

|                 |          |
|-----------------|----------|
| Consultant name |          |
| Code            | AA _____ |
| District        | _____    |
| Telephone no.   |          |



**Private & Confidential 私人及保密文件**

# Accident Insurance Claim Form (Part I)

|                        |                               |           |                              |
|------------------------|-------------------------------|-----------|------------------------------|
| Policy number<br>保單號碼  | Name of Life insured<br>受保人姓名 |           |                              |
| HKID number<br>香港身份證號碼 | Age<br>年歲                     | Sex<br>性別 | Contact phone number<br>聯絡電話 |

- This is a 申請這次意外的
- New claim 首次索賠      Further claim 再度索賠
- Benefits to claim 索賠類別
- Dismemberment / Permanent disability 斷肢 / 永久傷殘      Temporary disability income / Indemnity 暫時喪失工作能力  
 Medical expense 醫療費用      Daily Hospital Cash 每日住院現金

Mailing address 聯絡地址

(請加上“✓”號，如須更改聯絡地址)

**Employment particulars 就業詳情**

- Present occupation (if more than one, state all) and exact nature of occupational duties  
現職(倘有兼職，請列明)職位及職責
- Name address and telephone number of present employer  
現時僱主名稱、地址及電話號碼
- Are you self-employed?  
閣下是否自僱?
- Any official income proof? (i.e. Pay-slip, bank statement, IR tax return or employment letter /contract etc.)  
有否正式入息證明?(如糧單、銀行存款單、稅單或聘用合約)
- Did you file a medical leave certificate to your employer?  
曾否向僱主遞交病假證明書?
- State average monthly income (during the 12 months prior to injury)  
意外發生前12個月之平均收入
- Details of any income continuing whilst disabled  
受傷後若有其他收入，請列明細節

1.

2.

3.  Yes 是      No 否

4.  Yes 有      No 無

5.  Yes 有      No 無

6.

7. Amount  HK\$ 港元 per month 每月數目  
period from  to  為期

**Accident particulars 意外詳情**

- Date and time of accident  
遭受意外之日期及時間
- Where and how did it happen?  
事發地點及經過?
- Part of body injured and type of injury  
受傷部位及傷勢

8. Date(dd/mm/yy)        am / pm  
日期(日/月/年)   上午 / 下午

9.

10.

**Treatment particulars 治療詳情**

11. Details of hospitals confined or physicians consulted for the injury (Please attach discharge note).  
請列出因此次意外受傷而就診之醫生或醫院(請呈交出院證明書)

| Name of physician(s) and / or hospital(s)<br>醫生 / 醫院名稱 | Address(es)<br>地址    | Date of consultation(s) and / or period of confinement(s)<br>就診 / 住院日期 |
|--|----------------------|--|
| a. <input type="text"/>                                | <input type="text"/> | <input type="text"/>   |
| b. <input type="text"/>                                | <input type="text"/> | <input type="text"/>   |
| c. <input type="text"/>                                | <input type="text"/> | <input type="text"/>   |

12. State the Life Insured's usual doctor's name and address.  
請列出受保人慣常就診之醫生名稱及地址



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## Certificate of medical attendant (Part II) 醫療報告

No claims can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expense of the insured.

此表格必須由合資格及註冊西醫填妥，所需費用由受保人自負，否則不會受理。

|                |     |          |                  |
|----------------|-----|----------|------------------|
| Insured's name | Age | HKID no. | Date of accident |
|----------------|-----|----------|------------------|

1. (a) What is the exact diagnosis ? 1. (a)

(b) Is there any external and visible evidence of injury at your **1st consultation** (b)  Yes  No

(c) If yes, please state type of injury (c)

(d) State part of body injured (d)

(e) Describe the cause and extent of injury (e)

2. **Present** condition of injury 2.

