

為使敝公司能迅速地處理貴保戶之賠償申請，請於就醫後 30 日內填妥此表格及連同有關單據一併交回。  
In order to assist us in processing your claim promptly, please complete and return this form together with the original receipts / invoices within 30 days after receiving treatment.

1. Whole Life Hospital Cash Insurance Plan. Please call 2535 3502 for enquiry or fax to 2105 3403.  
「保一世」住院現金保障計劃。任何查詢，請致電 2535 3502 或 傳真致 2105 3403。
2. Hospital Cash Insurance, Hospital & Surgery Expenses Insurance. Please call 2903 9388 for enquiry or fax to 2968 1660.  
住院現金保障，住院及手術保障。任何查詢，請致電 2903 9388 或 傳真致 2968 1660。

所有問題均須由受保人或其監護人作答  
All questions must be answered by insured person or the guardian

保單號碼  
Policy no. \_\_\_\_\_

1. 保戶資料

保戶姓名  
Name of insured \_\_\_\_\_  
病人姓名  
Name of patient \_\_\_\_\_ 與保戶關係  
Relationship with insured \_\_\_\_\_  
地址  
Address \_\_\_\_\_  
身份證號碼  
Identity card no. \_\_\_\_\_ 電郵地址 (非必須填寫)  
Email address (Optional) \_\_\_\_\_  
病人職業  
Occupation of patient \_\_\_\_\_ 聯絡電話  
Telephone no. \_\_\_\_\_

閣下是否選擇以短訊形式通知確定收到索賠申請，以及賠款通知。  是，請以中文通知  是，請以英文通知  否  
Do you prefer to receive SMS messages for claim acknowledgement and notification of payment status? If yes, in English or Chinese?  
 Yes, in Chinese  Yes, in English  No

2. 住院詳情

Details of the hospitalization  
(a) 醫院名稱  
Name of hospital \_\_\_\_\_  
(b) 入院日期  
Date of admission \_\_\_\_\_  
(c) 主診醫生姓名  
Name of the attending doctor(s) \_\_\_\_\_

3. 閣下是否正就此次住院申領其他賠償

Are you making any other insurance or compensation claim as a result of this hospitalization  
( ) 否 No ( ) 是 Yes 若是，請提供以下資料 If yes, please provide the information below  
保單號碼 保險公司名稱 保障類別 (如: 醫療費用 / 住院現金)  
Policy no. Name of insurance company Type of insurance (eg. medical expenses / hospital cash)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. 若住院由疾病導致

If hospitalization was due to illness:  
(a) 病人之病徵  
Describe the patient's symptoms \_\_\_\_\_  
(b) 入院前多久此病徵才被發現  
How long had the patient been having these symptoms before admission into hospital \_\_\_\_\_  
(c) 請詳述 日期 醫生姓名地址及電話  
Give details of Date Name(s), address(es) and telephone no.(s)  
(i) 此症之首位主診醫生  
the doctor first consulted for this illness \_\_\_\_\_  
(ii) 轉介往醫院之醫生  
the doctors who referred the patient to hospital \_\_\_\_\_  
(iii) 診治病人之其他醫生  
all other doctors consulted during this illness \_\_\_\_\_  
(iv) 過去五年內所有醫生  
all other doctors consulted during the past five years \_\_\_\_\_

## Private & Confidential 私人及保密文件

### 5. 若住院由意外導致

If hospitalization was due to accident

(a) 意外何時發生

When did it happen

日期

Date: \_\_\_\_\_

時間

Time: \_\_\_\_\_

(b) 意外地點

Where did it happen \_\_\_\_\_

(c) 請述意外經過

Describe how it happened

\_\_\_\_\_  
\_\_\_\_\_

(d) 請述受傷情況

Describe the injuries

\_\_\_\_\_

(e) 曾到何警署報案

Police station to which the accident was reported \_\_\_\_\_

(f) 檔案編號

Police reference no. \_\_\_\_\_

### 6. 其他

Others

索償程序完成後, 閣下是否需要退回已遞交之有關文件

I request to return the submitted claim document(s) upon completed the claim procedure

