Forte Insurance (Cambodia) Plc.

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Group Hospital & Surgical Claim Form
集体住院和手术索赔表

The Claimant must answer all the relevant questions in Part 1 below, fully and accurately and together with ORIGINAL CONFIRM ITEMISED HOSPITAL BILLS AND RECEIPTS, which are to be claimed under the Policy, submit them to Forte Insurance (Cambodia) Plc. within thirty (30) days from the date of discharge. Any delay in settlement of claim caused by non-compliance of aforesaid may result in interest charge by the Hospital and this interest charge will be borne by the employer/claimant.
索赔人必须充分而又准确地在下列第一部分内回答所有相关的问题, 连同详细列出的医院帐单和收据原件, 这是在保单下索赔的依据。将这些在出院后的 30 天内提交到富得保险（柬埔寨）有限公司。如果没有遵守上述的内容，而引起的索赔结算的延迟，导致支付给医院利息费用, 而这个利息费用将由雇主或索赔者承担。

PART 1 第一部分

A. CLAIMANT DETAIL 索赔人详情

Name of Policyholder/Employer 保单持有人/雇主名称			Name of Claimant (if Dependant of Employee) 索赔人姓名(如果是雇员家属)	Age 年令	Marital 婚姻状况 ☐ S 未 ☐ M 已
Policy No. 保单号	Plan No. 计划号	Membership No. 会员号:	Relationship of Dependant 与雇员的关系		
			☐ Husband/Wife 丈夫/妻子 ☐ Son 儿子 ☐ Daughter 女儿		
Name of Employee 雇员姓名			Is Dependent employed? 家属是否受雇?	☐ Yes 是	☐ No 否
			If Yes, please furnish name of employer 如果是,请提供雇主姓名:		
Occupation: 职业	Date of Employment 受雇日期	Age 年令	Sex 性别 ☐ M 男 ☐ F 女	Name and Address of regularly/family doctor 定点医生/或家庭医生的地址和姓名	

B. SICKNESS (This section must be answered in full)
疾病（此部分请务必完全填写）

Diagnosis 诊断	Type of operation performed, if applicable 如果进行了手术，请说明手术类型	Has the sickness been treated previously? ☐ Yes 是 ☐ No 否 这种疾病以前是否接受过治疗？ If yes, Name and Address of Physician 如果是， 请提供主治医生的姓名和地址
Date first began 疾病开始的日期	Date First Treated 第一次治疗日期	Date of previous treatment 以前治疗的日期

Is the sickness arising from employment? ☐ Yes 是 ☐ No 否 疾病是否由工作引起?	Is the sickness due to pregnancy, abortion, miscarriage, sterilization, sub-fertility and infertility? 疾病是否由妊娠、堕胎 、 流产、节育、难以受孕或不育造 成? ☐ Yes 是 ☐ No 否
	If Yes, please specify condition and approximate date of commencement: 如果是，请具体说明情况和开始的大致日期

C. INJURY 受伤

Date of Accident 意外的日期 / Time of Accident 意外的时间	Describe how and where the accident happened 描述事故如何发生及发生的地点
Is this a job-related Accident? ☐ Yes 是 ☐ No 否 这个意外是否与工作有关	

D. OTHER INFORMATION 其它信息

Name of Hospital/Clinic 医院/诊所的名称	Is the Claimant entitled to claim against Workmen's Compensation Benefits, Employer's Medical Benefits Programmed, or insurances other than from Forte Insurance (Cambodia) Ltd. 索赔人是否享受劳工补偿金利益或在富得保险之外的其他保险公司受保 ☐ Yes 是 ☐ No 否
Address of Hospital 医院的地址	If Yes, please state insurance company: 如果是请说出保险公司的名称 :
Date of admission 入院日 期 / Date of Surgery Performed 手术日期 / Date of discharge 出院日期	
Name and Address of Attending Physician/Surgeon 主治医师或手术医师的名字和地址	Claim cheques shall be made payable to: 索赔支票应付给 ☐ Hospital 医院 $ _____ ☐ Employer 老板 $ _____ ☐ Employee 员工 $ _____

