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Policy Number

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DISABILITY/ACCIDENT/ HOSPITALISATION CLAIM FORM II

Important note:
Your patient is insured with us against the occurrence of certain contingent events associated with his or her health history. To enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement. [All costs associated with the claim form to be borne by the patient]

TYPE OF CLAIM BENEFIT

☐ Accident Benefit (ECARE/CARE/AB) (Please complete: Section 1, 2, 3, 5 & 7)	☐ Disability Income Benefit (DI) (Please complete: Section 1, 2, 3, 5, 6 & 7)	☐ Hospital Benefit (Please complete: Section 1, 2, 3, 4 ,6 & 7)	☐ Waiver of Premium for Disability (WP) Benefit (Please complete: Section 1, 2, 3, 5, 6 & 7)	☐ Cancer Treatment (Please complete: Section 1, 2, 3, 4, 6 & 7)

1. PATIENT'S INFORMATION

Name of patient (Insured)		HKID Card/Passport No.	
Did the patient have any of the following habits? If yes, please provide the duration and consumption details	☐ Yes ☐ No		
	☐ Smoking ☐ Drugs taking ☐ Drinking Duration _____ Consumption Per Day _____		

2. ABOUT THE CURRENT SICKNESS/ILLNESS

Date of first consultation for this condition	dd ____ mm ____ yyyy ____	Name of the Doctor	
Symptom(s)/ complaint(s) presented during the first consultation		How long had the patient been experiencing these symptoms before the first consultation	
Diagnosis (Provide diagnostic test results confirming the diagnosis)		ICD 10 Codes	
Date of accident	dd ____ mm ____ yyyy ____	Cause of Injury	
Nature, Severity of Injury and body parts injured			

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Any visible wound? If yes, please tick the appropriate box below and provide details	☐ Yes ☐ No
☐ Bruise	Details:
☐ Laceration / abrasion / wound / bleeding / fractures	Details:
☐ Others, please specify _____	Details:

Please check the box ☐ if this Disability may be related to any of the following and provide details as required

			If yes, please specify
Self-inflicted condition	☐ Yes	☐ No	
Under influence of alcohol and other psychoactive substances	☐ Yes	☐ No	
Involvement in high risk activities	☐ Yes	☐ No	
AIDS and/or other sexually transmitted diseases	☐ Yes	☐ No	
Occupation	☐ Yes	☐ No	
Psychological condition	☐ Yes	☐ No	

Name and address of doctor who has referred this patient to you for this condition

Name of the doctor	Corresponding Address

3. ABOUT THE HOSPITALISATION

Name of hospital				
Date of admission	dd _____ mm _____ yyyy _____	Date of discharge	dd _____ mm _____ yyyy _____	
Diagnosis at the time of discharge				
Any Operation/Surgery performed? If yes, provide date of operation	☐ Yes ☐ No Date of operation: dd _____ mm _____ yyyy _____			
Name of surgical procedures				
Any treatment other than Operation/ Surgery performed? If yes, please provide name and date of such treatment	☐ Yes ☐ No			
	Treatment Name		Date	dd _____ mm _____ yyyy _____
Whether above operation/surgery/ treatment can be managed on out-patient basis? If yes, please specify the reason(s) for hospitalisation.	☐ Yes ☐ No			

Was the hospitalization associated with treatment, procedure, supplies of experimental or investigative nature?	☐ Yes ☐ No

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

Did the patient take any home leave during the hospital confinement? If yes, please specify the reason and the period of home leave	☐ Yes ☐ No

