Pre-authorisation Form (For Hospitalization and Day Surgery)
醫療初步保障審核表格 (適用於住院及日症手術)

招商永隆保險 CMB WING LUNG INSURANCE

Bupa 保柏

Email 電郵 preauthapp@bupa.com.hk Fax No.傳真 (852)3973 6966 Please complete this form and send to Bupa by email or fax 請填妥此表格並電郵或傳真至保柏

Part I - To be Completed IN FULL by Member 第一部分 - 由會員填寫全部資料

Insured's Name 受保人姓名	Date of Birth 出生日期 (DD日 / MM月 / YY年)
CMB Wing Lung Insurance Membership No. 招商永隆保險會員編號	Tel No. / Email 電話號碼 / 電郵

Authorisation and Declaration 授權及聲明

I hereby acknowledge that CMB Wing Lung Insurance Company Limited ("CMB Wing Lung Insurance") has appointed Bupa (Asia) Limited ("Bupa") to provide customer service and insurance claims processing service, and subsequently the services may be provided by third party service providers selected by CMB Wing Lung Insurance or Bupa. CMB Wing Lung Insurance reserves the right to change the service providers and to amend the relevant terms and conditions at any time without prior notice.

I hereby declare that the below information given is true and correct. I hereby authorise any medical practitioner, hospital, clinic, by whom or where I / the Member have been observed or treated or any insurance company or organisation that has any records or health information concerning me / the Member for any reason, to give full particulars thereof including prior medical history to CMB Wing Lung Insurance and/or Bupa. A copy of this authorisation shall be considered as effective and valid as the original.

I understand that a shortfall may occur if the final costs for treatment exceed my plan coverage or the medical expenses are not eligible for reimbursement, I agree to reimburse to CMB Wing Lung Insurance and/or Bupa any shortfall incurred.

I understand and agree that all personal and medical information relating to me / the Member contained in this pre-authorisation application will be used by CMB Wing Lung Insurance and/or Bupa for the purpose of (1) processing this application and providing subsequent services; (2) processing any claims analysis and / or medical, identity or other insurance-related checks; (3) data matching, statistics, research, reporting and auditing; (4) communication with me about this pre-authorisation; (5) exercising the right to determine indebtedness, collecting and recovering amounts owning by me or any person who has provided any security or undertaking for my liabilities; and (6) satisfying any applicable legal or regulatory requirements. I agree that such information may be transferred for the above purposes to any of the following parties (within or outside Hong Kong): any of the private hospital(s) specified below, CMB Wing Lung Insurance and/or Bupa's group companies, any insurance intermediaries as authorised by myself and CMB Wing Lung Insurance and/or Bupa, any re-insurance companies authorised by CMB Wing Lung Insurance and/or Bupa, any claims investigation companies, any service providers providing services to CMB Wing Lung Insurance and/or Bupa, any association or federation relating to the insurance industry, and any person or organisation as required by law.

Consequences of non-provision of personal information: I understand that CMB Wing Lung Insurance and/or Bupa may be unable to process this application if I fail to provide any information requested in this application or otherwise by CMB Wing Lung Insurance and/or Bupa.

My rights in respect of my personal information: I have read and understood the Notice to Customers relating to the Personal Data (Privacy) Ordinance (the "Notice") included in this form. I have also brought the Notice to the attention of all relevant Insured Person(s) / Member(s) (or their guardians if applicable) and confirmed the understanding and agreement to it. I / We consent to the transfer of my / our personal data within or outside of Hong Kong for the purposes and to the types of transferees as set out in the Notice. I / We have understood the Statement's effect in respect of my / our personal information collected or held by CMB Wing Lung Insurance and/or Bupa, including the use, storage, processing, transfer, disclosure and / or sharing of part of or all of my / our personal information within the Group Companies in accordance with the Notice. The latest version of the Notice available at https://www.cmbwinglunginsurance.com.

本人謹此確認招商永隆保險有限公司（「招商永隆保險」）已委任保柏（亞洲）有限公司（「保柏」）提供客戶服務和保險索償服務，而該等服務隨後可能由招商永隆保險或保柏選定的第三方服務供應商提供。招商永隆保險保留隨時更換服務供應商以及修改相關條款及細則的權利，恕不另行通知。

本人謹此聲明，以下所填報之一切資料，均屬真確無訛。本人謹此授權任何為本人 / 會員觀察或治療的醫生、醫院、診所，或持有本人及 / 或會員健康或任何資料之保險公司或機構將本人及 / 或會員之資料（包括病歷）交予招商永隆保險 及/或 保柏，本授權書之副本與正本具同等效力。

本人明白若最終的治療費用超過本人的保障額，或有關費用不屬於保障範圍內，本人同意全數歸還因此所產生的任何差額給招商永隆保險及/或保柏。

本人明白及同意招商永隆保險 及/或 保柏透過此初步保障審核申請收集之本人 / 會員之個人及健康資料，可供招商永隆保險 及/或 保柏用作以下用途(1)處理此申請及提供有關服務；(2)處理任何索償分析及 / 或與醫療、身份或其他保險有關的查核；(3)資料核對、統計研究、報告及審計；(4)就此初步保障審核與本人聯絡；(5)行使本公司向閣下或屬下會員提供保險和相關服務及產品而享有的權利，例如釐定欠付閣下或閣下拖欠的任何款項的金額，及向閣下或任何已為閣下的債務提供任何擔保或承諾的人士，追收和收回拖欠的任何款項；及(6)遵守任何法例或監管要求。