MEDICAL INFORMATION AUTHORITY 授权医疗信息

I hereby authorize any hospital surgeon, medical practitioner or clinic or other person who has attended to me or examined me for any reason, to disclose to Forte Insurance (Cambodia) Co., Ltd. any and all information with respect to any illness or injury and, to provide to Forte Insurance (Cambodia) copies of all hospital or medical record, including prior medical history. A Photostat copy of this authorization shall be considered as effective and valid as the original.

我在此授权任何为我治疗护理或检查的医院的外科医生、内科医生开业者或诊所或其它的个人,在"富得保险公司"的要求下,向他们提供全面的任何有关疾病、受伤、病史、咨询或处置的信息，此授权书的复本应被视为与正本一样有效。

Employer's Signature/Company's Stamp/Date
雇主签名 /公司盖章/日期

Claimant's/Employee's Signature/Date
索赔者的/雇员的签字

PART 2 - CERTIFICATION OF HOSPITALIZATION
第二部分 住院证明

Name of patient 病人姓名	Age 年令	Sex 性别 ☐ M 男 ☐ F 女

1 a) What is the diagnosis/Extent of injury?
诊断/损伤程度

_____

_____

b) Is the condition due to:
造成这种情况的原因

i) Congenital anomaly ☐ Yes 是 ☐ No 否
先天畸形

ii) Nervous mental disorder ☐ Yes 是 ☐ No 否
神经精神疾病

iii) Treatment of teeth or gum tissue ☐Yes 是 ☐ No 否
牙龈或牙龈组织治疗

iv) Self-inflicted injury/drug addiction ☐ Yes 是 ☐ No 否
自我伤害和吸毒

v) Job-related injury ☐ Yes 是 No 否
因工作受伤

vi) Sexually transmitted disease ☐ Yes 是 ☐ No 否
性传播疾病

c) Is it due to or complication arising from pregnancy, childbirth, miscarriage, abortion, impotency, sterilization, sub-fertility or infertility?
疾病是否由于妊娠、分娩、流产、堕胎、节育、难以受育或不育造成或由上述原因引起的并发症？

☐ Yes 是 ☐ No 否

If yes, what was the approximate date of commencement?
如果是，疾病开始的大约日期是：

_____

If for miscarriage, was it due to accident ☐ Yes 是 ☐ No 否
如果是属于流产，是否由于意外事故造 成？

Is the surgery for cosmetic purpose? ☐ Yes 是 ☐ No 否
手术是否以整形为目的

Is the surgery medically necessary? ☐ Yes 是 ☐ No 否
从医学上讲手术是否必要

2 a) When you first consulted for the above sickness?
病人第一次就上术疾病来向您就诊是什么日期？

_____

b) What was his/he complaint when he/she first saw you?
病人第一次来就诊是怎样叙述自己的病情？

_____

c) How long do you think this injury or sickness has been existing?
您认为病人的病情或伤势存在多久了？

_____

d) How long had the patient been troubled by symptoms prior to consulting you?
病人来向您就诊之前已经有这种症状多久了？

_____

e) Had the patient ever had same or similar condition/symptoms/病人是否有过同样或类似的症状？

☐ Yes 是
☐ No 否
☐ Not to my knowledge 我不知道

f) Had the patient been treated by other doctors for the sickness? If so, please specify below.
病人以前是否因此疾病找过其他医生就诊？ 如果有，请说明具体情况。 ☐ Yes 是 ☐ No 否

Physician previously consulted by patient for the above sickness (Please specify referral made by physician)
病人以前因为上术病症就诊过的医生（请具体列出曾被诊治过的医生）

Name 姓名	Approximate Date 大致日期	Name of Clinic(s) and Address (es) 诊所的名称和地址

3. Surgical Cases 手术病历

a) Nature of operation(s) performed/surgical procedure(s)
所完成的手术/外科手术程序的性质

b) Date performed 所做的手术的日期

c) Where was the operation(s)/surgical procedure(s) performed?
该手术/外科程序 是在哪里进行的?

