The Insurance Complaints Bureau
保險投訴局

Annual Report
年報 2019-2020

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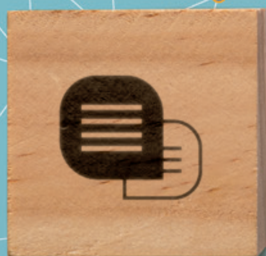


Statement of the Chairman
主席報告

30/04/2019 - 29/04/2020

Dr Pamela Chan Wong Shui, BBS, JP
陳黃穗博士，銅紫荊星章，太平紳士

Vision

"To be the independent and trusted body to the insuring public in resolving claim and non-claim related monetary disputes arising from personal insurance policies. We aim to be impartial, efficient and user friendly with respect to all parties."

The above statement was adopted by the General Committee in October 2019.

保險投訴局的抱負

「致力成為消費者信任的獨立機構，協助解決由個人保單引起，索償與非索償相關而涉及金錢性質的保險糾紛，旨在為大家提供公平公正、快捷及易於使用的服務。」

理事會於 2019 年 10 月通過上述宣言。

Membership and Board Governance

As at 29 April 2020, the Insurance Complaints Bureau (ICB) had 114 Member Insurers, i.e. 103 Full Members and 11 Affiliate Members.

ICB is governed by the General Committee consisting of an independent Chairperson and seven members of whom four are non-insurance industry professionals, namely, Dr C K Lo, Mr Herbert H K

會員及理事會管治

截至 2020 年 4 月 29 日，保險投訴局（投訴局）共有 114 間會員公司，其中 103 間為基本會員，11 間為附屬會員。

投訴局由理事會管理，成員包括獨立主席和七位理事，當中四位為非業界的專業人士，包括：盧子健博士、蔡克剛律師、衛皓民先

Tsoi, Mr Paul F Winkelmann and Prof Paul S F Yip, and three from the industry, namely Mr Praveen M Daswani, Mr Eric K K Hui and Mr Mike S C Lee.

生和葉兆輝教授；另外三位則來自業界，包括：戴宏年先生、許金桂先生和李少川先生。

ICB Secretariat is substantially supported by the Hong Kong Federation of Insurers (HKFI). In 2019, total expenditure of ICB was approximately HK$2,860,000.

投訴局祕書處得到香港保險業聯會（保聯）在管理及行政上的支援，於 2019 年，投訴局的營運費用約為 286 萬港元。

Operation

運作

The General Committee considered the operation process and in particular the efficiency of the process for handling complaints. In 2019, 88% of claim-related complaints were completed within six months. This is an improvement over 2018 where only 52% were completed within six months.

年內理事會對投訴局的運作流程作深入了解，特別是處理投訴的效率，2019 年有 88% 與索償相關的投訴個案在六個月內完成，相比 2018 年的 52% 大有進步。

New Funding Model

新收費模式

During 2019, the General Committee studied statistics of complaint cases received by ICB and the former ICCB in the past five years and found that almost 70% of the complaint cases received were lodged against 10 or less Member Insurers. Hence, charging a subscription fee on a flat rate basis may not be fair to all Member Insurers. We made reference to similar jurisdictions overseas and proposed a two-tier funding mechanism, consisting of a base annual membership subscription and a Case Fee.

在 2019 年，理事會研究過去五年投訴局及其前身「保險索償投訴局」收到的投訴個案統計數字，發現接近 70% 的投訴個案來自 10 間或更少的會員公司，因此向會員公司收取劃一年費並非一定公平。我們參考了海外類似機構的運作，從而構思了兩層的收費機制，包括會員公司的基本年費和個案費。

We were delighted with the positive feedback from the industry consultation conducted in early October 2019 on the proposed new ICB funding model. Out of 47 respondents, 45 (96%) expressed strong support and agreed that it would be a fairer and more reasonable fee structure in line with overseas practices.

我們在 2019 年 10 月初就擬建議的新收費模式進行業界諮詢，會員公司的正面回應令我們十分欣慰。在 47 名回應者中，有 45 名（96%）表示支持擬建議的新收費機制，並同意這是更公平及更合理的收費結構，且符合海外類似機構的做法。

At the ICB General Meeting held on 9 December 2019, Member Insurers passed a resolution to introduce the Case Fee, which is payable by Member Insurers for each case in excess of a prescribed threshold approved by the General Committee. This will be on top of a base annual membership subscription payable by all.

投訴局在 2019 年 12 月 9 日舉行會員大會，會員公司議決通過設立個案費，所有會員公司除了需要繳付基本年費外，個別會員公司還需要就超出理事會指定數量的每宗個案繳交個案費。

This new funding mechanism, based on a user-pay principle, is undoubtedly a relatively simpler, easier to administer and fairer system to Member Insurers. The General Committee shall regularly review the mechanism to ensure that it remains fair, equitable and sustainable over time.

根據用者自付原則的新收費機制無疑是相對簡單、易於管理及對會員公司更公平的制度。理事會將定期檢討新收費機制，以確保制度保持公平、公正及可配合投訴局的持續發展。

Public Perception of ICB

We participated in a section of the market research on customer experience conducted by the HKFI. The survey outcome was encouraging in that 88% of Hong Kong customers and 93% of Mainland customers surveyed were aware of ICB and its services. ICB was also found to be one of the most preferred channels consumers would seek help from on personal insurance disputes. This reflected that ICB is highly recognized by both Hong Kong and Mainland consumers. It should be noted that ICB only expanded its mandate to cover non-Hong Kong residents in May 2013.

投訴局的公眾認知度

投訴局參與由保聯進行就客戶體驗的市場調查的其中一部分，調查結果令人鼓舞，分別有 88% 及 93% 參與調查的香港及內地客戶知悉投訴局及其提供的服務，而投訴局亦是消費者遇上個人保險糾紛而需尋求協助時會優先選擇的渠道之一，這凸顯了投訴局得到香港和內地消費者的高度認知，特別一提的是：投訴局在 2013 年 5 月才擴大職權範圍至可以處理非香港居民的投訴。

Meeting with International Monetary Fund (IMF) Financial Sector Assessment Program (FSAP) Team

On 19 September 2019, we were pleased to meet with the IMF FSAP Team visiting Hong Kong for a comprehensive and in-depth analysis of Hong Kong's financial sector. Apart from introducing our background and operation, including the adjudication and mediation processes, we discussed the volume and nature of complaints received as well as areas for future improvements.

與國際貨幣基金組織的金融部門評估規劃小組會議

我們於 2019 年 9 月 19 日與國際貨幣基金組織的金融部門評估規劃小組會面，該評估規劃小組到訪香港的目的主要是就香港金融業進行全面及深入的分析。我們除了向小組專家介紹投訴局的背景、運作，以及裁決和調解個案的流程外，還討論接獲的個案數量、投訴類別的趨勢及日後可改善的地方。

The Insurance Claims Complaints Panel (Complaints Panel)

Disputes related to claims are handled by an independent Complaints Panel established under ICB, which impartially adjudicates claim disputes between insurers and policyholders or their beneficiaries. The five-member Complaints Panel is chaired by Mr Michael F S Tsui, barrister-at-law. Two non-insurance professionals are nominated respectively by Consumer Council and the Hong Kong Institute of Certified Public Accountants. Two members from the insurance industry are nominated by the Life Insurance Council and the General Insurance Council of the HKFI. The fact that the majority of Members of the Complaints Panel comes from outside the insurance industry clearly reflects the impartiality and independence of this alternate dispute resolution mechanism. Decisions of the Complaints Panel are binding only on Member Insurers of ICB. Complainants are free to seek legal remedy if they so desire. The legal rights of the complainants, therefore, are not affected by the decisions of the Complaints Panel.

In 2019, ICB handled 361 claim-related complaints, of which 35 cases were heard by the Complaints Panel, and 79 cases were settled directly by the Secretariat while the majority of the remainder were without merit.

保險索償投訴委員會（投訴委員會）

索償相關的糾紛是透過投訴局轄下的獨立組織－投訴委員會－以裁決方式公正審理保險公司與保單持有人或其受益人之間的索償糾紛。投訴委員會共有五位成員，主席為大律師徐福燊先生，四位委員當中，兩位為非業界的專業人士，分別為消費者委員會和香港會計師公會的代表；其餘兩位則來自保險業界，為保聯屬下壽險總會和一般保險總會的代表。投訴委員會大部分成員為非業界人士，充分顯示這個以非訴訟方式排解糾紛的機制不偏不倚、獨立自主。投訴委員會的裁決只對投訴局會員公司具約束力，投訴人如不滿有關裁決，可自行訴諸法律途徑，投訴委員會的裁決並不會影響其法律權益。

在 2019 年，投訴局共處理了 361 宗與索償相關的投訴個案，當中 35 宗是交由投訴委員會審理，另 79 宗經投訴局祕書處達成雙方和解，其餘大部分個案則沒有實質證據支持。

Honorary Secretaries

To date, ICB has 50 Honorary Secretaries (25 from the general business and 25 from the life business). The Complaints Panel has been most fortunate to have their enlisted assistance to review complaint cases and provide expert and professional opinions.

For each case which goes to the Complaints Panel, professional opinions of three Honorary Secretaries have to be sought beforehand. The Complaints Panel values very much the opinions of the Honorary Secretaries and takes into account their views when adjudicating these cases.

To help ensure the smooth operation of ICB and to ease the workload of Honorary Secretaries, I would like to appeal to all Authorized Representatives of Full Member Insurers to render support by nominating more insurance experts to join the team of Honorary Secretaries. We also welcome industry professionals who have relevant knowledge to volunteer and help out with this meaningful cause.

名譽顧問

投訴局現時有 50 位名譽顧問，當中從事一般保險業務及人壽保險業務各佔一半。投訴委員會有幸得到他們協助檢視投訴個案，提供專業意見。

個案交予投訴委員會審理之前，先尋求三位名譽顧問的意見。投訴委員會非常重視他們的意見，並在審理個案時充分考慮。

為使投訴局運作順利及減輕名譽顧問的工作量，我謹藉此機會，呼籲所有基本會員公司委任更多具備保險知識的專家加入名譽顧問的行列。我們亦歡迎擁有相關知識的業內專業人士，義務加入名譽顧問這項具意義的工作。

Acknowledgement

On behalf of the General Committee of ICB, I would like to convey our sincere thanks to Members of the Complaints Panel – Mr Michael F S Tsui, Chairman, Ms Orchis T L Li, Ms Vanessa C W Lau, Mr Lars Nielsen and Mr Jonathan C H Yau for their tireless endeavours and remarkable contributions during the year. A special vote of thanks must go to Ms Charity C S Au, who had served the Complaints Panel for more than eight years. Ms Au resigned from the Complaints Panel on 10 December 2019 when she retired from her company. Her valuable contributions to the Complaints Panel were greatly appreciated.

I would also like to express my gratitude to all the Honorary Secretaries who had volunteered their precious time and expertise so generously in support of our work. Likewise, I would also like to thank all the mediators on the ICB List of Mediators for their kind support to the work of ICB.

ICB would not have been able to accomplish its missions and tasks so smoothly without the wise counsel of my fellow General Committee Members as named above.

Last but not the least, I wish to thank all Member Insurers for their kind support and co-operation, and the ICB Secretariat and staff of the HKFI

鳴謝

謹代表理事會仝仁向投訴委員會徐福燊主席、委員李紫蘭女士、劉子芸女士、倪納思先生及丘振雄先生致意，感謝他們過去一年不辭勞苦審理投訴。特別感謝為投訴委員會服務了超過八年的歐之珊女士對投訴委員會的貢獻，她因退休而於 2019 年 12 月 10 日辭任。

謹此向所有名譽顧問致謝，感謝他們慷慨地貢獻寶貴的時間及專業知識，致力支持投訴局的工作。同時，我亦感謝投訴局《調解員名錄》上的所有調解員對投訴局工作的大力支持。

衷心感謝投訴局理事會理事（名字見上文），沒有他們明智的指導，投訴局將無法如此順利地履行其職責及任務。

最後，我感謝投訴局所有會員公司鼎力支持及衷誠合作。與此同時，多謝投訴局祕書處

for their dedication and hard work during the year.

During this unprecedented and unsettling time of Covid-19 pandemic, may I wish you all good health and may you remain safe from the virus.

Dr Pamela Chan Wong Shui, BBS, JP
Chairman
29 April 2020

及保聯所有員工過去一年克盡厥職的努力。

2019 冠狀病毒疫情肆虐全球，在這前所未有及人心不安的時刻，我衷心祝願大家身體健康、病毒不侵。

主席
陳黃穗博士，銅紫荊星章，太平紳士
2020 年 4 月 29 日

ICB Annual General Meeting on 29 April 2020
保險投訴局 2020 年 4 月 29 日的週年會員大會

List of Office-bearers

理事、委員、調解員及名譽顧問名錄

30/04/2019 - 29/04/2020

General Committee 理事會

Chairman 主席

Dr Pamela Chan Wong Shui, BBS, JP
陳黃穗博士，銅紫荊星章，太平紳士

Non-Industry Members 非業界理事

Dr C K Lo, JP
盧子健博士，太平紳士

Mr Herbert H K Tsoi, BBS, JP
蔡克剛先生，
銅紫荊星章，太平紳士

Mr Paul F Winkelmann
衛皓民先生

Prof Paul S F Yip
葉兆輝教授

Industry Members 業界理事

Mr Praveen M Daswani
戴宏年先生

Mr Eric K K Hui
許金桂先生

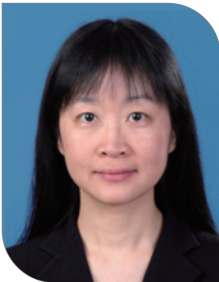
Mr Mike S C Lee
李少川先生

The Insurance Claims Complaints Panel
保險索償投訴委員會

Chairman 主席

Mr Michael F S Tsui, MH
Barrister-at-law
徐福燊先生，榮譽勳章
大律師

Members 委員



Ms Orchis T L Li
Life Insurance Council of the HKFI
李紫蘭女士
保聯壽險總會
(Appointed on 07/01/2020 委任)

Ms Vanessa C W Lau
Consumer Council
劉子芸女士
消費者委員會

Mr Lars Nielsen
Hong Kong Institute of Certified Public Accountants
倪鈉思先生
香港會計師公會

Mr Jonathan C H Yau
General Insurance Council of the HKFI
丘振雄先生
保聯一般保險總會

Mediators 調解員

Mr Kevin Bowers	Kevin Bowers 先生
Mr B W Chan, SBS, JP	陳炳煥先生，銀紫荊星章，太平紳士
Mr H C Chan	陳希政先生
Mr Danny K K Chan	陳健強先生
Mr Paul K L Chan	陳健樂先生
Mr Vod K S Chan	陳家成先生
Ms Teresa M H Chan	陳美卿女士
Mr W S Chan	陳偉升先生
Mr Harrison C H Cheung	張志雄先生
Mr Arthur C W Cheung	張祖維先生
Dr K C Cheung	張錦泉博士
Mr Peter K T Chung	鍾錦棠先生
Mr C C Ho	何志聰先生
Mr William C Y Kong	江仲有先生
Mr Jacky T K Lai	黎子健先生
Mr Y S Lai	黎潤生先生
Ms Y Y Lai	黎潤儀女士
Ms Amy W Y Lam	林慧儀女士
Mr W W Lau	劉偉華先生
Dr H M Leung	梁海明博士
Ms S C Leung	梁淑莊女士
Mr S K Li	李錫強先生
Ms Hayley K C Ng	吳敬慈女士
Mr Mark F Reeves	利瑪克先生
Mr H W Shum	岑漢和先生
Mr S M Yeung	楊世文先生

Honorary Secretaries

名譽顧問

Honorary Secretaries	名譽顧問	
Ms Candy P L Au Yeung	歐陽佩玲女士	
Mr C K Chan	陳智高先生	
Mr Simon K Chan	陳坤先生	(Resigned on 16/10/2019 退任)
Mr P L Chan	陳沛良先生	
Ms Betty Chang	張敏慧女士	
Ms Carmen K M Chau	周家敏女士	
Mr Zhaonan Chen	陳照男先生	
Mr Simon Y K Cheng	鄭銳強先生	
Ms Estella Chiu	趙黃舜芬女士	
Ms Vivian L C Choi	蔡靈芝女士	
Mr Philip W F Choi	蔡榮發先生	(Resigned on 22/07/2019 退任)
Mr Andrew Y M Chow	周耀明先生	
Mr Praveen M Daswani	戴宏年先生	
Ms Hazel Etherington	Hazel Etherington 女士	
Mr H M Fong	方向明先生	
Ms Fanny W M Fung	馮詠敏女士	
Ms Kit K H Fung	馮潔荇女士	(Resigned on 06/04/2020 退任)
Mr Eric L P Fung	馮立邦先生	
Mr Damien A Green	Damien A Green 先生	
Mr Z X Guo	郭振雄先生	
Mr Franz J Hahn	Franz J Hahn 先生	
Mr William W M Ho	何偉文先生	
Mr Eric K K Hui	許金桂先生	
Mr Charles T C Hung	孔德秋先生	
Mr Chris K K Ip	葉家駒先生	
Ms Kamini Kanagalingam	Kamini Kanagalingam 女士	
Ms Julia Kwan	關靜嫻女士	
Mr Y M Lai	賴遠文先生	
Mr Dominic W K Lam	林偉權先生	

Mr Mike S C Lee	李少川先生	
Ms Lydia Y L Lee	李英楠女士	
Ms Janey Leung	梁珍妮女士	(Resigned on 17/04/2020 退任)
Mr Robson K L Li	李嘉倫先生	(Resigned on 06/09/2019 退任)
Mr S K Li	李相健先生	
Mr Leo C H Ma	馬陳鏗先生	(Resigned on 31/07/2019 退任)
Mr Danny W L Ma	馬惠良先生	
Mr Guy R Mills	萬士家先生	(Resigned on 30/01/2020 退任)
Mr Ronnie W F Ng	伍榮發先生	
Mr Cillin O'Flynn	Cillin O'Flynn 先生	
Ms Maria W Y Pang	彭詠儀女士	
Mr Jimmy W F Poon	潘榮輝先生	
Mr Ivan K W Tam	譚國榮先生	
Mr James P K Tang	鄧伯訡先生	
Mr Clement H C Tang	鄧漢宗先生	
Ms Candice Y M Tang	鄧苑明女士	
Ms Margaret K C Tsang	曾潔聰女士	
Ms Noel K Y Tsang	曾菊英女士	
Mr Vincent V C Tso	曹宏昌先生	
Mr Robert L Valitchka	Robert L Valitchka 先生	
Mr Patrick C T Wan	尹志德先生	
Ms Winnie C S Wong	黃子遜女士	
Mr Harry K T Wong	黃國添先生	(Resigned on 23/08/2019 退任)
Ms Kelly Y H Wong	黃苑桁女士	
Ms Connie Y P Wong	王劉玉屏女士	
Mr F Yan	閻峰先生	(Resigned on 05/12/2019 退任)
Mr Yau Ka Ki	邱家騏先生	
Mr Thomson W W Yeung	楊永華先生	
Mr Thomas W L Yim	嚴維樂先生	
Mr Allan K N Yu	余健南先生	

