MSIG Insurance (Hong Kong) Limited
三井住友海上火災保險（香港）有限公司
9/F 1111 King's Road, Taikoo Shing, Hong Kong
Tel +852 2894 0555, Fax +852 2890 5741
msig.com.hk
A Member of MS&AD INSURANCE GROUP

Pre-authorisation Form for Cashless Service 免找數服務預先批核申請表

Please complete this form and send it to MSIG by email or fax. 請填妥此表格並以電郵或傳真至 MSIG。

Cashless service application shall be filed to MSIG at least 3 working days prior to hospitalization or day surgery.

付款保證申請必須在住院或日間手術前最少 3 個工作天通知 MSIG 預先安排。

Email 電郵: gop@hk.msig-asia.com **Fax 傳真:** +852 3500 5287 **Hotline 熱線：** +852 3122 6899 (press 按 4 字)

Part I : To be completed by the Insured Person 第一部份：由受保人填寫

Name of Insured Person (Patient) 受保人（病人）姓名		HKID no. 身份證號碼
Policy no. 保單號碼	Contact no. 聯絡電話	Date of birth (dd/mm/yyyy) 出生日期（日/月/年）

Declaration & authorisation

1. I understand and agree that MSIG Insurance (Hong Kong) Limited ("MSIG") will arrange guarantee of medical expenses for hospitalisation, provided that the above policy with MSIG for the above-named Insured Person is in force during the period of hospitalisation and the arrangements are made in accordance with the terms and conditions of the policy.
2. I understand and agree that such arrangement will cease immediately should subsequent verification proves that the above named Insured Person or his/her medical conditions should not be covered by the Policy.
3. I declare and agree that any hospital, clinic, physician, insurance company, organisation or any person that has any records or knowledge of my health, or that of the above named Insured Person, to furnish such information to MSIG Insurance (Hong Kong) Limited. A photocopy of this authorisation shall be considered as effective and valid as the original.
4. I understand and agree that all personal and medical information relating to me / the Insured Person contained in this pre-authorisation application will be collected, used or transferred to third party by MSIG located within or outside of Hong Kong in accordance with MSIG Personal Information Collection Statement ("MSIG PICS") particularly for the purpose of processing this request and providing subsequent services. The updated version of MSIG PICS is available for download from its website at www.msig.com.hk/en/privacy-policy or is made available upon request.
5. I understand that under the Personal Data (Privacy) Ordinance, I shall have the right to request access to and correction of any personal information concerning me provided to MSIG, and to request MSIG to cease using my Personal Information for direct marketing purposes, by writing to MSIG's Data Protection Officer at 9/F 1111 King's Road, Taikoo Shing, Hong Kong.
6. Neither submission of this Pre-authorisation Form nor the issuance of Letter of Guarantee by MSIG shall be construed as admission of liability on the part of MSIG.

聲明及授權

(1) 本人明白並同意上述受保人於住院期間上述保單必須仍然生效，在符合保單內一般條款的情況下，三井住友海上火災保險（香港）有限公司（簡稱「MSIG」）會安排直接支付住院費用。
(2) 本人明白並同意如隨後的核查證明上述受保人或其病況並非本保單承保，上述安排將會立即終止。
(3) 本人謹此聲明並同意任何擁有本人或上述病者的健康資料和記錄的醫院、診所、醫生、保險公司或任何機構的人士向MSIG提供有關資料。此授權書的影印本與正本具有同等的效力。
(4) 本人明白及同意，此預先批核申請上所載的本人 / 受保人的個人及健康資料，根據MSIG個人資料收集聲明，MSIG可收集、使用或轉移至香港境內或境外第三方，用作處理此申請及提供有關服務。有關MSIG個人資料收集聲明的最新詳情，可於其公司網頁：www.msig.com.hk/zh-hant/privacy-policy 下載，或根據要求向本人提供。
(5) 本人明白根據個人資料 (私隱) 條例，本人有權致函MSIG的資料保護主任，地址為：香港太古城英皇道1111號9樓三井住友海上火災保險（香港）有限公司，查閱及更正MSIG所持有的任何關於本人的個人資料的記錄；及要求MSIG停止將本人的個人資料作直接市場推廣用途。
(6) 遞交此預先批核申請表或由MSIG簽發出住院付款保證信均不能理解為MSIG承擔有關賠償責任。

Signature of policyholder 保單持有人簽署	Signature of insured (to be signed by guardian if insured is below 18 years old) 受保人簽署(若受保人年齡在18歲以下，本申請表格必須由監護人簽署)
Name of policyholder 保單持有人姓名	Name of insured/ guardian 受保人/ 監護人姓名
ID card / passport no. of policyholder 保單持有人身份證/ 護照號碼	ID card / passport no. of insured/ guardian 受保人/ 監護人身份證/ 護照號碼
Date signed (dd/mm/yyyy) 簽署日期（日/月/年）	Date signed (dd/mm/yyyy) 簽署日期（日/月/年）

MSIG

Credit card authorisation form **for shortfall collection** 信用卡授權書以收取差額費用

The credit card holder should be either the Policyholder or the Insured Person of this policy.

The notice for shortfall collection will be sent to you within 21 days prior to the collection.

