



# Accident insurance claim form 意外索償申請表

Private and confidential 私人及保密文件

## Important notes 重要事項

- Please fill the circle in full for appropriate place.  
請於適當的位置填滿圓圈。
- Please delete where inappropriate.  
請刪去不適用者。
- Please fill in correct policy number.  
請填上正確之保單號碼。
- Please fill in the full name as shown on HKID card/identification document.  
請填寫香港身份證/身分證文件上的全名。
- Please make sure that the signature of the life insured/policyholder is consistent with that in the policy application form.  
請確保此表格上受保人/保單持有人的簽名與保單申請書之簽名一致。
- For email submission with claimed amount below HKD10,000, original receipt is only required upon request by claims handler.  
如經電郵提交申請及索償金額低於10,000港元，只有在理賠員要求時才需提交正本收據。
- Please complete and return this form not later than 30 days after the date of injury.  
請在受傷日期30天內填妥及交上此表格。
- If accident has been reported to the police station, please provide the police report or relevant documents (e.g. policy statement, result of police investigation).  
如該意外事件已向警方報案，請提供有關資料。(例如：口供紙副本、警方調查結果等)。

Name of licensed  
insurance intermediary  
持牌保險中介人姓名

Contact no. of licensed  
insurance intermediary  
持牌保險中介人聯絡號碼

## Section A 部：Personal information 個人資料

Policy no.  
保單號碼

Mr. 先生  Mrs. 太太  Ms. 女士 Name of life insured 受保人姓名

HKID card no./Passport no.  
香港身份證號碼/護照號碼

Date of birth 出生日期  
Day日 Month月 Year年

Contact no.  
聯絡號碼

This is a  
這次意外乃

New claim  
首次索賠

Further claim  
再度索賠

Benefits to claim  
索賠類別

Dismemberment/Permanent disability  
斷肢/永久傷殘

Temporary disability indemnity/Permanent total disability  
暫時喪失工作能力/永久及完全傷殘

Medical expense  
醫療費用

Daily hospital cash  
每日住院現金

Claimant's residential address  
索償人住址

Claimant's correspondence address (if different from residential address)  
索償人之通訊地址(如與住址不同)

Claimant's relationship with the life insured  
索償人與受保人關係

Claimant's contact no.  
索償人聯絡號碼

Policyholder's email address  
保單持有人的電郵地址

This email address will be updated and recorded for future email communication in respect of ALL your life policies. Please fill the circle in full if you agree.  
此電郵地址將被更新以作閣下所有人壽保單的通訊電郵。如同意，請填滿圓圈。



2ZK-CLM-CLF-00028-ET-0622

## Section B 部 : Employment details 就業詳情

1. Job title of present occupation (if more than one, state all) and exact nature of occupational duties  
現職(倘有兼職·請列明)職位及工作性質
2. Name, address and phone no. of present employer  
現時僱主名稱、地址及電話號碼
3. Are you self-employed?  
閣下是否自僱?
4. Any official income proof?(i.e. pay-slip, bank statement, IR tax return or employment letter/contract etc.)  
有否正式入息證明?(如糧單、銀行存款單、稅單或聘用信/合約)
5. Have you filed a medical leave certificate to your employer?  
曾否向僱主遞交病假證明書?
6. Average monthly income (during the 12 months prior to injury)  
意外發生前12個月之平均收入
7. Details of any income continuing whilst disabled  
受傷後若有其他收入·請列明細節

\_\_\_\_\_

\_\_\_\_\_

Yes 是       No 否

Yes 是       No 否

Yes 是       No 否

HKD 港元 \_\_\_\_\_

Amount HKD 港元 \_\_\_\_\_ per month 每月數目  
period from \_\_\_\_\_ to \_\_\_\_\_ 為期

## Section C 部 : Accident details 意外詳情

1. Date and time of accident  
遭受意外之日期及時間
2. Where and how did it happen?  
事發地點及經過?
3. Injured body part and type of injury  
受傷部位及傷勢