會員名錄

29/04/2020

Full Members	基本會員
ABCI Insurance Co Ltd	農銀國際保險有限公司
Aetna Insurance (Hong Kong) Ltd	美國安泰保險（香港）有限公司
AIA International Ltd	友邦保險（國際）有限公司
AIG Insurance Hong Kong Ltd	美亞保險香港有限公司
Allianz Global Corporate & Specialty SE, Hong Kong Branch	安聯環球企業及專項保險 - 香港分公司
Allied World Assurance Co Ltd	世聯保險有限公司
Asia Insurance Co Ltd	亞洲保險有限公司
Asia Pacific Property and Casualty Insurance Co Ltd, Hong Kong Branch	亞太財產保險有限公司香港分公司
Assicurazioni Generali S.p.A.	忠意保險有限公司
Avo Insurance Co Ltd	安我保險有限公司
AXA China Region Insurance Co (Bermuda) Ltd	安盛保險（百慕達）有限公司
AXA General Insurance Hong Kong Ltd	安盛保險有限公司
Bank of China Group Insurance Co Ltd	中銀集團保險有限公司
BEA Life Ltd	東亞人壽保險有限公司
Berkley Insurance Co	Berkley Insurance Co
Berkshire Hathaway Specialty Insurance Co	Bershire Hathaway Specialty Insurance Co

Blue Cross (Asia-Pacific) Insurance Ltd	藍十字（亞太）保險有限公司
Blue Insurance Ltd	微藍保險有限公司
BOC Group Life Assurance Co Ltd	中銀集團人壽保險有限公司
Bowtie Life Insurance Co Ltd	保泰人壽保險有限公司
Bupa (Asia) Ltd	保柏（亞洲）有限公司
California Insurance Co Ltd	加洲保險有限公司
The Canada Life Assurance Co	The Canada Life Assurance Co
Chevalier Insurance Co Ltd	其士保險有限公司
China BOCOM Insurance Co Ltd	中國交銀保險有限公司
China Life Insurance (Overseas) Co Ltd	中國人壽保險（海外）股份有限公司
China Merchants Insurance Co Ltd	招商局保險有限公司
China Overseas Insurance Ltd	中國海外保險有限公司
China Pacific Insurance Co (Hong Kong) Ltd	中國太平洋保險（香港）有限公司
China Ping An Insurance (Hong Kong) Co Ltd	中國平安保險（香港）有限公司
China Taiping Insurance (Hong Kong) Co Ltd	中國太平保險（香港）有限公司
China Taiping Life Insurance (Hong Kong) Co Ltd	中國太平人壽保險（香港）有限公司
Chong Hing Insurance Co Ltd	創興保險有限公司
Chubb Insurance Hong Kong Ltd	安達保險香港有限公司
Chubb Life Insurance Co Ltd	安達人壽保險有限公司
CIGNA Worldwide General Insurance Co Ltd	信諾環球保險有限公司
CIGNA Worldwide Life Insurance Co Ltd	信諾環球人壽保險有限公司
CMB Wing Lung Insurance Co Ltd	招商永隆保險有限公司
Concord Insurance Co Ltd	合群保險有限公司
Dah Sing Insurance Co (1976) Ltd	大新保險 (1976) 有限公司
Desjardins Financial Security Life Assurance Co	Desjardins Financial Security Life Assurance Co
Falcon Insurance Co (Hong Kong) Ltd	富勤保險（香港）有限公司

First American Title Insurance Co	第一美國業權保險公司
Friends Provident International Ltd	英國友誠國際有限公司
FTLife Insurance Co Ltd	富通保險有限公司
Fubon Life Insurance (Hong Kong) Co Ltd	富邦人壽保險（香港）有限公司
FWD General Insurance Co Ltd	富衛保險有限公司
FWD Life Insurance Co (Bermuda) Ltd	富衛人壽保險（百慕達）有限公司
GAN Assurances	GAN Assurances
Generali Life (Hong Kong) Ltd	忠意人壽（香港）有限公司
Hang Seng Insurance Co Ltd	恒生保險有限公司
HDI – Global SE	HDI – Global SE
HKMC Annuity Ltd	香港年金有限公司
Hong Kong Life Insurance Ltd	香港人壽保險有限公司
Hong Leong Insurance (Asia) Ltd	豐隆保險（亞洲）有限公司
HSBC Life (International) Ltd	滙豐人壽保險（國際）有限公司
Liberty International Insurance Ltd	利寶國際保險有限公司
Lloyd's	勞合社
Manulife (International) Ltd	宏利人壽保險（國際）有限公司
MetLife Ltd	大都會人壽保險有限公司
Metropolitan Life Insurance Co of Hong Kong Ltd	美商大都會人壽保險香港有限公司
Min Xin Insurance Co Ltd	閩信保險有限公司
MSIG Insurance (Hong Kong) Ltd	三井住友海上火災保險（香港）有限公司
The New India Assurance Co Ltd	新印度保險有限公司
OneDegree Hong Kong Ltd	OneDegree Hong Kong Ltd
The Pacific Insurance Co Ltd	太平洋保險有限公司
Paofoong Insurance Co (Hong Kong) Ltd	寶豐保險（香港）有限公司
The People's Insurance Co of China (Hong Kong) Ltd	中國人民保險（香港）有限公司

Phoenix Life Ltd	Phoenix Life Ltd
Pioneer Insurance & Surety Corporation	信孚保險有限公司
Principal Insurance Co (Hong Kong) Ltd	美國信安保險有限公司
Prudential General Insurance Hong Kong Ltd	保誠財險有限公司
Prudential Hong Kong Ltd	保誠保險有限公司
QBE General Insurance (Hong Kong) Ltd	昆士蘭保險（香港）有限公司
QBE Hongkong & Shanghai Insurance Ltd	昆士蘭聯保保險有限公司
Quilter International Isle of Man Ltd	Quilter International Isle of Man Ltd
RL 360 Insurance Co Ltd	RL 360 Insurance Co Ltd
RL 360 Life Insurance Co Ltd	RL 360 Life Insurance Co Ltd
Scottish Widows Ltd	Scottish Widows Ltd
The Sincere Insurance and Investment Co Ltd	先施保險置業有限公司
Sompo Insurance (Hong Kong) Co Ltd	日本財產保險（香港）有限公司
St. James's Place International (Hong Kong) Ltd	St. James's Place International (Hong Kong) Ltd
Standard Life (Asia) Ltd	標準人壽保險（亞洲）有限公司
Starr International Insurance (Asia) Ltd	Starr International Insurance (Asia) Ltd
Sun Hung Kai Properties Insurance Ltd	新鴻基地產保險有限公司
Sun Life Hong Kong Ltd	香港永明金融有限公司
Swiss Re International SE, Hong Kong Branch	Swiss Re International SE, Hong Kong Branch
Tahoe Life Insurance Co Ltd	泰禾人壽保險有限公司
Target Insurance Co Ltd	泰加保險有限公司
The Tokio Marine & Fire Insurance Co (Hong Kong) Ltd	東京海上火災保險（香港）有限公司
Transamerica Life (Bermuda) Ltd	全美人壽百慕達
Trinity General Insurance Co Ltd	三聯保險有限公司
Tugu Insurance Co Ltd	德高保險有限公司
United Builders Insurance Co Ltd	建安保險有限公司

Utmost Worldwide Ltd, Hong Kong Branch	Utmost Worldwide Ltd, Hong Kong Branch
Well Link General Insurance Co Ltd	立橋保險有限公司
Well Link Life Insurance Co Ltd	立橋人壽保險有限公司
XL Insurance Co SE	XL Insurance Co SE
YF Life Insurance International Ltd	萬通保險國際有限公司
ZA Life Ltd	眾安人壽有限公司
Zurich Insurance Co Ltd	蘇黎世保險有限公司
Zurich International Life Ltd	Zurich International Life Ltd
Zurich Life Insurance (Hong Kong) Ltd	Zurich Life Insurance (Hong Kong) Ltd

Affiliate Members 附屬會員

AIA Co Ltd	友邦保險有限公司
AXA China Region Insurance Co Ltd	安盛金融有限公司
AXA Life Insurance Co Ltd	安盛人壽保險有限公司
AXA Wealth Management (Hong Kong) Ltd	安盛財富管理（香港）有限公司
Canada Life Ltd	Canada Life Ltd
The Manufacturers Life Insurance Co	The Manufacturers Life Insurance Co
The Pacific Life Assurance Co Ltd	太平洋人壽保險有限公司
The Sincere Life Assurance Co Ltd	先施人壽保險有限公司
Sompo Japan Nipponkoa Insurance Inc	Sompo Japan Nipponkoa Insurance Inc
Zurich Assurance Ltd	蘇黎世人壽
Zurich Life Insurance Co Ltd	蘇黎世人壽保險有限公司

Terms of Reference & Processing of Complaints
職權範圍及處理投訴個案之流程

Terms of Reference

1. The complaint is of a monetary nature.
2. The claim amount/monetary value of the complaints does not exceed HK$1,000,000 * .
3. The insurer concerned is a Member of the ICB.
4. The policy concerned is a personal insurance contract.
5. The complaint is filed by a policyholder, a policy beneficiary, an insured person or a rightful claimant.
6. The insurer concerned has made its final decision on the claim/dispute.
7. The complaint is filed with the ICB within six months from the day of notification by the insurer of its final decision.
8. The complaint in question does not arise from industrial, commercial or third party insurance.
9. The complaint is not subject to legal proceedings or arbitration.

For Non-claim related complaints:

10. The non-claim related complaint is not about quality of service or an underwriting decision of an insurer.
11. The non-claim related complaint is not related to investment performance, level of a fee, premium, charge or interest rate unless the dispute concerns an alleged non-disclosure, misrepresentation, incorrect application, negligence, breach of any legal obligation or duty or maladministration on the part of an insurer.

* *If an insured holds multiple policies, the aggregate amount of the individual claims involved should not exceed HK$1,000,000 should the causes of the claim rejection be identical or similar. As regards long-tail and periodic claims, the total claim amount, calculated up to a period of five years, should not exceed HK$1,000,000.*

職權範圍

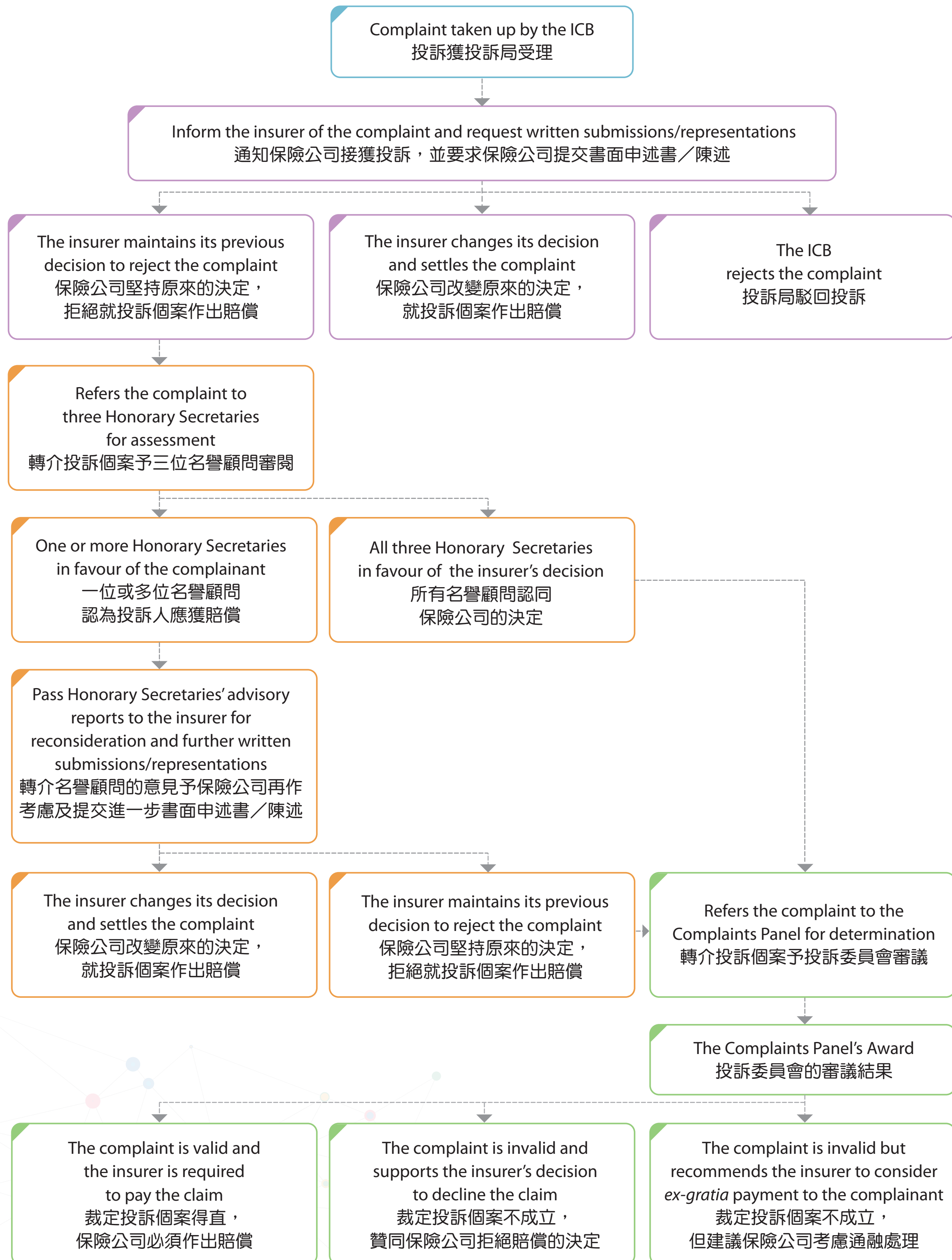
1. 投訴個案屬金錢性質。
2. 投訴個案的索償金額／爭議金額不超過 100 萬港元 *。
3. 涉案保險公司屬投訴局會員。
4. 涉案保單為個人保險合約。
5. 投訴人必須為保單持有人、保單受益人、受保人或合法索償人。
6. 涉案保險公司已對索償／爭議作出最終決定。
7. 投訴人必須於接獲保險公司發出的最終決定的六個月內，向投訴局作出書面投訴。
8. 投訴個案不涉及工業、商業或第三者保險。
9. 投訴個案並非正在進行法律程序或仲裁。

非索償相關的投訴個案：

10. 非索償相關的投訴個案與保險公司的服務水平或核保決定無關。
11. 非索償相關的投訴個案並非關乎投資表現、費用水平、保費、收費或利率，但指稱涉及隱瞞、失實陳述、不正確施行、疏忽、違反任何法律責任或職責；或涉案的保險公司一方在行政上出錯除外。

* *如果被保人持有多份保單，而被拒絕賠償的原因相同或類同，則索償總額以不超過 100 萬港元為限；如果索償涉及長期和定期賠償，則合計五年的索償總額不得超過 100 萬港元。*

Processing of Claim-related Complaints Flow Chart
處理索償相關的投訴個案之流程圖



Processing of
Non-claim related Complaints Flow Chart
處理非索償相關的投訴個案之流程圖

Remarks: These flow charts are summaries of the complaints handling procedures and for reference only.
For details, please refer to the Terms of Reference of ICB.

備註： 有關流程圖簡述處理投訴個案的步驟，僅作參考。
詳情請參閱投訴局的《職權範圍》。

Statistics
統計數字

01/01/2019 - 31/12/2019

In 2019, the ICB handled altogether 749 cases, of which 622 were new cases (about 4% increase compared with 598 in 2018) and 127 cases were brought forward from 2018. Out of these 749 cases, 233 were dismissed because they did not fall within the terms of reference of the ICB. Of the remaining 516 cases, 424 cases were closed whilst the balance of 92 cases were carried forward to 2020.

投訴局於 2019 年共處理了 749 宗投訴個案，其中 622 宗屬新接獲的個案，比 2018 年的 598 宗上升約 4%，而 127 宗則是 2018 年度尚未審結的個案。在 749 宗已處理的投訴個案中，有 233 宗超出投訴局的職權範圍，至於其餘的 516 宗受理個案中，有 424 宗已經審結，餘下的 92 宗尚未結案，須留待 2020 年處理。

The ICB handles both claim and non-claim related disputes of monetary nature. Table 1 below provides a summary of complaints handled by the ICB over the past five years.

投訴局處理索償與非索償相關的投訴，性質需涉及金錢糾紛。投訴局於過去五年處理的投訴個案概覽詳見下圖表一。

Summary of Complaints Handled
已處理的投訴個案概覽

Table 1 表一

	2015	2016	2017	2018 Total (Claim/Non-Claim) 總數（索償 / 非索償）	2019 Total (Claim/Non-Claim) 總數（索償 / 非索償）
Cases brought forward 承接上年度尚未審結的個案	81	111	120	148 (148/0)	127 (112/15)
Cases received 新接獲的個案	647	659	662	598 (535/63)	622 (455/167)
Cases handled 已處理的個案	728	770	782	746 (683/63)	749 (567/182)
Outside Terms of Reference 超逾職權範圍的個案	284	276	223	201 (157/44)	233 (120/113)
Cases closed 審結的個案	333	374	411	418 (414/4)	424 (361/63)
Cases carried forward 留待來年處理的個案	111	120	148	127 (112/15)	92 (86/6)

Claim-related Complaints

The 361 claim-related cases closed were related to the application of policy terms, non-disclosure, excluded items, amount of indemnity and breach of warranties or policy conditions (see Figures 1 and 2). And hospitalization/medical and life/critical illness insurance policies constituted the two largest groups of claim disputes in 2019 (see Figures 3 and 4).

