HOSPITALISATION & SURGICAL CLAIM FORM

For Individual/Employee Benefits/InternationalExclusive Members

For Employee Benefits Members only
(Not Applicable to InternationalExclusive Members)

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AXA China Region Insurance Company Limited
AXA General Insurance Hong Kong Limited

Mail the completed claim form to
Claims Department: P.O. Box. No. 90854,
Tsim Sha Tsui Post Office, Kowloon, Hong Kong
Policy No. starting with 1 & ZA/ZE ☎ (852) 2523 3061
Policy No. starting with 0/4/7 ☎ (852) 2519 1166

Policy No. starting with HA
Enquiry/Claim submission ☎ (852) 2867 8680
healthcare@axa.com.hk

Part I - TO BE COMPLETED BY THE INSURED

1. INSURED DETAILS

Please refer to your Health Card or e-Health Card for the following information. Your claim might be delayed if any of the following information is missing

Name of Employer/Policyholder			
Name of Employee (For Employee Benefits Member Only)		Name of Patient	
Policy No.		Member/Cert No. (For Employee Benefits Member Only)	_ _ _ _ _ _ _ _ — _ _
Mobile No. of Patient		Email of Patient	

☐ **For PortaProtection Policyholder**
Please "✓" this box If you would like to claim the balance of medical expense against your "PortaProtection" policy, please provide the **"PortaProtection"** policy no. below. Claim payment shall be made against the Employee Benefits Policy of the insured person first (if any). Any unpaid portion of the eligible expense shall then be paid under the PortaProtection Policy (subject to the coverage under this policy).

PortaProtection Policy No. _____

☐ **For other AXA Medical Insurance Policyholder**
Please "✓" this box If you would like to claim the balance of medical expense under other Medical Insurance policy(ies) you have with AXA (if applicable), please provide policy details below.

(1) Policy No. _____ Product _____

(2) Policy No. _____ Product _____

2. REQUEST FOR CERTIFIED TRUE COPY OF SUPPORTING DOCUMENT(S)

☐ **The original supporting document(s) including receipt(s) will not be returned**
Please "✓" this box if you want a certified true copy of original supporting document(s).

3. MEDICAL CONSULTATIONS

No reimbursement of claims shall be made for:
➢ Claims(s) submitted after 90 days from the date of consultation/treatment
➢ Insufficiency of required information
Please note that the final decision on the claim(s) will be subject to policy coverage, terms and conditions.

First Consultation	Doctor Name			
	Consultation Date	DD / MM / YYYY	Date of Symptoms First Noticed	DD / MM / YYYY
	Brief Description of Illness			
Have you had any prior treatment for this or related conditions? (If applicable)				
☐ Yes ☐ No	Date of Treatment	DD / MM / YYYY	Name of Physician	
Address of Clinic/ Hospital				
If treatment is due to pregnancy, please give expected date of delivery (if applicable)		DD / MM / YYYY		

4. PERSONAL INFORMATION COLLECTION STATEMENT

AXA China Region Insurance Company Limited / AXA General Insurance Hong Kong (referred to hereinafter as the "Company") recognises its responsibilities in relation to the collection, holding, processing, use and/or transfer of personal data under the Personal Data (Privacy) Ordinance (Cap. 486) (**"PDPO"**). Personal data will be collected only for lawful and relevant purposes and all practicable steps will be taken to ensure that personal data held by the Company is accurate. The Company will take all practicable steps to ensure security of the personal data and to avoid unauthorised or accidental access, erasure or other use.

Please note that if you do not provide us with your personal data, we may not be able to provide the information, products or services you need or process your request.

Purpose: From time to time it is necessary for the Company to collect your personal data (including credit information and claims history) which may be used, stored, processed, transferred, disclosed or shared by us for purposes ("Purposes"), including:

1. offering, providing and marketing to you the products/services of the Company, other companies of the AXA Group (**"our affiliates"**) or our business partners (see **"Use and provision of personal data in direct marketing"** below), and administering, maintaining, managing and operating such products/services;
2. processing and evaluating any applications or requests made by you for products/services offered by the Company and our affiliates;
3. providing subsequent services to you, including but not limited to administering the policies issued;
4. any purposes in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Company and/or our affiliates, including investigation of claims;
5. detecting and preventing fraud (whether or not relating to the products/services provided by the Company and/or our affiliates);
6. evaluating your financial needs;
7. designing products/services for customers;
8. conducting market research for statistical or other purposes;
9. matching any data held which relates to you from time to time for any of the purposes listed herein;

10. making disclosure as required by any applicable law, rules, regulations, codes of practice or guidelines or to assist in law enforcement purposes, investigations by police or other government or regulatory authorities in Hong Kong or elsewhere;
11. conducting identity and/or credit checks and/or debt collection;
12. complying with the laws of any applicable jurisdiction;
13. carrying out other services in connection with the operation of the Company's business; and
14. other purposes directly relating to any of the above.