Day日      Month月      Year年      am/pm上午/下午

Date 日期     

## Section D 部 : Treatment details 治療詳情

1. Details of hospitals in which the life insured have been confined or physicians consulted for the injury (Please attach discharge note).  
請列出因此次意外受傷而就診之醫生或留住之醫院(請呈交出院證明書)。

Name of physician(s) and/or hospital(s) 醫生/醫院名稱	Address(es) 地址	Date of consultation(s) and/or period of confinement(s) 就診/住院日期

2. State the life insured's usual doctor's name and address.  
請列出受保人慣常就診之醫生名稱及地址。

## Section E 部 : Other insurance information 其他投保資料

1. Are you insured, claiming or intend to claim similar benefit for this event from other insurance company(ies) or organization(s) (including employee compensation and group medical scheme)?  
閣下是否有就此事件向其他保險公司或機構(包括勞工及團體醫療保險計劃)投保、索償或有意索償類似賠償?
2. If "Yes", please state the name of that organization(s) and the policy number(s).  
如「是」,請列明該機構名稱及保單號碼。

Yes 是       No 否

Note: If the claim is settled, please provide the detailed breakdown and receipts.  
註: 如已完成索償,請提交相關資料和收據。

## Section F 部 : Declaration 聲明書

I believe that the answers given above are true to the best of my knowledge. 本人就本人所知認為上述之答案全屬正確無訛。

Documents attached with this claim form 與此申請表一起呈遞之文件

1. Sick leave certificate from \_\_\_\_\_ to \_\_\_\_\_  
病假證明書 由 \_\_\_\_\_ 至 \_\_\_\_\_
2. Receipts issued by registered doctor(s)  
由註冊西醫發出的單據 HKD 港元 \_\_\_\_\_
3. Other \_\_\_\_\_  
其他 \_\_\_\_\_

## Section G 部 : Payment details 付款詳情

The claim payment shall be credited to the bank account in the name of the policyholder or life insured in accordance with the terms of your policy, please provide relevant bank account details. However this is subject to the bank's arrangement.

有關之賠款將按其保單條款存入該保單持有人或受保人名下之銀行賬戶，請提供相關銀行資料。然而，此服務必須得到銀行安排下進行。

Our request of any information or documents under this section shall not be construed as an admission of liability under your policy. We reserve all our rights for assessing your claim subject to terms and conditions of your policy.

上述要求並不代表閣下之索賠已獲成功審批，我們保留根據閣下之保單條款作審批的權利。

- Bank name 銀行名稱
- The Hongkong and Shanghai Banking Corporation Limited 滙豐銀行
- Bank of China (Hong Kong) 中國銀行(香港)
- Others, please specify 其它，請列明 \_\_\_\_\_
- Standard Chartered Bank 渣打銀行
- Hang Seng Bank 恒生銀行

Name of account holder

賬戶持有人姓名 \_\_\_\_\_

Bank account no. 銀行賬戶號碼	Bank no. 銀行號碼	Branch no. 分行號碼	Account no. 戶口號碼

1. To prevent any unnecessary delay, please make sure the bank account number and account holder name are correct.  
請確保賬戶號碼及賬戶持有人姓名正確，以免不必要之延誤。
2. If the claim payment is remitted to a third party as a result of your provision of incorrect bank account number and/or account holder name, we shall not be liable to make any further payment regardless of whether the claim payment can be recovered.  
如索償人提供之銀行賬戶號碼及/或賬戶持有人姓名不正確，而導致我們錯誤將賠款轉賬至第三者之銀行賬戶，不論有關賠款是否能取回，我們無任何責任再支付該賠款。

## Section H 部 : Required documents 所需文件

1. Completed claim application form 填妥之索償申請表
  - a. Please complete all the questions in section A to G 此表格上A至G部份之所有問題都必須作答
  - b. Please ensure section M to be completed by a registered doctor 請確保填寫表格M部份之醫生是註冊西醫
2. Sick leave certificate 病假證明書
3. Original receipt(s) for medical reimbursement 醫療費用之正本單據
4. Proof of identity (i.e. identity cards/or passports) of the policyholder/assignee/life insured/claimants/payee (if not provided previously) and proof of residential address (if applicable). 保單持有人/受讓人/受保人/索償人/收款人之身分證明文件，如身份證及/或護照(如從未提供)及住址證明文件(如適用)

### Note 註

We reserve the right to seek further documentation or information which we consider necessary for processing your claim.