Amongst the 361 claim-related cases closed, 79 were mutually settled between the insurers and the complainants with the auspices of the ICB secretariat. These cases did not need to go to the Complaints Panel. No *prima facie* evidence was found in 188 cases and 59 cases were withdrawn by the claimants. The remaining 35 cases (9.7%) were referred to the Complaints Panel for deliberation (see Figure 5). The Complaints Panel ruled in favour of the complainants in 10 cases and upheld the insurer's decision in 25 cases (see Figure 6).

In dollar terms, 89 complainants received from insurers a total claims amount of HK$6.88 million, of which HK$6.27 million was from mutual settlement and HK$614,000 was from awards made by the Complaints Panel. The highest single case award was HK$234,000.

Further analyses of the 361 claim-related cases closed in 2019 are detailed in Tables 2 and 3.

索償相關的投訴個案

361 宗已審結的索償相關投訴個案的糾紛涉及保單條款的詮釋、沒有披露事實、不保事項、賠償金額和違反保證條款或保單條件（見圖一及二），而 2019 年引起最多索償糾紛的兩類保險產品分別是住院／醫療保險及人壽／危疾保險（見圖三及四）。

在 361 宗已審結的索償相關投訴個案中，有 79 宗個案在投訴局秘書處的調停下，保險公司與索償人雙方達成和解，毋須轉交投訴委員會處理。另有 188 宗個案的表面證據不成立，59 宗的索償人撤銷投訴，而餘下的 35 宗個案（9.7%）則交由投訴委員會審理（見圖五）。投訴委員會裁定 10 宗個案的投訴人得直而可獲賠償，而贊同保險公司的賠償決定的個案則有 25 宗（見圖六）。

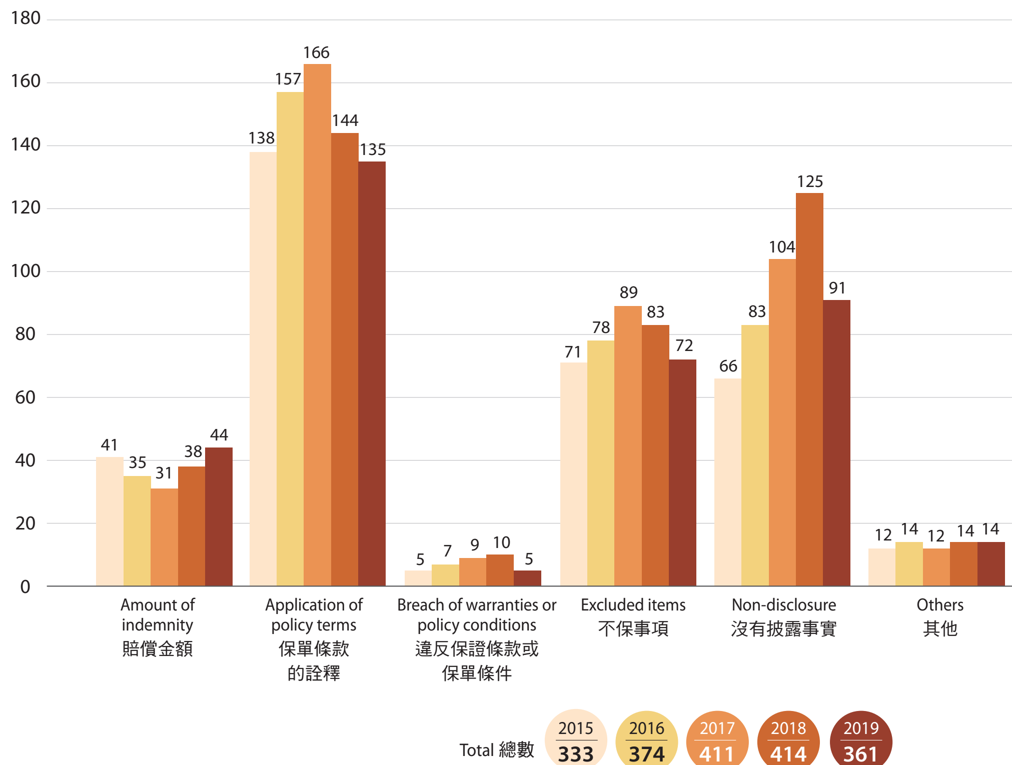
若以金額計算，共有 89 位投訴人獲得保險公司賠償，涉及的賠償額高達 688 萬港元，當中包括雙方和解金額 627 萬港元及投訴委員會裁定得直個案的賠償額 61 萬港元，而單一宗得直個案的最高賠償額則為 234,000 港元。

至於 2019 年已審結的 361 宗個案的進一步分析，請參看表二及表三。

Claim-related
索償相關

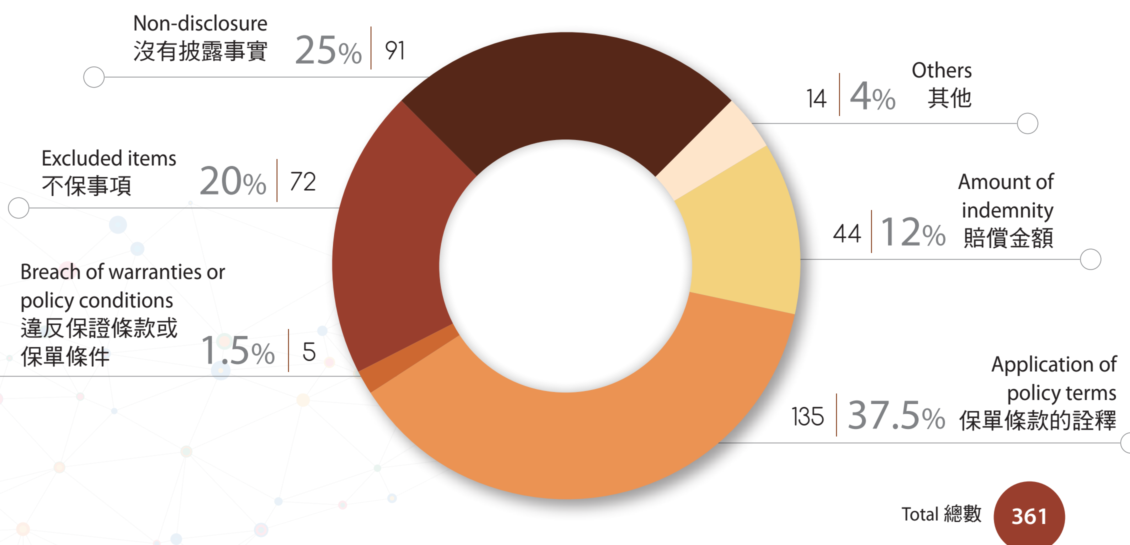
Nature of Complaints Closed
結案投訴類別

Figure 1 圖一



Nature of Complaints Closed in 2019
2019 年結案投訴類別

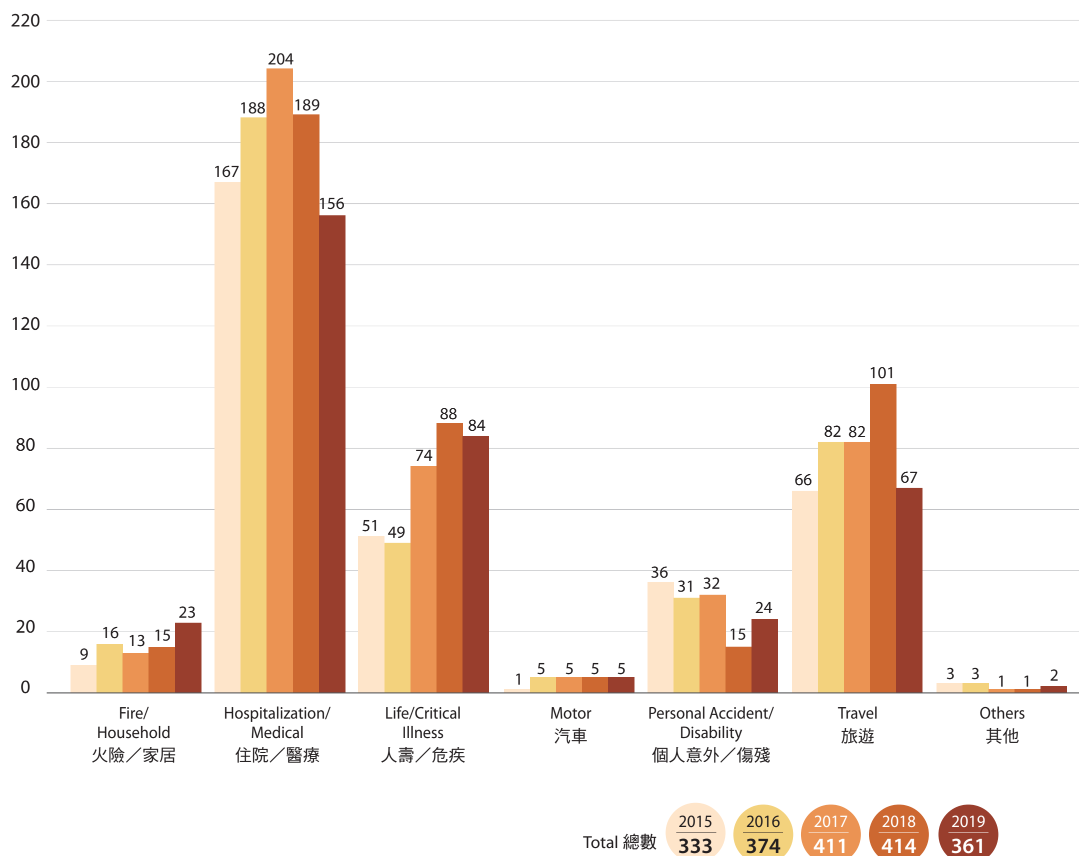
Figure 2 圖二



Claim-related
索償相關

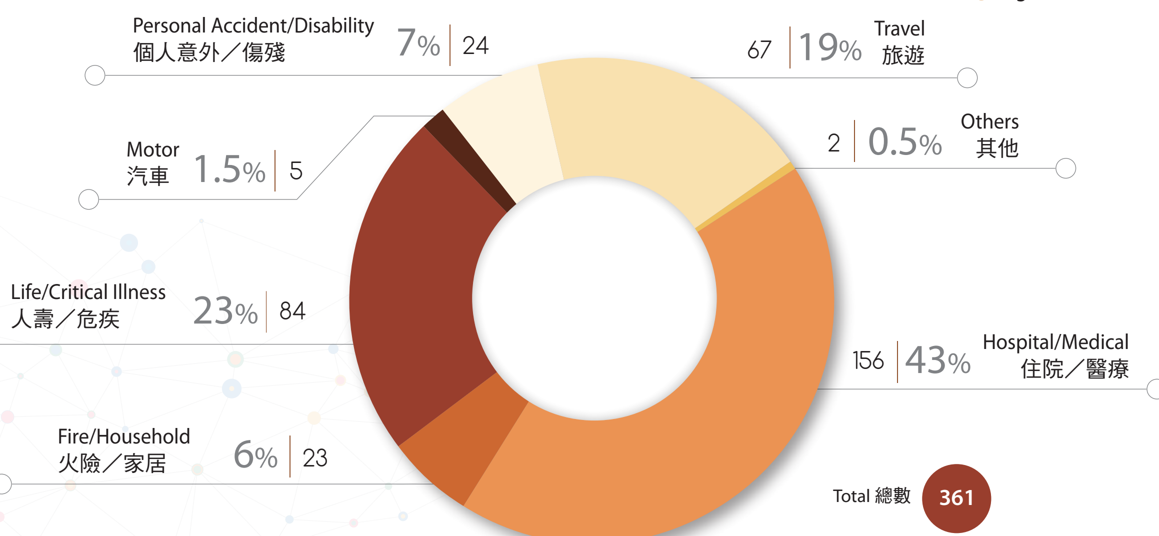
Types of Policies Closed
結案保單類別

Figure 3 圖三



Types of Policies Closed in 2019
2019 年結案保單類別

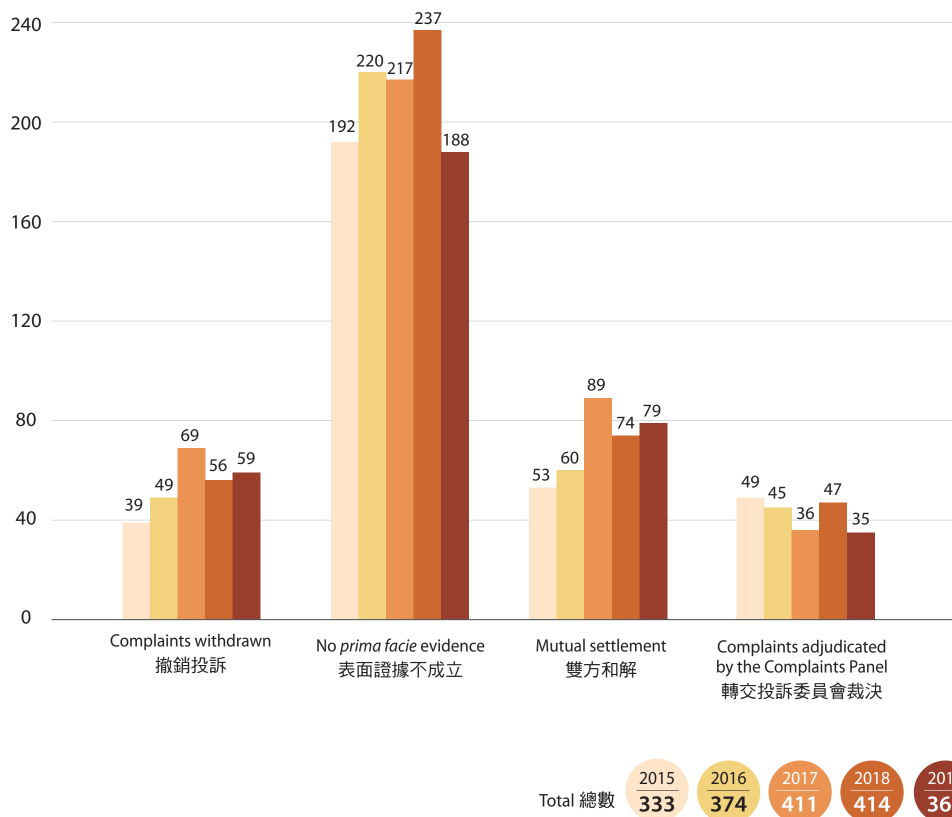
Figure 4 圖四



Claim-related
索償相關

Outcome of Cases Closed
結案分類

Figure 5 圖五

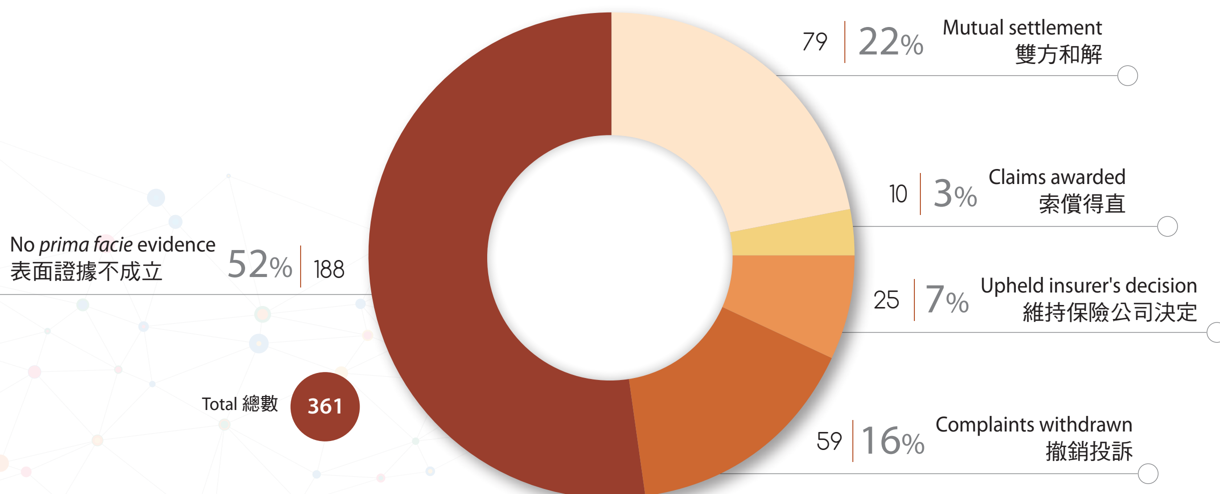


Total 總數

2015	2016	2017	2018	2019
333	374	411	414	361

Outcome of Cases Closed in 2019
2019 年結案分類

Figure 6 圖六



Claim-related
索償相關

Nature of Complaints by Types of Policies
各類型保單的投訴類別

Table 2 表二

Nature of complaints 投訴類別 \ Types of policies 保單類別	Fire/ Household 火險／家居	Hospitalization/ Medical 住院／醫療	Life/Critical Illness 人壽／危疾	Motor 汽車	Personal Accident/ Disability 個人意外／傷殘	Travel 旅遊	Others 其他	Total 總數
Amount of indemnity 賠償金額	10	22	1	3	3	5	0	**44**
Application of policy terms 保單條款的詮釋	6	45	24	0	17	43	0	**135**
Breach of warranties or policy conditions 違反保證條款或保單條件	1	2	0	2	0	0	0	**5**
Excluded items 不保事項	5	38	5	0	4	19	1	**72**
Non-disclosure 沒有披露事實	0	41	50	0	0	0	0	**91**
Others 其他	1	8	4	0	0	0	1	**14**
Total 總數	**23**	**156**	**84**	**5**	**24**	**67**	**2**	**361**

Outcome of Cases Closed by Types of Policies
各類型保單的結案分類

Table 3 表三

Outcome of cases closed 結案分類 \ Types of policies 保單類別	Fire/ Household 火險／家居	Hospitalization/ Medical 住院／醫療	Life/Critical Illness 人壽／危疾	Motor 汽車	Personal Accident/ Disability 個人意外／傷殘	Travel 旅遊	Others 其他	Total 總數
Claims awarded 索償得直	1	6	1	0	2	0	0	**10**
Mutual settlement 雙方和解	6	40	7	2	8	15	1	**79**
Upheld insurer's decision 維持保險公司決定	0	17	5	0	3	0	0	**25**
Complaints withdrawn 撤銷投訴	2	23	14	1	3	15	1	**59**
No *prima facie* evidence 表面證據不成立	14	70	57	2	8	37	0	**188**
Total 總數	**23**	**156**	**84**	**5**	**24**	**67**	**2**	**361**

Non-claim related
非索償相關

Non-claim related Complaints

The 63 non-claim related cases closed in 2019 were related to operational issues, contractual matters, company policies, mis-representation and policy returns (Figure 7). And life/critical illness and hospitalization/medical insurance policies constituted the two largest groups of non-claim disputes (Figure 8).

