



Avo Voluntary Health Insurance Scheme (Standard) Plan

Avo 自願醫保 (標準) 計劃

This form is applicable to both inpatient and outpatient surgical claim
本申請表適用於住院或門診手術費用索償

Claim Form 索償申請表

Attention 注意：

How to submit a claim 如何遞交賠償申請

1. Fill in Claim Form Part 1 by Insured Person / Policy Holder 由受保人 / 保單持有人填寫索償申請表第一部分
2. Complete Claim Form Part 2 by attending Registered Medical Practitioner 請主診註冊醫生填寫索償申請表第二部分
3. Submit original Claim Form and Medical Report together with all the necessary documents
正本索償申請表連同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 索償文件清單

1. Original duly signed Claim Form 正本已簽署索償申請表
 2. Original Medical Report 正本醫療報告
 3. Copy of Insured Person's ID card 受保人的身份證副本
 4. Other documents 其他文件： -
 - 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
 - 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
 - Laboratory tests report 化驗報告
 - Other imaging / scanning reports etc. 其他造影報告
- If involved in traffic accident 如涉及交通意外
- Copy of all police statement 口供紙副本
 - Traffic accident report 交通意外報告



**Avo Voluntary Health Insurance Scheme (Standard) Plan Claim Form
Part 1 – to be completed by Insured Person / Policy Holder**

Avo 自願醫保 (標準) 計劃索償申請表

第一部分 – 由受保人 / 保單持有人填寫

Part A: Personal Information of the Insured Person 受保人 (病人) 個人資料

Policy Number 保單號碼	_____	Email Address 電郵地址	_____
Name of Insured Person 受保人 (病人) 姓名	English 英文全名 _____	Chinese 中文全名 _____	
HKID Number 香港身份證號碼	_____	Mobile Phone Number 流動電話號碼	_____
Reference number of claimable amount estimate (if any) 可賠償金額估算的參考編號 (如有)	_____		

Part B: Patient's Declaration 病人聲明

1. Is this hospitalisation / surgery a result of an accident? 是次住院 / 手術是否由一宗意外引致? Yes 是 No 否
 - a. Date of accident 意外日期 (DD/MM/YYYY 日 / 月 / 年) _____
 - b. Details of accident 意外詳情

2. Is this hospitalisation / surgery due to illness? 是次住院 / 手術是否由疾病引致? Yes 是 No 否
 - a. Date of first consultation 首次求診日期 (DD/MM/YYYY 日 / 月 / 年) _____
 - b. How long have you been having these symptoms from the date of your first consultation?
閣下在首次求診日起, 以上的病徵已存在多久?

 - c. Details of Registered Medical Practitioner you first consulted for this illness
首次就此病而求診之註冊醫生姓名、電話號碼及地址
Registered Medical Practitioner Name
註冊醫生姓名 _____ Telephone Number
電話號碼 _____
Address
地址 _____
3. Have you ever had the same or similar symptoms / medical conditions before? Yes 是 No 否
If yes, please state details
病人是否曾經患有同一或相似病徵? 如是, 請提供詳情

4. Any other insurance claim made as a result of this hospitalisation / surgery? Yes 有 No 否
有否就是次住院 / 手術申請其他保險賠償? 如有, 請提供
Name of Insurance Company
保險公司名稱 _____ Policy Number
保單號碼 _____

Part C: Claim Details 索償詳情

Name of Hospital / Clinic admitted 入住醫院 / 診所名稱	_____	
Hospitalisation Period (DD/MM/YYYY, hh:mm) 入院日期 (日 / 月 / 年 · 時 : 分)	From 由 _____	To 到 _____
Reason / Diagnosis of hospitalisation / surgery 住院 / 手術原因或醫生診斷結果	_____	

Authorisation and Declaration 授權及聲明

I/We hereby authorise any hospital, physician, police, person, party and/or authority that has any records or is holding any information of the insured person or me /us to disclose to Avo Insurance Company Limited ("the Company") or its authorised representative, any and all information with respect to the insured person's or my/our loss, disability, medical history, police statement made and the like for the purpose of assessing my/our claim request(s). A photocopy of this authorisation shall have the same effect as the original.

I/We hereby declare that all the above information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief.

I/We have not withheld any material information and acknowledge that failure to supply true and accurate answers to this request or inform the Company of all material information may render the Company unable to accept or process this request and all rights to recover under the Policy shall be forfeited. I/We understand that the issuance or completion of this application does not constitute admission of liability or guarantee payment of the claim on behalf of the Company.