Transfer of personal data: Personal data will be kept confidential but, subject to the provisions of any applicable law, may be provided to:

1. any of our affiliates, any person associated with the Company, any reinsurance company, claims investigation company, your broker, industry association or federation, fund management company or financial institution in Hong Kong or elsewhere and in this regard you consent to the transfer of your data outside of Hong Kong;
2. any person (including private investigators) in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Company and/or our affiliates;
3. any agent, contractor or third party who provides administrative, technology or other services (including direct marketing services) to the Company and/or our affiliates in Hong Kong or elsewhere and who has a duty of confidentiality to the same;
4. credit reference agencies or, in the event of default, debt collection agencies;
5. any actual or proposed assignee, transferee, participant or sub-participant of our rights or business;
6. any government department or other appropriate governmental or regulatory authority in Hong Kong or elsewhere; and.
7. the following persons who may collect and use the data only as reasonably necessary to carry out any of the purposes described in paragraphs nos. 2, 3, 4 and 5 of the Purposes specified 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 data provided against existing data.

For our policy on using your personal data for marketing purposes, please see the section below **"Use and provision of personal data in direct marketing"**.

Transfer of your personal data will only be made for one or more of the Purposes specified above.

Use and provision of personal data in direct marketing: The Company intends to:

1. use your name, contact details, products and services portfolio information, transaction pattern and behaviour, financial background and demographic data held by the Company from time to time for direct marketing;
2. conduct direct marketing (including but not limited to providing reward, loyalty or privileges programmes) in relation to the following classes of products and services that the Company, our affiliates, our co-branding partners and our business partners may offer:
   a) insurance, banking, provident fund or scheme, financial services, securities and related products and services;
   b) products and services on health, wellness and medical, food and beverage, sporting activities and membership, entertainment, spa and similar relaxation activities, travel and transportation, household, apparel, education, social networking, media and high-end consumer products;
3. the above products and services may be provided by the Company and/or:
   a) any of our affiliates;
   b) third party financial institutions;
   c) the business partners or co-branding partners of the Company and/or affiliates providing the products and services set out in (2) above;
   d) third party reward, loyalty or privileges programme providers supporting the Company or any of the above listed entities
4. in addition to marketing the above products and services, the Company also intends to provide the data described in (1) above to all or any of the persons described in (3) above for use by them in marketing those products and services, and the Company requires your written consent (which includes an indication of no objection) for that purpose;

Before using your personal data for the purposes and providing to the transferees set out above, the Company must obtain your written consent, and only after having obtained such written consent, may use and provide your personal data for any promotional or marketing purpose.

You may in future withdraw your consent to the use and provision of your personal data for direct marketing.

If you wish to withdraw your consent, please inform us in writing to the address in the section on **"Access and correction of personal data"**. The Company shall, without charge to you, ensure that you are not included in future direct marketing activities.

Access and correction of personal data: Under the PDPO, you have the right to ascertain whether the Company holds your personal data, to obtain a copy of the data, and to correct any data that is inaccurate. You may also request the Company to inform you of the type of personal data held by it.

Requests for access and correction or for information regarding policies and practices and kinds of data held by the Company should be addressed in writing to:

Data Privacy Officer
AXA China Region Insurance Company Limited /AXA General Insurance Hong Kong Limited
5/F, AXA Southside, 38 Wong Chuk Hang Road, Wong Chuk Hang, Hong Kong

A reasonable fee may be charged to offset the Company's administrative and actual costs incurred in complying with your data access requests.

5. DOCUMENT CHECKLIST

Below is a list of documents required to proceed with your claim. In certain circumstances, more information may be required to process the claim.