☐ Hospital 医院
☐ Clinic 诊所

d) Were the surgical procedures approached through the same incision? ☐ Yes 是 ☐ No 否
多个相似的外科手术通过同一切口吗?

e) If excision is performed, please indicate the size(s)/measurement(s) of lesion(s)/tumor(s).
如果对损伤或肿瘤进行了功除/请说明大小和尺寸

f) Name of Surgeon(s) 各手术医生的姓名

g) Name of Anesthetist 麻醉医师的姓名

4 a) Is patient still under your care for the sickness? ☐ Yes 是 ☐ No 否
目前是否仍由您来为病人治疗该病?

b) If yes, how long do you expect this to continue and when are you going to review his/her condition again?如果是， 你估计这种情况要持续多久？ 您什么时间再为病人复查？

c) If no, please state date of termination
如果没有， 请说明终止的日期

d) If patient has been referred to another doctor for follow-up, furnish name & address of doctor.
如果病人被转诊到另一位医生处继续治疗, 请提供该医生的地址和姓名

e) What is the prognosis of this illness?
对病情的预计如何？

Physician's/Surgeon's Signature/Date
主治医生的/外科医生的签字

Name/Designations
姓名/职称

Address
地址

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MEDICAL REPORT FORM
医学报告表

Forte Insurance (Cambodia) Ltd.
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Tel: (855) 23 982 882/366 683/885 066 Fax: (855) 23 982 907
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Part I (To be completed by the Insured) 第一部分 (由保户填写)

Name of Patient 病人姓名	Passport / ID No. 护照/身份证号码
Policy No. 保单号码 Certificate No. 证书号码	Date of Hospitalization/Day Surgery/ *SOC attendance 住院日期/手术日期/专家门诊日期 From 从 To 至;

II hereby authorize any hospital, physician, or other person who has attended to me / my child or examined me / my child or is authorized to maintain medical records, to disclose when requested to do so by Forte Insurance (Cambodia) Ltd. any and all information with respect to any illness, or injury, medical history, consultation, prescription or treatment. A photostat copy of this authorization shall be considered as effective and valid as the original.
我在此授权任何为我/我的孩子治疗或栓查，或有权保存有我/我的孩子医疗档案的医院或个人,在富得保险公司的要求下,向他们提供全面任何有关疾病、受伤、病史、咨 询或处置的信息。此授权书的复本应被视为与正本一样有效。

Date 日期	Signature of Claimant 18 years of age and over if dependant of Insured Member 如果是保户家属, 18 岁或 18 岁以上的索赔人签名	Signature of Insured Member 保户签名

Part II (To be completed by the Medical Records Officer based on the notes in medical records or the Attending Doctor or any other doctor authorized by the Head of Department) 第二部分 (由管理病人医疗档案的人员根据医疗记录填写或由经部门负责授权的任何其他医生填写)

<table>
<tr><td colspan="2">Hospital Reference No.
医院记录号:</td></tr>
<tr><td colspan="2">Final Diagnosis of illness / Extent of injury
疾病的最终诊断/损伤的程度</td></tr>
<tr><td>Name and address of doctor who referred the patient to the hospital (if known)
建议转诊到该医院就医的医生的姓名和地址（如果知道）</td><td>Date of 1st consultation for the above condition
第一次就上述情况就诊的日期</td></tr>
<tr><td>Type of operation performed (if applicable)
手术类型(如有施行)</td><td>Date performed
施行手术的日期</td></tr>
<tr><td>Signature of ** MRO / Doctor
病案管理员 / 医生签名</td><td>Date
日期</td></tr>
</table>

*SOC – Specialist Out-Patient Clinic 专家门诊
**MRO – Medical Records Officer 病案管理员