

家傭保險(住院)索償書

Maid care insurance (hospitalization) claim form

Please note the following: 請注意以下事項:

It is not necessary to complete this claim form for Outpatient Claims. Please write the policy no. and your contact telephone no. on the original medical receipts and then send them to us by post. 若申請門診索償，並不須要填寫此索償書。請在醫生收據的正本上寫上你的保險單號碼及聯絡電話號碼，然後郵寄給我們。

If you are claiming under the Employee's Compensation Ordinance (e.g. Your domestic servant sustains bodily injury by accident or disease arising out of and in the course of employment), please contact us immediately. You need not fill in this claim form.

若你正根據僱傭補償條例索償(例如你的家傭因執行職務發生意外而蒙受身體損傷或患病)，請即聯絡我們。你並不須要填寫此索償書。

Name of insured: 投保人姓名:

Policy no. 保單號碼

Correspondence address: 通訊地址:

E-mail address (Optional): 電郵地址(非必須填寫):

Phone no.: (day) 電話號碼: (日)

(Night) (夜)

Fax no. (Optional): 傳真號碼(非必須填寫)

Name of patient: 病者姓名:

Sex 性別

Age 年齡

Patient's id/passport no.: (病者身份證/護照號碼):

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

Please attach the original of all medical receipts and reports pertaining to the claim. 請附上所有有關的醫療收據及報告的正本。

If hospitalization was due to illness 若因患病而住院

Please describe the symptoms before hospitalization. 請詳述入院前病徵

When did these symptoms first appear? 該病徵於何時首次出現?

Date 日期

Name(s) and Address(es) 姓名及地址

The physician first consulted for the illness.

首次診斷該病的醫生

All other physicians consulted for the illness.

所有其他應診該病的醫生

Physician who referred the Patient to hospital.

建議病人入院的醫生

If hospitalization was due to an accident 若因意外受傷而住院

When and where did the accident happen? 意外於何時何處發生?

Please describe how it happened. 請描述意外經過

Please describe the injury. 請描述受傷部位及傷勢

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 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

戶口持有人簽署

Bank A/C No. _____

Signature of Account Holder: _____

Private & Confidential 私人及保密文件

Declaration and authorization 聲明及授權

I/We declare that, to the best of my/our knowledge, this information is true. I/We also agree that if any of the above is intentionally untrue or missed, Zurich Insurance Company Limited has the right to repudiate my claim.

本人等在此聲明本人已盡力提供所有真實資料，並無虛報或漏報。本人等同意如以上任何資料有蓄意虛報或漏報，蘇黎世保險有限公司有權拒絕本人等之以上索償。

I hereby authorize any physician, hospital or other organization or persons, that has any records or knowledge of the patient or his/her health, to disclose to Zurich Insurance Company Limited or its representative any and all information about the patient with reference to the accident, his/her health and medical history and any hospitalization, advice, treatment, disease or ailment. A photostatic copy of his/her authorization shall be as effective and valid as the original.

本人謹此授權任何擁有或知悉病者或其健康狀況紀錄之醫生、醫院或其他機構或人士，將任何有關病者今次意外、過往健康狀況、病歷及求診之詳細資料向蘇黎世保險有限公司或其代表透露。本授權書之副本與正本具有同等效力。

I/We understand and agree that the personal information collected or held by Zurich 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（「貴公司」）從此表格或由 貴公司及其關連機構（「蘇黎世集團」）以其他任何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/our 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/our 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/our 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/us;
回覆、處理及辯護任何對本人/吾等之索償、訴訟及/或起訴；
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/We understand that I/we have the right to access to, correct and/or change any of my/our 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/吾等明白本人/吾等可向 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/吾等的任何個人資料，地址為香港港島東華蘭路 18 號港島東中心 24 - 27 樓。本人/吾等同意 貴公司有權收取合理之行政費用。

I/We understand I/we may also contact the Personal Data Privacy Officer if I/we 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。

如中文譯本與英文有異，概以英文文本為準。

Patient's Signature
病者簽署

Date
日期

Name (Block Letter)
姓名(正楷)

Insured's Signature
投保人簽署

Date
日期

Name (Block Letter)
姓名(正楷)

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

Attending physician statement

主診醫生報告

(Must be completed by the attending physician) 必須由主診醫生填寫

Name of patient	Age	Sex	Date admitted	Date discharged	Final Diagnosis
1. Date on which the patient first consulted you for the hospitalized illness or injury. _____					
2. Please describe the symptoms and complaints of the patient during the first consultation. _____					
3. If possible, please give the names & addresses of all other physicians consulted by the patient previously. _____					
4. a) According to the patient, how long had he/she been experiencing these symptoms before consulting you? _____					
b) How long do you feel the symptoms will last? _____					
5. What was your clinical diagnosis? _____					
6. Medical treatment given and test(s) performed _____					
Operation performed _____					
Date performed _____ Surgeon _____					
7. Prognosis of the Patient's condition? _____					
8. What is the chance of having a relapse? _____					
9. Was injury / sickness due to pregnancy? _____					
10. Was condition caused by congenital anomaly or infertility? _____					
11. Had the patient previously been treated or hospitalized for this or any other disorder? If so, please give details.					
<u>Dates</u>		<u>Disease / Disorder</u>		<u>Details of treatment / hospitalization</u>	
				<u>Name of Physician / Hospital</u>	
Name of Physician _____			Qualification _____		
Date _____			Name and address of Hospital _____		

Signature _____			Hospital Stamp _____		