	Documents Required (Please "✓" against the documents you have submitted.)
Basic Documents (Must be completed and submitted)	☐ Claim form completed by yourself and your attending doctor ☐ Original payment receipt(s) of medical expenses (including deposit receipt) ☐ Copies of statement for breakdown of hospital expenses (including daily charges, meal charges and package charges) ☐ Settlement advice from other insurer, if any
Additional Documents (If applicable)	☐ Discharge summary (If the patient is confined in ward level of government hospital that managed by Hospital Authority, the discharge summary would replace Part II of this claim form) ☐ Laboratory test breakdown ☐ Drug list (include drug name, dosage, quantity and amount) ☐ Copies of histopathology, endoscopic, diagnostic/laboratory tests written report, operating theatre summary (X-ray film, ultrasound photo are not required) ☐ Hospitalisation/Surgical package charges breakdown, if any ☐ Referral letter(s) for any specialists

6. CLAIM SUBMISSION

For Individual/Employee Benefits members

➢ After completing this claim form, please submit it together with the supporting documents to the mailing address as stated on the form.

For InternationalExclusive members

➢ After completing this claim form, please submit it together with the supporting documents to our mailing address as stated on the form, or send via email at healthcare@axa.com.hk.

7. DECLARATION AND AUTHORISATION

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

I/WE 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.

I/WE ACKNOWLEDGE AND CONFIRM that I/we have read and understood the Personal Information Collection Statement ("PICS") stated on page 2. I/We confirm that I/we have been advised to read carefully the PICS, and I/we have read it carefully its effect and impact in respect of my/our personal data collected or held by the Company (whether contained in this application or otherwise). Based on the foregoing, I/we hereby give my/our acknowledgement and agree to the use and transfer of my/our personal data by AXA China Region Insurance Company Limited/AXA General Insurance Hong Kong Limited in accordance with the PICS. In the event of any inconsistency between the English version and the Chinese version, the English version shall prevail.

Signature of Patient or Signature of Employee/Policyholder (if patient is under 18 years old)	Full Name in English BLOCK LETTER	Date
		DD / MM / YYYY

Part II - TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON AT THE CLAIMANT'S OWN EXPENSE

If the patient is confined in government hospital (managed by Hospital Authority, ward level), discharge summary would replace the completion of claim form Part II

1. GENERAL ITEMS

Name of Patient				Hospital Name			
Date of Admission	DD / MM / YYYY			Date of Discharge	DD / MM / YYYY		
Level of Hospital Ward	☐ Private	☐ Semi-private	☐ Ward	☐ Clinical Surgery			

2. CLINICAL HISTORY

Date of first consultation for this condition	DD / MM / YYYY	How long had the patient been experiencing these symptoms before the first consultation	
Symptom(s)/complaint(s) presented during the first consultation			

3. HOSPITALISATION DETAILS

Date of Operation	DD / MM / YYYY		
Final Diagnosis		Operation Procedure(s) Performed	
	ICD 10 Codes		CPT Codes

If the patient has consulted other physician during this hospitalisation, please provide the following

Name of Physician	Reason	Treatment Performed

Please provide details of the hospitalisation, including treatment, investigations, tests conducted, on-going treatment and recovery plan.	
Please provide details of the period of hospitalisation including reasons for number of days as in-patient.	
Is it possible that the treatments/investigations of the patient be managed on an out-patient basis?	☐ No, please provide reason(s): _____ ☐ Yes, please give reason(s) for this hospitalisation: _____

4. PROFESSIONAL COMMENT

In your opinion, was the hospitalisation a result of recurrent episode/chronic illness or related to a previous condition? If "yes", please provide dates and details.

Was the condition due to or associated with the following?

- ☐ Accidental bodily injury
- ☐ Self-inflicted injury
- ☐ Abuse of drugs or alcohol
- ☐ Mental disorder
- ☐ Refractive error
- ☐ Venereal disease , sexually transmitted disease or AIDS/HIV related illness
- ☐ Pregnancy
- ☐ Infertility or sterilization
- ☐ Contraception
- ☐ Treatment for cosmetic purpose
- ☐ Vaccination
- ☐ Congenital condition
- ☐ Developmental condition
- ☐ Hereditary condition
- ☐ General check-up

5. OTHERS

Are you the patient's usual physician?		☐ Yes ☐ No	
Referring Doctor Name and Address, if applicable			
Name of Physician		Address	

6. DECLARATION AND AUTHORISATION

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

Signature or Official Stamp of Attending Physician/Surgeon	Address and Telephone No.
Name of Attending Physician/Surgeon & Qualifications	Date
	DD / MM / YYYY