

PRE-AUTHORIZATION FOR CREDIT SERVICE FOR HOSPITALIZATION FORM (*Submit to ClaimSimple*) 代缴住院费用服务初步授权申请表格 (经 *ClaimSimple* 提交)

Eligible Products: ManuMaster Healthcare Series/Benefit, ManuShine Healthcare Series/Benefit, Manulife Supreme VHIS Flexi Plan and Manulife Supreme Lite VHIS Supplementary Benefit (“Designated Products”)

晋领医疗保障系列／附加保障、活亮人生医疗保障系列／附加保障、宏利晋悦自愿医保灵活计划及宏利晋逸自愿医保附加保障(「指定产品」)

We understand that hospitalization and inpatient treatments often come with the burden of unexpected medical expenses. The Credit Service for Hospitalization is designed exclusively for Designated Products’ customers, and you can submit pre-authorization request prior to admission. Once approved, we will pay the estimated credit amount of eligible hospital and surgical expenses on your behalf. Let us take care of the bills for you so you can focus on treatment.

我们深明住院及住院治疗往往会带来突如其来的财政压力。代缴住院费用服务专为「指定产品」客户而设，您于入院前提交初步授权申请，一经批核，我们将代缴已批核的估算金额以支付您的合资格住院及手术费用。让我们为您处理账单，以便您专注接受治疗，回复健康。

6 simple steps to request for pre-authorization for credit service for hospitalization 6 个简单步骤即可就代缴住院费用服务作初步授权申请



Complete the form (Page 2-3 by attending physician/surgeon, Page 4 by policy owner/insured person)
填写表格(第2-3页由主诊医生填写,第4页由保单持有人/投保人填写)

– Be sure to have the attending physician/surgeon provide the medical information in the form, at the insured/policyowner’s expense (if any)

请确保由主诊医生或外科医生于申请表提供医疗详情,并由保单持有人/投保人自行承担填写表格费用(如有)



Submit the completed form and any diagnostic report(s) and other related clinical information to [ClaimSimple – Pre-assessment \(claimsimple.hk\)](https://claimsimple.hk) **at least 5 working days** before admission to hospital

于入院前**不少于五个工作日**将填写的表格、诊断报告及其他相关临床资料经 [ClaimSimple - 预先评估 \(claimsimple.hk\)](https://claimsimple.hk) 提交

– This form is only applicable for ClaimSimple submission. If you would like to submit by other channels, please contact your Manulife advisor for assistance.

此表格仅适用以 ClaimSimple 提交申请。如欲于其他渠道提交申请,请联络您的宏利顾问寻求协助。



Upon approval, we will send you a Letter of Confirmation and inform the hospital concerned of the pre-authorized credit amount.

一经批核,我们将向您发出「批核确认书」,并将初步授权金额通知医院。



Upon admission, please present insured’s identification document for verification.

入院时,请向医院出示投保人的身份证明文件以作核实。



At discharge, please settle any deductible and/or net balance that exceeds the pre-authorized amount, and then submit a completed [Medical Insurance - Hospitalization and Surgical Claim Form \(C13\)](#) to us by referring to our [“Hospital Claims Instructions”](#). When we receive the invoice from the hospital and complete the claims assessment, we will notify you on the shortfall, if any.

出院时,请缴付任何自付额及/或超出初步授权金额的费用,及依照「[住院索偿指引](#)」交回已填写的[医疗保险-住院及手术赔偿表\(C13\)](#)给我们。当我们接获医院账单及完成索偿评估后,我们会通知您缴付超出可赔偿金额的费用(如有)。



When using the Credit Service for Hospitalization, “Designated Products” will take priority for reimbursements over other medical plans during the medical claims assessment.

如使用代缴住院费用服务,宏利进行医疗理赔评估时,会先从「指定产品」作出赔偿。

**If you have any questions, please contact your Manulife insurance advisor.
如有任何疑问,请联络您的宏利顾问。**

Details of Treatment and Estimated Expense

治疗详情及预算费用表格

(To be completed by the Insured's attending Physician/Surgeon at the Policyowner/Insured's expenses if any)
(由受保人之主诊医生或外科医生填写, 如有需要保单持有人或受保人需自行承担填写表格费用)

Patient's Information 病人资料

Name of Patient 病人姓名:	HKID of Patient 病人香港身份证:	Sex 性别: <input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女
Hospital name 医院名称:	Room Class 住房级别: <input type="checkbox"/> Day Surgery 日间手术 <input type="checkbox"/> Ward 普通病房 <input type="checkbox"/> Semi-private 半私家 <input type="checkbox"/> Private 私家 Room Price (per day): 住房价格(每日)	
Planned Date of Admission (DD/MM/YYYY) 预计入院日期(日/月/年):		
Planned Number of days of Confinement 预计住院日数:		

