CHUBB

Agent's/Intermediary's name 保險代理 / 中介人姓名
Agent's/Intermediary's contact phone no. 保險代理 / 中介人聯絡電話
Agent's/Intermediary's code 保險代理 / 中介人代號
Agency 組別 ___ – ___

Claim Form - Hospitalization/Surgery

住院 / 手術賠償申請書

Claim Type 賠償類別

- ☐ Hospital & Surgery Benefit
- ☐ Hospital Cash Benefit
- ☐ Select Top Up Medical Benefit
- ☐ VCARE Cancer Protector Benefit

☐ New claim 首次索償	☐ Pending claim 待決索償	☐ Further claim 再度索償	☐ Review/appeal 重批/覆核
	Please provide claim no. for reference 請提供賠償編號以作參考		

Part I (To Be Completed by Claimant/Insured) 甲部（由索償人 / 受保人填寫）

A. Insured's Particulars 受保人資料

Policy no. 保單編號	Insured's name 受保人姓名	HKID card/passport no. 香港身份證 / 護照號碼	Date of birth 出生日期 DD日MM月YYYY年 / /	Sex 性別	Age 年齡	Tel. no. 電話號碼

B. Employment Particulars 就業詳情

1. Present occupation 現時職業	Duties 工作範圍	Employer's name, address & tel. no. 僱主名稱、地址及電話

If more than one occupation, state all and exact nature of occupational duties. 若有兼職請全部列明，並詳述職位及職責。

2. Did you file a medical leave certificate to your employer? 有否向僱主遞交病假證明書？ ☐ Yes 有 ☐ No 沒有

3. Did you submit a claim for workmen's compensation for this accident? 有否就此意外申請勞工賠償？ ☐ Yes 有 ☐ No 沒有

Submission date 遞交日期：(/ /)
DD日 MM月 YYYY年

C. Other Insurance Coverage 其他保險資料

Does the Insured have any other insurance policy covering this case? 受保人會否就是次索償獲得其他保險賠償？ ☐ Yes 有 ☐ No 沒有

If "Yes", please complete below particulars. 若有，請詳細填寫以下資料。

Name of insurer 投保公司	Policy no. 保單號碼	Benefit type 保障類別	Benefit amount 保障金額

As part of our endeavour to keep our records updated and to maintain high quality of service, we sincerely invite you to provide us your email address. Please visit our website https://eservice.chubblife.com.hk to update your email address.
為使能為閣下提供更完善的服務及本公司可不時更新客戶個人資料，本公司現誠邀閣下使用本公司網上服務 https://eservice.chubblife.com.hk，以提供閣下的電郵地址。

D. Details Of Hospitalization Or Surgery 住院或手術詳情

1. Name of hospital/clinic 醫院 / 診所名稱	Confinement/Surgery period 住院 / 手術時段	Name of attending doctor 主診醫生姓名
a.	a. From 由 (/ /) To 至 (/ /) DD日 MM月 YYYY年 DD日 MM月 YYYY年	a.
b.	b. From 由 (/ /) To 至 (/ /) DD日 MM月 YYYY年 DD日 MM月 YYYY年	b.

2. Have you taken any home leave during hospital confinement? 有否於住院期間請假外出？ ☐ Yes 有 ☐ No 沒有
If yes, please state the date and time of your home leave 如有，請列明外出之日期及時間

3. Hospitalization or surgery due to accident 因意外住院或手術

a. When (date and time) did the accident occur? 意外在何時（日期及時間）發生？	(/ /) (:) ☐ AM 上午 DD日 MM月 YYYY年 HR時 MIN分 ☐ PM 下午
b. Where did the accident occur? 意外在何地發生？	
c. How did the accident occur? (Please describe in details) 意外如何發生？（請描述詳情）	
d. Which part of the body injured and type of injury? 受傷部位及傷勢？	

4. Hospitalization or surgery due to illness 因病住院或手術

a. Describe the symptoms & abnormalities which led to the hospitalization or surgery 請描述導致受保人是次入院或手術的不適及病徵	
b. Details of first consultation for the illness 初診詳情	Date of first consultation 初診日期 (/ /) DD日 MM月 YYYY年 Doctor's name 醫生姓名 _____ Address of the doctor 醫生地址 _____ Details 詳細情形 _____
c. Since when the insured had the sign or symptom first appeared? 受保人何時出現上述徵兆或症狀？	(/ /) DD日 MM月 YYYY年
d. Has the insured been treated by other doctor(s) for similar or related illness in the past? 受保人有否因相同或有關病症而求診於其他醫生？	☐ Yes, please state 如有，請詳述 ☐ No 沒有 Date of first consultation 初診日期 (/ /) DD日 MM月 YYYY年 Doctor's name 醫生姓名 _____ Address of the doctor 醫生地址 _____ Details 詳細情形 _____