4. ABOUT THE CANCER TREATMENT

Did the patient suffer from any tumour, malignant or benign, including pre-cancerous conditions? ☐ Yes ☐ No If yes, please state details			
Site and organ involved		Lymph node involved	
Was biopsy done for the patient? If yes, please provide date and result		☐ Yes ☐ No	
Date	Biopsy result	Other diagnostic/investigation test result	
dd _____ mm _____ yyyy _____			
Type of treatment administered	☐ Surgical ☐ Hormonal Therapy ☐ Chemotherapy ☐ Target Therapy ☐ Others _____	Date	dd _____ mm _____ yyyy _____
Please provide details of the treatment including drug name, dosage, frequency, duration of treatment, all other types of treatment and any complications			
Has the cancer/tumour been completely removed/eradicated?		Completion Date of all treatments:	dd _____ mm _____ yyyy _____

5. ABOUT THE DISABILITY

Specify all physical or mental impairment - impact, severity and duration as a result of this disability (Provide documentation supporting the degree of disability)	
Provide the prognosis for each of the above (if any)	
Patient's occupation and exact nature of occupational duties	
Please state period in which patient is not able to perform some of his job duties	From _____ To _____ dd/mm/yyyy dd/mm/yyyy
Please state period in which patient is not able to perform all of his job duties	From _____ To _____ dd/mm/yyyy dd/mm/yyyy

Please tick against the box that most accurately describes the Policyholder's/Applicant's ability.	Date the disability started	dd _____ mm _____ yyyy _____
Washing or bathing - Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.	☐ No help is needed ☐ Some help or supervision is needed (e.g. To wash the back, hair) ☐ Needs someone to help most of the times ☐ Not able to do at all (needs to be washed or bathed entirely by caregiver)	
Dressing - Ability to put on, take off, secure and unfasten all garments (upper and lower) and, as appropriate, any braces, artificial limbs or other surgical or medical appliances	☐ No help is needed ☐ Some help or supervision is needed (e.g. To button clothes, to put on trousers) ☐ Needs someone to help most of the times ☐ Not able to do at all (needs to be dressed entirely by caregiver)	
Feeding - Ability to feed oneself food after it has been prepared and made available.	☐ No help is needed ☐ Some help or supervision is needed (e.g. To scoop food, to put food into mouth) ☐ Needs someone to help most of the times ☐ Not able to do at all (needs caregiver to feed entirely or is tube-fed)	

Toileting - Ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate.	☐ No help is needed ☐ Some help or supervision is needed (e.g. To get on or off the toilet) ☐ Needs someone to help most of the times ☐ Not able to do at all (needs to be placed on the toilet and cleaned by caregiver)
Transferring - Ability to move from a lying position on the bed to an upright chair or wheelchair, and vice versa.	☐ No help is needed ☐ Some help or supervision is needed (e.g. To get on or off the chair/bed) ☐ Needs someone to help most of the time ☐ Not able to do at all (needs to be placed on the chair/bed by caregiver)
Mobility - Ability to move indoors from room to room on level surfaces.	☐ No help is needed ☐ Some help or supervision is needed ☐ Needs someone to help most of the time ☐ Not able to do at all

6. ABOUT HEALTH HISTORY

Has the patient previously suffered from related conditions of this illness? If yes, please provide the dates of consultation, details of conditions and diagnosis				☐ Yes ☐ No
Date of doctor Consultation or Hospital admission	Name of doctor or hospital	Complaints and Symptoms	Diagnosis	Treatments given (please state name of surgical procedure if performed or to be performed)
dd _____ mm _____ yyyy _____				
dd _____ mm _____ yyyy _____				

Have the biological parents, siblings or children of the patient been diagnosed prior to age 60 with any of the following? If Yes, please complete the table below with exact nature of the illness e.g. breast cancer, colon cancer or heart attack etc.	☐ Yes ☐ No

☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Alzheimer's Disease
☐ Diabetes ☐ Polycystic Kidney Disease ☐ Other Inherited Disease or Disorder

Relative	Diagnosis/Condition	Onset Age

7. DECLARATION AND AGREEMENT

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his/her condition. I declare and agree to make the declaration on this claim form.

Name of Physician	Contact tel. no. and mailing address
Qualification	Specialty
Signature of Physician	Signature Date
	dd _____ mm _____ yyyy _____