Among the 63 non-claim related cases closed, 10 were mutually settled between the insurers and the complainant with the auspices of the ICB secretariat, amounting to around HK$200,000. No *prima facie* evidence was found in 17 cases and 35 cases were withdrawn by the claimants. The remaining one case was referred to mediation but no agreement was reached between the parties involved at the mediation.

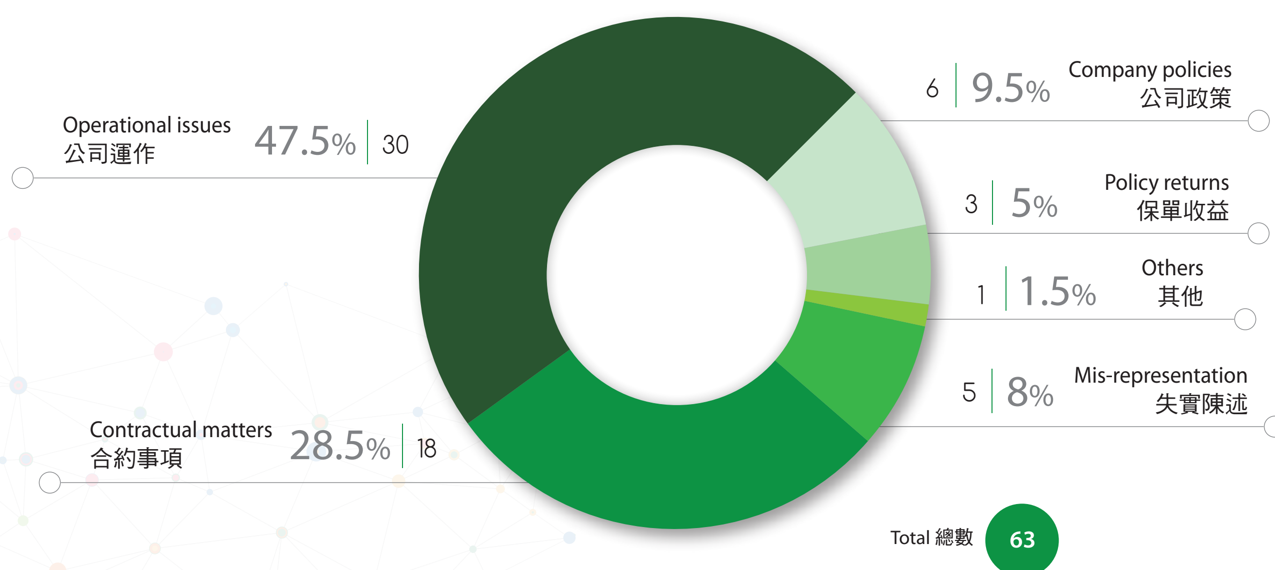
非索償相關的投訴個案

63 宗於 2019 年結案的非索償相關投訴個案的糾紛涉及公司運作、合約事項、公司政策、失實陳述和保單收益（見圖七），而引起最多非索償糾紛的兩類保險產品分別是人壽／危疾保險及住院／醫療保險（見圖八）。

在 63 宗已結案的非索償相關投訴個案中，有 10 宗個案在投訴局祕書處的調停下，保險公司與索償人雙方達成和解，涉及的金額接近 20 萬港元，另有 17 宗個案的表面證據不成立，35 宗的索償人撤銷投訴，而餘下的 1 宗個案則以調解處理，惟涉案雙方未能於調解中達成協議（見圖九）。

Nature of Complaints Closed
結案投訴類別

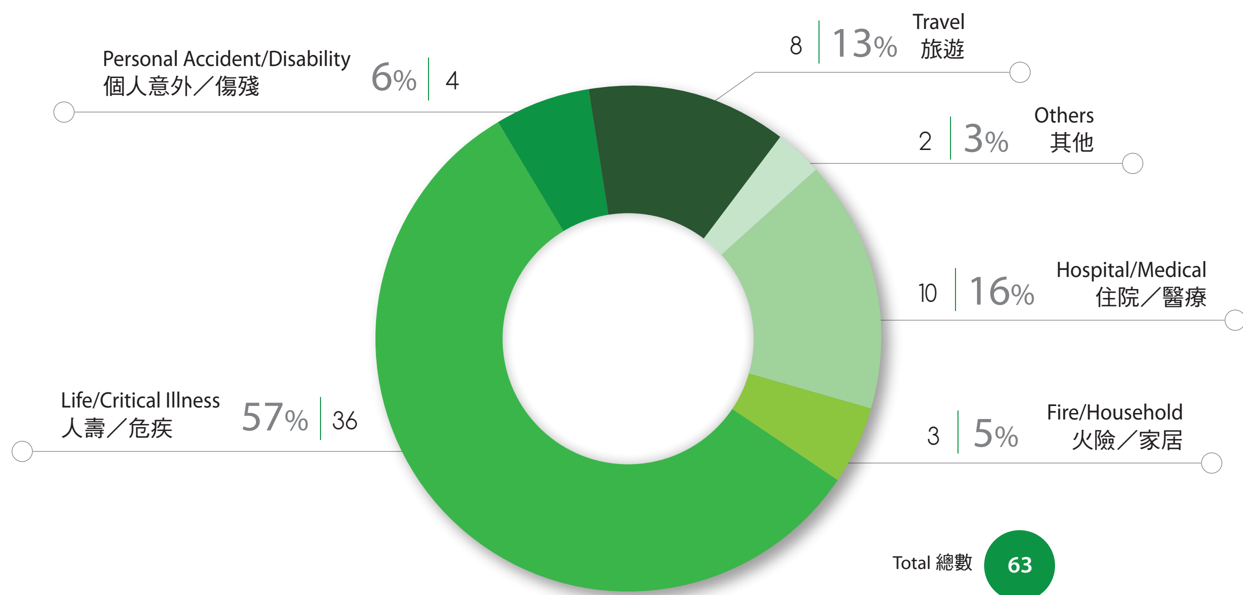
Figure 7 圖七



Non-claim related
非索償相關

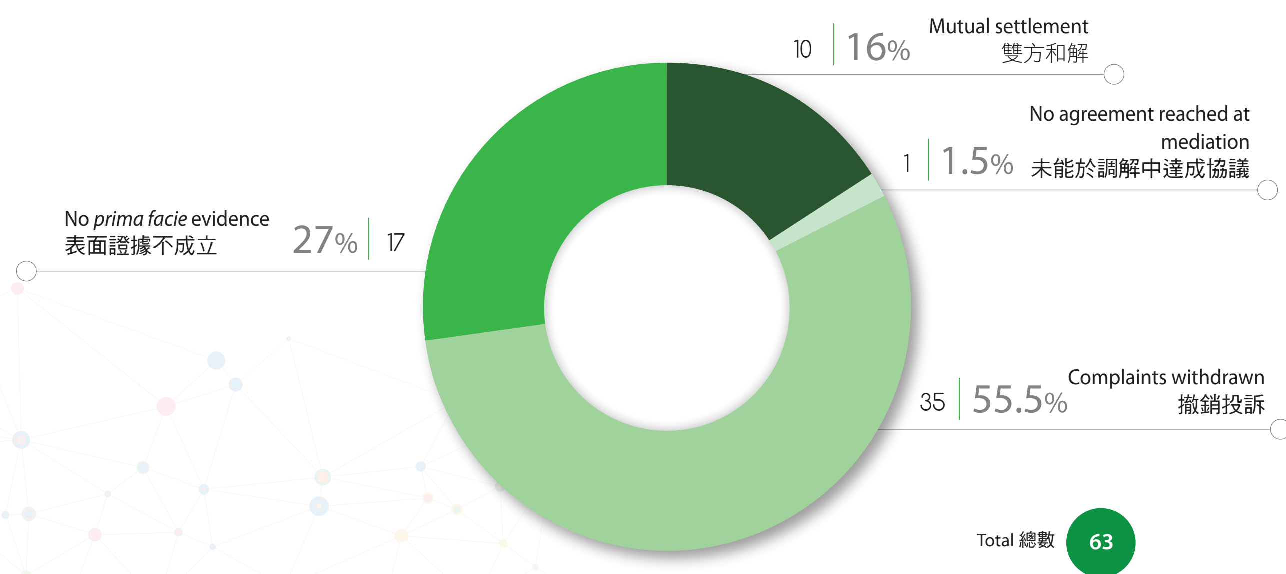
Types of Policies Closed
結案保單類別

Figure 8 圖八



Outcome of Cases Closed
結案分類

Figure 9 圖九



Powers of the Insurance Claims Complaints Panel
保險索償投訴委員會的權力

Chairman 主席

Mr Michael F S Tsui, MH
徐福燊先生，榮譽勳章

Powers of the Complaints Panel

According to Articles 89(b) & (c) of *Articles of Association* of the ICB, the Complaints Panel, in making its ruling, "shall have regard to and act in conformity with the terms of the relevant policy, general principles of good insurance practice, any applicable rule of law or judicial authority, and any codes and guidelines issued from time to time by the HKFI or the ICB. In respect of the terms of the personal insurance contracts, these shall prevail unless they would, in the view of the Complaints Panel, produce a result that is unfair and unreasonable to the complainant". In other words, the Complaints Panel, in making a ruling, is given the power by its Members to look beyond the strict interpretation of policy terms.

投訴委員會的權力

投訴局《組織章程細則》第 89 條（b）及（c）款規定，投訴委員會裁決時「必須尊重及遵守保險合約條款、優良保險慣例的原則、任何適用法例或司法機構法規、保聯或投訴局不時頒布的守則及指引。除非投訴委員會認為履行有關個人保險合約條款的後果對投訴人既不公道，又不合理，否則必須以保險合約條款為準」。換言之，投訴委員會獲會員賦予權力，裁決時可考慮個案涉及的其他事宜，毋須死硬詮釋保單條款。

As far as good insurance practice is concerned, the Complaints Panel relies heavily on the expected standards set out in *the Code of Conduct for Insurers* published by the HKFI, with particular reference to "Part III: Claims". The first requirement of the section states, "Insurers should seek to handle all claims efficiently, speedily and fairly". As such, as to whether or not an insurer has acted fairly in the settlement of claims is subject to the scrutiny of the Complaints Panel.

投訴委員會界定何謂優良保險慣例時，會參照保聯編製的《承保商專業守則》列舉的預期水平，尤以「第三章：索償」為主，其首要條文是「承保商應迅速、快捷及公道地處理索償」。有鑑於此，投訴委員會會仔細查究承保商處理賠償時是否公道。

In the deliberation of claim-related complaints, the Complaints Panel often faces the arduous task of balancing evidence submitted by one party against the other, without the benefit of exhaustive examination and cross-examination as in a proper court of law. In order to achieve what would be a fair and reasonable solution to the complainant, the Complaints Panel would carefully consider the merits of each case before making a ruling. This unfettered power of the Complaints Panel is reflected in Article 89(d) of the *Articles of Association*, which stipulates that the Complaints Panel shall not be bound by its previous decisions.

由於投訴委員會並非如正規法庭般運作，只能從控辯雙方提交的證據取得平衡，不能巨細畢究及盤問控辯雙方，故此審理索償相關投訴個案時經常面對嚴峻考驗。為求判決公道和合理，投訴委員會會小心考慮每宗個案的曲直是非，方行裁決。《組織章程細則》第 89 條（d）款賦予投訴委員會彈性斷案的權力，說明投訴委員會的裁決並不囿於以往案例。

Chairman of the Complaints Panel Mr Michael F S Tsui, together with his fellow member Ms Orchis T L Li attended an e-media conference on 28 April 2020
投訴委員會主席徐福燊先生與委員李紫蘭女士出席 2020 年 4 月 28 日舉行的網上新聞發布會

Case Review
個案分析

01/01/2019 - 31/12/2019

Case 個案 01

Application of policy terms
保單條款的詮釋

Essence of Complaint:
Medically Necessary (chemotherapy drugs)

投訴爭議點：
醫療必須（化療藥物）

Type of Insurance:
Hospitalization

保險類別：
住院保險

The Complaint

The insured was diagnosed as suffering from stage II primary mediastinal large B cell lymphoma which is a subtype of diffuse large B cell lymphoma. He was recommended to have chemotherapy treatment. He was then treated with Obinutuzumab-ProMACE-CytaBOM (OPC) as the first-line treatment for his lymphoma. The insured subsequently filed a number of hospitalization claims to the insurer for the hospital expenses incurred during his five confinements for receiving chemotherapy treatment.

The insurer considered that the aforesaid chemotherapy drugs were not the standard treatment regimen for diffuse large B cell lymphoma. Since there was a lack of medical evidence to support the safe and effective use of OPC, the insurer reimbursed the insured the hospital expenses incurred except those expenses related to the chemotherapy drugs on the grounds that the treatment was not medically necessary.

投訴內容

受保人被診斷患上原發縱膈型大型 B 細胞淋巴瘤第二期（屬瀰漫性大型 B 細胞淋巴瘤的一個子類型），獲建議接受化療，主診醫生處方 Obinutuzumab-ProMACE-CytaBOM (OPC) 作為化療的一線藥物。受保人其後五次入院接受化療，並就相關的住院費用向保險公司提出住院索償。

保險公司認為有關化療藥物並非治療瀰漫性大型 B 細胞淋巴瘤的標準藥物，由於缺乏醫療證據支持 OPC 為安全及有效的藥物，保險公司因此以相關治療並非醫療必須為理由，僅向受保人賠付除化療藥物以外的住院費用。

Findings of the Complaints Panel

It is stipulated in the policy provisions of the hospitalization plan that "…the insurer shall not be liable to pay expenses incurred directly or indirectly in connection with and/or for, or in relation to treatment, medical service, medication or investigation which is not medically necessary" while "medically necessary" means "the necessity to have a treatment, medical service or medication which is:

(a) consistent with the diagnosis and customary medical treatment for the condition at a normal and customary charge…

(c) necessary for such a diagnosis or treatment…

(e) furnished at the most appropriate level which can be safely and effectively provided to the insured…".

The Complaints Panel learnt from the attending physician that the insured suffered from a distinct form of lymphoma, which was different from diffuse large B cell lymphoma as currently classified by the World Health Organization. Since it did not respond well to the conventional treatment for diffuse large B cell lymphoma, the insured was treated with a more intensive regimen, comprising of type II anti-CD20 antibody Obinutuzumab and regimen ProMACE-CytaBOM. Such therapy was medically necessary to improve the treatment outcome of the insured. As the insurer was unable to adduce further evidence to prove that the aforesaid chemotherapy drugs were unsafe and ineffective, the Complaints Panel was convinced that the use of OPC was medically necessary for the insured's lymphoma.

Ruling of the Complaints Panel

The Complaints Panel ruled in favour of the insured and resolved that the insurer should settle his hospital expenses related to the chemotherapy drugs, amounting to around HK$190,000.

Message from the Complaints Panel

Nearly all hospitalization policies exclude those medical treatments or operations which are experimental or unproven in their efficacy. In handling such kind of disputes, the Complaints Panel relies very much on whether or not there is sufficient evidence to prove the treatment/operation is medically justified for the claimed medical condition.

投訴委員會的調查結果

有關住院保單的條款訂明：「……保險公司將不會負責因非醫療必須的治療、醫療服務、藥物或檢驗而直接或間接引致的費用」；而「醫療必須」乃指「醫療上必須的治療、醫療服務或藥物，並須：

(a) 以正常及慣常費用就病症之診斷提供相應之治療……

(c) 就有關診斷或治療而所需的……

(e) 以最合適的程度向受保人提供安全及有效的治療……」。

投訴委員會從主診醫生得悉受保人患上一種罕見的淋巴瘤，與世界衛生組織現時對瀰漫性大型 B 細胞淋巴瘤的分類不同。由於針對瀰漫性大型 B 細胞淋巴瘤的傳統治療方法對受保人的淋巴瘤未見療效，主診醫生遂採用力度較強的治療方案，包括第二代抗 CD20 抗體藥物 Obinutuzumab 及 ProMACE-CytaBOM 化療法，在醫學上對改善受保人的治療結果是必須的。鑑於保險公司未能提出更多的證據證明有關化療藥物是不安全和欠缺療效，投訴委員會因此相信處方 OPC 藥物醫治受保人的淋巴瘤乃屬醫療必須的治療。

投訴委員會的裁決

投訴委員會裁定受保人得直，保險公司需向他賠付約 190,000 港元的化療藥物費用。

投訴委員會的意見

幾乎所有住院保單均豁免保障屬試驗性質或未經證實療效的治療或手術。當處理涉及醫療必須的糾紛時，投訴委員會會依重是否有充分證據支持所進行的治療／手術在醫學上對醫治所索償的病況是有理可循。

Case 個案 02

Application of policy terms
保單條款的詮釋

Essence of Complaint:
Medically Necessary (pre-operative assessment)

Type of Insurance:
Hospitalization

投訴爭議點：
醫療必須（手術前評估）

保險類別：
住院保險

The Complaint

A woman was admitted to a private hospital for painful perianal swelling and right upper quadrant pain which she had been experiencing for two weeks. Magnetic resonance imaging (MRI) of pelvis, ultrasound and laboratory tests were performed during her hospitalization. The final diagnosis was fistula-in-ano and she was discharged the next day. Nine days later, the woman was re-admitted to the hospital for fistula-in-ano with fistulectomy. The insurer settled her claim for the second admission, but not the first one. The insurer explained that the first admission was not medically necessary and its main purpose was for pre-operative assessment. Also, the diagnostic tests done during the first admission could have been effectively performed on an outpatient setting and the admission was of no emergency need.

