



ZURICH®

Private & Confidential

Claim Statement (Critical Illness / Female Products Insurance)

Please fully complete the below information:

Agent Name _____ Agent Code _____ District _____ Agent Tel No. _____

1. Policy Particulars

Policy Number(s) _____ Name of Policyowner * _____

Name of Life Insured * _____ Life Insured's HKID Card / Passport No. _____

Name of Claimant(s)* _____ Claimant's HKID Card / Passport No. _____
(Please fill in if claimant is not the Life Insured) * Please complete full name as shown on HKID Card/identification document

Address of Life Insured / Claimant(s) _____

Relationship with the Life Insured _____ Tel No. _____

- 1. Life Insured's job nature, name and address of current Employer. (If occupation has been changed since Application)
2. Name of other insurers that the Life Insured has ever held any Insurance policy(ies) during his/her lifetime.

2. Details of Illness/Injury & Health History

1. Date of Diagnosis/Accident 2. Nature of Illness/Injury 3. If the incident was reported to the Police, please provide the name of the police station and the case reference no.

4. Name of hospitals confined or physicians consulted for such illness/injury. 5. State the doctor or hospital names whom usually / most of the time provide consultation to the Life Insured.

3. Payment Particulars

I/We request that subject to proof of title, the claim payment be converted into: [] HK\$ [] US\$ [] Sterling (Please tick [x] one Box)

4. Required Documents

- 1. Original Identity Card of Life Insured and Claimant* (If not provided previously) 2. Original Policy Document or Lost of Policy Declaration (If claim for 100% of sum insured) 3. Critical Illness / Female Products Attending Physician Statement* (Please complete the appropriate form for different nature of illness)

*The documents must be certified true copy by our Life Claims Dept. or by any authorized persons to be accepted by our Company.

5. Declaration and Authorization

- 1. I/We, the above Life Insured or claimant(s) hereby request payment of the total benefits in accordance with the Policy and I/We warrant that I am/We are legally and beneficially entitled to such sum.
2. I/We, the above Life Insured or claimant(s) do hereby authorize any hospitals, physicians, medical practitioners, insurance companies or organizations that have any records or knowledge of the above Life Insured to disclose to our Company or its authorised representatives any and all the information with respect to his/her health, medical history, disease, hospitalization, advice, treatment, investigatory result, employment records or any other policies details and claim records, etc.
3. I/We also agree our Company to utilize the copy of myself/ourselves or my/our relative's identification for the above claim purpose. A photostatic copy of this authorization shall be considered as effective and valid as the original.
4. I/We declare and agree that the personal information collected or held by our Company, whether contained in this application form or otherwise obtained, may be used by our Company or disclosed to any individual or organization within or outside Hong Kong for the following purposes: (1) to assess and process this application, (2) to provide insurance and customers services, (3) to conduct insurance claims or analysis.
5. I/We shall have the right of access to and to request correction of any personal information concerning themselves held by our Company. A request for such access may be made to the Personal Data Privacy Officer of Our Company at 24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong.

Date : _____ Signature of Life Insured or Claimant(s) : _____

Zurich Insurance Group (Hong Kong)

24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong
Life Claims Hotline: (852) 2535 3502 Fax: (852) 2105 3403 http://www.zurich.com.hk