香港浸信會醫院
Hong Kong Baptist Hospital

浸聯會員工保險賠償餘數優惠申請
Baptist Convention Member Discount – Application for Refund of Balance After Insurance Claims

1. 申請人資料 Applicant's Personal Particulars

病人姓名 Patient's Name：(中)(Chi)_____ (英)(Eng)_____

住院日期 Hospitalization Period：(日 / 月 / 年) (DD/MM/YY) _____ 至 to _____

日間聯絡電話 Day-time Contact No.：_____

電郵地址 Email Address：_____

2. 受薪員工資料 Staff's Personal Particulars

姓名 Name：_____ 與申請人之關係 Relationship with Applicant：_____

職位 Position： ☐ 牧師/傳道/宣教士 Pastor/Minister/Missionary ☐ 職員 Staff

事奉教會 / 機構名稱 Name of the Employer：_____

3. 退款支票抬頭：(必須填寫) Cheque made payable to: (must complete)

英文 English in BLOCK Letters: _____

4. 申請手續 Application Procedures

如受惠者有多過一間保險公司之保險賠償，必須將所有有關文件之正本或保險公司核實副本同時遞交。
If there are more than ONE insurance claim, ALL original or insurance companies' certified true copy documents must be submitted together.

a) 請於保險賠償後 **2 個月內**向本院提交申請，逾期作廢。
All applications should be submitted to the Hospital **within 2 months** after insurance claims. Overdue application is not accepted.

b) 請遞交以下所需文件 Please submit the following required documents：
(請於適當 ☐ 內加上「✓」號 Please tick the appropriate box)

(i) 填妥之「浸聯會員工保險賠償餘數優惠申請」(此表) completed [Baptist Convention Member Discount – Application for Refund of Balance After Insurance Claims] (this form) ☐ 正本Original

(ii) 本院收費單 Invoice ☐ 正本Original 或 or ☐ 保險公司的核實副本 Insurance company's Certified True Copy

(iii) 本院正式收據 Official Receipt ☐ 正本Original 或 or ☐ 保險公司的核實副本 Insurance company's Certified True Copy

(iv) 保險公司賠償單 Claims Settlement Statement ☐ 正本Original ____份 Set(s)

(v) 已付郵費回郵信封壹個 Stamped Envelope with Return Address ☐

c) 請將申請文件寄往**九龍塘窩打老道222號香港浸信會醫院院牧部收**。
Please send the documents to:
Pastoral Care Department, Hong Kong Baptist Hospital, 222 Waterloo Road, Kowloon

備註:
1) 本院收妥申請文件後，約 **6-8 星期**處理申請。退款支票將以回郵信封寄出。
2) 查詢電話： 2339-8908 (院牧部)

Remarks:
1) **6-8 weeks** are needed to proceed the application. Refund will be given in cheque by mail.
2) For enquiry: 2339-8908 (Pastoral Care Department)

病人或監護人簽署 Signature of Patient or Guardian：_____ 日期 Date：_____

此欄只供本院專用 **For office use**

Validated by	: _____	Approved by	: _____
Name	: _____	Name	: _____
Date	: _____	Date	: _____
Payor Plan	: _____	Episode no.	: _____