投訴內容

一位女士因肛周腫脹和疼痛及右上腹疼痛持續兩星期入住私家醫院，住院期間接受骨盆磁力共振、超聲波及化驗，最終診斷結果為肛瘺，於翌日出院。九天後，她再度入院接受瘻管切除手術。保險公司僅向她發放第二次的住院賠償，卻不予受理她首次住院的索償。保險公司解釋，受保人首次住院並沒有醫療需要，其主要目的是為手術前作評估；況且，在首次住院進行的診斷性檢查大可於門診診所有效地進行，住院亦屬非緊急性質。

Findings of the Complaints Panel

It is stipulated in the contract provisions of the hospitalization policy that “medically necessary” means “a medical service which is (a) consistent with the diagnosis and customary western medical treatment for the condition; (b) in accordance with standards of good medical practice…” There is also a policy exclusion stating that “no benefit will be payable if the treatment is a direct or indirect consequence of general checkup or health tests… or diagnosis of an insured’s sickness, injury or any treatment which is not medically necessary and which can be done on outpatient basis”.

The Complaints Panel noted from the available information that the insured’s first admission was mainly for carrying out diagnostic tests in order to evaluate the provisional diagnosis of fistula-in-ano. There was no active treatment given during the confinement. As MRI and ultrasound could have been performed safely and effectively on an outpatient basis and there was no evidence to support that the insured’s condition was of urgent or emergency nature, the Complaints Panel supported the insurer’s view that the first admission was not medically necessary.

Ruling of the Complaints Panel

The Complaints Panel concurred with the insurer’s decision to decline the insured’s first hospitalization claim for about HK$15,500.

Message from the Complaints Panel

If there is concrete evidence showing that the hospital confinement is arranged solely for conducting diagnostic or laboratory tests with no element of medical emergency, the Complaints Panel will generally agree that such confinement is not medically necessary under the provisions of a hospitalization policy.

投訴委員會的調查結果

有關住院保單的條款訂明：「醫療必須」是指「符合以下條件的醫療服務：（a）診斷及治療按照慣常西醫手法；（b）符合醫療專業操守……」；而保單的「不保事項」條款亦訂明：「本保單將不賠償直接或間接因一般身體檢查或健康測試……或受保人因傷病接受並非醫療必須的診斷或治療，及可於門診完成之醫療服務而引致的治療……」。

投訴委員會從現有的資料得悉，受保人首次住院主要是為接受診斷性檢查，以評估肛瘺的初步診斷，她於住院期間沒有接受任何特定治療。由於磁力共振及超聲波檢查大可安全及有效地於門診診所進行，加上現時沒有證據支持受保人的病況屬緊急性質，投訴委員會遂支持保險公司的決定，認同受保人首次住院沒有醫療需要。

投訴委員會的裁決

投訴委員會贊同保險公司拒絕受保人首次住院的索償，涉及金額約 15,500 港元。

投訴委員會的意見

倘若有充分證據證明住院純粹是為了接受診斷性檢查或測試，而病況在醫學上並非緊急性質，投訴委員會一般同意在醫療保單的條款的規定下，這類住院是沒有醫療需要。

Case 個案 03

Application of policy terms
保單條款的詮釋

Essence of Complaint:
Medically Necessary (prolonged hospital stay)

投訴爭議點：
醫療必須（長時間住院）

Type of Insurance:
Hospitalization

保險類別：
住院保險

The Complaint

The complainant was admitted to a private hospital complaining of increased blood pressure and chest pain for one day. She finally stayed in the hospital for 52 days. Magnetic resonance imaging, laboratory, x-ray, ECG examination, etc. were performed during her confinement. The final diagnoses were hypertension, sinusitis, chest infection and bronchial hyperreactivity. The insurer settled all the hospital expenses except those expenses incurred during the last week of her hospital stay.

投訴內容

投訴人入住私家醫院，主訴為血壓上升及胸痛一天，她最終住院 52 天，期間接受了磁力共振、化驗、X 光、心電圖等檢查，最終診斷為高血壓、鼻竇炎、胸部感染及支氣管過敏反應。除了最後一週的住院費外，保險公司向投訴人賠付了其餘所有的住院費用。

Findings of the Complaints Panel

It is stipulated in the policy provisions of the hospitalization rider that "medically necessary" means "medical or health services which are necessary for the treatment of an illness, sickness, disease or injury and which are: (i) consistent with the diagnosis and customary medical treatment for medical condition; (ii) in accordance with good and prudent medical practice; (iii) not for the convenience of the policyholder, the insured person or the registered medical practitioner; and (iv) covered service performed at normal and customary charge".

The Complaints Panel learnt from the attending doctor that the complainant's condition was complicated by multiple symptoms – chest pain, shortness of breath, dizziness, labile blood pressure and left side weakness, which accounted for her long hospital stay. She was discharged after all the symptoms subsided. As the complainant's oxygen and blood level were not yet stable and she still required oxygen therapy and titration of medicine in the last week of her hospital stay, the Complaints Panel agreed that she was medically justified for hospital stay during her last week of confinement.

投訴委員會的調查結果

有關住院保單的條款訂明:「必要的醫療服務」指「治療病痛、不適、疾病或受傷所必須的醫療或保健服務，而有關服務：（i）須符合病情的診斷及慣常療法；（ii）須符合良好和謹慎的行醫標準；（iii）並非為了方便投保人、受保人或註冊醫生；及（iv）須為承保服務及在正常及慣常費用下進行」。

投訴委員會留意到主診醫生指投訴人的病況因為出現了多項病徵，包括：胸痛、呼吸急促、暈眩、血壓不穩、左身無力而變得複雜，需要長時間留院，並在所有病徵消退後出院。由於投訴人於最後一週住院時的含氧量及血壓仍未穩定，需要接受氧氣治療及控制藥物劑量，投訴委員會因此認為她最後一週的住院有醫療需要。

Ruling of the Complaints Panel

The Complaints Panel ruled that the insurer should reimburse the complainant's hospital expenses incurred during the last week of her confinement, amounting to around HK$20,500.

投訴委員會的裁決

投訴委員會裁定保險公司需向投訴人賠付她最後一週的住院費用，金額約 20,500 港元。

Message from the Complaints Panel

In deciding whether or not a hospital confinement is medically necessary, the Complaints Panel takes into consideration the medical condition of the insured at the time of his/her confinement and the medical treatments he/she received during the confinement.

投訴委員會的意見

在處理涉及住院是否醫療必須的糾紛時，投訴委員會會考慮受保人在住院時的病況及於住院期間所接受的治療。

Case 個案 04

Application of policy terms
保單條款的詮釋

Essence of Complaint:
Chinese Medicine Practitioner Treatment
(herbal medicine expenses)

Type of Insurance:
Medical

投訴爭議點：
中醫治療（中藥費用）

保險類別：
醫療保險

The Complaint

A 10-year-old boy had suffered from food allergy and dermatitis due to ingested food since he was six. He received daily herbal medicines from 29 May to 15 July 2018 prescribed by a western allergist in the United States. The boy's father (the complainant) filed a claim to the insurer for the Chinese Medicine Practitioner (CMP) treatment under the optional outpatient benefit of his medical policy. The insurer initially declined the claim as no medical consultation had taken place during the aforesaid period when the herbal medicines were dispensed. However, the insurer subsequently agreed to grant an exceptional offer to the complainant and settle his claim in full on the condition that no similar claim would be allowed in future.

The complainant rejected the offer and filed another claim to the insurer for the insured's medical expenses incurred from 16 July to 8 October 2018. Other than the herbal medicine expenses, there was also a consultation fee and four acupuncture treatments. The insurer settled the expenses for the consultation and the acupuncture treatments, but declined the claim for the herbal medicine expenses on the grounds that there was no evidence showing that medical consultations had taken place when the medicines were dispensed.

投訴內容

一位十歲男孩自六歲起因進食引致食物敏感和皮膚炎。他於 2018 年 5 月 29 日至 7 月 15 日期間每天服用由美國的西方過敏病專家處方的中藥，男孩的父親（投訴人）就其醫療保單之自選門診保障內的中醫治療向保險公司提出索償。由於受保人在上述獲配發藥物的日子並沒有應診，保險公司最初拒絕有關索償，惟其後同意作出特別安排，向投訴人全數賠償，條件是日後不會再就同類型的索償作出賠償。

投訴人拒絕接納保險公司的賠償建議，並就受保人於 2018 年 7 月 16 日至 10 月 8 日期間的醫療費用向保險公司提出另一宗索償，當中除了中藥費外，還涉及一次應診費和四次針灸費。保險公司向投訴人賠付了應診費及針灸費，但拒絕就中藥費作出賠償，原因是沒有證據證明有關中藥是於受保人應診時配發。

Findings of the Complaints Panel

It is stipulated in the "CMP Treatment" under the optional outpatient benefit of the medical policy that "If during the period of insurance, an insured, as a result of a disability, is treated in a clinic or the outpatient department of a hospital as an outpatient or day patient, eligible expenses shall be payable in respect of CMP Treatment – charges for the consultation rendered by a CMP for Chinese medicine treatment including bone-setting and charges for medicine dispensed at the clinic or hospital where the medical consultation takes place".

Having duly studied all the information available, the Complaints Panel was given to understand that the insured had been covered under his father's group medical plan since November 2011 and his current individual medical plan was effected in April 2017. Both plans were provided by the insurer. The insured had received CMP treatment since July 2014 for his food allergy and dermatitis. All along, the insurer had fully settled the herbal medicine expenses incurred by the insured on a daily basis as long as the receipt for each dispense of herbal medicines was submitted. Even after the individual plan was effected, the insured's herbal medicine expenses from 10 April 2017 to 28 May 2018 was also settled by the insurer based on the same methodology.

The Complaints Panel observed that the insurer had waived some of the claim requirements in handling the complainant's claims in respect of the CMP treatment for the insured since July 2014. Although the Complaints Panel concurred that the insurer had the right to revoke such wavier and to assess the claim strictly in accordance to the policy terms and conditions, the insurer bore the liability to explicitly inform the complainant of such measure.

Ruling of the Complaints Panel

Given that the insurer only notified the complainant on 12 October 2018 that similar claims in future would not be accepted, the Complaints Panel resolved that the insurer should fully settle the insured's herbal medicine expenses at least up to 12 October 2018. The amount involved was around HK$50,000. For herbal medicine expenses incurred after 12 October 2018, the insurer could assess the claim strictly according to the terms and conditions of the policy.

Message from the Complaints Panel

It is not uncommon for insurers to waive some of the terms and conditions as stipulated in the policy provisions in claims handling for the sake of flexibility and simplicity. To avoid doubt, it is preferable that insurers clearly inform the policyholders in advance of such special arrangement in order to avoid disputes that may arise when the waiver is subsequently revoked.

投訴委員會的調查結果

有關醫療保單之自選門診保障內的「中醫治療」條款訂明：「若於受保期內，受保人因傷病而需於診所或醫院門診部接受門診或日症治療，保險公司將根據中醫治療所列賠償符合索償資格的費用：由中醫師因進行中醫治療（包括跌打）而提供的診症及於接受診症之診所或醫院配發藥物所招致之費用」。

經考慮所有資料後，投訴委員會得悉受保人自 2011 年 11 月起受保於其父親公司的團體醫療計劃，而現時的個人醫療計劃則於 2017 年 4 月生效，兩份保單均由保險公司承保。受保人自 2014 年 7 月起因食物敏感和皮膚炎接受中藥治療，一直以來，只要提交每次配發藥物的收據，保險公司便會全數支付受保人每天的中藥費用。即使在個人醫療保單生效後，保險公司一直以同一方法賠付受保人由 2017 年 4 月 10 日至 2018 年 5 月 28 日的中藥費用。

投訴委員會留意到保險公司自 2014 年 7 月起在處理投訴人就中醫治療保障的索償申請時已豁免執行部分理賠要求。雖然投訴委員會同意保險公司有權撤銷有關豁免，並嚴格根據保單的條款及條件審核索償，但保險公司有責任清晰地通知投訴人有關措施。

投訴委員會的裁決

基於保險公司僅於 2018 年 10 月 12 日才通知投訴人日後將不再受理類似的索償，投訴委員會因此裁定保險公司需賠付受保人的中藥費用最少至 2018 年 10 月 12 日，涉及的賠償金額約 50,000 港元。至於在 2018 年 10 月 12 日以後的中藥費用，保險公司則可嚴格地按照保單的條款及條件再作審核。

投訴委員會的意見

保險公司為求彈性和簡化程序，於理賠時豁免執行保單合約內訂明的某些條款及條件並不罕見。為免存疑，保險公司最好能夠事先清楚通知保單持有人有關的特別安排，以避免在日後撤銷相關豁免時可能出現的糾紛。

Case 個案 05

Application of policy terms
保單條款的詮釋

Essence of Complaint:
Definition of "Heart Attack"

投訴爭議點：
「心臟病」定義

Type of Insurance:
Critical Illness

保險類別：
危疾保險

The Complaint

The insured was admitted to a hospital in China for coronary angiogram and percutaneous coronary intervention (PCI). The final diagnoses were acute non-ST elevation myocardial infarction, coronary atherosclerotic heart disease, impaired heart function, etc. He submitted a critical illness claim to the insurer for "heart attack".

Since the insured's condition did not fulfil the definition of "heart attack" in the policy, the insurer declined his critical illness claim for "heart attack", but paid him the advanced payment for PCI under the early stage critical illness benefit, which was 20% of the sum insured of the critical illness benefit.

投訴內容

受保人入住內地一間醫院接受冠狀動脈造影及經皮冠狀動脈介入治療（俗稱：通波仔），最終診斷結果為急性非 ST 段抬高型心肌梗塞、冠狀動脈粥樣硬化性心臟病、心臟功能受損等，他其後向保險公司提出「心臟病」的危疾索償申請。

由於受保人的情況不符合保單內「心臟病」的定義，保險公司遂拒絕作出「心臟病」的危疾賠償，惟向他賠付「經皮穿刺冠狀動脈介入」早期危疾預支保障，金額是危疾保障額的 20%。

Findings of the Complaints Panel

It is stipulated in the contract provisions of the critical illness policy that "heart attack" means "the death of a portion of the heart muscle (myocardium) as a result of inadequate blood supply, where all of the following criteria are met: a) a history of typical chest pain; b) new characteristics ECG changes indicating acute myocardial infarction at the time of the relevant cardiac incident; and c) either (i) elevation of cardiac enzymes (CPK-MB) at levels above the generally accepted laboratory levels of normal, or (ii) troponins recorded at a level of Troponin I > 0.5 ng/ml or higher".

The Complaints Panel learnt from the two ECG reports of the insured during his confinement that there was no ST elevation or any indication of acute myocardial infarction. Since the results showing "sinus rhythm", "T wave inversion" and "aVL lead, abnormal Q wave and T wave inversion" were not considered as characteristic ECG changes indicating acute myocardial infarction, the Complaints Panel agreed that criteria (b) as stated in the definition of "heart attack" was not met.

投訴委員會的調查結果

有關危疾保單訂明：「心臟病」是指「因心臟血液供應不足，引致部分心臟肌肉（心肌）壞死，並須符合下列所有準則：（a）典型的胸痛病歷；（b）在相關心臟事故期間心電圖顯示新近具急性心肌梗塞特徵的變化；及（c）以下其中一項：（i）心肌酵素（CPK-MB）提高至一般公認的實驗室水平的正常水平以上；或（ii）心肌旋轉蛋白水平達到心肌旋轉蛋白 I（Troponin I）＞ 0.5ng/ml 或以上」。

投訴委員會從受保人住院期間的兩份心電圖報告得悉，受保人並沒有 ST 段抬高或任何急性心肌梗塞的情況。由於顯示出現「竇性心律」、「T 波倒置」及「aVL 導聯、異常 Q 波、T 波倒置」的結果並不視為具急性心肌梗塞特徵的典型心電圖變化，投訴委員會因此同意受保人的情況不符合「心臟病」定義內的（b）項準則。

Ruling of the Complaints Panel

The Complaints Panel concurred with the insurer's decision in paying the advanced payment for PCI under the early stage critical illness benefit, but not the critical illness benefit for "heart attack". The difference in the two claims amounted to around HK$900,000.

投訴委員會的裁決

投訴委員會贊同保險公司向受保人支付「經皮穿刺冠狀動脈介入」早期危疾預支保障，而非「心臟病」的危疾賠償，兩者的金額相差約 900,000 港元。

Message from the Complaints Panel

Critical illness contracts cover specific serious illnesses which are listed and explicitly defined in the policy provisions. The contract terms contain specific descriptions of the medical conditions of the critical illnesses and may state that specific criteria or tests should be met or prescribed to confirm the diagnosis. In handling such disputes, the Complaints Panel usually looks into the medical reports to see if there is evidence proving that the claimant has fulfilled all the medical conditions and criteria as stipulated in the definition of the critical illness.

投訴委員會的意見

危疾保險為保單列明及附明確定義的指定嚴重疾病提供保障，合約條款清楚訂明有關嚴重疾病的具體描述，及或會註明該等診斷必須符合特定的標準或透過特定測試來確診。當處理涉及危疾保險的糾紛時，投訴委員會一般會參考醫療報告以確定是否有證據證明受保人已達到有關危疾定義內的所有醫療狀況及要求。

Case 個案 06

Application of policy terms 保單條款的詮釋

Essence of Complaint:
Same Disability (prostatic disorder)

投訴爭議點：
同一傷病（前列腺不適）

Type of Insurance:
Hospitalization

保險類別：
住院保險

The Complaint

A 67-year-old man was admitted to a private hospital to receive flexible cystoscopy for his obstructed uroflow which had been existed for two years. The diagnoses were prostatic enlargement and obstruction. He was recommended to have transurethral resection of prostate (TURP). The insured was re-admitted to hospital for TURP procedure around one month later. The final diagnosis was benign prostatic hyperplasia.

The insurer reimbursed most of the hospital expenses incurred during the insured's first confinement. Given that the underlying cause of the insured's two admissions was inter-related, the insurer treated them as the same disability and settled the insured's second confinement subject to the capped maximum benefit limits. As such, only about 70% of the total medical expenses incurred by the insured during his second hospitalization was settled.