E. Details Of Usual Doctor 經常求診醫生詳情

Name and address of the insured's usual doctor 受保人經常求診之醫生姓名及地址：

Payment Instruction 賠款方式

☐ HKD Cheque 港幣支票

☐ HKD Bank Draft 港幣本票 (drawn in Mainland China 於中國內地兌現)

☐ Telegraphic Transfer (TT) 電匯

☐ Direct Credit to Bank Account 直接存入銀行戶口 (Credit to existing premium collection account only 只轉賬至現時用於繳交保費之戶口)

Cheque will be delivered to policyowner 發送支票予保單持有人方法：

☐ by Agent's/intermediary's 予保險代理 / 中介人　　☐ by mail 郵寄

Remarks 備註：

1) For TT payment, please provide the SWIFT code, bank name, bank address and bank account number.
   若選擇電匯，請提供銀行代號、銀行名稱、銀行地址及戶口號碼。
2) Bank charges may be incurred by client for clearing the bank draft and TT. Policyowner is recommended to check with the bank before applying this instruction.
   銀行或會向閣下徵收兌現本票或電匯的相關手續費。建議保單持有人於遞交指示前先向銀行查詢。
3) For payment by direct credit to bank account, bank account holder must be the Policy Owner and only apply to HK$50,000 or below payment amount.
   若選擇直接存入銀行戶口，銀行戶口持有人必須為保單持有人及只適用於港幣50,000元或以下的賠償金額。
4) If no option is selected or unclear information, the claim payment will be settled by cheque and mailed to correspondence address directly.
   如沒有選擇或資料不清，賠償金額將以支票發出，並直接寄予通訊地址。

For Agent's/Intermediary's Use Only 保險代理 / 中介人適用

Attachment	☐ Sick leave certificate 病假證明書	☐ Copy/original receipt(s) issued by registered doctor 由註冊醫生所發出之收據副本 / 正本	☐ Copy/original receipt(s) issued by non-registered doctor 由非註冊醫生所發出之收據副本 / 正本
	☐ HKID card copy of insured 受保人之香港身份證副本	☐ HKID card copy of policyowner 保單持有人之香港身份證副本	☐ Others 其他 _____

I/We have verified the original HKID card/passport/residential address proof of the policyowner and confirmed the identity details in the HKID card/passport to be matched with the identity of the policyowner in this claim form. I/We will provide the required information and copies of the relevant documents to Chubb Life Insurance Company Ltd. without delay.

本人 / 吾等已核對保單持有人之香港身份證 / 護照 / 居住地址證明之正本，並確認香港身份證 / 護照之身份資料與此賠償申請書上保單持有人之資料一致。本人 / 吾等將會儘快遞交有關文件之副本予安達人壽保險有限公司。

Agent's/intermediary's name　　Agent's/intermediary's code　　Agency

保險代理 / 中介人姓名：_____ 保險代理 / 中介人代號：_____ 組別：_____

Agent's/ intermediary's signature 保險代理 / 中介人簽署：_____ Sign date 簽署日期：_____

Important Note 注意事項

In order to speed up your claim application, please attach the below documents together with this application form. Should any extra information or document be required for your claim processing, we will notify you or your agent or intermediary. Meanwhile please tick against the Required Documents submitted with this application form. 為使能儘速辦理您的索償申請，請將此表格連同以下文件遞交。如需要額外資料或文件，我們將另函通知閣下或閣下的保險代理或中介人。請於連同此表格提交的基本文件欄內劃上“X”號。