( ) 否 No

如是, 請選擇

( ) 正本之醫療單據

( ) 醫療報告

If yes, please tick ( ) original medical receipts

( ) Medical report

索償文件

請填妥本索償表並提交以下所需證明文件(正本), 如適用, 寄回本公司以便處理閣下之賠償事宜

(1) 住院索償:

醫療賬單詳列:

各項費用, 病人姓名, 留院日期

(2) 所有主診醫生/專科醫生/麻醉師/外科醫生/物理治療師之賬單詳列:

病人姓名, 求診日期, 診斷證明及/或治療紀錄, 醫療報告, 各項費用

(3) 手術後/住院後之覆診費:

醫生賬單詳列:

病人姓名, 求診日期, 診斷證明及/或治療紀錄, 費用

Claim documentation

Please complete and return this claim form together with the following documents (original copy), if appropriate, for our handling:

(a) Hospitalization

Hospital statement showing:

Itemized charges, name of the patient, period of confinement

(b) Receipt(s) of all attending doctors/specialists/anesthesiologist/surgeons/physiotherapists showing:

Name of the patient, date of consultation, diagnosis and/or treatment given, medical report(s), amount charged

(c) Post surgery / post hospitalization out-patient

Doctor's receipt showing:

Name of the patient, date of consultation, diagnosis and/or treatment given, amount charged

Payment Details (付款資料):

在保單條款許可的情況下, 閣下可選擇以支票或銀行轉帳方式收取賠償款項。

Subject to policy liability, you are given an option for settlement by claims cheque or by direct credit.

By cheque 支票

By direct credit/ wire transfer 銀行轉帳 (只適用於以下列出之銀行及少於港幣貳萬元之賠償 limited to listed banks below and for claim less than HKD20,000)

如閣下選擇銀行轉帳, 請提供相關銀行資料。此服務必須得到銀行安排下進行。本公司特此聲明, 上述要求並不代表閣下之索賠現正獲成功審批。有關決定, 本公司在收妥全部證明文件後, 將根據保單一切條款才作最後審批。敬請留意。

Please provide your banking details if you prefer payment by direct credit. However this is subject to the bank's arrangement. Furthermore, the supply of any information or documents under this section is not construed as an admission of liability under your policy. We hereby reserve all our rights for assessing your claim subject to terms and conditions of your policy.

戶口持有人姓名 (必須與保單持有人相同) Account Holder's Name (Must be the same as the Policyholder): \_\_\_\_\_

銀行名稱:  匯豐銀行 The Hongkong and Shanghai Banking Corporation Limited  渣打銀行 Standard Chartered Bank

Bank Name:  中國銀行(香港) Bank of China (Hong Kong)

恆生銀行 Hang Seng Bank

銀行帳戶號碼

Bank A/C No. \_\_\_\_\_

戶口持有人簽署

Signature of Account Holder: \_\_\_\_\_

I understand and agree that the personal information collected or held by Zurich Insurance Company Ltd. and/or Zurich Life Insurance Company Ltd. ("the Company"), whether contained in this form or otherwise obtained by the Company and/or its associated companies ("the Zurich Group"), may be used by the Zurich Group for the following purposes:

本人/吾等明白並同意一切由蘇黎世保險有限公司及/或蘇黎世人壽保險有限公司（「貴公司」）從此表格或由 貴公司及其關連機構（「蘇黎世集團」）以其他方式所收集及保存之個人資料，均可能被「蘇黎世集團」使用於下列目的：

