Medical Insurance - Dental Claim Form
醫療保險 - 牙科賠償申請表

Part I - To be completed by the Patient (or parent if patient is a minor)
甲部 – 須由病人填寫（若病人為小童，可由家長填寫）

No. of original receipt(s) attached　醫生發出之正本收據數量 (　　) 張。

Employer/Policyholder: 僱主/保單持有人	Policy No.: 保單號碼
Name of Employee/Member 僱員/成員姓名: (For group insurance policy only 只適用於團體保險)	Employee Code 僱員編號: (if applicable 如適用)
Name of Patient: 病人姓名	ID Card/ Passport No. of Patient: 病人身份證/護照號碼
Return original receipt(s) after claim settlement: 賠償完成後，需退回正本收據：☐ No 否　☐ Yes 是	
If the consultation was due to accident, please provide: 若診治因意外引起，請提供: Date of Accident 意外發生日期: _____ Time 時間: _____ Place 地點: _____ Brief Description 經過 : _____	

Claim Type: 賠償類別　☐ (1) Routine Oral Examination (including Scale & Prophylaxis) 例行口腔檢查(包括洗牙及預防治療)

☐ (2) Other Dental Treatment 其他牙科治療

Please complete part I only for claim type (1) and both Part I & II for claim type (2).
賠償類別(1)，只須填寫甲部。 如屬於賠償類別(2)，必須填寫甲部及乙部。

DECLARATION & AUTHORIZATION 聲明及授權:

I hereby declare that the above information given is true and correct. I further authorize any physician, hospital, insurance company or organization to furnish part of or all medical history (including but not limited to information in respect of consultations, diagnostic test results, prescriptions or treatment) with respect to any illness or injury of me to FWD General Insurance Company Limited or its authorized representative. A photocopy of this authorization shall be considered as effective and valid as the original.

本人現聲明上述所填報的資料正確無訛。本人授權任何醫生、醫院、保險公司或機構，可以將部分或全部有關本人傷患之病歷(包括但不限於診症、診斷性檢驗結果、藥方或治療資料)給予富衛保險有限公司或其已獲授權之代理人。此授權書之副本與正本具同等效力。

Signature of Patient 病人簽署: _____　Date 日期: _____

If the patient is a minor, the patient's parent / legal guardian can sign on his/her behalf *若病人為小童，則可由家長 / 合法監護人簽署*

Signature of Parent / Legal Guardian: _____ Relationship: _____

家長/合法監護人簽署　與病人關係

Notes : 注意

(1) Please return the completed claim form together with the original receipt to the Company.
請填妥賠償申請表，連同正本收據寄回本公司。
(2) All original receipts must bear the clinic's chop and doctor's signature.
所有收據正本須蓋有診所印章及由醫生簽署。

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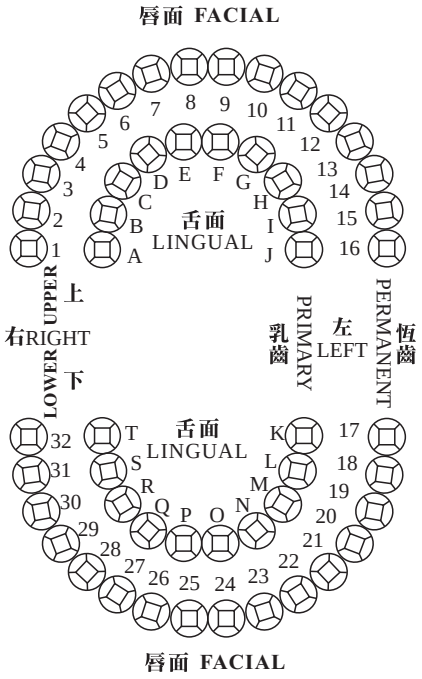
Part II - To be completed by the dentist
乙部 – 須由負責治療之牙科醫生填寫

Name of Patient: _____
病人姓名

Policy No.: _____
保單號碼

Please mark teeth treated on the following chart.
請在下圖顯示接受治療之牙齒。



Date of Service 日期 (dd/mm/yy) (日/月/年)	Tooth No. 牙齒號碼	No. of Surface / root 部位	Particulars (cause & description of services) 治療詳情	Charges 收費

Is the above condition arising from congenital condition?
以上情況是否屬先天性症狀？

☐ Yes 是 ☐ No 否

If No, please state the cause of the above condition.
如“不是”，請簡述致病原因。

_____

Dentist's Name: _____
牙科醫生姓名

Address: _____
地址

Telephone: _____
電話

Signature of Dentist and Chop
牙科醫生簽署及蓋印

Date
日期

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