Medical Condition 医疗详情

1. Chief complaint of current consultation 是次就诊之主诉:
2. Diagnosis and associated signs and symptoms 诊断和相关病状及病征:
3. Date of accident (if applicable) 意外日期(如适用) DD日/MM月/YYYY年
4. Where and how did the accident happen (if applicable) 意外地点及经过(如适用):
5. Part of body injured and type of injury caused by accident (if applicable) 意外受伤部位及伤势(如适用):
6. Onset date of first symptoms 首次发病日期(DD日/MM月/YYYY年):
7. First consultation date of first symptoms 首次发病求诊日期(DD日/MM月/YYYY年):
8. Is the condition recurrent/chronic? 此情况是否为复发性/慢性? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 If "Yes", onset date of the first episode. 如"是", 首次病发日期(DD日/MM月/YYYY年):
9. Name of the physician that the patient first consulted for this illness (if any) 病人就此疾病首次求诊的医生姓名及电话(如有): Physician name 医生姓名: Telephone Number 电话号码:
10. If hospitalization is for scans, diagnostic tests, physiotherapy, or any procedure that could be carried out in out-patient or day surgical centre, please provide details and explain why hospital stay is necessary 如是次住院之目的为进行诊断扫描、临床化验、物理治疗或任何程序可于门诊或日间手术中心进行, 请提供详情及说明留院之原因: <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 If "Yes", please give details. 如是, 请详述之:

11. Is illness/injury related to the following condition 此疾病/受伤是否由以下情况引起:

a) Congenital/Hereditary anomaly 先天性异常	<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否
b) Psychiatric condition 精神病	<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否
c) Influence of alcohol, drug or intoxicant 酒精, 药物或麻醉剂影响	<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否
d) Obesity, weight control 肥胖, 体重控制	<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否
e) Pregnancy, childbirth, abortion 怀孕、分娩、流产	<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否
f) Dental condition 牙齿状况	<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否
g) Cosmetic related treatment 美容相关疗程	<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否

12. Has the patient ever had the same or similar symptoms/medical conditions before? 病人是否曾经患有同一或相似病征/病况?
 Yes 是 No 否
 If "Yes", please state when and describe details. 如"是", 请说明何时及描述详情。

13. Is the patient having any treatments or taking medicines? 病人现在是否接受任何治疗或服用药物?
 Yes 是 No 否
 If "Yes", please provide details (including onset date, consulted doctor's name, diagnosis, name of medicine taking, etc).
 如"是", 请提供详情(包括病发日期, 应诊医生姓名, 诊断, 药名等)。

Treatment Details 治疗详情

14. Surgery/treatment required 建议之手术/治疗:

 Estimated Surgeon Fee 预计外科手术费:

15. Anaesthesia 麻醉: General 全身麻醉 Monitored Anesthesia Care 监测麻醉 Local 局部麻醉
 Estimated Anaesthesia Fee 预计麻醉费用:

 Estimated Operation Theatre Fee 预计手术室费用:

16. Please list out any lab tests/imaging/other diagnostic investigation required for the hospitalization and reasons for having those. If patient's condition fits to have the diagnostic investigation done at outpatient setting, kindly refer accordingly.
 建议需要住院之化验/影像检查/其他诊断性检查及接受该等检查的原因。如病人的情况适合于门诊进行诊断性检查, 请作相应的转介安排。
 Can the investigations be carried out in the outpatient setting? 是否可以从门诊设施中接受该等检查?

 Estimated hospital expenses 预计医院费用:

17. Doctor's Visit Fee 医生巡房费: _____ /day 每日
 Specialist Fee 专科医生费:

18. Estimated total fee for this confinement 预计是次住院总费用:

Doctor's information 医生资料

Are you related to the patient in any way other than your professional capacity? 除专业身份外, 与病人是否有其他关系?
 No 否 Yes, please specify the relationship with patient 是, 请注明与病人之关系:

Doctor's Name 医生姓名: Contact Telephone Number 联络电话号码: Fax Number 传真号码: Email 电邮:	Doctor's Signature and Chop 医生签署及印章: Date 日期: _____ (DD日/MM月/YYYY年)
------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------

Declaration and Authorization 声明及授权

(To be completed by Policyowner/Insured 由保单持有人或受保人填写)

I/We hereby declare that all information provided by me/us in this form is complete and true to the best of my/our knowledge. I/We further authorize any physician, hospital, medical service provider, insurance company, claims investigation company, government authority or organization that has any record or knowledge of me/us, my/our health or my/our activities (including records relating to Social Welfare, Workers' Compensation, credit, financial, earnings and employment history) to furnish to Manulife or its authorized representative such information including without limitation all information with respect to any illness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records and the original invoices concerning the medical services rendered. A photostatic copy of this authorization shall be as effective and valid as the original.

