ZURICH
蘇黎世

Medical insurance claim form
醫療保險索償申請表

Enquiry no. 查詢電話：+852 2903 9388　Fax 傳真：+852 2968 1660　Email 電郵：claims@hk.zurich.com

Clear form

Please ✓ the appropriate box and * delete where inappropriate. 請 ✓ 適用方格及於*號刪去不適用者

Please use blue or black ink and write clearly in **BLOCK LETTERS**. 請用藍色或黑色原子筆，用**英文大楷**清晰填寫資料。

Claim submission 申請索償：

- Hospital cash benefit or Surgical cash benefit under "I-Gen" plan can submit through "Zurich HK" mobile app. 住院現金保障 或「i-世代」手術現金保障可透過手機應用程式「Zurich HK」遞交
- Medical Claim Form should be completed and submitted within 30 days from the date of incident through email or post. 一般醫療索償必須於事故發生後30日內填妥此索償申請表並電郵或郵寄至本公司：

Email 電郵：claims@hk.zurich.com

Address: Zurich Insurance Company Ltd, Claims Department, 26/F, One Island East, 18 Westlands Road, Island East, HK.
地址：香港港島東華蘭路18號港島東中心26樓蘇黎世保險有限公司理賠部

Remarks 備註：

If you are applying for a medical claim, please settle the payment before submitting this claim, and be reminded to obtain the documents from your hospital before discharge. 如您申請醫療索償，請先繳付後索償，並在出院前向醫院索取所需文件。

You are responsible for the cost of requesting the medical report(s). 您需要自行承擔醫療報告之相關費用。

If you receive treatment at a Hong Kong public hospital, please obtain the Discharge Slip before you leave the hospital and submit it to our company. 如您在香港公立醫院接受治療，請於出院前索取出院紙，並於申請索償時一併提交。

For additional supporting documents, please email or post to our company.如需補交文件，可電郵或郵寄至本公司。

You may also check your claims status through our Claims Virtual Assistant on Zurich Website. 您可以在蘇黎世網站上向我們的索償智能助理查詢索償進度。

1. General Information 一般資料

Claim no. (if any)
索償編號 (如有)

Policyholder name
保單持有人姓名 (英文)

Policy no.
保單號碼

Insured name
受保人姓名 (英文)

Insurance agent/broker name (if any)
保險代理 / 經紀姓名 (如適用)

Insured occupation
受保人職業

Insured gender ☐ Male 男 ☐ Female 女
受保人性別

Insured HKID card no.
受保人香港身份證

Insured date of birth 受保人出生日期　Day日 Month月 Year年　D D M M Y Y Y Y

VHIS claim 自願醫保索償 ☐ **Yes 是** ☐ **No 否**

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1. General Information (continued) 一般資料（續）

Contact person mobile phone no.
聯絡人流動電話號碼

Contact person email address
聯絡人電郵地址

Contact person correspondence address
聯絡人通訊地址

Flat/Room*
室 / 單位*

Floor
樓

Block
座

Building
大廈

Estate name/No. & name of street/Lot no.*
屋苑名稱 / 街名及門牌 / 地段*

District
地區

HK/KLN/NT*
香港 / 九龍 / 新界*

We will send you the claim acknowledgment and claim settlement notification by SMS and/or email according to the above information. Also, we will contact you by email to obtain additional information to process your claim if necessary. If you have an insurance agent/broker, we will contact you via insurance agent/broker.
本公司根據以上填寫的資料，以電話短訊及 / 或電郵發送確認索償申請通知及賠款通知。 如有需要，本公司將以電郵方式聯絡您獲取更詳細資料，如您有保險代理 / 經紀，本公司將透過保險中介人 / 經紀與您聯絡。

Are you making any other insurance claim as a result of this incident (including employee compensation, group or company medical scheme)?
您是否正就此次損失向其他保險公司索償（包括勞工、團體或公司醫療保險）？

