redefining / standards

Policy Number 保單編號：

MediPartner Health Plan
安盛安心醫療計劃
Pre-authorisation Form I
預先授權申請表 I

Customer Service Hotline 客戶服務熱線：(852) 2802 2812 **Fax 傳真號碼：(852) 2285 6297**

To be completed by the Insured/claimant 由被保人/索償人填寫 -

Important note :

1. This form is to be filled by the Insured/claimant. Please do not sign on a blank form and do use the same signature as the policy record.
2. No fees, commission or charges of whatever nature are payable to Financial Consultant or Employees of The Company in respect of this claim.
3. To enable us to process your application promptly, please answer all questions in this form fully and accurately.
4. Please submit a copy of the identification document of the Insured and/or Policyholder, unless submitted before, together with this form.
5. The Guaranteed amount is valid for 30 days from the date of approval.

重要事項：

1. 此申請表應由被保人/索償人填寫。請勿在空白申請表上簽署，而簽名式樣須與保單的記錄相符。
2. 有關本索償，客戶無需支付任何手續費、佣金或其他任何性質的費用予本公司的理財顧問或其他僱員。
3. 請回答此申請表上的所有問題，以供我們批核閣下的申請。
4. 如在之前未有遞交被保人及/或持有人的身份證明文件，請隨此申請表一併遞交。
5. 預先授權獲批核的金額由批核當日起有效期為30日。

"The Company" : AXA China Region Insurance Company (Bermuda) Limited (Incorporated in Bermuda with limited liability)
"本公司"或"貴公司"：安盛保險(百慕達)有限公司(於百慕達註冊成立的有限公司)

Financial Consultant's Name 理財顧問姓名	Financial Consultant's Code 理財顧問編號	Financial Consultant's Contact No. 理財顧問聯絡電話

1. Details of Insured 被保人資料

Full name of Insured 被保人姓名	HKID Card/Passport No. 香港身份證 / 護照號碼	Date of birth (dd/mm/yyyy) 出生日期 (日 / 月 / 年)

2. Cause of hospitalisation 住院原因

1) If caused by illness 若由疾病導致

Date symptoms first noticed 病徵首次出現日期

Diagnosis 診斷

First consultation date 首次求診日期

2) If caused by an accident 若由意外導致

Date and time 日期及時間

Place 地點

Description 意外詳情

3) Have you previously suffered from or been treated for the same symptoms or disability in the past 5 years? If "Yes", please provide details below.
過去五年曾否患有上述傷病或就上述傷病接受治療？如有，請在下面提供詳情。

Date 日期	Disease / Disorder(Details of treatment) / 疾病 (治療詳情)	Medical practitioner / Hospital 醫生 / 醫院	Contact Details 聯絡詳情

CHK1MEDIC1

LFC018-1504

3. Deductible/Shortfall (Credit Card Authorisation) 自付額/欠繳費用(信用卡授權)

Please note that the deductible amount (if applicable) ("Deductible Amount") must be paid before the approval of Pre-authorisation. Shortfall may occur if final costs for treatment exceed the applicable limits in the Benefit Schedule or the treatment is not eligible under the Basic Plan ("Shortfall"). You can pay by credit card for the Deductible Amount / Shortfall (where applicable). This form authorises The Company to collect the Deductible Amount / Shortfall (where applicable) from the credit card as detailed below.

請注意在預先授權批核前，必需繳付自付額(如適用)。若最終的治療費用超出最高的適用賠償額或不符合保單規定的資格，閣下可以以信用卡授權去繳付自付額 / 欠繳費用(如適用)。如選擇信用卡授權，而本公司會於下列信用卡帳戶收取自付額 / 欠繳費用(如適用)。

Deductible Amount*
自付額* ☐HKD 0 ☐HKD 15,000 ☐HKD 30,000

Credit Card Authorisation 信用卡授權

The credit card holder must be the Insured/Policyholder of this policy. The Shortfall advice will be sent to you 15 days prior to the charging of the Shortfall from your credit card.

持卡人必須為此保單之被保人 / 保單持有人。 本公司將於收取差額費用15天前郵寄欠繳費用付款通知書通知閣下。

I hereby authorise and direct AXA China Region Insurance Company (Bermuda) Limited (Incorporated in Bermuda with limited liability) to charge the Deductible Amount / Shortfall (where applicable) from my credit card account.

本人授權及指示安盛保險(百慕達)有限公司(於百慕達註冊成立的有限公司)從本人之信用卡戶口扣除自付額 / 欠繳費用（如適用）。

Please fill in the Credit Card Payment Authorisation.
請填妥信用卡付款授權書。

* The exact Deductible Amount will be reflected in the Letter of Confirmation which will be issued once your Pre-Authorisation application is approved. The Company reserves the right to debit the Shortfall (if any) that may exceed the specified Deductible Amount.

*自付額的確實金額將以是次預先授權申請獲批核後發出的「確認信」為準。本公司將保留收取欠繳費用（如有）的權利，而該金額或高於上列所註明之自付額。

4. Declaration and authorisation 聲明及授權

I HEREBY DECLARE AND AGREE on behalf of myself and other person referred to this form that all statements and answers to all questions are to the best of my /our knowledge and belief complete and true.