Claims Document Checklist 索償文件參考表 **Document Type 文件類別**	Hospital & Surgical Benefit (HS) 住院及手術賠償	Hospital Cash Benefit (HC) 住院現金
☐ Claim Form - Hospitalization/Surgery Part II - Attending Physician's Statement 住院 / 手術賠償申請書－乙部－主診醫生報告	✓	✓
☐ Laboratory/X-Ray/CT Scan/MRI/pathological report(s) 化驗 / X-光 / 電腦掃描 / 磁力共震 / 病理檢驗報告	✓	✓
☐ Certified true copy of travel document for overseas hospitalization by Chubb 由Chubb核證之旅遊文件（海外住院適用）	✓	✓
☐ Original medical/hospital receipts and statement of charges (Claimed amount:) 醫療 / 醫院收據及收費單正本（索償金額： ）	✓	*
☐ Hospital discharge summary/sick leave cert. with clear diagnosis (Period: From To) 列有診斷證明之出院總結 / 病假證明書（時段：由 至 ）	✓	✓
☐ Photocopy of medical/hospital receipt and statement of charges 醫療 / 醫院收據及收費單副本	*	✓
☐ Compensation breakdown from other insurer party 其他保險公司 / 機構之賠償細算表	✓	*
☐ Patient card copy of consulted doctor(s) 病人覆診卡副本	*	*
☐ Police report/traffic accident report/statement 警察報告 / 交通意外報告 / 口供紙	*	*
☐ Copy of HKID card/passport/birth certificate copy of the Insured 受保人香港身份證 / 護照 / 出生證明書副本	✓	✓
☐ Copy of HKID card/passport/business registration document of the policyowner 保單持有人香港身份證 / 護照 / 商業登記文件之副本	✓	✓

✓ Required Documents 基本文件 **✲ Optional Documents 附加文件**

Note: We reserve the right to request for the submission of the optional documents if necessary. 本公司保留要求客戶提交附加文件之權利。

F. Declaration 聲明

PERSONAL INFORMATION COLLECTION STATEMENT AND CONSENT I/WE UNDERSTAND AND CONSENT THAT, by signing the claim form, any personal data collected or held by Chubb Life Insurance Company Ltd. (the "Company") is provided and may be used, processed, stored, disclosed, transferred by the Company to the companies within the group of which the Company is a subsidiary (the "Group Companies"), its authorized agents, reinsurers, claims investigators, loss adjudicators, medical advisors, recovery agents, insurance industry associations and federations, credit reference bureaus, government or judicial or regulatory bodies or any person to whom the Company is under legal and/or regulatory obligation to make disclosure, and the Company's appointed third party agents, contractors and advisors, in each case whether within or outside of Hong Kong to (i) process and evaluate claims and any future insurance application I/we may make; (ii) provide all services related to this claim, administer and process policy, medical and underwriting checks, payment instructions, premiums collection, data matching, and communicate with me/us for such purposes; (iii) enable the industry associations, the federations, the government or regulatory bodies to carry out the functions and requirements that may be assigned to them from time to time and are reasonably required in their interest and that of the insurance industry; and (iv) provide payment, data processing, administration, communications, computer, security and other services (including medical services, emergency assistance services, mailing and IT services) in connection with the operation of the Company and the provision of services to me/us. Moreover, the Company is hereby authorized to obtain access to and/or to verify any of my/our data with the information collected by the insurance industry associations, the federations, the government and regulatory bodies and medical personnel or organizations. I/We am/are obliged to supply the information required from me/us under the claim form which is a condition precedent for me/us to apply the claim. Failure to supply the required information may result in the Company being unable to process the claim. I/We understand that I/We have the right to obtain access to and to request correction of any personal data held by the Company or be given reasons for any refusal of access or correction. I/We also understand that a reasonable fee may be charged by the Company for processing of any access. Any questions regarding personal data, access to or correction of personal data should be made in writing and forwarded to The Data Protection Officer of Life Administration of Chubb Life Insurance Company Ltd. at 33/F, Chubb Tower, Windsor House, 311 Gloucester Road, Causeway Bay, Hong Kong. **個人資料收集聲明及授權**就簽署此賠償申請書，本人／吾等明白及同意安達人壽保險有限公司（「貴公司」）可以使用、處理、儲存、透露、轉移任何貴公司所收集或持有任何本人／吾等的個人資料與貴公司隸屬同一集團附屬公司之其他公司（「集團公司」）、其獲授權的代理人、再保險公司、理賠調查員、處理索賠個案的理賠師、醫療顧問、索償代理、保險行業協會及聯會、信貸資料服務公司、政府或司法或監管機構或對貴公司具有法律及／或監管責任而須予以披露的任何人士，及貴公司指定的第三方代理、承包商及顧問，不論屬本地或海外，以 (i) 處理及審批索償及本人／吾等將來提交之保險申請 ；(ii) 提供所有關於此賠償申請之服務，管理及處理保單、醫療和核保檢查、付款指示、保費收取、資料核對，及因此等用途與本人／吾等聯絡 ；(iii) 令保險行業協會及聯會、政府或監管機構執行其經不時修定及為合理要求以維護其及保險行業利益的功能及規定；及 (iv) 提供因貴公司營運及給予本人／吾等服務之相關付款、數據處理、行政、通訊、電腦、保安及其它服務（包括醫療服務、緊急救援服務、郵寄服務及資料科技服務）。此外，貴公司獲授權向保險行業協會及聯會、政府及監管機構、及醫務人員或機構取閱及／或核實任何該等機構向本人／吾等收集之資料。本人／吾等有責任提供此賠償申請書上之所需資料，以作為申請賠償之先決條件。如未能提供所需的資料，可能會導致貴公司無法處理本賠償申請。本人／吾等明白本人／吾等有權取閱及要求更正任何貴公司持有之有關本人／吾等的任何個人資料，或被給予拒絕查閱或更正的理由。本人／吾等亦明白貴公司可能會收取任何查閱資料的要求之合理費用。如欲查詢有關個人資料事宜，查閱或更正個人資料必須以書面形式向貴公司壽險行政部的資料保護主任提出，並送交至香港銅鑼灣告士打道三一一號皇室大廈安達人壽大樓三十三樓。