☐ Yes, please provide the following details
是，請提供以下資料

☐ No
否

Name of insurance company
保險公司名稱

Policy no.
保單號碼

If you are making other insurance claims with other insurer and required to have a certified true copy of medical receipts(s) and/or medical report returned to you, please fill in the above information and send an email request to claims@hk.zurich.com with your Policy No. and email subject 'Request for return of certified true copy of medical receipts(s) and/or medical report.
如您正就此次損失向其他保險公司索償（必須填寫以上資料）並需取回醫療單據或 / 及醫療報告的核實副本，可電郵至claims@hk.zurich.com並註明您的保單號碼及標題註明「需取回醫療單據或 / 及醫療報告的核實副本」作申請。

2. Payment method 賠償支付方式

By direct credit (Please provide below bank details and copy of ATM card or bank book for the payment arrangement)
銀行轉賬（請提供銀行卡副本或存摺作收取索償款項之用）

Bank account holder name
銀行戶口持有人姓名（英文）

Bank code
銀行編號

Branch code
分行編號

Account no.
賬戶號碼

Bank account no.
銀行賬戶號碼

☐☐☐ – ☐☐☐ – ☐☐☐☐☐☐☐☐☐

- The compensation will only be paid to the policyholder or insured person.
  賠款項僅支付給保單持有人或保單受保人。
- If the Insured is below the age of 18, please provide his/her guardian's bank information and relationship proof.
  如受保人未滿18歲，請提供其監護人之銀行資料及提交關係證明。
- Please ensure the filled bank information of the policyholder is correct.
  請確保填寫的銀行資料為保單持有人賬戶並確定所填寫的資料無誤。

3. Claim items 索償項目

Please ✓ the claim item(s) and submit together with the required documents to our company. Our company may request for additional documents.
請在申請索償項目的空格內 ✓，並連同所需之文件及此表格一併交回本公司。本公司可能要求提供額外相關索償文件。

	Claim item(s) 申請索償項目	Basic supporting documents required 索償所需的基本文件
☐	Personal Accident Cover – Accidental Death and Permanent Disablement 個人意外保障 - 個人意外死亡或永久傷殘	☐ Death certificate or presumed death proclaimed by court (disappearance case) (applicable to accidental death claim only) 死亡證或法庭假定死亡證（失蹤事件）（只適用於意外死亡索償） ☐ Certificate issued by registered medical practitioner certifying the severity of injury and percentage of disablement (applicable to permanent disability claim only) 註冊醫生發出之有關傷殘程度證明書（只適用於永久傷殘索償） ☐ Police investigation report and outcome (if applicable) 警方調查報告及結果（如適用） ☐ Certified true copy of the grant of probate/Letters of Administration (applicable to accidental death claim only) 授予遺囑認證書 / 遺產管理書核實副本（只適用於意外死亡索償） ☐ Original of Attending Physician Statement completed by the attending physician or hospital admission/discharge summary if there was hospitalization (applicable to Hong Kong public hospital only) 如住院，由主診醫生填妥的主診醫生報告或入院摘要 / 出院總結正本（只適用於香港公立醫院）
☐	Medical expenses 醫療費用	☐ Original medical receipt(s) 醫療收據正本 • Hospital – Original hospital receipt(s), Doctor professional slip, official receipt and deposit receipt issued by hospital 住院 – 由醫院發出的正本醫療收據，醫生專業收費單，正式收據及按金收費單 • Outpatient/Day patient/Outpatient surgery – Original medical receipt(s) issued by registered medical practitioner showing the patient name, diagnosis of condition, consultation date and medical expenses breakdown 門診 / 日症病人 / 門診手術 - 由註冊醫生發出的正本醫療收據並列出病人姓名，診斷結果，診症日期及醫療費用明細 ☐ Attending physician/Specialist/Anesthetist/Surgeon /Physical therapist diagnosis and/or treatment records, medical reports showing the patient name, diagnosis and consultation date 主診醫生 / 專科醫生 / 麻醉師 / 外科醫生 / 物理治療師之診斷及治療記錄，醫療報告並列明病人姓名、診斷結果及診症日期 ☐ Sick leave certificate issued by registered medical practitioner 註冊醫生發出之病假證明書 ☐ Original of Attending Physician Statement completed by the Attending Physician Statement or hospital admission/discharge summary if there was any surgery or hospitalization (applicable to Hong Kong public hospital only) 如有手術或住院，由主診醫生填妥的主診醫生報告或入院摘要 / 出院總結正本（只適用於香港公立醫院）
☐	Hospital cash/Surgical cash 住院現金 / 手術現金	☐ Attending physician/Specialist/Anesthetist/Surgeon/Physical therapist diagnosis and/or treatment records, medical reports showing the patient name, diagnosis and consultation date 主診醫生 / 專科醫生 / 麻醉師 / 外科醫生 / 物理治療師之診斷及治療記錄，醫療報告並列明病人姓名、診斷結果及診症日期 ☐ Medical receipt(s) issued by hospital/registered medical practitioner with with patient name, final diagnosis, consultation date and medical expenses 由醫院 / 註冊醫生發出之之醫療收據，並詳列病人姓名、診斷結果、診治日期及醫療費用 ☐ Attending Physician Statement completed by the Attending Physician Statement or hospital admission/ discharge summary (applicable to Hong Kong public hospital only) 由主診醫生填妥的主診醫生報告（本表格的第四部份）或入院摘要 / 出院總結（只適用於香港公立醫院）