I HEREBY AUTHORISE that (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of me/us to disclose such information to the Company as the Company may request; (2) the Company or any of its appointed medical examiners, paramedical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ourselves in relation to this application and any claim arising therefrom. This authorisation shall bind the successors and assignees of the Relevant Persons and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.

The updated version of AXA PICS is available for download from its website: www.axa.com.hk, and is made available upon request.

本人謹此代表本人及其他在此申請表提及之人士聲明及同意上述一切陳述及問題的所有答案，就本人/我們所知所信，均為事實全部並確實無訛；
本人謹此代表相關人士授權(1)任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構、或其他組織、機構或人士，凡知道或持有任何有關本人/我們之記錄，均可應貴公司要求將該等資料提供給貴公司；(2)貴公司或任何其指定之驗身醫生、醫療人員或化驗所，可就 此申請或任何與此有關之賠償申請替本人/我們進行所需之醫療評估及測試，作為審核本人/我們之健康狀況。此授權對相關人士之繼承人及受讓人具有約束力；即使相關人士死亡或無行為 能力時，此授權仍具效力。此授權書的影印本與正本均有同等效力。

AXA 個人資料收集聲明的最新版本可於以下網址下載：www.axa.com.hk，及可向貴公司索取。

Name of claimant+ 索償人姓名+	Signature of claimant+ 索償人簽署+	Signature date 簽署日期
HKID Card/Passport No. 香港身份證/護照號碼	Nationality 國籍	Relationship to Insured 與被保人關係
Correspondence address 通訊地址		Mobile phone no. 流動電話號碼

Residential address (if different from Correspondence address above) 住宅地址（如與上述通訊地址不同）	Permanent address (if different from Correspondence address above) 永久地址（如與上述通訊地址不同）

Name of Financial Consultant/witness 理財顧問/見証人姓名	Signature of Financial Consultant/witness 理財顧問/見証人簽署	Signature date 簽署日期

+ Claimant refers to Insured (if the Insured is 18 years old or above) or Policyholder (if the Insured is below 18 years old).
+ 索償人指被保人(如被保人為十八歲或以上)或保單持有人(如被保人為十八歲以下)。

Credit Card Payment Authorisation 信用卡付款授權書

"The Company"
"本公司"或"貴公司"

AXA China Region Insurance Company (Bermuda) Ltd
(Incorporated in Bermuda with limited liability)
安盛保險(百慕達)有限公司(於百慕達註冊成立的有限公司)

1. Credit Card Authorisation and Declaration 信用卡付款授權和聲明

I HEREBY AUTHORISE The Company to charge the Deductible Amount / Shortfall (where applicable) of the following policy with The Company bearing the policy number(s) shown below to my credit card account in accordance with instructions The Company may give to Citibank (Hong Kong) Limited from time to time. I understand that the amount of the Deductible Amount / Shortfall (where applicable), is in accordance with the provisions of the policy.

本人同意授權 貴公司，按其不時給予花旗銀行(香港)有限公司之指示，於本人之信用卡帳戶內，扣除在 貴公司編有下列保單的自付額/欠繳費用(如適用)。本人明白自付額/欠繳費用(如適用)將根據保單條款而轉變。

I HEREBY also authorise the Company to disclose my information in below section to Citibank (Hong Kong) Limited from time to time.

本人授權貴公司不時提供本人在下欄之資料予花旗銀行(香港)有限公司。

I HEREBY AGREE that any notice of cancellation or variation of this authorisation shall be given directly to the Company in writing at least one month prior to the date on which such cancellation or variation is to take effect.

本人同意若本人欲取消或更改此授權書，須於取消或更改生效一個月前以書面通知貴公司。

I/We hereby declare that the below information is true, accurate and complete and agree to fully indemnify and hold the Company harmless from any loss, claim, damage, proceeding, cost, expense and liability directly or indirectly suffered or incurred by the Company in connection with the disclosure of any of the information contained herein or process any such transfer(s) or payment(s).

本人/我們謹此聲明下述之資料乃屬真實、準確及完整，並同意對貴公司作全面賠償擔保，不使貴公司因披露本授權書中之任何資料或處理任何該等轉帳或付款因而令貴公司直接或間接遭受或招致任何損失、申索、損害、訴訟、費用、支出及責任。

The updated version of AXA PICS is available for download from its website: www.axa.com.hk, and is made available upon request.

AXA 個人資料收集聲明的最新版本可於以下網址下載：www.axa.com.hk，及可向貴公司索取。

2. Policy details/Credit card details 保單資料/信用卡資料

Policy Number 保單號碼	Full name of Insured 被保人姓名	Policyholder's Name 持有人姓名

Cardholder's Name:
持卡人姓名：

Credit Card Account No:
信用卡賬戶號碼：

Expiry Date:
有效日期至：

Type of Credit Card (Please tick the appropriate box):
信用卡類別(請於適當格子內加上✓號)：
☐ VISA
☐ Master

IMPORTANT : PLEASE DO NOT SIGN ON BLANK FORM
請勿在空白表格上簽署

Signature of Cardholder (must be consistent with signature of your credit card) 持卡人簽署 (須與信用卡紀錄相符)	Signature of Policyholder 持有人簽署	Date(YYYY/MM/DD) 日期(年/月/日)