G. Authorization 授權

I hereby irrevocably authorize or authorize on behalf of the Insured (if different) (i) any employer, doctor, hospital, clinic, insurance company, government office or any organizations or persons who have any records, knowledge or information (whether medical or otherwise) of me or the Insured (if different) to disclose, release or transfer to Chubb Life Insurance Company Ltd."the Company"or its representative such information pertinent to this claim; (ii) the Company or any of its appointed medical/para-medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate my or the Insured (if different) health status in relation to this claim. This authorization shall bind my and the Insured's successors and assignees and remain valid notwithstanding my or the Insured's death or incapacity in so far as legally possible. A photocopy of this Authorization shall be valid as the original. 本人或受保人授權 （如有不同）(i) 任何僱主、醫生、醫院、診所、保險公司、政府部門，或其他機構及人士，如具有本人／受保人（如不同）的任何紀錄、知識或資料，可將該等資料向貴公司或貴公司代表透露、發放或移交，用以作為該份索償申請的參考； (ii) 貴公司或貴公司委任的醫療／輔助醫療檢查員或檢驗所，就有關索償的申請，進行醫療評估或測驗，以檢定本人／受保人（如有不同）的健康狀況。該授權書對本人／受保人的繼承人及承讓人均有約束力，即使在本人／受保人（如有不同）死亡或喪失行為能力後仍然有效。該授權書的影印本具有與正本同等的效力。

<table>
<tr><td>Agent's/intermediary's code
保險代理/中介人號碼</td><td>Signature of insured
受保人簽署</td><td>Signature of policyowner (if other than insured)
保單持有人簽署（如並非受保人）</td></tr>
<tr><td rowspan="2">Signature of witness/agent/intermediary
見證人／保險代理／中介人簽署</td><td>Date
日期</td><td>Date
日期</td></tr>
<tr><td>Full name of insured
受保人姓名</td><td>Full name of policyowner*
保單持有人姓名*</td></tr>
<tr><td rowspan="2">Name of witness/agent/intermediary in full
見證人／保險代理／中介人姓名</td><td>HKID card/passport no. of insured
受保人香港身份證／護照號碼</td><td>HKID card/passport/BR no. of policyowner*
保單持有人香港身份證／護照／商業登記號碼*</td></tr>
<tr><td>Date of birth of insured
受保人出生日期</td><td>Date of birth of policyowner*
保單持有人出生日期*</td></tr>
<tr><td>Date
日期</td><td>Nationality of insured
受保人國籍</td><td>Nationality of policyowner*
保單持有人國籍*</td></tr>
</table>

* In compliance with the Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance and the Guideline on Anti-Money Laundering and Counter-Terrorist Financing which is issued by the Office of the Commissioner of Insurance as amended from time to time, Chubb Life Insurance Company Ltd. is required to collect the identity information for the above items with asterisk (*) and verify the identity of the Policyowner. Your agent/intermediary, therefore, is needed to verify the original identification documents and collect the copies of the relevant and other documents as deemed necessary of the Policyowner.