如有需要，我們保留權利向閣下索取進一步文件或資料以作審核。

Upon submission of the required documents, your claim will be processed by our Life Claims Department. Should you have any questions, please call our Life Claims Hotline at +852 2535 3502 or visit <https://www.zurich.com.hk/en/customer-services/contact-us/e-form/life-claims>.

閣下的索償申請表格將由理賠部(人壽業務)處理。若有任何查詢，請致電我們的理賠熱線+852 2535 3502或前往 <https://www.zurich.com.hk/zh-hk/customer-services/contact-us/e-form/life-claims>。

## Section I 部：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

This Notice sets out the privacy policy of each of **Zurich Assurance Ltd/Zurich Life Insurance (Hong Kong) Limited** (each a “Company”) in respect of their respective customers. The rights and obligations of each Company under this Notice are several and not joint, whereby no Company shall be liable for any act or omission of another Company.

本通知列載蘇黎世人壽/蘇黎世人壽保險(香港)有限公司(以下個別稱「本公司」)有關各自對其客戶的私隱政策。各公司就本通知所列之權利和責任為獨立而非連帶的，因此各公司無須為其他公司之行為或不作為負責。

The personal information of customers (including policyholders, insured persons, beneficiaries, premium payors, trustees, policy assignees and claimants) collected or held by the 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](http://www.zurich.com.hk/pics) or by scanning the QR code. You may also contact our Customer Care Center at +852 2968 2383 or insurance intermediaries for enquires.**

本公司之私隱政策詳載於 [www.zurich.com.hk/pics](http://www.zurich.com.hk/pics) 或可透過掃描 QR 碼細閱。閣下亦可致電 +852 2968 2383 與我們的客戶服務部聯絡或向保險中介人查詢。



### Consent for marketing purposes - Voluntary:

就市場推廣用途之同意 – 自願性：

Certain personal information of policyholders and insured persons collected or held by the Company (which also includes data collected or generated in the ordinary course of the Company's business and the continuation of relationship with the customer), in particular, names, contact information, age, gender, identity document reference, marital status, financial background, demographic data, transaction pattern and behavior, policy information, claim information, and medical history may be used by the Company, **only upon having such policyholders' or insured persons' consent or indication of no objection**, for providing marketing materials and conducting direct marketing activities in relation to insurance and/or financial products and services of the Zurich Insurance Group and/or other financial services providers, and/or other related services of business partners, with whom the Company maintains business referral or other arrangements (such as reward, loyalty, co-branding or privileges programs and related services and products, services and products offered by the Company's business or co-branding partners, donations or contributions for charitable and/or non-profit making purposes). For the avoidance of doubt, the latest instruction (for example, consent or indication of no objection, or request for opt-out) received from a customer shall override any previous instruction given to the Company in this regard in relation to all personal information of the customer collected or held by the Company from time to time.

由本公司收集或持有的保單持有人及受保人的某些個人資料(其中亦包括在本公司日常業務過程中以及就持續與客戶的關係收集或產生的資料)，特別是姓名、聯絡資料、年齡、性別、身分證明文件資料、婚姻狀況、經濟背景、人口統計數據、交易模式和行為、保單資料、索償資料及醫療紀錄等，**於獲該保單持有人或受保人同意或不反對指示後**，均可供本公司使用作為蘇黎世保險集團及/或與本公司維持業務引薦關係或其他安排之其他金融服務供應商的保險及/或金融產品及服務，及/或其他商業合作夥伴之相關服務，提供市場推廣資料及進行直接市場推廣活動。(例如獎賞、忠誠獎勵、合作品牌或優惠計劃以及相關服務和產品，由本公司商業合作夥伴或合作品牌夥伴提供的服務和產品，出於慈善及/或非牟利目的的捐贈或捐款)。為免生疑問，就本公司不時收集或持有的所有客戶個人資料，本公司將會以從客戶收到的最新指示(例如同意或表示不反對的指示，或提出反對要求)。

