Personal Accident and Health Insurance Claim Form

ZURICH

① Claim submission

- For claim submission, please complete this claim form and email/post to our company
  - Email: claims@hk.zurich.com ***OR***
  - Post: Zurich Insurance Company Ltd, Claims Department, 26/F, One Island East,18 Westlands Road, Island East, Hong Kong

Please download "Zurich HK" mobile app to enjoy a straight-through claim service for the following:

- Hospital cash benefit
- Surgical cash benefit under "I-Gen" plan

② Claim acknowledgement

- Receive acknowledgment SMS and / or email in 2 working days

③ Claim result

- After submitting all the required documents, claim assessment will be completed in 14 working days with the acknowledgement sent by email/ SMS/ mail

Remarks:

1. Any claim submission must be made ***within 30 days*** from the date of incident
2. For inquiry, please contact us through the following:

General enquiry:

- Tel: 2903 9388
- Fax: 2968 1660
- Email:claims@hk.zurich.com

HealthNoble / HealthAngel enquiry:

- Tel: 2903 9382
- Fax: 2802 6633
- Email: zurich.medical@hk.zurich.com

Claim Type

(Please ☑ the box) ☐ New claim ☐ Existing claim / submit supporting document(s), please provide the claim no. _____
(Do not need to fill in "Personal details" if there is no update of relevant information)

Personal Details (*Mandatory fields)

*Policy no._____ *Insured name _____

*Insured HKID / Passport no. _____ *Insured date of birth (DD/MM/YY) _____

*Insured sex _____ Insured occupation _____ *Contact person _____
(If the same as insured person, please ignore this field)

*Contact person / Insured mobile no. _____ *Contact person / Insured email address _____
(Our company will send you the ***claim acknowledgement*** and ***direct credit claim settlement*** by SMS and/or email.)

*Contact person / Insured postal address_____

_____

Our company may contact you by ***email*** to obtain additional information to process your claim, if necessary. If you would like to change the communication channel to ***mail***, please ☑ the box: ☐ By mail (If you have an insurance intermediary/agent, our company will contact you via insurance intermediary/agent.)

General Information

Are you making any other insurance claim as a result of this incident (including employee compensation, group/company medical scheme)?

☐ No ☐ Yes, please specify: Name of insurance company _____ Policy no. _____

Type of coverage (e.g. Medical expenses/Hospital Cash) _____

If you need to have a certified true copy of medical receipt(s) and/or medical report returned, please ☑ the box. ☐ Medical receipt(s) ☐ Medical report(s)

Payment Method

☐ ***By direct credit /wire transfer*** (Only applicable to the listed banks below and for claim amount less than HKD100,000), please provide your bank details below:

- Account holder's name (insured person OR the father or mother of the insured under 18 years old) _____
- Bank (please ☑) ☐HSBC ☐Standard Chartered Bank ☐Hang Seng Bank ☐Bank of China (Hong Kong) ☐Other bank, please specify _____ (Remark: If you choose to make a direct credit via "Other bank", the bank may charge you an additional transfer fee and deduct from the amount transferred.)
- Bank account no. _____

☐ ***By cheque*** (Post to Insured person's policy address or insurance intermediary; if it is absent, will post to contact person postal address, please fill in.)

Claim items and documentation

Please ☑ the relevant section(s), submit the required documents together with this form to our company. Our company may request for additional documents.

Claim items	Claim documents checklist
☐ Medical expenses caused by accident (Please fill in Section 1 (Part I)) (If there is any surgery or hospitalization, please also fill in Sections 2 and 4)	1. Original medical invoice(s) issued by registered medical practitioner / bone-setter / acupuncturists showing the insured name, diagnosis, consultation date and medical expenses 2. Copy of sick leave certificate issued by registered medical practitioner 3. Original of Attending Physician Statement completed by the attending physician (Section 4 in this form) or hospital admission / discharge summary if there was any surgery or hospitalization (applicable to Hong Kong public hospital only)
☐ Personal accident or permanent disability (Please fill in Section 1 (Part I)), Sections 2 and 4)	1. Copy of Death Certificate or Presumed death proclaimed by court (disappearance case) (applicable to accidental death claim only) 2. Copy of certificate issued by registered medical practitioner certifying the severity of injury and percentage of disablement (applicable to permanent disability claim only) 3. Copy of Police report (if applicable) 4. Copy / certified true copy of the grant of probate / Letters of Administration (applicable to accidental death claim only) 5. Original of Attending Physician Statement completed by the attending physician (Section 4 in this form) or hospital admission/ discharge summary if there was any surgery or hospitalization (applicable to Hong Kong public hospital only)
☐ Surgery/hospitalization medical fees (Please fill in Section 1 (Part I) or (Part II), Sections 2 and 4)	1. Original invoice(s) for all related medical fees 2. Copy of Attending Physician / Specialist / Anesthetist / Surgeon / Physical therapist diagnosis and/or treatment records, medical reports showing the insured name, diagnosis and consultation date 3. Original of Attending Physician Statement completed by the attending physician (Section 4 in this form) or hospital admission/ discharge summary (applicable to Hong Kong public hospital only) 4. Original invoice(s) showing the insured person's name, date of attendance, diagnosis and/or treatment record(s) and all medical expenses incurred after conducted surgery or before hospitalization
☐ Hospital cash / Surgical cash (Please fill in Section 1 (Part I) or (Part II), Sections 2 and 4)	1. Copy of Attending Physician / Specialist / Anesthetist / Surgeon / Physical therapist diagnosis and/or treatment records, medical reports showing the insured name, diagnosis and consultation date 2. Copy of Attending Physician Statement completed by the attending physician (Section 4 in this form) or hospital admission / discharge summary (applicable to Hong Kong public hospital only)
☐ Income benefit (Please fill in Section 1 (Part I), Sections 2 to 4) Remark: The insured does not have to wait until full recovery and discharge before making any claim for income benefit if his/her claim hereunder exceeds two (2) weeks.	1. Copy of sick leave certificate issued by registered medical practitioner 2. Copy of sick leave certificate issued by registered bone-setter / acupuncturists (if applicable) 3. Copy of income proof e.g. Pay-slip, bank statement, Inland Revenue Department tax return or employment letter/ contract 4. Copy of proof of in-patient record (applicable to self-employed only) 5. Original of Employer-approved sick leave certificate completed by the employer (Section 3 in this form)