I/We confirm having read and understand and agreed to all the Declarations, terms and conditions and the Company's Personal Information Collection Statement as accompanied with this form.

本人 / 我們謹此授權任何持有受保人或本人 / 我們之任何記錄或資料的醫院、醫生、警方、人士、有關人等、及 / 或有關當局、向安我保險有限公司（「貴公司」）或其授權代表提供任何或所有有關受保人或本人 / 我們之損失、損傷、病歷、口供或任何相關資料作評估賠償申請之用途。此授權書之正本及副本皆具同等效力。

本人 / 我們謹此聲明，上述所有問題的答案包括所有資料及細節均是準確無誤、真實及為事實之全部，並且是盡本人 / 我們所知及所信而作答的。

本人 / 我們並沒有隱瞞任何重要資料及確認如未能提供真實及準確無誤之資料或通知貴公司任何有關此索償申請之重要資料，將可能導致貴公司不能接受或處理此索償申請及喪失所有追討保單權益之權利。本人 / 我們明白此索償申請表之發出及填妥並不代表貴公司確認責任或保證賠償。

本人 / 我們確認已閱讀及明白並同意所有聲明、條款及細則及隨本表格附上有關貴公司的收集個人資料聲明。

Signature of Insured Person 受保人簽署	Name of Insured Person 受保人姓名	Date (DD/MM/YYYY) 日期 (日 / 月 / 年)
Signature of Policy Holder (If Insured Person is not the Policy Holder) 保單持有人簽署 (如受保人非保單持有人)		Name of Policy Holder 保單持有人姓名

Personal Information Collection Statement 收集個人資料聲明

It is the policy of Avo Insurance Co., Ltd. ("Avo Insurance") to safeguard and keep confidential the personal data of all our customers. Avo Insurance shall at all times observe and ensure our staff strictly adhere to all the requirements under the Personal Data (Privacy) Ordinance ("the Ordinance").

1. Personal Data collected and/or held by Avo Insurance

Personal data such as first name, last name, HKID Card, date of birth, email address, telephone number, policy number, medical and health records, and question or comment will be collected by us when you make enquires or submit any forms for products or services provided by Avo Insurance.

2. Importance of Personal Data Collection

From time to time, you will be requested to provide your personal data to Avo Insurance. Provision of personal data to Avo Insurance by you is voluntary. However, Avo Insurance may not be able to provide or continue to provide products and services to you if you fail to provide your personal data as requested by us.

3. Purposes of Personal Data Collection and Usage

Your personal data held by Avo Insurance may be used for the following purposes:-

a. Administration of insurance or reinsurance related business, which include underwriting, processing and evaluation of applications, identity and credit checking, suitability checking, policy servicing, claims processing, investigation, account/debt collection, litigation, communications, preparing statistics, data analysis and research, internal and external audit, maintaining quality services, sales and marketing;

b. Avo Insurance will collect, use and disclose my personal information (including claims history) for the purposes necessary to process my application, investigate and settle claims and detect and prevent fraud (whether or not relating to the policy issued in respect of this application);

c. Make disclosure to any applicable regulators, governmental bodies or industry recognised bodies as required by any law, rule, regulation, code of practice or guideline, binding on Avo Insurance or our affiliates including without limitation the laws and regulatory requirements of Hong Kong SAR.

4. Personal Data Confidentiality

The personal data you provide to Avo Insurance will be kept confidential, except that it may be shared with following parties:-

a. Avo Insurance will transfer personal information to the following persons who may collect and use this information only as reasonably necessary to carry out the purposes described above: insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organisations that consolidate claims and underwriting information for the insurance industry; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information;

b. any subsidiary, holding company, associated company or affiliates of Avo Insurance for any of the purposes set out in section 3a and b;

c. Any agent, contractor or third party service provider, including but not limited to providers of risk intelligence, loss adjusters, private investigators, letter shopping service providers and debt collectors who provides administrative, telecommunications, computer, internet, payment or other services to Avo Insurance for any of the purposes set out in section 3a;

- d. Any actual or proposed reinsurers of Avo Insurance for any of the purposes set out in section 3a;
 - e. Any co-branding partners and our business partners for any of the purposes set out in section 3a and b; and
 - f. Any person to whom Avo Insurance is under an obligation to make disclosure under the requirement of any law or regulation binding on or applicable to Avo Insurance or any of our group companies.
5. Personal Data Access / Correction Request
- a. You have the right to check whether Avo Insurance holds personal data about you and of access to and correction of your personal data.
 - b. Avo Insurance has the right to charge a reasonable fee for the processing of any personal data access request.
 - c. Requests shall be made in writing to our Personal Data Protection Officer, Avo Insurance Company Limited, 5/F, 160 Des Voeux Road West, Sai Ying Pun, Hong Kong SAR.
6. We reserve the right to change this Statement.