本人同意該等資料可因上述用途提供予下述任何各方（不論在香港境內或境外）：任何下述之醫院、招商永隆保險及/或保柏的集團公司、任何由本人及招商永隆保險及/或保柏授權的保險代理人、任何由招商永隆保險及/或保柏授權的再保險公司、賠償調查公司、任何向招商永隆保險及/或保柏提供服務的供應商機構、與保險業相關之團體及任何法律要求的任何人士及團體。

未能提供個人資料的後果：本人明白若本人不能提供此申請或招商永隆保險及/或保柏要求的其他資料，招商永隆保險及/或保柏不能處理此申請。

有關個人資料的權利：本人已細閱並明白包含在本表格中的「關於個人資料（私隱）條例）致客戶的通知」（「通知」）。本人亦已促有關受保人/會員（或其監護人，如適用）留意「通知」並確認明白及同意有關內容。本人/我們同意就「通知」所述用途視乎情況提供本人/我們的個人資料至香港境內外予「通知」所載的資料承讓人。本人/我們明白「通知」對招商永隆保險/保柏（亞洲）有限公司收集或持有的本人/我們的個人資料的效力及影響，包括按照個人資料收集聲明使用、儲存、處理、轉移、公開或分享本人的部分或全部個人資料致任何集團公司之成員。該「通知」最新的版本請參閱 https://www.cmbwinglunginsurance.com

Signature of Insured / Guardian **受保人 / 監護人簽署** X	Name 姓名： X	Date 日期 X DD日 MM月 YY年

Credit Card Authorisation: Applicable to Individual Policy for Hospitalisation and Clinical Operation Only 信用卡授權書 (僅適用於個人保障計劃之住院和門診手術)

Please note that a shortfall may occur if final costs for treatment exceed your plan coverage or the medical expenses are not eligible for reimbursement. This form authorises Bupa to collect any shortfall from the credit card account detailed below. The credit cardholder must be the Subscriber or the Member of this policy. Bupa will hold a HK$500 credit limit until the claim assessment is fully completed. The shortfall collection notice will be sent to you 21 days prior to the collection.

請注意若最終的治療費用超過你的保障額，或有關費用不屬於保障範圍內，此授權書將授權保柏在下列信用卡帳戶收取差額。持卡人必須為此保單之投保人或會員。保柏將保留港幣500元的信用額直至索償程序完結為止。保柏將於收取差額費用21天前郵寄結欠付款通知書通知閣下。

I hereby authorise and direct Bupa (Asia) Limited to debit the shortfall due from my credit card account.

本人授權及指示保柏（亞洲）有限公司從本人之信用卡戶口扣除到期之差額費用。

Cardholder's Name 持卡人姓名	ID Card No. 身份證號碼	Tel No. 電話號碼
Credit Card Account No. (MasterCard / VISA)* 信用卡號碼		Credit Card Expiry Date (MM 月 / YY 年) 信用卡到期日

Cardholder's Signature **持卡人簽署** X	Relationship with Insured 與受保人之關係	Date 日期 X DD日 MM月 YY年

* Credit card must be valid for at least 3 months from date of hospital admission 信用卡有效期必須多於三個月(由入院日期起計)

Part II - To be Completed IN FULL by Attending Doctor 第二部分 - 由主診醫生填寫全部資料

Diagnosis Details 診斷詳情

Has the Insured presented CMB Wing Lung Insurance Medical Card upon consultation
受保人有否於求診時出示招商永隆保險醫療卡?
☐ Yes 有 ☐ No 沒有

Chief Complaint of the Current Consultation 是次就診之主訴 / sign and symptoms 病徵及症狀

Onset Date 病徵出現日期 (DD日 / MM月 / YY年)

Diagnosis 診斷 With sign and symptoms 病徵及症狀

Is it a chronic / recurrent illness 是否慢性 / 復發疾病
☐ Yes 是 First Onset Date 首次病徵出現日期 (DD日 / MM月 / YY年) .....
☐ No 否

(Please enclose referral letter 請提供轉介信)

Was the medical condition caused by or related to the following 此病是否與下列情況有關或引致？
☐ accidental bodily injury 身體意外受傷
☐ congenital, hereditary, developmental condition 先天性，遺傳性或發育異常

Diagnostic / Surgical Procedures 診斷性 / 外科手術
Non-network Specialist (if applicable) 轉介非網絡專科醫生 (如適用)

Requested Fees (please attached quotation if available)
HKD 所需費用 (請附上報價單，如有) 港元

Treatment Location 治療地點
please tick the appropriate one

☐ Clinic 診所
☐ Day Case 日症
☐ Hospital OPD 醫院門診部
☐ In-patient 住院

Name of Hospital / Day Case Unit 醫院 / 日症中心名稱

Date of Treatment /Admission
治療 /入院日期
(DD日 / MM月 / YY年)

Anaesthesia 麻醉
☐ GA 全身麻醉
☐ MAC 監察麻醉
☐ LA 局部麻醉
☐ IVS 靜脈注射鎮靜

Bed Class 住院級別 ☐ Private 私家房 ☐ Semi-private 半私家房 ☐ Ward 大房

Estimated Length of Stay
預計留院日數 days日

Doctor's Particulars and Signature 醫生資料及簽署

Doctor / Clinic Chop

Doctor's Signature
X .....
Doctor's Name

Date 日期 (DD日 / MM月 / YY年)

Email 電郵

Fax 傳真

Tel 電話