Section 1 – Details of injury and sickness

(Please ☑) ☐ This claim is caused by **accident** (Please fill in Part I) ☐ This claim is caused by **sickness** (Please fill in Part II)

Part I (The details of outpatient /hospitalization caused by accident)

Location of accident _____ Date and time of accident (DD/MM/YY, HH:MM) _____

Details of accident _____

Was the above accident reported to the police? ☐ No ☐ Yes, please provide copy of the police statement or police report

Injured part(s) ☐ Right leg ☐ Left leg ☐ Right upper limb ☐ Left upper limb ☐ Upper body ☐ Head Injury diagnosis _____

Nature of Injury ☐ Minor ☐ Moderate ☐ Severe ☐ Dead Medical fee(s) (HKD)_____

Do you need to attend follow up treatment/consultation?

☐ No ☐ Yes, please specify how long will the treatment last / follow up consultation date (DD/MM/YY) _____

Part II (The details of outpatient /hospitalization caused by sickness)

Symptom(s) before admitted to hospital/consultation

_____

Date of symptom(s) first appeared (DD/MM/YY)

_____

Date of first consultation (DD/MM/YY) _____ Diagnosis _____

Do you need to attend follow up treatment/consultation?

☐ No ☐ Yes, please specify how long will the treatment last / follow up consultation date (DD/MM/YY) _____

Medical fee(s) (HKD) _____

Section 2 (Applicable to hospitalization/surgery claim only)

Name of hospital / medical provider _____

Date of surgery (DD/MM/YY) _____ Date of admission (DD/MM/YY) _____ Date of discharge (DD/MM/YY) _____

	The name of doctor(s)	The address of doctor(s)
The doctor of the first consultation		
The doctor recommending admission to hospital		
The doctor consulted for the same sickness/accident		

During hospitalization period, did you have any home leave period?

☐ No ☐ Yes, please specify the period from (DD/MM/YY) _____ To _____

Do you need to attend follow up treatment/consultation?

☐ No ☐ Yes, please specify how long will the treatment last / follow up consultation date (DD/MM/YY) _____