投訴內容

一位 67 歲男士因排尿困難持續兩年入住私家醫院接受軟性膀胱鏡檢查，診斷結果為前列腺增大及阻塞，獲建議接受經尿道前列腺切除術。受保人約於一個月後再度入院接受前述手術，最終診斷結果為良性前列腺肥大。

保險公司支付受保人首次住院的大部分醫療費用。基於他兩次住院的根本成因相關，保險公司因此以同一傷病處理兩次住院索償，並以保障項目的最高賠償額為限，處理其第二次的住院理賠。有鑑於此，保險公司僅賠付了受保人第二次住院約 70% 的醫療費用。

Findings of the Complaints Panel

According to the contract provisions of the hospitalization policy, “disability” means “injury, sickness, disease or illness and shall include all disabilities arising from the same cause including any and all complications arising thereof, except that where after 90 days following the latest treatment or consultation, no further treatment for the said disability is required, any subsequent disability from the same cause shall be considered as a separate disability”.

The Complaints Panel noted from the available information that the reason for the insured’s two confinements was related to his prostatic disorder. The procedure of TURP performed during his second confinement was indeed recommended by the attending physician during his first admission. As the two admissions were not separated by more than 90 days, the Complaints Panel agreed with the insurer to treat them as the same disability.

投訴委員會的調查結果

有關住院保單的條款訂明：「傷病」是指「受傷、不適、疾病或病痛，並包括由同一原因造成的所有傷病及其一切併發症。不過，若受保人完全康復持續 90 天（由最後經註冊醫生治療或出院日起計算，以較後者為準），任何繼發的治療皆作新的傷病計算」。

投訴委員會從現有的資料文件得悉，受保人兩次住院的原因均與他的前列腺病況有關，而他也是基於第一次住院時的主診醫生的建議，才再次入院接受經尿道前列腺切除術。由於兩次住院相距不超過 90 天，投訴委員會同意保險公司把受保人的兩次住院視作為同一傷病。

Ruling of the Complaints Panel

The Complaints Panel ruled that the insurer’s decision in rejecting to pay a further payment of approximately HK$30,000 was appropriate. Such amount was the extra payment which the insured was entitled to receive if his two hospital confinements were treated separately.

投訴委員會的裁決

投訴委員會裁定保險公司不予賠償額外約 30,000 港元的決定合理，有關金額乃保險公司若分開處理受保人的兩次住院索償而可獲得的額外賠償。

Message from the Complaints Panel

Nearly all medical insurance policies have “same disability” provision to limit its coverage to recurrent confinement(s) due to disabilities arising from the same cause. In most cases, subsequent confinement(s) arising from the same cause will be considered as the same disability unless they are separated by at least 90 days with no treatment or consultation in between. The Complaints Panel urges the policyholders to pay special attention to such policy terms and the maximum benefit limits of the policy if they need to be re-admitted for the same or related medical condition.

投訴委員會的意見

幾乎所有住院醫療保單均載有「同一傷病」條款，為由同一原因導致的傷病而需重覆住院的賠償費用設限。在大多數的情況下，因相同原因引致的後續治療會被視為同一傷病，除非兩次的治療相距至少 90 日，而期間受保人亦不需要接受任何相關治療或求診。投訴委員會敦促保單持有人如因相同或相關醫療狀況而需再度住院，應特別留意有關條款及保單內各保障項目的最高賠償額。

Case 個案 07

Non-disclosure
沒有披露事實

Essence of Complaint:
Material Fact (fact influencing underwriting decision)

Type of Insurance:
Accident

投訴爭議點：
重要事實（影響承保決定）

保險類別：
意外保險

The Complaint

The insured applied for a life policy with accident benefit. He declared clean health history on the application form and the insurer then issued the policy on standard terms. Seven months after policy issuance, the insured sustained left low back injury with prolapsed intervertebral disc after lifting a heavy object at work. The diagnosis was left low back accidental injury. The attending doctor stated that his injury was not due to any degenerative change and there was redness and swelling noted at the first consultation after the injury. The insured was granted sick leave for 32 days. He submitted an accident claim to the insurer for disability benefit.

During claims investigation, the insurer found that the insured had a history of spinal surgery done in 1980 due to prolapsed intervertebral disc. Since the insured failed to disclose the aforesaid medical history at the time of policy application, the insurer declined his accident claim on the grounds of material non-disclosure.

投訴內容

受保人投購附有意外附加保障的人壽保單，於投保申請書上申報健康病歷，保險公司遂以標準條款繕發保單。保單生效七個月後，受保人因在工作時提重物導致左下背受傷和椎間盤突出，最終診斷結果為左下背意外受傷。主診醫生指出，受保人的受傷並非因任何退化導致，他在受傷後首次求診時背部呈現紅腫。受保人獲發 32 天病假，向保險公司就傷殘保障提出意外索償。

於審核索償期間，保險公司得悉受保人在 1980 年曾因椎間盤突出接受脊椎手術。由於受保人在投保時沒有申報有關病歷資料，保險公司遂以他沒有披露重要事實為理由，拒絕其意外索償。

Findings of the Complaints Panel

The Complaints Panel noted that the insured's spinal surgery was done some 37 years before his policy application and there was no evidence showing that he had received continuous follow-up consultation or treatment relating to his spinal problem. The Complaints Panel therefore believed that the non-disclosed medical history of the insured was too remote to be considered as material information which would have affected the underwriting decision of the insurer.

投訴委員會的調查結果

投訴委員會留意到有關脊椎手術是在受保人投保大約 37 年前進行，由於沒有證據顯示他持續接受與脊椎問題相關的覆診或治療，投訴委員會因此認為沒有披露的病歷資料發生太久遠，不應被視為會影響保險公司承保決定的重要事實。

Ruling of the Complaints Panel

The Complaints Panel ruled in favour of the insured and awarded him the accident claim of about HK$56,000.

投訴委員會的裁決

投訴委員會裁定受保人得直，保險公司需作出意外賠償，涉及金額約 56,000 港元。

Message from the Complaints Panel

In dealing with non-disclosure disputes, the Complaints Panel focuses mainly on whether or not the non-disclosed fact is:

1. a material fact, which would influence a prudent underwriter in accepting or declining a risk or in fixing the premium or terms and conditions of the contract;
2. a fact within the knowledge of the applicant; and
3. a fact which the applicant could reasonably be expected to disclose.

The Complaints Panel is mindful of whether or not it is fair and reasonable to expect an insured to disclose a particular piece of information alleged by the insurer to be a material fact. If there is no concrete and objective evidence to prove how a single incident of a particular medical condition and/or a treatment occurred long time prior to the policy application would have affected the insurer's underwriting decision, the Complaints Panel believes that it would be unfair and unreasonable for the insurer to base solely on that medical condition to decline a claim for material non-disclosure.

投訴委員會的意見

於審議涉及沒有披露事實的糾紛時，投訴委員會會集中考慮下列各點：

1）沒有披露的資料是否重要事實，足以影響審慎的承保商決定應該接受或拒絕承保，或如何釐定保費和保單條款及條件；
2）投保人是否知道有關事實；
3）在正常情況下，預期投保人披露有關事實是否合理。

投訴委員會會仔細考慮預期受保人披露某項被保險公司視為重要事實的資料，是否對受保人公平和合理。如果沒有具體及客觀的證據，證明某單一出現的特定病況及／或在投保一段長時間前接受的治療會影響保險公司的承保決定，投訴委員會相信保險公司純粹以受保人沒有披露該病況屬重要事實，繼而拒絕賠償並不公平和合理。

Case 個案 08

Non-disclosure 沒有披露事實

Essence of Complaint:
Material Fact (fact reasonably be expected to disclose)

投訴爭議點：
重要事實（合理預期會披露）

Type of Insurance:
Critical Illness

保險類別：
危疾保險

The Complaint

The complainant effected a life policy with critical illness rider for his one-year-old son (the insured). He declared clean medical history on the application form and the policy was issued on standard terms. About half year later, the insured was diagnosed as suffering from autism spectrum disorder by a child development centre. The complainant then filed a critical illness claim to the insurer for Early Stage Major Disease Benefit for Autism.

During claims investigation, the insurer learnt from the consultation summaries of a public hospital that the insured was noted *"failure to thrive at six months, catching up to 3% at eight months, borderline gross and fine development"*. Furthermore, it was recorded in the musculoskeletal assessment that the insured was found unresponsive to name by his mother at eight months old and had consulted for being unable to walk at 12 months old. Since the aforesaid medical information was not disclosed on the policy application form, the insurer declined the critical illness claim on the grounds of material non-disclosure.

The complainant argued that the insured was confirmed to suffer from autism only six months after the policy was effected. Although the insured was small, his development was within normal range when the policy was applied. The doctor even advised him that there was no need to worry as the insured was at the third percentile on the growth curve and had been maintaining his own growth curve since eight months old. Furthermore, he had also stated the height and the weight of the insured on the policy application form.

投訴內容

投訴人為一歲大的兒子（受保人）投購附有危疾附加保障的人壽保單，他在投保申請書上申報健康病歷，保險公司以標準條款繕發保單。約半年後，受保人被一間兒童發展中心診斷患上自閉症，投訴人遂向保險公司提出「自閉症」的早期危疾保障索償。

於調查索償期間，保險公司從一所公立醫院的醫療紀錄，得悉受保人在六個月大時發育遲滯，於八個月大時追至生長曲線圖的第三百分位，大小肌肉發展能力屬邊緣性。此外，肌肉骨骼評估的紀錄指出受保人於八個月大時對母親呼喚其名字沒有反應，並在12個月大時因未學懂步行而求診。由於投訴人沒有在投保申請書上披露相關病歷資料，保險公司遂以他沒有披露重要事實為理由，拒絕其危疾索償。

投訴人聲稱受保人於保單生效六個月後才被確診患上自閉症，雖然他的體型較小，在投保時的生長屬正常範圍內。基於受保人的身高和體重自他八個月大起均一直維持在生長曲線圖的第三百分位內，所以醫生也向投訴人表示毋須擔心。此外，投訴人在投保申請書上亦已申報了受保人的身高和體重。

Findings of the Complaints Panel

The Complaints Panel learnt from the Child Health Record that the growth curve of the insured was along the third percentile line and his height and weight were within normal range of growth for boys at 12 months old. Since babies come in all shapes and sizes and the insured had been growing along the curve for his size of baby, the Complaints Panel found it acceptable for the complainant to provide a negative answer on the application form when being asked if the insured had any physical defects or shown any signs of slow physical or mental development.

投訴委員會的調查結果

投訴委員會從受保人的兒童健康紀錄冊得悉他一直維持在生長曲線圖的第三百分位線上，於 12 個月大時的身高和體重均在男孩的正常生長範圍內。由於不同嬰孩的發展均有差異，而受保人一直按照與其體型相若的嬰兒的生長曲線圖成長，投訴委員會因此認為投訴人於投保申請書內被問及受保人是否有缺陷或心理上或心智發展緩慢的跡象時，回答「否」是可以接受。

Ruling of the Complaints Panel

As the grounds for the insurer to decline the complainant's claim for Early Stage Major Disease Benefit was not strong, the Complaints Panel ruled in favour of the complainant and awarded him the said benefit of about HK$234,000.

投訴委員會的裁決

由於保險公司拒絕向投訴人賠償早期危疾保障的理據不太充分，投訴委員會因此裁定投訴人得直，保險公司需賠付他約 234,000 港元的早期危疾保障。

Message from the Complaints Panel

The Complaints Panel reminds consumers that the information given by an applicant on the application form has significant impact on the insurer's underwriting assessment. From the information given on the application form, the insurer can identify high-risk features and decide whether or not to take the risk and at what premium and terms. However, if the non-disclosed information is not a fact which the insured could reasonably be expected to disclose or the insured has answered the questions on the application form honestly and completely to his best knowledge and belief, the Complaints Panel may rule in favour of the claimant.

投訴委員會的意見

投訴委員會提醒消費者，投保人在投保申請書上提供的資料，對保險公司的核保評估影響重大；保險公司會根據投保申請書上的資料，判斷是否有高風險的特徵，從而決定應否承保有關風險、釐定保費水平和保險合約條款。然而，如果沒有披露的資料並不屬投保人認知範圍內並在合理預期下需要披露的重要事實，或受保人已根據他認知和相信的事實如實和全面地回答投保申請書上的問題，投訴委員會或會裁定受保人得直。

Case
個案
09

Non-disclosure
沒有披露事實

Essence of Complaint:
Material Fact (fact influencing underwriting decision)

投訴爭議點：
重要事實（影響承保決定）

Type of Insurance:
Critical Illness

保險類別：
危疾保險

The Complaint

The insured applied for a critical illness policy with the insurer. He declared in the policy application that he had been admitted to private hospitals in China for excision of vocal polyp four years ago and for cervical spine disease four months ago. The insurer issued the policy at standard rate after duly assessed the declared health information.

About two years later, the insured was admitted to a private hospital in China for right papillary thyroid carcinoma. He filed a critical illness claim to the insurer for cancer benefit. Upon claims investigation, the insurer found that the insured had outpatient consultations eight months and 14 months prior to policy application for bronchitis and renal disease respectively. Since such information was material which would have affected the insurer's underwriting decision, the insurer declined the critical illness claim and rescinded the policy on the grounds of material non-disclosure.

投訴內容

受保人向保險公司投購危疾保障，在投保申請書上申報於四年前因接受聲帶瘜肉切除手術及於四個月前因頸椎病入住內地私家醫院。保險公司經考慮他所申報的病歷資料後，以標準條款繕發保單。

約兩年後，受保人因右甲狀腺乳頭狀癌入住內地私家醫院，隨後就癌症向保險公司提出危疾索償。於調查索償期間，保險公司得悉受保人在投保八個月和十四個月前分別因支氣管炎和腎病於門診求診。由於有關資料為重要事實，會影響保險公司的承保決定，保險公司遂以他沒有披露重要事實為理由，拒絕其危疾索償申請，並撤銷保單。

Findings of the Complaints Panel

According to the insured, the non-disclosed two outpatient consultations for bronchitis and renal disease were trivial matters which did not require much medical attention. The Complaints Panel, however, noted from the consultation record that the insured was diagnosed with renal disease 14 months prior to policy application with urine investigations performed.

投訴委員會的調查結果

受保人辯稱沒有披露的兩次門診求診乃因支氣管炎和腎病，病況僅屬輕微，不需要太多的醫療護理。然而，投訴委員會從有關的門診應診紀錄得悉，受保人在投保 14 個月前已被確診患上腎病，並曾接受尿液測試。

Ruling of the Complaints Panel

The Complaints Panel agreed that the non-disclosed information was material and would have affected the insurer from making a fair and accurate underwriting decision. It therefore upheld the insurer's decision to decline the critical illness claim of HK$233,700 for material non-disclosure.

投訴委員會的裁決

投訴委員會同意沒有披露的資料乃屬重要事實，會影響保險公司作出公平和準確的承保決定，投訴委員會因此支持保險公司以沒有披露重要事實為理由，拒絕賠償 233,700 港元的危疾保障。

Message from the Complaints Panel

Insurance contracts are based on trust. Insurers trust the insureds to give precise and true details of the subject matter to be insured. This is called the principle of "Utmost Good Faith". The nature of the subject matter of insurance and the circumstances pertaining to it are facts within the knowledge of the insureds. Insurers, on the other hand, are not aware of these facts unless the insureds tell them. The insureds, therefore, should always take care to tell the whole truth. Non-disclosure arises when an applicant for an insurance policy fails to disclose on the application form facts within his/her knowledge.

If the non-disclosed fact is a material fact which is within the knowledge of the insured and which the insured could reasonably be expected to disclose, the Complaints Panel will generally support the insurer's rejection of claim for material non-disclosure even though the non-disclosed information may not be related to the current illness. This is because the non-disclosure has prejudiced the insurer from making a fair and accurate underwriting assessment.

The Complaints Panel reminds all insureds that "if in doubt as to whether a fact is material, it would be advisable to disclose it".

投訴委員會的意見

保險合約建基於信任，保險公司信任投保人會對投保事項提供準確和真實的資料，此之謂「最高誠信原則」。投保事項的性質，以及與之相關的各種狀況，均是投保人認知範圍內的事實，除非投保人主動相告，否則，保險公司不會知道。因此，投保人有責任交代所有事實。如果投保人在投保時沒有披露已知的事實，則會被視為沒有披露事實。

如沒有披露的資料屬投保人認知範圍內，並在合理預期下需要披露的重要事實，投訴委員會一般會支持保險公司以沒有披露重要事實為理由拒絕賠償，即使沒有披露的資料與索償的病症沒有關係，因為沒有披露的事實令保險公司無法作出公平及準確的承保決定。

投訴委員會提醒所有投保人：如不確定某些事實是否重要，最好還是加以披露。

Case 個案 10

Excluded items
不保事項

Essence of Complaint:
Venereal Disease (cervical disorder)

投訴爭議點：
性病（宮頸疾病）

Type of Insurance:
Hospitalization

保險類別：
住院保險

The Complaint

The complainant consulted a physician for low-grade squamous intraepithelial lesion (LGSIL) and human papillomavirus (HPV) which were detected about one month ago in a routine checkup at the Family Planning Association of Hong Kong. Ten days later, she was admitted to a private hospital for loop electrosurgical excision procedure. The final diagnosis was cervical intraepithelial neoplasia (CIN) 1. The complainant subsequently lodged a hospitalization claim to the insurer for the hospital expenses incurred. Since there was an indication on the molecular pathology report that HPV DNA (high risk type 66) was detected and the type of HPV revealed was associated with sexually transmitted disease, the insurer declined the hospitalization claim based on the policy exclusion on venereal disease.

投訴內容

投訴人向私家醫生求診，她約一個月前在香港家庭計劃指導會的例行檢查中發現子宮頸出現低度鱗狀上皮病變及人類乳頭狀病毒。十天後，她入住私家醫院接受環式電頻手術切除術，最終診斷結果為第一級子宮頸上皮內贅瘤。投訴人隨後向保險公司提交住院索償申請，由於分子病理學報告顯示偵測到人類乳頭狀病毒去氧核醣核酸（高致癌風險型66），加上該人類乳頭狀病毒的類型與性病相關，保險公司因此以性病屬保單的不保事項為理由，拒絕作出住院賠償。

Findings of the Complaints Panel

It is stated in the "Exclusion" provisions of the hospitalization policy that "the insurer shall not cover medical or other health care services or treatment rendered in connection with any injury, sickness, disease or illness directly or indirectly resulting from or consequent upon… venereal disease…".

The Complaints Panel learnt from the complainant's attending physician that not all LGSIL were caused by HPV. As there was no evidence to prove that the complainant's condition was consequent upon HPV and her confinement was to receive treatment for cervical disorder, but not venereal disease, the Complaints Panel considered that the insurer's decision to decline the claim based on the policy exclusion on venereal disease was not fair and appropriate.

