

## Individual Medical Insurance - Dental Claim Form

### 個人醫療保險 - 牙科賠償申請表

Part I - To be completed by the Patient 甲部 - 須由就診者填寫	
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	Employee code 僱員編號 : ( if applicable 如適用 )
Name of Patient : 就診者姓名	ID Card / Passport no. of Patient : 就診者身份證 / 護照號碼
If the consultation/treatment 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： <input type="checkbox"/> (1) Routine Oral Examination 例行口腔檢查 (including Scale & Prophylaxis 包括洗牙及預防治療) <input type="checkbox"/> (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。 Are you making any other insurance claim for this claim? 有關此次索償，閣下有否申請其他保險索償？ <input type="checkbox"/> No 沒有 Original receipt will not be returned in any circumstances. If copy of receipt for other purpose is needed, please make a copy before submission. 在任何情況下不設退回正本收據，如需副本作其他用途，請於遞交前自行影印收據。 <input type="checkbox"/> Yes 有 (Required information 必需填寫) Name of the Insurance Company 保險公司名稱： _____ Policy No. 保單號碼： _____ Type of Policy 保單類別： _____ 請注意只退回附有索償餘額之正本收據以申請其他索償，如需副本作其他用途，請於遞交前自行影印收據。 Please note that only the original receipt with unpaid claim balance will be returned for applying other claims. If copy of receipt for other purpose is needed, please make a copy before submission.	

## Declaration 聲明

I/We have read, understood and accepted the Personal Information Collection Statement of the Company ("PICS"). By signing below, I/We confirm this application and agree that the Company may use and disclose all personal data about me/us that the Company currently or subsequently hold for the purposes as set out in the PICS, and I understand I can scan the QR code below for review of the PICS or else I can request a copy of the PICS by calling the Company's Customer Service Hotline at 2603 9435.



本人/我們已閱讀、明白及接受本公司的收集個人資料聲明。透過以下簽名，本人/我們確認此申請並同意本公司可根據收集個人資料聲明列出之目的使用及披露本公司目前或將來持有的關於本人/我們的所有個人資料，並理解本人可以掃描以下二維碼查看本公司的收集個人資料聲明，或可致電本公司的客戶服務熱線 2603 9435 索取收集個人資料聲明副本。



Signature of Patient 就診者簽署：\_\_\_\_\_ Date 日期：\_\_\_\_\_

If the patient is a minor, the patient's parent / legal guardian can sign on his/her behalf 若就診者為小童，則可由家長 / 合法監護人簽署

Signature of Parent / Legal Guardian 家長 / 合法監護人簽署：\_\_\_\_\_ Relationship 與就診者關係：\_\_\_\_\_

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 Dentist's signature.  
所有收據正本須蓋有診所印章及由牙醫簽署。



## Personal Information Collection Statement (“PICS”) 收集個人資料聲明

Please scan the following QR code for review of Bolttech Insurance (Hong Kong) Company Limited’s (the “Company”) PICS. You can also request a copy of the PICS by calling the Company’s Customer Service Hotline at 2603 9435.

請掃描以下二維碼查看保特保險(香港)有限公司(「本公司」)的收集個人資料聲明。您亦可致電本公司的客戶服務熱線 2603 9435 索取收集個人資料聲明副本。



English



中文