本人/我们特此声明本人/我们于本表格内所提供之资料是本人/我们所知之全部并为真实无误。本人/我们兹授权任何医生、医院、医疗服务提供者、保险公司、赔偿调查公司、政府有关部门或其他持有本人/我们个人资料、健康状况或记录(包括有关本人/我们所获之社会福利及劳工赔偿、本人/我们之信贷、财务状况、入息及就业记录)之组织可以将该等资料,包括但不限于所有有关本人/我们之疾病或受伤,伤患之病历、诊断报告、药方或治疗及所有医院或医疗记录副本及已提供医疗服务之正本发票等资料予宏利或其代理人。此授权书之复制本与正本具同等效力。

I/We understand that the pre-authorized credit service approval for hospitalization/day surgery/treatment shall not be regarded as admission of liability on the part of Manulife for any claim payment. The eventual actual claimable amount will be based on the final claim decision that is subject to insured's eligibility and case-based exclusion(s) (if any), reasonable & customary charges of all eligible expenses, claim documents/information to be received, benefit limits, remaining balance of the benefit limits, general exclusions and other terms and conditions as stated in the policy provisions, and reduced by annual deductible amount (if applicable). Should there be any discrepancy between the pre-authorized credit amount provided and the eventual actual claimable amount, the actual claimable amount shall prevail. **It means that, if the pre-authorized credit amount is higher than the eventual actual claimable amount, I/we would need to settle any shortfall as resulted from the credit service arrangement to Manulife (International) Limited ("Manulife") within the specified period as stated in the Repayment/Shortfall Notice.** Otherwise, I/we authorize Manulife to offset the shortfall amount against (to the fullest extent permissible by the applicable law) the amount due or payable to me/us from this Policy/Benefit and/or any Policy/Benefit issued by Manulife of which I/we am/are owner(s) or trustee(s) including but not limited to any death benefit, dividends or return of premium (for whatever reason). If the eventual actual claimable amount is higher than the pre-authorized credit amount, Manulife will settle the claim in accordance with the eventual actual claimable amount.

本人/我们明白住院/日症手术/治疗代缴费服务之初步授权批核不能被视为宏利承担有关赔偿责任。最后的实际赔偿额将取决于最终理赔决定,并受制于受保人的受保资格及个别不保项目、所有合资格的费用是否合理及惯常收费、随后收到的理赔文件/资料、保障限额、保障额的余额、一般不保事项及保单条款下之其他条款及细则,并需扣减每年的自付费(如适用)。如初步授权的批核金额与最后的实际赔偿金额有任何差异,将以最后实际赔偿金额为准。**意思是,若初步授权的批核金额高于最后的实际赔偿金额,本人/我们须于欠款/差额通知书中指定期限内向宏利人寿保险(国际)有限公司(「宏利」)缴付所有由代缴费服务引至的差额及欠款。**否则,本人/我们授权宏利把应收款项(在有关法律允许的最大范围内)从此保单/保障,及/或任何由宏利签发并以本人/我们作为保单持有人或信托人的保险单/保障所获支付予本人/我们的金额中抵销扣除,包括但不限于任何身故赔偿、红利或保费退还(不论何种原因)。若最后的实际赔偿金额高于初步授权的批核金额,宏利将按最后的实际赔偿金额支付赔偿。

I/We understand that acceptance of this Pre-Authorization for Credit Service for Hospitalization Form by Manulife shall not be regarded as admission of liability on the part of Manulife. Actual eligible claim amount will be subject to the final claim decision. All benefits payable are subject to the terms and conditions and the full list of policy exclusions. Should there be any discrepancy between this assessment and the final claim decision; the final claim decision shall prevail.