Ruling of the Complaints Panel

The Complaints Panel ruled in favour of the complainant and resolved that the insurer should reimburse her the medical expenses incurred, amounting to around HK$40,000.

Message from the Complaints Panel

Most hospitalization policies contain exclusion clause to exclude loss directly or indirectly resulting from certain conditions. In deciding whether or not a claimed condition falls within the relevant policy exclusion, the Complaints Panel, other than referring to common medical literatures or references, relies heavily and very often on the opinions given by the attending doctors.

投訴委員會的調查結果

有關住院保單的「不保事項」條款訂明：「保險公司不承保直接或間接因……性病……而引致或造成的受傷、病痛、不適或疾病，並因此而接受的醫療或其他護理服務」。

投訴委員會從投訴人的主診醫生得悉並非所有的低度鱗狀上皮病變都是由人類乳頭狀病毒引起。由於現有資料未能證明投訴人的病況源於人類乳頭狀病毒，而她入院是為治療子宮頸疾病，而非性病，因此投訴委員會認為保險公司以性病屬保單的不保事項為理由，拒絕投訴人住院賠償的決定並不公平和合理。

投訴委員會的裁決

投訴委員會裁定投訴人得直，保險公司需向她賠付住院費用，涉及金額約 40,000 港元。

投訴委員會的意見

大部分住院保單均載有豁免條款，豁免保障因某些情況直接或間接引致的損失。在判斷某項病狀是否屬於相關不保事項條款時，投訴委員會除了參考一般醫療文獻或資料外，很多時亦會倚重主診醫生的意見。

Case 個案 11

Excluded items
不保事項

Essence of Complaint:
Pre-existing Condition (colon polyps)

投訴爭議點：
投保前已存在的病狀（結腸瘜肉）

Type of Insurance:
Hospitalization

保險類別：
住院保險

The Complaint

The insured effected a hospitalization policy with the insurer and declared clean health history on the application form. Three months after policy issuance, the insured consulted a physician for epigastric pain, abdominal pain and rectal bleeding presenting for more than a week. Two weeks later, she was admitted to a private hospital to receive oesophageal-gastro-duodenoscopy (OGD) and colonoscopy with polypectomy. The final diagnoses were gastritis, gastric polyps and external piles. The insured lodged a hospitalization claim to the insurer for the hospital expenses incurred.

During claims investigation, the insurer learnt from the referral letter issued by another medical practitioner whom the insured consulted for stomachache and flu that the insured had colonoscopy done two years ago and colon polyps were revealed. The insurer initially declined the hospitalization claim for material non-disclosure. The insured later appealed against the insurer's decision by providing it with a letter from her attending physician together with the endoscopy report issued two years ago. The attending physician confirmed in the letter that the insured's previous OGD and colonoscopy showed no evidence of polyp in both upper and lower gastro-intestinal tract. The mentioning of polyps in the referral letter should be a wrong entry. The insured also indicated that she might have provided wrong information to the medical practitioner when she consulted him for stomachache and flu since she had misinterpreted the colonoscopy result. After further negotiations, the insurer finally agreed to reimburse the insured all the hospital expenses except for the charges relating to colonoscopy on the grounds that pre-existing condition of colon was excluded.

投訴內容

受保人投購住院保單，在投保申請書上申報健康病歷。保單繕發三個月後，受保人因上腹痛、腹痛及直腸出血逾一星期向私家醫生求診。她於兩星期後入住私家醫院接受食道胃十二指腸鏡及結腸鏡檢查和瘜肉切除手術，最終被確診患上胃炎、胃瘜肉及外痔。受保人就有關住院費用向保險公司申請住院索償。

於調查索償期間，保險公司知悉受保人曾因胃痛及感冒向另一名醫生求診，該名醫生的轉介信指出受保人於兩年前接受結腸鏡檢查，結果顯示結腸瘜肉。保險公司最初以受保人沒有披露重要事實為理由拒絕作出住院賠償。受保人其後就保險公司的決定提出上訴，並提交其主診醫生的信函及兩年前的內窺鏡檢查報告。主診醫生在信中確定受保人之前進行的食道胃十二指腸鏡及結腸鏡檢查均沒有顯示上及下消化道瘜肉，有關轉介信內提及的結腸瘜肉實屬錯誤記錄。受保人亦指出她就胃痛及感冒向該名醫生求診時，可能因為誤解結腸鏡報告結果而向該名醫生提供錯誤資料。經過進一步商討後，保險公司最後同意除涉及結腸鏡檢查的費用外，向受保人賠付所有住院費用，理由是受保人的結腸問題屬投保前已存在的病狀。

Findings of the Complaints Panel

It is stipulated in the "General Exclusions" provisions of the hospitalization policy that "the policy shall not cover… any medical conditions arising therefrom pre-existing conditions" and "Pre-existing condition" means "any medical condition which has been diagnosed, or has required medical treatment, or commenced or presented signs or symptoms of which the insured person was aware or should reasonably have been aware of prior to the effective date of the insurance policy, irrespective of whether treatment was actually received".

Since the insured was presented with rectal bleeding during her first consultation, the Complaints Panel considered that it was justified for her to receive colonoscopy investigation. Having duly considered the fact that no polyp was found in her previous colonoscopy, the Complaints Panel was not convinced that the insurer should decline the current colonoscopy charges incurred based on the pre-existing condition of colon.

Ruling of the Complaints Panel

The Complaints Panel ruled in favour of the insured and decided that the insurer should reimburse her the colonoscopy charges of around HK$15,400.

Message from the Complaints Panel

"Pre-existing Conditions" are commonly found in most medical and hospitalization policies to exclude injuries or sicknesses which occur, exist or present signs or symptoms before the commencement of the policy coverage.

In dealing with these cases, the Complaints Panel relies heavily on whether or not there is sufficient evidence to show that the injury or sickness occurred earlier than the policy effective date, or whether the signs or symptoms of the illness existed before the policy is effected.

投訴委員會的調查結果

有關住院保單內的「一般不保事項」條款訂明：「保險公司不會就……任何因投保前已存在的病狀而引致的醫療狀況作出賠償」，而「投保前已存在的病狀」是指「在保單生效日前已獲診斷或需接受治療或已呈現病徵或症狀的醫療狀況，而受保人已察覺或理應合理地察覺，不論有否實際接受過治療」。

由於受保人於首次求診時有直腸出血的症狀，投訴委員會認為安排她進行結腸鏡檢查實屬合理。經考慮她之前進行的結腸鏡檢查並沒有發現結腸瘜肉後，投訴委員會並不贊同保險公司以受保人的結腸問題屬投保前已存在的病狀為理由，不予賠償是次結腸鏡檢查的費用。

投訴委員會的裁決

投訴委員會裁定受保人得直，保險公司需向她賠付結腸鏡檢查的費用，涉及金額約15,400 港元。

投訴委員會的意見

大部分的醫療及住院保單均載有「投保前已存在的疾病」條款，豁免保障於保單生效前已發生、存在、顯現病徵或症狀的傷病。

在審理這些個案時，投訴委員會非常重視是否有充分證據，證明有關傷病在保單生效前已經出現，或病症的病徵或症狀於保單生效前已存在。

Case 個案 12

Excluded items 不保事項

Essence of Complaint:
Dental Treatment (TMJ internal derangement)

投訴爭議點：
牙科治療（顳顎關節內部紊亂）

Type of Insurance:
Hospitalization

保險類別：
住院保險

The Complaint

The insured lodged a hospitalization claim for her admission to a private hospital for receiving temporomandibular joint (TMJ) bilateral arthrocentesis and injection under the care of a specialist in Oral & Maxillofacial Surgery (OMFS). The final diagnosis was TMJ internal derangement. Given that the hospitalization policy excludes dental treatment, the insurer declined the claim. The insured later referred to the policy exclusion which clearly states the types of dental treatments/oral surgeries which would be covered by the policy and emphasized that her surgery belonged to one of those dental treatments. However, since the insured's attending physician is a dentist who specialized in OMFS, but not a registered medical practitioner as defined in the policy, the insurer maintained its decision to decline the claim.

投訴內容

受保人在口腔頜面外科專科醫生的安排下入住私家醫院進行雙側顳顎關節穿刺術及注射，最終診斷為顳顎關節內部紊亂，他隨後向保險公司提交住院索償申請。由於有關住院保單並不保障牙科治療，保險公司遂拒絕賠償。受保人其後向保險公司指出保單合約內的「不受保項目」明確地列明了可獲承保的牙科治療／口腔手術的類型，並強調她接受的手術屬於該類牙治療。然而，由於受保人的主診醫生為牙醫，屬口腔頜面外科專科，不符合保單內「註冊醫生」的定義，保險公司因此維持原來不予賠償的決定。

Findings of the Complaints Panel

It is defined in the hospitalization policy that "Registered Medical Practitioner" means "...those persons duly qualified and legally registered as such to practice Western medicine in HKSAR…". According to the "Exclusions" provisions, "The insurer shall not cover dental oral or oro-surgical care and treatment of any kind… The only services related to dental treatment which shall be covered under the policy are... (b) oral surgery when properly referred for reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant neoplasm of the jaw".

Having duly examined the policy wordings and provisions, the Complaints Panel considered that since the aforesaid policy exclusion has clearly listed out the types of dental treatments/oral surgeries which would be covered by the policy, these dental treatments/oral surgeries should not be bound by the requirement that they should be performed by a registered medical practitioner. Having sought further clarifications from the insured's attending physician, the Complaints Panel learnt that the insured's condition was anterior disc displacement with pain and arthritis which was not related to a dislocation or fracture of the jaw. It therefore agreed that the claim fell within the aforesaid policy exclusion.

投訴委員會的調查結果

有關醫療保單訂明：「註冊醫生」指「……具有正式資格並在香港特別行政區合法註冊為西醫的人士……」；而「不受保項目」的條款訂明：「保險公司不承保任何類別的牙科及口腔手術護理和治療……保單只承保下列與牙科治療有關的服務：……(b) 經適當轉介的口腔手術，以治療頜骨脫位或骨折；切除頜骨良性或惡性腫瘤」。

投訴委員會經檢視了保單的用詞及條款後，認為保單內的「不受保項目」條款已清晰列出可獲保障的牙科治療／口腔手術的類型，故這些牙科治療／口腔手術不應再受「只由註冊醫生進行」的限制。應投訴委員會的要求，受保人的主診醫生其後澄清受保人的病況為顳顎關節盤前移，並出現疼痛及關節炎，惟卻與頜骨脫位或骨折無關，投訴委員會因此贊同受保人的索償屬保單的不保事項。

Ruling of the Complaints Panel

The Complaints Panel ruled that the insurer's decision in declining the hospitalization claim of around HK$79,000 was appropriate.

投訴委員會的裁決

投訴委員會裁定保險公司不予向受保人作出住院賠償的決定合理，涉及的金額約 79,000 港元。

Message from the Complaints Panel

All insurance contracts contain an "exclusion" section which lists all the losses, perils, situations, conditions or circumstances that are excluded from the insurance coverage. The purpose of exclusions is to limit the coverage to only those risks the policies are intended to cover at the agreed premium.

投訴委員會的意見

所有保險合約均設有「不保事項」條款，羅列所有不受保單保障的損失、風險、情況、狀況或環境，目的是以設定的保費，限制保單的保障範圍於擬承保的風險之內。

Case 個案 13

Amount of indemnity
賠償金額

Essence of Complaint:
Adjustment Factor for Room Upgrade

投訴爭議點：
病房升級而作出賠償調整

Type of Insurance:
Hospitalization

保險類別：
住院保險

The Complaint

The complainant took out a medical policy for his family. The class of benefit was ward level. The complainant's son (the insured) was later admitted to a private hospital to receive circumcision for his balanitis. The hospital expenses incurred was about HK$21,000. Since the insured was admitted to a semi-private room during his confinement, the insurer applied a room adjustment factor of 50% to the claims settlement.

The complainant subsequently submitted to the insurer a letter from the private hospital. It was stated that the insured was admitted to a semi-private room instead of a ward room because all the ward rooms were fully occupied upon his admission. The insured was charged for the semi-private room rate but his hospital services fees such as meals, pathology tests, medical imaging services, medications and nursing services, etc. were charged according to the ward room rate. The insurer then agreed to remove the room adjustment factor for meals, drugs, hospital expenses and the operating theatre fee, and settled an extra HK$2,500 to the complainant. However, the insurer maintained to apply 50% adjustment to room charge, surgeon's fee, anaesthetist's fee and doctor's visit fee. The complainant was not satisfied with the decision and emphasized that surgeon's fee, anaesthetist's fee and doctor's visit fee had been agreed with the attending physician prior to the insured's admission and these fees had not been raised when the room was upgraded.

投訴內容

投訴人為家人購買住院保單，病房級別為「大房」。投訴人的兒子（受保人）其後因龜頭炎入住私家醫院接受環切術，住院費用約21,000港元。由於受保人入住了半私家病房，保險公司因此在處理相關住院賠償時加入了50%的調整。

投訴人隨後向保險公司遞交由醫院發出的信函，指出受保人入院時所有大房已爆滿，所以他被安排入住半私家病房；然而，除了住房費按半私家病房費用收取外，其餘的住院服務，如：膳食、病理檢查、影像掃描服務、藥物及護理服務等均按大房費用收費。保險公司其後同意取消膳食費、藥物費、住院服務費及手術室費的賠償調整，並向投訴人額外賠償2,500港元，惟卻堅持需於住房費、外科醫生手術費、麻醉師費及醫生巡房費加入50%的賠償調整。投訴人不滿有關決定，強調他在受保人入院前已與其主診醫生商議好外科醫生手術費、麻醉師費及醫生巡房費的費用，相關費用並沒有因為病房升級而上調。

Findings of the Complaints Panel

According to the "Benefits" provisions of the hospitalization policy, "If an insured person is confined to a higher level of room accommodation than that he/she is entitled to under the policy, the insurer will adjust the amount of benefit payable by multiplying the respective adjustment factor". The adjustment factor will be 50% if the insured person is entitled to ward class but he/she receives treatment in a semi-private room.

Having studied the hospital receipt and other available information, the Complaints Panel considered that there was no information indicating that surgeon's fee, anaesthetist's fee and doctor's visit fee were charged at a higher cost as a result of room upgrading during the insured's confinement. Given that only room charge was charged at semi-private level, the Complaints Panel was not convinced that the insurer's application of 50% adjustment factor to surgeon's fee, anaesthetist's fee and doctor's visit fee was fair and reasonable.

投訴委員會的調查結果

有關住院保單的「保障」條款訂明：「如受保人入住的病房級別較保單合約指定的病房級別為高，保險公司在計算賠償時，將按相關病房類別的賠償調整百分比作出賠償」；如受保人合資格入住的病房級別為「大房」，卻入住了半私家病房，相關的賠償調整百分比為 50%。

經檢視了醫院收據及其他文件後，投訴委員會認為現有資料沒有顯示外科醫生手術費、痲醉師費及醫生巡房費在受保人入住較高級別病房後有所上調。由於只有住房費是按半私家病房的費用收取，投訴委員會並不贊同保險公司在賠償外科醫生手術費、痲醉師費及醫生巡房費時加入 50% 調整的決定為公平和合理。

Ruling of the Complaints Panel

The Complaints Panel ruled that the insurer should re-adjust the claims settlement by taking away the adjustment factor to all charges other than the room rate. The extra amount involved was around HK$9,000.

投訴委員會的裁決

投訴委員會裁定保險公司需重新計算賠償金額，除住房費用外，不應在其他項目作出賠償調整，重新計算後的賠償金額增加了約 9,000 港元。

Message from the Complaints Panel

Most hospitalization policies contain "adjustment factor" clause. If an insured stays in a hospital room class higher than he/she is entitled to under his/her plan, the insurer will reduce the benefits paid by multiplying the room level adjustment factor. However, if it turns out that the hospital does not charge all the expenses at the rate of higher room class in situation where its lower class rooms are fully occupied, the Complaints Panel considers that it may not be fair to the insured if the insurer maintains to apply the adjustment factor to those benefit items which have not been charged at the rate of higher room class in its claims settlement.

投訴委員會的意見

大部分醫療保單均載有「賠償調整」的條款。如受保人入住的病房級別高於其保單指定的病房級別，保險公司在賠償時會乘以相關病房升級的調整百分比，以減少應支付之賠償。然而，如果醫院因為較低級別的病房床位額滿而沒有按較高級別的病房收費收取全部的住院費用，投訴委員會認為保險公司如在理賠時向該些沒有按較高級別病房收費的住院項目作出賠償調整，則對受保人不公平。

Case 個案 14

Amount of indemnity 賠償金額

Essence of Complaint:
Normal and Reasonable Meal/Beverage Allowance

Type of Insurance:
Hospitalization

投訴爭議點：
正常及合理膳食／飲料津貼

保險類別：
住院保險

The Complaint

A woman lodged a hospitalization claim to the insurer for her admission to a private hospital for seven days due to osteoarthritis of bilateral knees, lumbar spondylosis, hypertension and diabetes. The insurer reimbursed most of the hospital expenses incurred during her confinement in accordance with policy terms and conditions. The only dispute was the meal/beverage allowance. The insurer noted that the insured is a diabetes patient and was suggested by the attending physician to have diet control. However, she had ordered large amount of high sugar food every day. Since the food ordered was not reasonable and beyond reasonable daily consumption of a normal individual, the insurer deducted the excess meal/beverage allowance (amounting to around 30% of the total meal/beverage expenses) in the claims settlement.

投訴內容

一位婦人因雙膝骨關節炎、腰椎病、高血壓及糖尿病入住私家醫院七天，其後向保險公司遞交住院索償申請。保險公司按照保單條款及條件支付了大部分的住院費用，唯一爭議涉及膳食／飲料津貼。保險公司知悉受保人乃一名糖尿病患者，而主診醫生亦建議她要控制飲食；然而，她每天卻點選了大量高糖份的食物。由於點選的食物不合理，且超出一位正常人的每天合理食量，保險公司因此於理賠時扣減過量的膳食／飲料津貼，金額約佔總膳食／飲料費用的 30%。

Findings of the Complaints Panel

It is stipulated in the hospitalization policy that "meal/beverage allowance… shall be paid during the time that an insured person is registered and staying as an inpatient in a hospital for treatment of a covered disability and incurs charges thereof. The amount of benefit shall be equal to the normal, proper and actual charges by the hospital during the insured person's hospital confinement…".