The Company may provide (and may receive money or property in return for providing) certain personal information, in particular, name, contact information, age, gender and policy information of a policyholder and an insured person, **only upon having such policyholder's and insured person's written consent**, to be used by the following parties, within or outside of Hong Kong, for their own and/or the Company's **marketing purposes** set out above:

**於獲保單持有人及受保人書面同意後**，本公司方可就以下人士本身及/或就本公司的市場推廣用途，向以下於香港境內或境外的人士提供其某些個人資料(並可能收到金錢或其他財產作為回報)，特別是姓名、聯絡資料、年齡、性別、保單持有人及受保人的保單資料等，以供其使用：

- (1) companies within the Zurich Insurance Group;  
蘇黎世保險集團成員公司；
- (2) other banking/financial institutions, commercial or charitable organizations with whom the Company maintains business referral or other arrangements;  
與本公司維持業務引薦關係或其他安排的其他銀行/金融機構、商業或慈善組織；
- (3) third party reward, loyalty, co-branding or privileges program providers;  
第三方獎賞、忠誠獎勵、合作品牌或優惠計劃提供者；
- (4) third party marketing service providers and insurance intermediaries.  
第三方市場推廣相關服務供應商及保險中介人。

I/We understand that I/we can withdraw any consent provided for marketing purposes anytime by notice to the Company.

本人/我們明白可隨時通知 貴公司以撤回任何就市場推廣用途所給予之同意。

## Section J 部：Declaration for data protection 個人資料保障聲明

I/We confirm that I/we, agree to the use or transfer of my/our personal data for the purposes as set out above.

本人/我們確認本人/我們同意 貴公司使用或向第三方提供本人/我們的個人資料作上述用途。

I/We declare that proper consent from the life insured or policyholder (if different from the claimant) has been obtained before the personal data is provided to Zurich Assurance Ltd and/or Zurich Life Insurance (Hong Kong) Limited.

本人/我們於提供受保人或保單持有人(如與索償人不同)的個人資料予蘇黎世人壽及/或蘇黎世人壽保險(香港)有限公司前已獲得受保人或保單持有人的正式同意。

## Section K 部：Levy on premium 保費徵費

1. Levy collected by the Insurance Authority has been imposed on relevant policy at the applicable rate. Therefore, the policyholder is required to pay the prescribed levy along with the premium/contribution. For further information, please visit [www.zurich.com.hk/ia-levy](http://www.zurich.com.hk/ia-levy).  
保險業監管局已向相關保單按照適用的徵費率收取保費徵費。因此，保單持有人於繳付保費/供款時，須同時繳付徵費。更多有關保費徵費資料，請瀏覽 [www.zurich.com.hk/ia-levy](http://www.zurich.com.hk/ia-levy)。
2. For particular product(s) which require the deduction of unpaid premium(s) when benefit claims is applied, I/we hereby agree that the Company shall deduct all of the unpaid premium(s) and correspondence levy(ies) (if any) from the claim payment. I/We also understand and agree that the policyholders' information may be provided to the Insurance Authority if the levy is overdue.  
有關在申請保險賠償時須扣除所有逾期未繳付保費的個別產品，本人/我們在此同意，貴公司從保險賠償金額中扣除所有逾期未繳付的保費及相應之保費徵費（如適用）。本人/我們明白及同意若保單持有人有逾期的保費徵費，貴公司可能會向保險業監管局提供保單持有人的資料。