本人/我们明白宏利接受此初步授权申请表不能被视为宏利承担有关赔偿责任。实际赔偿金额以最终理赔决定为准。所有保障项目只会在符合所有保单条款及细则及所有不保之事项的情况下支付。如此评估与最终理赔决定有任何差异,均以最终理赔决定为准。

Personal Information Collection Statement 个人资料收集声明

Information (including but not limited to personal data and health information and claims history) collected from me/us/my dependent, the policyowner/policyholder and the proposed insured, can enable Manulife to carry on its insurance/financial business and may be:

从本人/吾等/本人的家属、保单持有人及拟受保人所收集的资料(包括但不限于个人资料、健康资料及索偿记录),可供宏利用于经营保险/金融业务之用,并可供:

i) used by Manulife, its associated companies, employees, third-party vendors/service providers, reinsurers and/or distributors for the purpose of (a) processing my application, including, but not limited to, determining eligibility and approval; (b) underwriting; (c) handling claim(s) including, but not limited to, administering, assessing, adjudicating, investigating, seeking external professional advice, disbursing payment, shortfall management, subrogation, analysis and reporting; (d) requests for payment and/or credit services; (e) administering the policy or any alterations, cancellation or renewal of it; (f) detecting and preventing fraud (whether or not relating to the policy issued in respect of this application); (g) providing customer service, including but not limited to, any follow up on related enquiry and/or communication with you and/or your representative(s); (h) statistical or actuarial research of Manulife, Manulife's associated companies or the insurance/financial industry; (i) automated/artificial intelligence decision making or profiling; (j) complying with applicable laws, regulations and other related purposes;

宏利、其关联公司、雇员、第三方供应商/服务供应商、再保险公司及/或分销商用于以下目的:(a) 处理本人申请,包括但不限于厘定资格及批核申请;(b) 核保;(c) 处理索偿,包括但不限于管理、评估、裁决、调查、征求外部专业意见、支付款项、差额管理、代位申索、分析及汇报事宜;(d) 付款请求及/或信贷服务;(e) 管理保单或有关保单的任何变更、取消或续期事宜;(f) 侦查及防范欺诈(无论是否与本申请书所签发的保单有关);(g) 提供客户服务,包括但不限于跟进相关查询,以及/或与阁下及/或阁下代表之间的通讯事宜;(h) 宏利、宏利的关联公司或保险/金融行业所开展的统计或精算研究工作;(i) 基于自动化/人工智能的决策或分析;(j) 遵守适用法律、法规及其他相关目的。

ii) transferred to (a) any related company or other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business or any regulatory/statutory bodies, association or federation of insurance companies that exists or is formed from time to time; (b) any person/organization to fulfill any of the above purposes and/or for the purpose of data verification by way of matching procedures or otherwise; and/or reinsurance of the policy; (c) health care professionals, hospitals, accountants, legal advisors, employers; (d) 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), law enforcement agencies and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information.

转移至(a)任何相关公司或其他从事保险或再保险相关业务的公司、中介人、提供保险相关服务的索偿、调查或其他机构,或任何现存或不时成立的监管/法定机构、协会或保险公司联合会;(b)以实现上述任何一项目的及/或以核对程序或其他方式进行数据核实,以及/或进行保单再保险事宜的任何个人/组织;(c) 医护专业人员、医院、会计师、法律顾问、雇主;(d) 为保险业整合索偿及核保资料的机构、防范欺诈机构、其他保险公司(无论是直接转移至或透过防范欺诈机构或本段所述之其他人士作出转移)、执法机构、可供保险业根据现有资料进行资料分析和核实的数据库或登记册(及其营运者)。

All data processes may involve a transfer of information to places either within or outside the Hong Kong Special Administrative Region/Macau Special Administrative Region. 所有资料处理程序可能涉及将资料转移至香港特别行政区或澳门特别行政区境内外的地方。

I/We understand that by completing and returning to Manulife this form, I/we am/are agreeing to the Notice to Customers relating to the Personal Data (Privacy) Ordinance ("Notice"), and the Notice is available on Manulife's website (www.manulife.com.hk) or upon request from my/our Manulife advisor ("Advisor").

本人/我们明白透过填写及交回此表格,即表示本人/我们同意《有关〈个人资料(私隐)条例〉的客户通知》(「通知」)之内容,而该通知可于宏利网址(www.manulife.com.hk)或本人/我们的宏利顾问(「顾问」)索取。

X

Signature of Insured (if Aged 18 or Above) *
受保人签署(如十八岁或以上) *

Name (In BLOCK LETTERS) & I.D. No. of Insured
受保人姓名(请以正楷书写)及身份证号码

Signature Date (DD/MM/YYYY)
签署日期(日/月/年)

X

Signature of Policyowner
保单持有人签署

Name (In BLOCK LETTERS) & I.D. No. of Policyowner
保单持有人姓名(请以正楷书写)及身份证号码

Signature Date (DD/MM/YYYY)
签署日期(日/月/年)

* For Insured aged below 18, signature of the policyowner must be provided for the application for Pre-Authorization Request
18岁以下受保人之初步授权申请必须由保单持有人签署

Manulife (International) Limited (Incorporated in Bermuda with limited liability)
宏利人寿保险(国际)有限公司(于百慕达注册成立之有限责任公司)

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