4. Details of injury and sickness 傷病詳情

Part I : Outpatient or hospitalization claims due to accident
第一部分：由意外引致的門診或住院索賠

Accident Location
意外地點

Details of accident
意外發生經過詳情

Accident date and time
意外日期及時間

Day日 Month月 Year年
D D M M Y Y Y Y

Hour時 Minute分
H H M M AM/PM*
上午/下午*

Date of symptom(s) first appeared
首次出現病徵的時間
Day日 Month月 Year年
D D M M Y Y Y Y

Symptom(s) before admitted to hospital/consultation
入住醫院 / 求診前的病徵

Date of first consultation
首次求診日期
Day日 Month月 Year年
D D M M Y Y Y Y

Do you need to attend follow up treatment/consultation?
是否需要繼續接受治療 / 覆診？
☐ Yes 有 ☐ No 否

If Yes, please specify how long will the treatment last or follow up consultation date
如是，請列明是次疾病之療程還需要多久或覆診日期

Medical fee (HKD)
醫療費用（港元）

Part II : Hospitalization or surgery claim (if applicable)
第二部分：住院或手術索償（如適用）

Name of hospital/medical provider
醫院 / 提供醫療服務機構名稱

Symptoms before hospitalization
入院前之病徵

How long had you been having these symptoms
受保人發現病徵多久

What treatments had been performed relating to these symptoms
請列明是次疾病接受之治療

Date of surgery
手術日期
Day日 Month月 Year年
D D M M Y Y Y Y

Date of admission
入院日期
Day日 Month月 Year年
D D M M Y Y Y Y

Date of discharge
出院日期
Day日 Month月 Year年
D D M M Y Y Y Y

First consultation doctor's name
首次就診醫生姓名

Hospital addressor service provider name and address
醫院或服務提供者名稱及地址

Name of the doctor of recommending admission to hospital
建議入院的醫生姓名

Hospital addressor service provider name and address
醫院或服務提供者名稱及地址

Name of the doctor of consulted for the same sickness/accident
過往就同樣病症 / 意外曾求診的醫生姓名