維護和保密所有客戶的個人資料是安我保險有限公司（「本公司」）的政策。本公司會一直遵守和確保員工嚴格遵守《個人資料（私隱）條例》（「條例」）的所有規定。

1. 本公司所收集及 / 或持有的個人資料
在閣下查詢或提交由本公司提供的產品或服務的表格時，本公司將會收集個人資料如姓名、身份證、出生日期、電郵地址、電話號碼、保單號碼、醫療及健康紀錄、以及問題或意見。
2. 個人資料收集的重要性
本公司會不時地要求提供閣下的個人資料。向本公司提供閣下的個人資料是自願的。若閣下沒有按照本公司的要求提供該等資料，可能會令本公司無法向閣下提供或繼續提供保險產品及服務。
3. 個人資料收集和使用的目的
閣下的個人資料可能會用於以下目的:-
- a. 保險管理或再保險業務有關的用途，其中包括承保、處理和評估申請、身份和信用檢查、適用性檢查、保單服務、理賠處理、調查、賬戶 / 債務追收、訴訟、通訊、編制統計、數據分析和研究、內部 / 外界審計、保持優質的服務、銷售和營銷；
 - b. 安我保險有限公司將收集、使用和披露我的個人資料（包括以往申索紀錄），以用作處理我的申請、調查和解決申索、以及偵測和防止欺詐行為（無論是否與就此申請而發出的保單有關）所需的目的。
 - c. 在對本公司或其附屬機構具有約束力的任何法律、法規、規例、實務守則或指引的要求下（包括但不限於香港法例及監管的要求），向任何適用的監管機構、政府機構或相關行業的認可機構進行披露。
4. 個人資料保密
本公司會對閣下的個人資料加以保密，但可能會與下列各方透露該等資料:-
- a. 安我保險有限公司將把個人資料轉移給以下人士，而他們只能在有合理需要履行上述目的之情況下才可收集和使用這些資料：保險理算人、代理和經紀；僱主；醫護專業人士；醫院；會計師；財務顧問；律師；整合保險業申索和承保資料的組織；防欺詐組織；其他保險公司（無論是直接地，或是通過防欺詐組織或本段中指名的其他人士）；警察；和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊（及其運營者）；
 - b. 任何本公司的附屬公司、控股公司、聯營公司或聯屬公司作在第3a和b段中所列出的任何用途；
 - c. 任何本公司的代理人、承包商或會向本公司提供行政、電訊、電腦、網際網路、付款或其他服務的第三方服務供應商（包括但不限於風險分析顧問、公證行、私人調查員、信函裝封服務機構及財務公司）作在第3a段中所列出的任何用途；
 - d. 任何本公司的實際或建議再保險公司作在第3a段中所列出的任何用途；
 - e. 任何品牌合作伙伴及本公司生意伙伴作在第3a和b段中所列出的任何用途；及
 - f. 在對本公司或其任何集團公司具有約束力或適用性的任何法律或法規的要求下而使本公司有責任對其進行披露的任何人士。
5. 個人資料的查閱 / 改正要求
- a. 閣下有權查詢本公司是否持有關於閣下的個人資料及查閱這些資料及改正不準確的資料；
 - b. 本公司有權就處理任何個人資料查閱要求收取合理的費用；
 - c. 有關要求須以書面提交香港西營盤德輔道西160號5樓安我保險有限公司的個人資料保護主任。
6. 我們保留更改本聲明的權利。

(If any conflict or inconsistency between the English and Chinese versions, the English version shall prevail. 中文譯本內容如與英文本有歧異，一概以英文為準。)