1. to assess, process, evaluate and determine my requests for applications, claims or services; 評核、辦理、評估及決定此項申請、索償或其他服務；
2. to process and give effect to my requests for direct debit authorization or credit card payment; 辦理及履行銀行賬戶或信用卡直接付款；
3. to collect any premium and/or deductible payable to the Zurich Group; 收取應繳付予「蘇黎世集團」之保費及/或自負額；
4. to analyze, investigate, approve and/or determine my claims; 分析、調查、批核及/或決定本人/吾等之索償；
5. to answer, handle and defend any claim, action and/or proceedings brought against me; 回覆、處理及辯護任何對本人/吾等之索償、訴訟及/或訴；
6. to exercise the Zurich Group's rights as more particularly defined in applicable policy wordings, including but not limited to the subrogation right; 行使代位權及/或根據保單條例賦予「蘇黎世集團」之其他權利；
7. to disclose and transfer to the Zurich Group's authorized service providers for their carrying out of the above mentioned purposes, and such service providers include legal advisors, investigators, loss adjusters, reinsurers, medical and rehabilitation consultants, surveyors, specialists, repairers, debt collectors and accountants; 交予及提供第三方服務供應商以執行上述目的，第三方服務供應商包括法律諮詢人、調查員、理賠師、再保公司、醫護及復康人員、考察員、專業人員、維修人員、追討公司及會計師等；
8. to comply with the legitimate requests or orders of the courts of Hong Kong and regulators including but not limited to the Insurance Authority, Hong Kong Federation of Insurers, auditors, governmental bodies and governmental-related establishments; 履行任何香港法庭或其他監管機構所發出之合法要求或命令，包括保險業監管局、香港保險業聯會、核數師、香港政府或其相關機構；
9. to conduct market research, insurance surveys, and to compile statistics, for the Zurich Group's development of services and insurance products. 進行市場調查、保險研究及數據統計，供「蘇黎世集團」研發相關服務及保險產品。

I understand that I have the right to access to, correct and/or change any of my personal information held by the Zurich Group by contacting the Company's Personal Data Privacy Officer at 24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong. I/we agree that the Company may charge a reasonable administrative fee.

本人明白本人可向 貴公司之個人資料私隱主任要求查閱、更正及/或更改由「蘇黎世集團」持有有關本人的任何個人資料，地址為香港港島東華蘭路 18 號港島東中心 24 - 27 樓。本人同意 貴公司有權收取合理之行政費用。

I understand I may also contact the Personal Data Privacy Officer if I do not wish to receive any marketing materials from the Zurich Group. 本人明白本人可以書面向 貴公司之個人資料私隱主任要求停止收取「蘇黎世集團」任何市場推廣資料。

For Whole Life Hospital Cash Insurance Plan, please refer to Part 1 of the "Declaration and Authorization". 有關「保一世」住院現金保障計劃，請參照本表格「聲明及授權」之第一部分。

For Hospital Cash, Hospital & Surgery Expenses Insurance Plan, please refer to Part 2 of the "Declaration and Authorization". 有關住院現金、住院及手術保障，請參照本表格「聲明及授權」之第二部分。

#### Part 1

I declare that the answers given above are true and complete to the best of my knowledge and belief.

本人謹此聲明，以上所填報之資料及所列各項之事件乃屬完全真確並無對保險公司作任何資料之保留。

I hereby authorize any employers, hospital, physician, insurance company or other organization or person who has any records or knowledge with reference to the accident or the health and medical history of the patient, to give such information to Zurich Life Insurance Company Limited or its agents. A photocopy of this authorization shall be considered as effective and valid as the original. By signing below, I, for the purpose of the Personal Data (Privacy) Ordinance, agree that the personal information collected or held by Zurich Life Insurance Company Limited (whether contained in this form or otherwise obtained) or its agents to utilize the copy of my identification or may be used by or disclosed to any individual or organization within or outside of Hong Kong for the purposes of insurance or reinsurance related business including claim processing, investigation, account collection and litigation.

本人授權任何僱主、醫院、醫生、醫務人員、保險公司等任何有關人士或組織而持有本人有關意外，身體狀況和醫療紀錄等資料，可以將該等資料提供貴公司或其代理人，此授權書之影印本亦屬有效。

為符合個人資料(私隱)條例，從以下簽署，本人同意由蘇黎世人壽保險有限公司或其代理人所收集或持有的個人資料包括使用本人之身份證明文件副本，不論包含在這報告表或以其他方式獲取，均可供貴公司使用或向在香港境內或境外之任何人或機構披露作其保險或再保有關事項包括處理索償，調查，收集客戶資料和訴訟。

#### Part 2

I declare that the answers given above are true and complete to the best of my knowledge and belief.