Hospital addressor service provider name and address
醫院或服務提供者名稱及地址

Part III: Other claims related information
第三部分：其他索償有關資料

5. Declaration and Authorization 聲明及授權

1. I/We declare that all information provided by me/us above is true and complete to the best of my/our knowledge and belief and such information is provided without reservation or withholding of any kind.
本人 / 我們謹此聲明，以上由本人 / 我們所提供之全部資料乃據本人 / 我們所知所信屬真確及完整無誤，而本人 / 我們在提供資料方面並沒有任何保留或隱瞞。
2. I/We confirm that I/we have read, understood and agreed to **Zurich Insurance Company Ltd's ("the Company") privacy policy** as described below.
本人 / 我們確認本人 / 我們已閱讀、明白並同意以下所述**蘇黎世保險有限公司（「貴公司」）之私隱政策**。
3. I/We hereby authorize any physician, medical practitioners, hospitals or clinics by whom or where I/we have been observed or treated to give full particulars about my/our health or provide the relevant report or document to the Company or its agents.
本人 / 我們授權於任何曾替本人 / 我們作診療之醫生、醫務人員、醫院或診所提供有關本人 / 我們病歷之資料或提供有關的報告或文件予　貴公司或其代理人。
4. I/We hereby further authorize any parties, including but not limited to police and government authorities, airlines, travel agents, insurance companies etc. who are in possession of my/our insurance proposal information, claim information or any related information to release part or all of the information about me/us or related incidents of injury, loss or damage to the Company or its agents.
本人 / 我們授權持有本人 / 我們投保資料，索償紀錄或任何有關資料之一方，包括但不限於警方及政府機構、航空公司、旅遊公司、保險公司等任何有關人士或組織，可以將部份或全部有關本人 / 我們是次受傷、損失或損毀相關事件等資料提供予　貴公司或其代理人。
5. A photocopy of this authorization shall be considered as effective and valid as the original.
此授權書之影印本與正本同屬有效。

6. Notice to customers relating to the Personal Data (Privacy) Ordinance ("Ordinance") 有關個人資料（私隱）條例（「私隱條例」）的客戶通知

The personal information of customers (including policyholders, insured persons, beneficiaries, premium payors, trustees, policy assignees and claimants) collected or held by **Zurich Insurance Company Ltd** ("**Company**") from time to time, which also includes data collected or generated in the ordinary course of the Company's business and the continuation of relationship with the customer (such as claim information and medical history received from third parties), may be used by the Company and/or a company within its group ("**Zurich Insurance Group**") for the purposes **necessary** in providing services to the customers (otherwise the Company is unable to provide services to customers who fail to provide the required information).

由**蘇黎世保險有限公司**（「**本公司**」）不時收集或持有的客戶（包括保單持有人、受保人、受益人、保費付款人、信託人、保單受讓人及索償人）個人資料，其中亦包括在公司日常業務過程中以及就持續與客戶的關係而收集或產生的資料（例如從第三方收到的索償資料和病歷），均可供本公司及 / 或其所屬集團（「**蘇黎世保險集團**」）內的公司使用作為向客戶提供服務而**必須**的用途（否則本公司將無法為未能提供所需資料的客戶提供服務）。

Please read carefully the details of the Company's privacy policy which is made available on our website at www.zurich.com.hk/pics or by scanning the QR code. You may also contact our Customer Care Center at 2968 2288 or insurance intermediaries for enquires.

本公司之私隱政策詳載於www.zurich.com.hk/pics或可透過掃描QR碼細閱。您亦可致電2968 2288與我們的客戶服務中心聯絡又或向保險中介人查詢。

Name of insured person (Name of policyholder of the insured under 18 years old)
受保人姓名（如受保人未滿18歲，請填寫保單持有人姓名）

Insured HKID card no./ Passport no.*
受保人香港身份証號碼 / 護照號碼*

Signature of insured person (Signature of policyholder of the insured under 18 years old)
受保人簽署（如受保人未滿18歲，請由保單持有人簽署）

Date
日期

Day日 Month月 Year年
D D M M Y Y Y Y

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Zurich Insurance Company Ltd (a company incorporated in Switzerland with limited liability)
25-26/F, One Island East, 18 Westlands Road, Island East, Hong Kong

蘇黎世保險有限公司（於瑞士註冊成立之有限公司）
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Telephone 電話：+852 2903 9388　Fax 傳真：+852 2968 1660　Website 網址：www.zurich.com.hk

ZURICH®
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Attending physician statement
主診醫生報告

ZURICH 蘇黎世

(This section should be completed by the patient's attending doctor during patient's hospitalization at the insured person's cost 此欄須由病人在住院期間之主診醫生填寫，而費用須由受保人負責)