持卡人必須為此保單的持有人或受保人。

差額費用通知書將於收取差額前 21 天發出予閣下。

Declaration & authorisation

1. I understand and agree that MSIG Insurance (Hong Kong) Limited ("MSIG") will arrange guarantee of medical expenses for hospitalisation, provided that the above policy with MSIG for the above-named Insured Person is in force during the period of hospitalisation and the arrangements are made in accordance with the terms and conditions of the policy.
2. I am aware of the limits as to my/the Insured Person's medical insurance in respect of this application. I hereby undertake to settle any account in excess of my/the Insured Person's entitlement, or that it is not within the insurance coverage. I hereby agree and authorize MSIG to deduct the reimbursement of claims payment from the following credit card in the event that I/the Insured Person have any shortfall amount, for whatever reason, due to MSIG.
3. The Authorisation Form for Shortfall Collection authorises MSIG to collect the shortfall amount from the following credit card.

聲明及授權

1. 本人明白並同意三井住友海上火災保險（香港）有限公司（簡稱「MSIG」）會安排直接支付住院費用，唯上述受保人於住院期間之上述保單必須仍然生效，而安排須符合保單內的一般條款及細則。
2. 本人已清楚知道就此申請本人 / 受保人的醫療保險的最高保障金額。本人亦同意並負責支付任何超出本人 / 受保人的保險最高賠償金額或不受保事項的費用。若本人 / 受保人尚有任何未清還或任何其他原因之欠款，本人同意及授權 MSIG 從以下信用卡扣除任何賠償金額。
3. 此授權書將授權 MSIG 在下列信用卡帳戶收取差額。

Name of cardholder 信用卡持卡人姓名	HKID no. 身份證號碼
Credit card account number 信用卡號碼					—				—				—				
Credit card expiry date MM 月 YY 年 信用卡到期日 /	Contact no. 聯絡電話
I hereby authorise MSIG to debit my credit card account, listed above, for the collection of any shortfall. **本人茲授權 MSIG 從本人以上的信用卡戶口內收取差額。**	
Signature(s) of cardholder 持卡人簽署	Date (DD/MM/YYYY) 日期（日 / 月 / 年） / /

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Part II : To be completed by the attending doctor 第二部分：由主診醫生填寫

Please complete this form and send it to MSIG by email or fax. 請填妥此表格並以電郵或傳真至 MSIG。
Email 電郵: gop@hk.msig-asia.com **Fax 傳真:** +852 3500 5287 **Hotline 熱線：** +852 3122 6899 (press 按 4 字)

Name of patient 病人姓名	HKID no. of patient 病人**身份證號碼**
Name of hospital/day centre/clinic 醫院 / 日症中心 / 診所名稱	Treatment location 治療地點 ☐ Inpatient 住院 ☐ Hospital OPD 醫院門診 ☐ Day centre 日間中心 ☐ Clinic 診所 ☐ Diagnostic imaging/laboratory centre 診斷 / 化驗中心
Date of admission/treatment (dd/mm/yyyy) 入院 / 治療日期（日 / 月 / 年）	Expected length of stay 預計留院日數
Chief complaint/sign and symptoms 主訴 / 病徵及症狀	
Onset date (dd/mm/yyyy) 病徵出現日期（日 / 月 / 年）	Is it a chronic or recurrent illness 是否慢性或復發疾病 ☐ Yes 是, First onset date (dd/mm/yyyy) 病徵首次出現日期 （日 / 月 / 年） ______________________________ ☐ No 否
Diagnosis 診斷	
Full name of surgery / treatment / purpose of admission 手術名稱 / 治療 / 入院原因	
Please list out any laboratory tests/ imaging tests / other diagnostic investigations required. **請詳列化驗/ 影像檢查/ 其他診斷性檢查**。	
Please provide reason(s) for hospitalisation if this type of case can be managed on day care/out-patient basis 假若這類個案可於日間護理 / 門診護理，請提供入住醫院原因。	
Estimated cost (HK$) 估計費用（港幣）：	
Room and board fee per day 每日病房費用	Room type 病房級別 ☐ Private 私家房 ☐ Semi-private 半私家房 ☐ Ward 大房 ☐ Day Case **日間病房**
Ward round fee per day 每日巡房費用 (If more than one doctor, please provide the breakdown and justification. **如多於一位醫生，請列出明細及原因**。)	Surgeon's fee 外科醫生費用(If more than one surgical procedure, please provide the breakdown. 如多於一項手術程序，請列出明細。)
Anesthetist's fee 麻醉師費用	Anaethesia 麻醉 ☐ G.A. 全身麻醉 ☐ M.A.C. 監察麻醉 ☐ L.A. 局部麻醉 ☐ IVS 靜脈注射鎮靜
Operating theatre fee 手術室費用	Hospital miscellaneous charges 醫院雜項費用
Estimated total fee 總估計費用	
Attending doctor's information 主診醫生資料	
I/ We hereby certify that I/ we have personally examined and treated the above patient in connection to the above condition and the information given on this form is true to the best of my/ our knowledge and belief. 本人 / 我們謹此聲明曾為上述病人作出診治，並跟據我 / 我們所知及所信提供本表格上的資訊。	
Name of attending doctor 主診醫生姓名	Signature and stamp of attending doctor 主診醫生簽署及蓋印

Date (DD/MM/YYYY) 日期（日/月/年）	Contact no. 聯絡電話	Fax no./Email 傳真號碼 / 電郵