本人謹此聲明，以上所填報之資料及所列各項之事件乃屬完全真確並無對保險公司作任何資料之保留。

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為符合個人資料(私隱)條例，從以下簽署，本人同意由蘇黎世保險有限公司或其代理人所收集或持有的個人資料包括使用本人之身份證明文件副本，不論包含在這報告表或以其他方式獲取，均可供貴公司使用或向在香港境內或境外之任何人或機構披露作其保險或再保有關事項包括處理索償，調查，收集客戶資料和訴訟。

如中文譯本與英文有異，概以英文文本為準。

Signature of policy holder 保單持有人簽署

Signature of patient 病人(受保人)簽署

Date 日期

Name of policy holder 保單持有人姓名

Name of patient 病人(受保人) 姓名

HKID Card no / 香港身份證號碼  
Passport no 或護照號碼

HKID Card no / 香港身份證號碼  
Passport no 或護照號碼

#### 蘇黎世人壽保險有限公司

理賠部(人壽業務): 香港港島東華蘭路 18 號港島東中心 24 - 27 樓  
電話: 2535 3502 圖文傳真: 2105 3403

#### Zurich Life Insurance Company Limited

Life Claims Dept.: 24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong  
Tel: 2535 3502 Fax: 2105 3403

#### 蘇黎世保險有限公司(於瑞士註冊成立之公司)

理賠部: 香港港島東華蘭路 18 號港島東中心 24 - 27 樓  
電話: 29039388 圖文傳真: 29681660

#### Zurich Insurance Company Limited (a company incorporated in Switzerland)

Claims dept.: 24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong  
Tel: 29039388 Fax: 29681660

**Private & Confidential 私人及保密文件**

由主診醫生填寫，有關費用由索償者支付

**To be completed by the attending physician / surgeon at the claimant's own expense**

Please complete in block letters

Name of patient _____	Identity card no _____
Date of admission _____	Date of discharge _____
Name of hospital _____	
(1) Clinical history of this patient:	
(a) Date on which the patient first consulted you relating to this medical condition(s)/injury _____	
(b) If caused by injury, please describe the cause and extent of injury _____	
(c) Symptoms and complaints for this hospitalization/treatment _____	
(d) Underlying cause(s) of the hospitalization _____	
(e) According to the medical history given by the patient, how long had he/she been experiencing these symptoms before the first consultation and the date of the first consultation? _____	
(f) How long, in your opinion, has the patient been suffering from this illness/injury? _____	
(g) Was the patient confined in an Intensive Care Unit during this hospitalization or did he/she suffer from 3 <sup>rd</sup> or 4 <sup>th</sup> degree of burning? If yes, please indicate the period/numbers of days stayed _____	
(2) Hospitalization history of this patient:	
(a) Final diagnosis _____	
(b) Date of operation _____ Operational procedure(s) performed _____	
(c) If you have consulted other doctor during this hospitalization, please provide the following: Consulted doctor's name _____ Reason _____ What treatment(s) had the doctor performed _____	
(d) Please give brief discharge summary (including onset and duration of signs and symptoms/disease, etiology, types and results of major examination, treatment, complications and follow up plan _____	
(e) Has the patient taken any home leave during this hospitalization? If yes, please state the date, time and reason _____	
(f) Please provide reason(s) for hospitalization if this type of cases can be managed on day care _____	
(3) Professional comment:	
(a) In your opinion, was the hospitalized illness a recurrent episode or a chronic illness or related to a previous complaint/diagnosis? If yes, please provide date of the first episode and details _____	
(b) Has the patient ever had the same symptoms before/has the patient been treated or hospitalized for these same symptoms before? If yes, please state, to the best of your knowledge, on a separate sheet when and describe details (including a brief summary describing the onset date, duration of signs and symptoms, disease, etiology, types and results of major examination, treatments, complications and follow up plan) _____	
(c) Was the condition due to or associated with the following (please circle the right answers)? Accidental bodily injury, abuse of drugs or alcohol, AIDS / HIV related illness, venereal disease or sexually transmitted disease, pregnancy, childbirth, miscarriage, abortion, infertility or sterilization, correction of vision, refractive error, cosmetic or plastic surgery, mental or nervous disorder, congenital condition heredity condition, developmental condition, suicide, attempted suicide, ionizing radiation, self-inflicted injury, participation in any sports, general check up or vaccination or none of the above.	
(e) If you are referred by another doctor, please provide the referring doctor's full name and address _____	
I hereby certify that all information given above is accurate and true to the best of my knowledge	
Name of attending doctor / surgeon / qualification _____	Signature of attending doctor / surgeon with practice / hospital stamp _____
Date _____	Address and telephone no _____