**Part 2 is to be completed by the claimant's attending Registered Medical Practitioner
at the claimant's own expense.**

第二部分須由索償人之主診註冊醫生填寫，所需費用由索償人自行承擔。

Patient Basic Information 病人基本資料		
Name of Patient 病人姓名	HKID Number 香港身份證號碼	
Name of Hospital / Clinic admitted 入住醫院 / 診所名稱		
Hospitalisation Period (DD/MM/YYYY, hh:mm) 入院日期 (日 / 月 / 年 · 時 : 分)	From 由	To 到
Level of ward class 入住病房級別		
<input type="checkbox"/> Day Centre / Clinic 日間中心 / 診所	<input type="checkbox"/> Semi-private 半私家房	
<input type="checkbox"/> Ward 普通病房	<input type="checkbox"/> Private 私家房	
Consultation Details 診症詳情		
1. Clinical History 門診病歷		
Symptom(s) or diagnosis(s) 病徵 / 診斷結果		
First consultation date 首次求診日期 (DD/MM/YYYY 日 / 月 / 年)	How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前已患有此症多久?	
2. Hospitalisation Details 住院詳情		
Final diagnosis 最後診斷	Date of operation 手術日期 (DD/MM/YYYY 日 / 月 / 年)	
Operation procedure(s) performed 手術詳情		
If the patient has been referred to other Registered Medical Practitioner during this hospitalisation, please provide the following 如病人於是次住院期間曾被轉介向其他註冊醫生求診，請提供以下資料		
Name of Registered Medical Practitioner consulted 求診註冊醫生姓名		
Reason(s) and treatment(s) performed by physician 求診原因及治療詳情		
Please give a brief discharge summary (including onset and duration of sign and symptoms / disease, etiology, types and results of major examinations, treatments, complications and follow up plan) 請提供出院摘要 (包括病發及疾病徵狀、病因、類型及主要檢查、治療、併發症之結果及跟進計劃)		
Please provide reason(s) of hospitalisation if this type of cases can be managed on day care / out-patient basis 如這類個案可於日間護理 / 門診護理處理，請提供入住醫院原因		

3. Professional Comment 專業意見		
Is this a chronic/recurrent illness? 此情況是慢性 / 復發性疾病?		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
To the best of your knowledge, has the patient ever had the same or similar symptoms/medical conditions before? If yes, please state the date of consultation, details of conditions and diagnosis 據閣下所知，病人是否曾經患有同一或相似病徵？如有，請提供詳情		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
Was the condition due to / associated with the following? (Please tick the appropriate boxes) 上述情況是否由於或與以下問題相關？(請選擇適當空格)		
<input type="checkbox"/> Accidental bodily injury 意外身體受傷	<input type="checkbox"/> Pregnancy 懷孕	<input type="checkbox"/> Congenital condition 先天性疾病/異常
<input type="checkbox"/> Developmental condition 發展障礙	<input type="checkbox"/> Self-inflicted injury 自我傷害	<input type="checkbox"/> Infertility or sterilisation 不育或絕育
<input type="checkbox"/> Contraception 避孕	<input type="checkbox"/> Hereditary condition 遺傳性問題	<input type="checkbox"/> Abuse of drugs or alcohol 濫用藥物或酒精
<input type="checkbox"/> Mental disorder 精神紊亂	<input type="checkbox"/> General check-up 一般身體檢查	<input type="checkbox"/> Refractive error 視力問題
<input type="checkbox"/> Treatment for cosmetic purpose 美容手術	<input type="checkbox"/> Vaccination 疫苗接種	<input type="checkbox"/> N/A 不適用
<input type="checkbox"/> Venereal disease, sexually transmitted disease or AIDS / HIV related illness 性病、性傳染病或愛滋病 / 與愛滋病毒有關的疾病		
4. Others 其他		
a. If the patient was referred by other physician, please provide the referring physician's name and address 如病人為其他醫生轉介，請提供該轉介醫生之姓名及地址		
b. (Only applicable to Claimable Amount Estimate of VHIS Product) Compared with Claimable Amount Estimate, are there any variations on the medical services actually received (e.g. cost and treatment)? If yes, please provide reason(s) (僅適用於自願醫保產品初步評估) 與可賠償金額估算相比，實際接受之醫療服務有否任何改變(例如費用及治療)? 如有，請提供原因		
c. Are you the patient's usual physician? 閣下是否該病人的慣常醫生?		<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否
Declaration 聲明		
I hereby certify that all information given above is accurate and true to the best of my knowledge. 本人特此聲明，就本人所知，上述所有資料均準確無誤。		
_____ Contact Telephone Number 聯絡電話號碼	_____ Email Address 電郵地址	_____ Fax Number 傳真號碼
_____ Signature of the Registered Medical Practitioner with official chop 註冊醫生簽署及蓋章	_____ Name of Registered Medical Practitioner 註冊醫生姓名	_____ Signature Date 簽署日期