Declaration and authorization

1. I / We declare that all information and particulars contained above are true and complete to the best of my/our knowledge and belief and they are made without reservation of any kind.
2. I / We understand and agree the following issues about the arrangement of my/our personal information collected or held by Zurich Insurance Company Ltd ("the Company").
   1) The personal information of customers (include policy owners, insured persons, beneficiaries, premium payors, trustees, policy assignees and claimants) collected or held by the Company may be used by the Company for the following obligatory 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):
      I. to process, investigate (and assist others to investigate) and determine insurance applications, insurance claims and provide ongoing insurance services;
      II. to process requests for payment, and for direct debit authorization;
      III. to manage any claim, action and /or proceedings brought against the customers, and to exercise the Company's rights as more particularly defined in applicable policy wording, including but not limited to the subrogation right;
      IV. to compile statistics or use for accounting and actuarial purposes;
      V. to meet the disclosure requirements of any local or foreign law, regulations, codes or guidelines binding on the Company and /or its group ("Zurich Insurance Group") and conduct matching procedures where necessary;
      VI. 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 government-related establishments;
      VII. to collect debts;
      VIII. to facilitate the Company's authorized service providers to provide services to the Company and /or the customers for the above purposes; and
      IX. to enable an actual or proposed assignee of the Company to evaluate the transaction intended to be the subject of the assignment.
   2) The Company may provide any personal information of customers to the following parties, within or outside of Hong Kong, for the obligatory purposes:-
      I. companies within the Zurich Insurance Group, or any other company carrying on insurance or reinsurance related business, or an intermediary;
      II. any agent, contractor or third party service provider who provides administrative, telecommunications, computer, payment or other services to the Zurich Insurance Group in connection with the operation of its business;
      III. third party service providers including legal advisors, accountants, investigators, loss adjusters, reinsurers, medical and rehabilitation consultants, surveyors, specialists, repairers, and data processors;
      IV. credit reference agencies, and, in the event of default, any debt collection agencies or companies carrying on claim or Investigation services;
      V. any person to whom the Zurich Insurance Group is under an obligation to make disclosure under the requirements of any law binding on the Zurich Insurance Group or any of its associated companies and for the purposes of any regulations, codes or guidelines issued by governmental, regulatory or other authorities with which the Zurich Insurance Group or any of its associated companies are expected to comply;
      VI. any person pursuant to any order of a court of competent jurisdiction; and
      VII. any actual or proposed assignee of the Zurich Insurance Group or transferee of the Zurich Insurance Group's rights in respect of the policy owners.
   3) All customers have the right to access to, correct, or change any of their own personal information held by the Company by request in writing to the Company's Personal Data Privacy Officer at the address below.

      Personal Data Privacy Officer
      26/ F, One Island East
      18 Westlands Road
      Island East
      Hong Kong

   4) In accordance with the Personal Data (Privacy) Ordinance (Cap 486), the Company has the right to charge a reasonable fee for processing any data access request.
   5) In the event of any discrepancy or inconsistencies between the English and Chinese versions of this notice, the English version shall prevail.
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 to the Company or its agents.
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 the subject or related incidents of injury, loss or damage to the Company or its agents.
5. A photocopy of this authorization shall be considered as effective and valid as the original.

Name of insured person (Name of father or mother of the insured under 18 years old)	Signature of insured person (Signature of father or mother of the insured under 18 years old)
_____	_____
HKID / Passport no.	Date of signature
_____	_____

Section 3 Employer-approved sick leave certificate (to be completed by claimant's employer)

This certificate is shown as proof of (name of claimant) _____

being the employee of our company (Position) _____

who sustained injury due to (reason(s)) _____ happening on (DD/MM/YY) _____.

This caused him/her to have sick leave period from (DD/MM/YY) _____to (DD/MM/YY) _____.

I / our company confirm the monthly salary (excluding bonus, commission, overtime allowance and other allowances) is HKD _____

Name of employer _____ Position of employer _____

Address of employer _____

Employer's signature and date

_____

Company chop

_____

Claimant's signature and date

_____

(I hereby declare that the above information is true to my fullest understanding)

Section 4 Attending Physician Statement (This section should be completed by the insured person's attending doctor during patient's hospitalization at the insured person's cost)

第四部份 主診醫生報告 (此欄須由受保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 甲部 - 醫療資料

Full name of patient 病人姓名 _____ HKID no. 香港身份證號碼 /Passport no. 護照號碼: _____ Age 年齡 _____ Sex 性別 _____

(a) Treatment period (DD/MM/YY) 診治日期 (日/月/年) From 由 _____ To 至 _____

(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? If so, 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？

☐ No 否 ☐ Yes 是, the first consultation was since (DD/MM/YY) 第一次求診日期自 (日/月/年) _____

(e) What sign(s) and symptom(s) was the patient aware of at the first consultation? 病人在第一次求診有什麼主要病徵？

_____

(f) Were there any external visible signs of bodily injury were revealed at the first consultation? 傷者在首次求診時，受傷部位有否可見明顯外傷?

_____

(g) Was there any evidence of external bruise, wound or abrasion at the first consultation? 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？ _____

(h) According to the patient, for how long had such symptom(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?

_____ year(s) 年_____ month(s) 月_____ day(s) 日

(i) Was the patient referred to you by another doctor for further management? 病人是否由另一位醫生轉介予您在進一步治療?

☐ No 否 ☐ Yes 是, the name of referral doctor is 該醫生姓名是 _____

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

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

☐ Yes 有, Hospitalization period from (DD/MM/YY) 住院日期(日/月/年) 由 _____ to 至 (DD/MM/YY) (日/月/年) _____

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

☐ No 否 ☐ Yes 有, from (DD/MM/YY) 由 (日/月/年) _____ to 至 (DD/MM/YY) (日/月/年) _____

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

☐ 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

☐ 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, psychiatric problems 心理，精神病科

☐ 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

Part II – Declaration 乙部 - 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	Signature of attending doctor 主診醫生簽署	Signature Date (DD/MM/YY) 簽署日期 (日/月/年)
_____	_____	_____

Chop of hospital / clinic 醫院或診所蓋印	Address of hospital / clinic 醫院或診所地址
_____	_____