3. (a) Is there any treatment administered ? 3. (a)  Yes  No

(b) If yes, please give details (such as suturing, physiotherapy, type of dressing, etc.) (b) Date  Time (am/pm)  Treatment

4. (a) Any other physicians who treated insured for the same injury ? 4. (a)  Yes  No  Unknown

(b) If yes, please give : 

| Name(s)              | Address(es)          | Approximate date(s)  |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

5. Did injury require : (a) Hospitalization ? 5. (a)  Yes From       to        No

(b) X-ray ? (b)  Yes   No

(c) Special diagnostic procedures ? (c)  Yes   No

(d) Surgery ? (d)  Yes   No

If any of the above is yes, please give details

6. Was such injury induced from or effected by any of the following which may contribute to the accident and / or lengthen the period of disability ? 6. (a)  Yes   No

(a) Physical defects / congenital anomaly (a)  Yes   No

(b) Unfavourable past medical history (b)  Yes   No

(c) Degenerative changes (c)  Yes   No

(d) Alcohol or drugs (d)  Yes   No

If any of the above is yes, please give details

7. (a) Was healing complicated ? 7. (a)  Yes  No

(b) If so, state why & any special treatment given (b)

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8. Bearing in mind the insured's occupation as stated in item(1) of employment particulars, do you feel that the injuries would have prevented him / her from working ?

8. (a) at your 1st consultation

Yes

No

(b) at your latest consultation

Yes

No

9. If an absence from work of more than 7 days was necessary, please describe in detail the reasons why you feel the insured could not return to work earlier

9.

|  |
|--|
|  |
|--|

I hereby certify that I have personally examined & treated the insured for the above injury and that the facts as given above present my opinion of his / her condition.

Signed

Name of physician (with stamp)

Date (dd/mm/yy)

|  |  |  |  |  |  |
|--|--|--|--|--|--|
|  |  |  |  |  |  |
|--|--|--|--|--|--|

Address

|  |
|--|
|  |
|--|

Qualification

Tel. no.

### Required document 所需文件

- Complete application form.  
請填妥完索償申請表。
  - Please complete all the questions in Part I.  
此表格上第一部份之所有問題都必須作答。
  - Please ensure Part II to be completed by a registered doctor.  
請確保填寫表格第二部份之醫生是註冊西醫。
- Sick Leave Certificate.  
病假證明書。
- Original receipt for medical reimbursement.  
醫療費用之正本單據。

### Points to note 注意事項

- Please write down the correct policy number.  
請填上正確之保單號碼。
- Please make sure the signature of the insured / owner is consistent with that in policy application.  
請確保以上之簽名與保單申請書之簽名一致。
- Please complete and return this form not later than 7 days after the date of injury.  
請在受傷日期七天內填妥及交上此表格。
- If accident has been reported to the police station, please produce the police report or relevant documents.  
如該意外事件已向警方報案，請提供有關資料。例如：口供紙副本、無罪證明文件等等。
- In some rare occasions, it may take more than 7 days for us to assess an individual case. In such circumstance, we will advise you in writing.  
在罕見的情況下，本公司可能會視乎個別賠償申請所需，作出進一步調查，故此，這申請的處理將需要超過七個工作天的時間。然而，本公司將會以書面作出通知。

### Processing of your claim form 索償申請表的處理

After submission, your claim form will be processed by our Life Claims Department. The Department will advise you the result. Should you have any enquiry, please dial the telephone number 2535 3502.

閣下的索償申請表格由理賠部(人壽業務)處理。負責職員會盡快通知閣下有關於結果。若有任何垂詢，請致電 2535 3502。

#### Zurich Insurance Group (Hong Kong)

24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong

Claims Hotline: (852) 2535 3502 Fax: (852) 2105 3403 <http://www.zurich.com.hk>

#### 蘇黎世保險集團(香港)

香港港島東華蘭路18號港島東中心24-27樓

賠償熱線: (852) 2535 3502 傳真: (852) 2105 3403 <http://www.zurich.com.hk>