How long had the patient been experiencing these symptoms before the first consultation?

_____ month(s)

Date on which the diagnosis was made

_____
(DD/MM/YYYY)

Does the patient need follow-up treatment or consultation?

□ Yes □ No

Part D: Details of Hospitalization (If applicable) 住院詳情 (如適用)

Name of Hospital _____

Date of admission_____

Date of discharge_____

Diagnosis at the time of discharge

_____

_____

Any Operation/Surgery performed? If so please provide the date and name of the surgical procedure?

_____

_____

_____

Any treatment other than Operation / Surgery performed? If yes, please provide date and name of such treatment?

_____

_____

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Discharge summary (including investigation tests and results, procedures, treatment, operations, result of such treatment, and/ or any complications and follow up plans)

_____

_____

_____

_____

_____

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_____

_____

Part E: Cancer / Tumour questions 有關癌症/腫瘤之問題

Site and organ involved

_____

Was any lymph node involved?

_____

Was biopsy done for the patient? If yes, please provide date and results

_____

_____

_____

_____

Has the cancer / tumour been completely removed / eradicated?

_____

What was the Surgical-Pathological cancer staging for this patient? What was the cancer staging system used?

_____

_____

_____

What is tumour grading?

_____

Please state the type of treatment administered, including drug name, dosage, frequency, duration of treatment and any complications

_____

_____

_____

_____

Completion date of all treatments, if not, please state any treatments to be followed

_____

_____

_____

_____

Is there any distant metastasis? What are the body parts involved?

_____

_____

_____

_____

_____

Part F: Related Cause(s) 相關病因

Is the condition caused by or associated with the following?

Pre-malignant tumor	□ Yes	□ No
Abuse of drugs or alcohol	□ Yes	□ No
Nuclear, biological or chemical contamination	□ Yes	□ No
General check-up	□ Yes	□ No
HIV or HIV related illness	□ Yes	□ No
Convalescence, custodial or rest care	□ Yes	□ No

Part G: Declaration 聲明

I hereby certify that all information given above is accurate and true to the best of my knowledge.

_____ _____

(Signature of the physician with official chop) (Name of physician)

_____ _____

(Name of hospital or clinic) (DD/MM/YYYY)

Important Notes 重要告示

Any personal information collected by Avo Insurance Company Limited may be used, stored or disclosed to any individual or organization to evaluate this claim, or to provide subsequent services. A detailed version of the Personal Information Collection Statement (PICS) can be found on the Company website at: www.heyavo.com
安我保險有限公司所收集到之任何個人資料均有可能被使用、儲存或披露予任何個人或公司以審核索償，或用以提供相關及連帶服務。閣下可在 www.heyavo.com 瀏覽詳細的個人資料收集聲明。

Requests for personal data access or correction may be addressed to the Data Protection Officer of Avo Insurance Company Limited to the address below:
有關查閱或改正閣下的個人資料要求，可以書面形式向本公司的資料保護主任提出並將函件郵寄至以下地址：

Data Protection Officer
Avo Insurance Company Limited
5/F, 160 Des Voeux Road West,
Sai Ying Pun,
Hong Kong

香港西營盤德輔道西一百六十號五樓
安我保險有限公司
資料保護主任

For further queries, you may contact our customer hotline at: +852 3572-8222.
如有任何疑問，敬請致電本公司之客戶服務熱線： +852 3572-8222。

Declaration and Authorization 聲明及授權

I hereby declare that the above information given is true and correct. I hereby authorize any hospital, physician, insurance company or organization that has any records or knowledge of me or my health, to furnish to Avo Insurance Company Limited or its authorized representative any and all information with respect to any illness or injury, medical history, consultation prescriptions or treatment and copies of all hospital or medical records. A photo copy of this authorization shall be considered as effective and valid as the original.
本人謹此聲明以上提供的資料及細節均是準確無誤。本人在此授權予任何醫院、醫生、保險公司及持有本人及有關本人健康狀況之紀錄或資料之機構均可將所有本人之疾病或意外、醫療紀錄、諮詢處方或治療及所有醫院及醫療紀錄披露予安我保險有限公司及其已授權代表。此授權之影印本亦與正本同效。

_____ _____
(Signature of the Patient 病人簽署) (DD/MM/YYYY 日/月/年)