Having duly reviewed the breakdown of the meal/beverage charges, the Complaints Panel noted that the items ordered during the insured's seven-day hospital confinement included 19 sets of dessert, 18 cans of energy drink, 33 cups of different kinds of drink/soft drink, 12 cups of fruit juice, etc. The Complaints Panel agreed that the food and drinks ordered by the insured during her confinement was excessive and unreasonable even for a person with no symptom of diabetes.

投訴委員會的調查結果

有關住院保單的條款訂明：「受保人登記為住院病人以治療受保傷病，並因而產生費用，保險公司將支付……膳食／飲料津貼。賠償額將相當於受保人住院期內，醫院正常、適當和實際收取的費用……」。

投訴委員會從醫院提供的膳食／飲料費用細明表得悉，受保人於七天住院期間共點選了19 份甜品、18 罐能量飲料、33 杯不同的飲料或汽水、12 杯果汁等；就此，投訴委員會同意即使對於一名沒有糖尿病病徵的人士，受保人於住院期間所點選的食品和飲料實屬過量及不合理。

Ruling of the Complaints Panel

Under such circumstances, the Complaints Panel ruled that the insurer's settlement offer on the meal/beverage allowance was fair and appropriate. The disputed amount was around HK$1,200.

投訴委員會的裁決

在此情況下，投訴委員會裁定保險公司就膳食／飲料津貼作出的賠償公平和合理，相關爭議金額約 1,200 港元。

Message from the Complaints Panel

Other than contract terms and conditions, the Complaints Panel believes that in some cases, common sense and common understandings are crucial and essential for sound decision making.

投訴委員會的意見

除了合約的條款和條件外，投訴委員會相信在某些情況下，常識和常理乃作出合理決定的關鍵要素。

Case 個案 15

Mutual settlement
雙方和解

"The ICB always believes that claims disputes can be best resolved by way of conciliation. The existing claims handling procedures provide an opportunity for insurers to settle disputes without having to refer them to the Complaints Panel for adjudication. The referral of cases to the Honorary Secretaries for assessment is an important and critical part of the process. In quite a number of cases, insurers alter their positions after taking due consideration of the opinions of the Honorary Secretaries who are seasoned and experienced insurance professionals.

投訴局一直堅信和解是解決索償糾紛的最佳方法，在目前的投訴機制下，保險公司有機會與投訴人達成和解，毋須投訴委員會介入審理。轉介個案予名譽顧問審理是非常重要及關鍵的步驟，有不少的個案是保險公司考慮了經驗豐富及具專業知識的名譽顧問的意見後而改變初衷，作出賠償。"

Essence of Complaint:
Medication purchased from Public Hospital

投訴爭議點：
公立醫院購買的藥物

Type of Insurance:
Medical

保險類別：
醫療保險

The Complaint

A woman effected a medical policy with outpatient cover which provides outpatient doctors' consultation benefit and prescriptions benefit with 80% reimbursement. She had regular consultations in a public hospital and prescribed long-term medication for hepatitis B since 2012. Her outpatient consultations and medication fees incurred from 2012 to 2017 were duly settled by the insurer.

The insured filed medical claims to the insurer in respect of her two consultations at the public hospital in 2018 and the medication fees incurred. However, the insurer only settled the consultation fees incurred but not the medication fees. The insurer explained that the medicine was purchased from a public hospital but not from a medical dispensary licensed as a pharmacy under the laws of HKSAR. The insured was dissatisfied with the decision and contended that she had purchased the prescribed medicines from the public hospital for more than five years and it was more economical to purchase medicines there than from medical dispensaries outside.

投訴內容

一名婦人投購了附有門診保障的醫療保險，保單提供西醫門診保障及處方藥物保障，賠償比率為 80%。投保人為乙型肝炎患者，自 2012 年起於公立醫院定期覆診及獲處方長期藥物，保險公司已就她於 2012 年至 2017 年期間的西醫門診費用及處方藥物費用作出悉數賠償。

投保人就 2018 年兩次於公立醫院求診所涉的西醫門診費用及相關的處方藥物費用向保險公司提出索償，惟保險公司只賠償了西醫的門診費用，卻沒有就處方藥物費用作出賠償。保險公司解釋有關處方藥物是購自公立醫院，而非香港特別行政區法律規定的持牌藥房。投保人不滿有關決定，重申她在公立醫院藥房購買有關處方藥物已超過五年，公立醫院藥房的價格較市面的藥房更經濟。

Brief Facts

It is stated in the "Prescriptions benefit" of the policy that "if an insured person is prescribed medicines by a registered medical practitioner for the treatment or management of a covered disability requiring medication in excess of 30 days, a benefit shall be paid in an amount equal to the costs of such prescribed medicines subject to their being purchased from a medical dispensary which is licensed as a pharmacy under the laws of HKSAR or other jurisdiction where the medicines are purchased, and which is not a doctor's clinic…".

基本資料

有關保單內「處方藥物保障」 的條款訂明：「若註冊醫生向受保人處方藥物，以治療或控制需要用藥多於 30 日的受保傷病，保險公司將支付此項保障，賠償額相當於該等處方藥物的費用，但該等處方藥物須購自根據香港特別行政區或購藥地點所屬其他司法管轄區法律規定的持牌藥房，而非購自醫生診所……」。

Comments of the Honorary Secretaries

The case was referred to three Honorary Secretaries and all of them recommended the insurer to honour the claim. They considered that the intention of the prescriptions benefit is to cover prescribed medicines purchased from legally permitted sources. Since a public hospital dispensary is a licensed pharmacy under the law of HKSAR and not a doctor's clinic, they believed that the insurer should entertain the insured's claim for prescriptions acquired at the public sector subject to the yearly maximum limit of HK$3,000.

名譽顧問的意見

個案轉交三位名譽顧問考慮，他們均建議保險公司作出賠償，並認為處方藥物保障的用意乃為受保人於合法地點購買的處方藥物提供保障。由於公立醫院的藥房屬香港特別行政區法律下註冊的藥房，而非醫生診所，名譽顧問因此相信保險公司理應就投保人購自公共機構的處方藥物作出賠償，以每年 3,000 港元保障額為上限。

Feedback of the Insurer

The opinions of the Honorary Secretaries were relayed to the insurer who subsequently agreed to settle extra HK$3,000 to the insured for her claim for long-term medications.

保險公司的回應

保險公司考慮名譽顧問的意見後，同意就受保人購買長期處方藥物的費用向她額外賠付 3,000 港元。

Case
個案
16

Mutual settlement
雙方和解

Essence of Complaint:
Confinement for Investigation

投訴爭議點：
入院檢查

Type of Insurance:
Hospitalization

保險類別：
住院保險

The Complaint

The complainant suffered from severe left loin pain while he was travelling in Switzerland. CT scan done in Switzerland revealed left ureteric stone. When he returned to Hong Kong, he consulted a private doctor for left loin pain and was then admitted to a private hospital for further investigation on the same day. CT urogram, laboratory test and x-ray were performed and the final diagnosis was left ureteric stone. The complainant later filed a hospitalization claim to the insurer for the hospital expenses incurred.

Given that the examinations could have been safely done in an outpatient basis and that there was no evidence showing medical urgency and necessity for admission, the insurer considered that the admission was not medically necessary and declined the claim.

投訴內容

投訴人在瑞士旅遊期間左腰出現嚴重痛楚，於當地進行的電腦斷層掃描檢查顯示左輸尿管結石。回港後，他就左腰疼痛向私家醫生求診，並獲安排同日入院接受進一步檢查。他於住院期間進行了電腦斷層尿路造影、化驗及 X 光檢查，最終診斷結果為左輸尿管結石，他其後就有關住院費用向保險公司提出住院索償申請。

由於投訴人所進行的檢查大可於門診診所安全地進行，加上沒有證據顯示有關住院有緊急醫療需要和必要性，保險公司因此以住院沒有醫療需要而拒絕賠償。

Brief Facts

According to the policy provisions, "Confinement" means "necessary residence in a hospital as an inpatient while under the care of a doctor for which the hospital makes a charge for room and board". According to the complainant's attending physician, the complainant's admission was medically necessary for management of his loin pain.

基本資料

有關醫療保單條款訂明：「住院」是指「必須留宿醫院接受醫生診治，並需繳付病房費用」。根據投訴人的主診醫生的意見，投訴人有醫療需要入院接受腰痛的治療。

Comments of the Honorary Secretaries

The case was referred to three Honorary Secretaries and all of them disagreed with the insurer's decision in declining the hospitalization claim. They considered that it was not uncommon for a patient to be admitted to hospital for management of pain, in particular pain caused by ureteric or renal stone could be very severe. Having duly reviewed the statement from the attending doctor, the complainant's admission was deemed medically necessary and fulfilled the definition of "confinement". They recommended the insurer to pay the claim.

名譽顧問的意見

個案轉交三位名譽顧問考慮，他們均不同意保險公司拒絕醫療索償的決定，並認為病人因接受疼痛治療而入院並不罕見，尤其是由輸尿管或腎結石引致的痛楚可以非常劇烈。經考慮了投訴人主診醫生的意見後，名譽顧問一致認為投訴人的住院屬醫療必須，符合保單內「住院」定義的要求，故建議保險公司作出賠償。

Feedback of the Insurer

Having duly considered the opinions of the Honorary Secretaries, the insurer subsequently revised its previous claims decision and settled the complainant's hospitalization claim for around HK$9,000.

保險公司的回應

經考慮名譽顧問的意見後，保險公司改變之前的賠償決定，向投訴人作出住院賠償，金額約 9,000 港元。

財務報表

01/01/2019 - 31/12/2019

Independent auditor's report to the members of The Insurance Complaints Bureau

(Incorporated in Hong Kong and limited by guarantee)

Opinion

We have audited the financial statements of the ICB set out on pages 64 to 69, which comprise the statement of financial position as at 31 December 2019, the statement of comprehensive income and the cash flow statement for the year then ended and notes to the financial statements.

In our opinion, the financial statements give a true and fair view of the financial position of the ICB as at 31 December 2019 and of its financial performance and its cash flows for the year then ended in accordance with Hong Kong Financial Reporting Standards ("HKFRSs") issued by the Hong Kong Institute of Certified Public Accountants ("HKICPA") and have been properly prepared in compliance with the Hong Kong Companies Ordinance.

Basis for opinion

We conducted our audit in accordance with Hong Kong Standards on Auditing ("HKSAs") issued by the HKICPA. Our responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of our report. We are independent of the ICB in accordance with the HKICPA's *Code of Ethics for Professional Accountants* ("the Code") and we have fulfilled our other ethical responsibilities in accordance with the Code. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Information other than the financial statements and auditor's report thereon

The members of the General Committee of the ICB are responsible for the other information. The other information obtained at the date of this auditor's report is the Report of the General Committee, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work we have performed on the other information obtained prior to the date of this auditor's report, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the members of the General Committee for the financial statements

The members of the General Committee are responsible for the preparation of the financial statements that give a true and fair view in accordance with HKFRSs issued by the HKICPA and the Hong Kong Companies Ordinance and for such internal control as the members of the General Committee determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the members of the General Committee are responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the ICB or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. This report is made solely to you, as a body, in accordance with section 405 of the Hong Kong Companies Ordinance, and for no other purpose. We do not assume responsibility towards or accept liability to any other person for the contents of this report.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with HKSAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with HKSAs, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error,

design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the ICB's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the members of the General Committee.

- Conclude on the appropriateness of the members of the General Committee's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

KPMG
Certified Public Accountants
Honorary Auditor
Hong Kong, 3 April 2020

Statement of financial position as at 31 December 2019

(Expressed in Hong Kong dollars)

	Note	2019 $	2018 $
Current assets			
Tax recoverable		125	-
Prepayments and receivables		18,922	17,881
Cash and cash equivalents	4	2,868,071	1,814,079
Total current assets		2,887,118	1,831,960
Current liabilities			
Tax payable	7	-	4,972
Account payable		194,000	-
Subscriptions received in advance		2,059,000	1,175,785
Total current liabilities		2,253,000	1,180,757
Net assets		634,118	651,203
Accumulated surplus		634,118	651,203

Approved and authorised for issue by the General Committee on 3 April 2020

Dr Pamela Chan Wong Shui
Chairman

Mr Mike Lee
Member

The notes on pages 67 to 69 form part of these financial statements.

Statement of comprehensive income for the year ended 31 December 2019

(Expressed in Hong Kong dollars)

	Note	2019	2018
		$	$
Income			
Subscriptions	5	2,836,000	2,552,000
Interest income		1,493	235
		2,837,493	2,552,235
Expenditure			
Administration fees charged by the HKFI	6	2,700,000	2,257,000
Printing and stationery		102,200	114,350
Liability insurance		32,150	33,442
Entertainment		7,890	4,758
Web-site fees		3,963	3,039
Sundry expenses		13,440	76,254
		2,859,643	2,488,843
(Deficit)/surplus for the year before taxation		(22,150)	63,392
Profit tax credit/(expense)	7	5,065	(5,210)
(Deficit)/surplus and total comprehensive income for the year		(17,085)	58,182

Since the only movement in reserves is the (deficit)/surplus for the year, no statement of changes in reserves is provided.

The notes on pages 67 to 69 form part of these financial statements.

Cash flow statement
for the year ended 31 December 2019

(Expressed in Hong Kong dollars)

	Note	2019	2018
		$	$
Cash flows from operating activities			
(Deficit)/surplus for the year before taxation		(22,150)	63,392
Interest income		(1,493)	(235)
Increase/(decrease) in accounts payable		194,000	(114,810)
(Increase)/decrease in prepayments and other receivables		(1,041)	3,134
Increase/(decrease) in subscriptions received in advance		883,215	(284,215)
		1,052,531	(332,734)
Hong Kong profits tax paid		(32)	(93)
Net cash inflow generated from/(used in) operating activities		1,052,499	(332,827)
Cash flows from investing activities			
Interest received		1,493	235
Net cash inflow generated from investing activities		1,493	235
Net increase/(decrease) in cash and cash equivalents		1,053,992	(332,592)
Cash and cash equivalents at the beginning of the year		1,814,079	2,146,671
Cash and cash equivalents at the end of the year	4	2,868,071	1,814,079

The notes on pages 67 to 69 form part of these financial statements.

Notes to the financial statements

(Expressed in Hong Kong dollars)

1 Legal status

The ICB is a company incorporated under the Hong Kong Companies Ordinance and is limited by a guarantee of $100 per member. Income and assets of the ICB shall be applied solely towards the promotion of the objectives of the ICB as set forth in its Memorandum of Association and no portion thereof shall be payable to the members of the ICB. The address of its registered office is 29th floor Sunshine Plaza, 353 Lockhart Road, Wanchai, Hong Kong.

It is a compulsory requirement for all life and general insurers who carry out personal insurance business to become members. The ICB's principal activities are to receive complaints relating to claims and non-claims made in connection with or arising out of Personal Insurance Contracts with any members and to facilitate the satisfaction, settlement or withdrawal of such complaints, disputes or claims.

2 Statement of compliance and basis of preparation

(a) Statement of compliance

These financial statements have been prepared in accordance with Hong Kong Financial Reporting Standards ("HKFRSs"), which collective term includes all applicable individual Hong Kong Financial Reporting Standards, Hong Kong Accounting Standards ("HKASs") and Interpretations issued by the Hong Kong Institute of Certified Public Accountants ("HKICPA"), accounting principles generally accepted in Hong Kong and the requirements of the Hong Kong Companies Ordinance.

(b) Basis of preparation

These financial statements have been prepared under the historical cost convention, and are presented in Hong Kong dollars, which is the functional currency of the ICB.

The preparation of financial statements in conformity with HKFRSs requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets, liabilities, income and expenses.

There are no critical accounting judgements involved in the application of HKFRSs by the ICB.

The HKICPA has issued a number of new HKFRSs and amendments to HKFRSs that are first effective for the current accounting period of the ICB.

None of these developments have had a material effect on how the ICB's results and financial position for the current or prior periods have been prepared or presented.

3 Financial risk management

Exposure to credit, liquidity and interest rate risks arises in the normal course of the ICB's operations.

The ICB's exposure to these risks and the financial risk management policies and practices used by the ICB to manage these risks are described below:

(a) Credit risk

The ICB's credit risk is primarily attributable to cash and cash equivalents. Cash and cash equivalents are deposited with a reputable and creditworthy bank. The ICB considers there is a minimal risk associated with the deposit balances held by the bank.

(b) Liquidity risk

The ICB's policy is to regularly monitor its liquidity requirements, to ensure that it maintains sufficient reserves of cash to meet its liquidity requirements in the short and longer term.

In order to meet its liquidity requirements, subscriptions are collected in advance each year.

(c) Interest rate risk

The ICB's only interest bearing financial instruments are balances with bank, which bear interest at market rates. Hence the ICB's income and operating cash flows are not subject to significant interest rate risk.

4 Cash and cash equivalents

Cash and cash equivalents include current and savings accounts held at call with banks.

	2019	2018
	$	$
Cash at bank and on hand	2,868,071	1,814,079

5 Revenue

Revenue is measured at the fair value of the consideration received or receivable.

(i) Subscriptions are recognised as income in the accounting period to which the subscription relates which is the calendar year commencing on 1 January each year. That portion of fees received during the year which relates to future accounting periods is carried forward in the statement of financial position as subscriptions received in advance.

(ii) Interest income is recognised on a time proportion basis, taking into account the principal amounts outstanding and the interest rates applicable.

6 Administration fee charged by the HKFI

The HKFI provides management and administrative services to the ICB. The fees charged cover salaries, administration support and office accommodation. The fees are based on actual salary cost and the remaining fees are based on the allocated cost by headcount. The HKFI is regarded as a related party.

7 Taxation

No Hong Kong Profits Tax has been provided as the ICB has incurred a deficit for the year. (2018: 8.25% on the estimated assessable profit for the year) The profits tax credit is due to the write-back of an over provision for 2018 due to a 100% concession announced in respect of that year.

8 General Committee members' emoluments

During the years ended 31 December 2019 and 2018, no amounts have been paid in respect of General Committee members' emoluments, pensions or for any compensation in respect of services provided by the General Committee members.

The Insurance Complaints Bureau

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