Part I : Treatments details
第一部分：醫療資料

Patient full name
病人姓名

HKID card no.
香港身份證號碼

Age
年齡

Gender 性別 ☐ Male 男 ☐ Female 女

(a) Was there any hospitalization for the patient? 病人有否住院？

☐ Yes 有, hospitalization period 住院日期

from 由 Day日 Month月 Year年 D D M M Y Y Y Y to 至 Day日 Month月 Year年 D D M M Y Y Y Y

☐ No 否, the patient does not require to stay at hospital for treatment 病人不需要住院接受治療

(b) Diagnosis of conditions
病況診斷

(c) Investigations, treatment, therapy, surgical procedures done and result during the above mentioned treatment period
上述診斷期間曾接受之檢查、治療、手術項目及結果

(d) Prior to this consultation, did patient first consult you for the related signs and symptoms and when was the first consultation
在是次求診日期前，病人有否在您執業之診所治療有關上述病況之紀錄？如有，病人自何時求診？

☐ Yes 有, the first consultation was since 第一次求診日期 Day日 Month月 Year年 D D M M Y Y Y Y

According to the patient, for how long had such symptoms(s) persisted before the first consultation?
據病人自述，上述病徵在首次求診前出現多久? Day日 Month月 Year年 D D M M Y Y Y Y

☐ No 否

(e) What sign(s) and symptom(s) was/were the patient aware of at the first consultation?
病人在第一次求診時發現的病徵及症狀？

(f) Was there any evidence of external bruise, wound or abrasion was revealed at the first consultation? If yes, please provide details
傷者在首次求診時，受傷部位表面有否可見之瘀傷、傷口或擦損？如是，請提供詳情。

☐ Yes 有

☐ No 否

(g) Was the patient referred to you by another doctor for further management? 病人是否由其他醫生轉介？

☐ Yes 有, the name of referral doctor is 該醫生姓名是

☐ No 否

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Please complete next page and sign
請填寫下頁並簽署

(h) Did the patient have any home leave period during hospitalization period? 病人在住院期間有否請假外出？

☐ Yes 有 Reason of leave 外出原因 _____

from 由 Day日 Month月 Year年 D D M M Y Y Y Y to 至 Day日 Month月 Year年 D D M M Y Y Y Y

☐ No 否

(i) Please indicate if the medical condition and its subsequent treatment are associated with the followings
請指出上述病況及其後的治療是否與下列情況有關

☐ Congenital anomalies, infertility or sterilization
先天性不正常情況、不育或絕育情況

☐ Dental care, general check up
牙科治療，身體檢查

☐ Under the influence of drugs or alcohol
受藥物或酒精影響

☐ Rest cure, rehabilitation, convalescence or extended car
休養、復康或延續護理

☐ None of above
以上皆否

☐ Self-inflicted injuries or suicidal attempt while sane or insane
不論在神智清醒與否下之自我損傷或自殺行為

☐ Mental condition
精神病科問題

☐ Pregnancy conditions or any related complications
懷孕或由此引發之病況

☐ Cosmetic / Plastic surgery
整形外科手術

(j) Was the patient confined in an Intensive Care Unit during this hospitalization? 住院期間病人是否曾入住深切治療部？

☐ Yes 有, hospitalization period 住院日期

from 由 Day日 Month月 Year年 D D M M Y Y Y Y to 至 Day日 Month月 Year年 D D M M Y Y Y Y

Total no. of days stays 總入住日數 _____

☐ No 否

Part II : Declaration
第二部分：聲明

I declare that all the above information are to the best of my knowledge, is true and complete.
本人在以上所有填報資料乃根據本人所知及所信為確實及完全而填報，屬實無訛。

Name of attending doctor
主診醫生姓名

Chop of hospital or clinic
醫院或診所蓋印

Signature of attending doctor
主診醫生簽署

Day日 Month月 Year年 D D M M Y Y Y Y

Address of hospital or clinic address
醫院或診所地址

No. & name of street/Lot no.*
街名及門牌 / 地段*

District
地區

HK/KLN/NT*
香港 / 九龍 / 新界*

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Zurich Insurance Company Ltd (a company incorporated in Switzerland with limited liability)
25-26/F, One Island East, 18 Westlands Road, Island East, Hong Kong

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