* 根據打擊洗錢及恐怖分子資金籌集（金融機構）條例及保險業監理處所發出及不時修訂之「打擊洗錢及恐怖分子資金籌集指引」，安達人壽保險有限公司必須收取以上註有星號 (*) 項目之保單持有人身份資料並核實保單持有人之身份。閣下之保險代理／中介人必須核實保單持有人之正本身份證明文件，並收取有關及其他所須文件之副本。

Part II – Attending Physician's Statement (To Be Completed by Attending Physician at the Claimant's Own Expense)

乙部－主診醫生報告（由申請人自費，由主診醫生填寫） **Policy No.** | | | | | | | | | | |

A. General Information 一般資料

Patient's name 病人姓名	HKID card/passport no. 香港身份證 / 護照號碼	Date of birth 出生日期	Sex 性別	Age 年齡

Are you the patient's usual doctor? 閣下是否病人之慣常醫生？ ☐ Yes 是 ☐ No 否

B. Hospitalization Or Surgery Details 住院或手術詳情

Name of hospital/clinic 醫院 / 診所名稱	Admission/surgery date 入院 / 手術日期	Discharge date 出院日期

1. Date on which the patient first consulted you for the illness or injury. 病人就是次傷病首次向閣下求診之日期	(/ /) DD日 MM月 YYYY年
2. Please describe the signs, symptoms and complaints of the patient during first consultation. 請描述病人於首次求診時之徵兆、症狀及不適	
3. If the hospitalization or surgery was due to accident, please provide the date, time and details of the accident. 若因意外住院或接受手術，請提供意外日期、時間及詳情。	(/ /) DD日 MM月 YYYY年 (:) HR時 MIN分 ☐ AM 上午 ☐ PM 下午 Accident details 意外詳情 _____
4. a. When did the signs/symptoms first appear? 徵兆 / 症狀於何時出現？ b. How long had the signs/symptoms been presented prior to the first consultation? 該徵兆 / 症狀於首次求診時已存在多久？	a. (/ /) DD日 MM月 YYYY年 b. (/ /) DD日 MM月 YYYY年
5. If the hospitalization or surgery was due to accident, was there any evidence of visible contusion, an accidental cut or wound on the exterior of the patient's body at time of admission or first consultation? 若因意外住院或接受手術，於入院或首次求診時病人身體是否有明顯可見之瘀痕或傷口？	Please give details (if any) 請詳述（如有）
6. Had the patient had any history of these signs, symptoms or related illness? If "yes", please give details 病人過往曾否出現上述徵兆、症狀或診斷有關疾病？如有，請詳述	☐ Yes 有 ☐ No 沒有 (/ /) DD日 MM月 YYYY年 Disease/disorder 病況 _____ Details of treatment/hospitalization 治療 / 住院詳情 _____ Name of doctor/hospital 醫生 / 醫院名稱 _____
7. Was the patient referred to you by another doctor? If "yes", please give details including name & address of the doctor 病人是否由其他醫生轉介？如有，請提供該醫生姓名及地址	☐ Yes 有 ☐ No 沒有 Name of doctor 醫生姓名 _____ Address of doctor 醫生地址 _____
8. a. What was the diagnosis? 診斷為何？ b. What was the diagnosing date? 診斷在何時確定？	a. Diagnosis 診斷 b. Diagnosing date 診斷日期 (/ /) DD日 MM月 YYYY年

