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在索取、列印或填寫表格前，請閣下先詳閱下文。

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CTF Life
周大福人壽

Claimable Amount Estimate Form

可賠償金額估算表格

Claimable Amount Estimate provides an estimate for how much you can claim under your policy, with an aim to provide information on the medical expenditure budget before surgery / hospital admission.

可賠償金額估算服務為您估算從保單可獲得的賠償金額，幫助您於手術/住院前掌握醫療開支的預算。

1	Complete by the attending physician/surgeon 由主診醫生/外科醫生填妥表格
2	Submit the completed form by e-mail to **CTFLife.PA@ump.com.hk** before surgery / admission. 於入院 / 手術前填妥的表格電郵 **CTFLife.PA@ump.com.hk**
3	You/ you and your handling agent will receive email message on the Estimated Claimable Amount from CTF Life in **5 working days** 您/您及您的理財顧問將在 **5** 個工作日內收到周大福人壽的電子郵件通知有關可賠償金額*之估算。
4	After the treatment or on discharge, please submit the bill and "Hospitalization and Surgical Claim Form", please quote the reference no. under the Estimated Claimable Amount to facilitate the claim settlement. 治療後或出院後，遞交單據及「住院和手術賠償申請書」，請在賠償申請書內填上可賠償金額估算之參考編號，以便加快理賠進度。

* Please note that the Estimated Claimable Amount is for reference only, the final Claimable Amount might be varies based on the final medical bill and claim assessment. 請注意：此金額及結果只供參考，最終可賠償金額因應實際醫療單據及賠償批核情況而定

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保單號碼 Policy Number		保險代理 / 經紀姓名 Name of Agent / Broker	
電郵地址 Email address		保險代理 / 經紀編號 Code of Agent / Broker	
電話 Telephone No.		電話 Telephone No.	

Details of Treatment and Estimated Expenses 治療詳情及預算費用

Submit the completed form by e-mail to CTFLife.PA@ump.com.hk 將填妥的表格電郵 CTFLife.PA@ump.com.hk 提交

(To be completed by the Insured's attending Physician/Surgeon at the Policyowner/Insured's expenses if any)

(由受保人之主診醫生或外科醫生填寫，如有需要保單持有人或受保人需自行承擔填寫表格費用)

病人姓名 **Name of patient**	身份證/護照號碼 **ID / Passport No.**

A. Medical Condition 醫療詳情

1. Diagnosis and associated signs and symptoms 診斷和相關病狀及病徵：	
2. Accident date (if applicable) 意外日期（如適用）（DD 日 / MM 月 / YYYY 年）:	
3. Onset date of first symptoms 首次發病日期（DD 日 / MM 月 / YYYY 年）:	
4. First consultation date 首次求診日期（DD 日 / MM 月 / YYYY 年）:	
5. Date on which symptoms/complaints first appeared (DD/MM/YY) 病徵或不適首次出現之日期 (日/月/年) :	
6. Has the patient ever had the same or similar symptoms/medical conditions before or is this a chronic/recurrent illness? 病人是否曾經患有同一或相似病徵 / 病況或此情況為慢性 / 復發性？ If yes, please provide the date of the first episode and details 如是，請提供首次病發日期及詳情：	☐ Yes 是 ☐ No 否
7. Name of referring physician (if any) 轉介醫生的姓名（如有）：	
8. Name of the physician that the patient first consulted for this illness (if any) 病人就此疾病首次求診的醫生姓名及電話（如有）：	

Physician name 醫生姓名：		Telephone Number 電話號碼：	

B. Treatment Details 治療詳情

1. Name of Surgical Procedure/Treatment (If more than one surgery, please provide the name for each surgery.)
手術 / 治療名稱（如多於一項手術，請提供每項手術的名稱）：

1.	2.	3.

2. Anaesthesia 麻醉：	☐ GA 全身麻醉	☐ MAC 監測麻醉	☐ LA 局部麻醉
3. Name of Hospital/Medical Centre 醫院 / 診所名稱：			
4. Intended Level of Room Class 預計入住病房級別：			
☐ Day Centre/Clinic 日間中心 / 診所	☐ Ward 普通病房	☐ Semi-private 半私家房	☐ Private 私家房
5. Date of Admission/Surgery 入院 / 手術日期（DD 日 / MM 月 / YYYY 年）:			
6. Expected length of stay 預計住院日數：			

7. Can the treatment and the medical test(s) be managed under an out-patient setting instead? 是次檢查及治療可否在門診處理,而無須在醫院進行? ☐ Yes 可以 ☐ No 不可以	If "Yes", why was the patient admitted to hospital? 若可以在門診處理,請說明病人住院的原因

8. Estimated Total Fee for this confinement/surgery (HKD) 預計住院 / 手術所需總費用（港幣）：

If more than one surgery, please provide the estimated cost for each surgery 如多於一項手術，請提供每項手術的預算費用。

Surgeon's Fee # 外科醫生費用#	1.	2.	3.
Daily Physician's Hospital Visit (if any) 每日醫生巡房費用（如有）			
Daily Hospital Room Rate (if any) 每日住院病房收費（如有）			
Anaesthetist's Fee (if any) 麻醉醫生費用（如有）			
Operation Theatre Fee (if any) 手術室費用（如有）			
Miscellaneous Hospital Charges (if any). Please provide the details. 醫院雜項費用（如有）, 請提供細項資料			
Prescribed Diagnostic Imaging Tests (if any). Please provide the details. 訂明診斷成像檢測 （如有）, 請提供細項資料			

C. Doctor's information 醫生資料

1. Are you the patient's usual physician? 閣下是否該病人的慣常醫生？ ☐ Yes 是 ☐ No 否

2. Are you related to the patient in anyway other than your professional capacity? 除專業身份，閣下與病人是否有其他關係？ ☐ No 否

☐ Yes please specify the relationship with patient 是，請提供與病人之關係：

I hereby certify that all information given above is accurate and true to the best of my knowledge. 本人特此聲明，就本人所知，上述所有資料均準確無誤。

Contact Telephone Number 聯絡電話號碼	Email Address 電郵地址	Fax Number 傳真號碼
Doctor's Signature and Chop 醫生簽署及蓋章	Doctor's Name 醫生姓名	Date 日期（DD 日 / MM 月 / YYYY 年）：

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