

# Marsh Study Abroad Protection

## Medical Expenses Claim Form

醫療費用索償申請表

Please submit your claim to  
**Marsh (Hong Kong) Limited**  
26<sup>th</sup> Floor, Central Plaza  
18 Harbour Road, Wanchai, Hong Kong  
Tel: 852 2301 7680 Fax: 852 2539 5368

*Claim notification must be submitted within 30 days of incurring such expenses* 索償申請必須在接受診療後 30 天內通知或提交

### Name of Policyholder

保單持有人姓名

### HK Contact Phone No

香港聯絡電話

### HK Correspondence

Address 香港聯絡地址

### Student Name

學生姓名

### Date of First

Consultation

初次醫療門診日期

### Diagnosis

病症

### Certificate No

保險證明書號碼

### Policyholder's

Email Address

保單持有人電郵地址

### Student's Email

Address

學生電郵地址

### Claimed Amount /

Currency

索償總額 / 貨幣

*All Payments will be credited to the Student's / Policyholder's designated Bank Account by auto-pay in Hong Kong (Pay in HKD)*

所有醫療費用賠償將會直接存入學生 / 保單持有人指定之香港銀行賬戶 (以港幣入賬)

### Name of Bank

銀行名稱

### Bank Account No

銀行賬戶號碼

### Payee Name in the Bank

收款人銀行賬戶姓名

(Please use BLOCK LETTER 請以英文正楷填寫)

*Please ✓ where appropriate and provide document* 請在適當項目 ✓ 及提供有關文件

- Medical receipts &/or attending physician's report (showing the date of treatment, patient's name, diagnosis and the clinic's or hospital's chop & attending physician's signature)** 醫療費用收據 / 報告 (必須註明診療日期、病人姓名、病症、醫療機構印章及主診醫生簽署) \_\_\_\_\_ piece(s)張
- Receipts for buying drugs from pharmacy &/or receipts from laboratory for undergoing X-ray examination & laboratory tests, supported by attending physician's prescription &/or referral (showing the date of treatment, patient's name, diagnosis and the clinic's or hospital's chop & attending physician's signature).** 醫生處方藥物購買單據、X光檢查 / 醫療化驗報告費用正本收據、主診醫生處方或轉介文件、醫療報告(須註明診療日期、病人姓名、病症、醫療機構印章及主診醫生簽署) \_\_\_\_\_ piece(s)張
- Other Document** 其他文件 \_\_\_\_\_ piece(s)張

**Please note that all attached payment receipts must be original 請注意所有附上之單據必須為正本**

### Declaration and Authorization 聲明及授權書

*I declare that to the best of my knowledge and belief the above statement and particulars contained are in all respects true and complete and are made without reservation of any kind. I hereby authorize any physician, medical practitioner, hospital or clinic by whom or where I have been observed or treated to give full particulars about my health to Federal Insurance Company. A photocopy of this authorization shall be considered as effective and valid as the original.*  
本人謹此聲明本人確信以上所填報之資料及所列各項之事件乃屬完全真確並無對保險公司作出任何資料之保留。本人授權於任何曾替本人作診療之醫生，醫務人員，醫院或診所提供有關本人病歷之資料予聯邦保險公司，此授權書之影印本亦屬有效。

### Name & Signature of student / policyholder

學生或保單持有人簽署及姓名

### Application Date

申請日期

*Additional documents relevant to the claim may be required to be forwarded upon request of Federal Insurance Company*

因理賠所需，聯邦保險公司可能要求提供額外有關文件