9. Medical treatment given and investigation procedures performed during the hospitalization and the results. 住院期間所需的治療、檢查及其結果	
10. Operation details 手術詳情	Name of the operation 手術名稱 Date of the operation 手術日期 (/ /) DD日 MM月 YYYY年
11. Please provide reason(s) why the relevant investigation test/ treatment could not be done as day patient (at outpatient setting)/ clinic/laboratory centre 請提供原因為何有關之檢查 / 治療不能於日間病房（於門診設置）/ 診所 / 化驗中心進行	
12. Did the patient need to stay in the Intensive Care Unit during the hospitalization? If "yes", please indicate the numbers of days of stay and the inclusive dates. 住院期間是否須要入住深切治療部？如是，請提供入住日數及日期	☐ Yes 是 ☐ No 否 No. of days 入住日數 _____ Dates inclusive 日期 _____
13. Had the patient taken any home leave during the hospital confinement? If yes, please state the date, time and reason of home leave. 病人是否於住院期間請假外出？ 如有，請列明外出之日期、時間及原因	☐ Yes 有 ☐ No 沒有 Date and time 日期及時間 _____ Reason 原因 _____
14. a. Did the patient suffer from any malignant tumor, cancer or carcinoma-in-situ? 病人是否患有任何惡性腫瘤、癌症或原位癌？	a. ☐ Yes 是 ☐ No 沒有 Site and organ involved 涉及部位及器官 _____
b. Was biopsy done for the patient? If yes, please provide date and result. 病人是否進行活組織檢查？如有，請提供檢查日期及結果。	b. ☐ Yes 是 ☐ No 沒有 (/ /) DD日 MM月 YYYY年 Result 結果 _____
c. Was any diagnostic / investigation test done for the patient? If yes, please provide date and result. 病人是否進行任何診斷程序 / 檢查。	c. ☐ Yes 是 ☐ No 沒有 (/ /) DD日 MM月 YYYY年 Result 結果 _____
d. Type of treatment administered for the patient 病人接受之治療。	d. ☐ Surgical 外科手術 ☐ Chemotherapy 化療 ☐ Radiotherapy 電療 ☐ Targeted therapy 標靶治療 ☐ Hormonal therapy 激素治療 ☐ Other(s) 其他 _____ Treatment date 治療日期 (/ /) DD日 MM月 YYYY年
e. Please provide details of the treatment including drug name, dosage, frequency, duration of treatment. 請提供治療詳情包括藥物名稱、劑量、頻率、治療時期。	e. Drug name 藥物名稱 _____ Dosage 劑量 _____ Frequency 頻率 _____ Duration of treatment 治療時期 _____
f. Please provide the date of completion of active treatment. 請提供完成積極治療之日期。	f. (/ /) DD日 MM月 YYYY年

15. Please indicate if the insured's medical condition and its subsequent treatment are associated with the following. If "yes", please give the details 請指出上述病人病況是否與下列情況有關，如是，請詳述	
a. Alcoholism/influence of alcohol or drug addiction? 酗酒 / 受酒精或服用藥物影響？	a. ☐ Yes 是 ☐ No 否 _____
b. Depression or anxiety? 情緒低落或精神緊張？	b. ☐ Yes 是 ☐ No 否 _____
c. Mental or functional disorder? 精神病態？	c. ☐ Yes 是 ☐ No 否 _____
d. Venereal disease? 性病？	d. ☐ Yes 是 ☐ No 否 _____
e. Pregnancy, miscarriage, child birth or any related complications? 懷孕、流產、生產或由此引發之病況？	e. ☐ Yes 是 ☐ No 否 _____
f. Congenital anomalies, infertility or sterilization? 先天性不正常情況、不育或絕育？	f. ☐ Yes 是 ☐ No 否 _____
g. Inherited condition? 遺傳性情況？	g. ☐ Yes 是 ☐ No 否 _____
h. Vaccination or immunisation injection? 疫苗接種或注射？	h. ☐ Yes 是 ☐ No 否 _____
i. Experimental treatment or novel drug/stem cell therapy not yet approved by relevant authorities? 醫療實驗治療或未經相關機構批准之新型藥物或幹細胞治療？	i. ☐ Yes 是 ☐ No 否 _____
j. Genetic test? 基因測試？	j. ☐ Yes 是 ☐ No 否 _____
k. General check up? 一般身體檢查？	k. ☐ Yes 是 ☐ No 否 _____
l. Narcotics not prescribed by doctor? 非由醫生處方之麻醉劑？	l. ☐ Yes 是 ☐ No 否 _____
m. Rest care, rehabilitation, convalescence or extended care? 休養、復康或延拓護理？	m. ☐ Yes 是 ☐ No 否 _____
16. To your best knowledge, has the patient ever been treated for any other serious disorders? If "yes", please state the details below 據閣下所知，病人過往是否曾接受任何嚴重病況治療？如有，請提供資料如下	☐ Yes 有 ☐ No 沒有 Disease / disorder 病況 _____ Details of treatment/hospitalization 治療 / 住院詳情 _____ Name of doctor / hospital 醫生 / 醫院名稱 _____

Signature (with chop) 簽署	Name of physician 主診醫生姓名	Tel. no. 電話號碼
Date 日期	Qualification 資歷	
Name of hospital/clinic 醫院/診所名稱		Tel. no. 電話號碼
Address of hospital/clinic 醫院/診所地址		Hospital/clinic stamp 醫院/診所蓋印

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