## Section L 部：Authorization 授權

1. I/We hereby request payment of all benefits in accordance with the policy and I/we warrant that I am/we are legally and beneficially entitled to such sum.  
本人/我們現就上述保單作出賠償申請，及聲明本人/我們有合法資格受益於此保單之所有賠款。
2. I/We hereby authorize any hospitals, physicians, medical practitioners, insurance companies, employers or organizations that have any records or knowledge of the life insured \_\_\_\_\_, the holder of HKID card/Passport no. \_\_\_\_\_ to disclose to the Company or its authorized 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.  
本人/我們在此授權任何醫院、醫療專業人士、內外科醫生、保險公司、僱主或機構及凡持有受保人 \_\_\_\_\_，香港身份證/護照號碼 \_\_\_\_\_ 資料之人士。可向 貴公司或其授權代表披露有關他/她的資料，包括：健康狀況、過往之病歷、病狀、入院紀錄、診治建議、治療方法、調查結果、在職紀錄或其他保單資料及賠償紀錄等。
3. I/We also agree that the Company may use the copy(ies) of my/our identification document(s) and the life insured's identification document for claim purposes.  
本人/我們亦同意 貴公司使用本人/我們之身分證明文件副本或受保人之身分證明文件副本以作上述查詢用途。
4. A faxed or photographic copy of any section of this claim statement shall be as valid as the original.  
此申請表各項之影印本亦屬有效。

Full name 姓名	HKID card/Passport no. 香港身份證/護照號碼						
Signature 簽署	Date signed 簽署日期 <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;">Day日</td> <td style="text-align: center;">Month月</td> <td style="text-align: center;">Year年</td> </tr> <tr> <td style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </td> <td style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </td> <td style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </td> </tr> </table>	Day日	Month月	Year年	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
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**PLEASE DO NOT SIGN ON BLANK FORM. 請勿於空白表格簽署。**

In the event of any discrepancies or inconsistencies between the English and Chinese versions of this form, the English version shall prevail.  
如此表格之中英文版本有任何歧異或不一致，概以英文版為準。

## Section M 部 : Certificate of medical attendant 醫療報告

No claims can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expense of the life insured.

此表格必須由合資格及註冊西醫填妥，所需費用由受保人自負，否則索償不會獲得受理。

Name of life insured 受保人姓名

HKID card no./Passport no.

香港身份證號碼/護照號碼

Age 年齡 Date of accident 意外日期

Day 日 Month 月 Year 年

1. a. What is the exact diagnosis?

b. Is there any external and visible evidence of injury at your **1st consultation**

Yes  No

c. If "Yes", please specify type of injury

d. Specify injured body part

e. Describe the cause and extent of injury

2. Present condition of injury

3. a. Is there any treatment provided?

Yes  No

b. If "Yes", please give details (such as suturing, physiotherapy, type of dressing, etc.)

Date (DD/MM/YYYY) \_\_\_\_\_

Time (am/pm) \_\_\_\_\_ Treatment \_\_\_\_\_

4. a. Any other physicians who treated the life insured for the same injury?

Yes  No  Unknown

b. If "Yes", please give: Name(s) Address(s) Approximate date(s)

\_\_\_\_\_

\_\_\_\_\_

5. Did injury require:

a. Hospitalization?

Yes From         to          No

b. X-ray?

Yes  No

c. Special diagnostic procedures?

Yes  No

d. Surgery?

Yes  No

If any of the above is "Yes", please provide details of the investigation result and/or the name of hospital admitted.

6. Was the injury induced from or effected by any of the following which may contribute to the accident and/or lengthen the period of disability?

a. Physical defects/congenital anomaly

Yes  No

b. Unfavourable past medical history

Yes  No

c. Degenerative changes

Yes  No

d. Alcohol or drugs

Yes  No

If any of the above is "Yes", please provide details of the investigation result.

7. a. Was healing complicated?

Yes  No

b. If so, specify reason(s) and any special treatment given

8. Bearing in mind the life insured's occupation as stated in item(1) of the employment particulars section, do you opine that the injuries would have prevented him/her from working?

at your 1st consultation  Yes  No

at your latest consultation  Yes  No

9. If absence from work of more than 7 days was necessary, please describe in detail the reasons why you opine the life insured could not return to work earlier.

\_\_\_\_\_

I hereby certify that I have personally examined and treated the life insured for the above injury and that the facts as given above is my opinion of his/her condition.

The personal information collected from the physician in this form will be used by the Company for administration, verification and record purposes in respect of the subject matter of this form. The Company will not be able to process the request in the form, if the physician fails to provide the personal information as requested. For personal data access or change requests, please write to our Personal Data Privacy Officer, 26/F, One Island East, 18 Westlands Road, Island East, Hong Kong.

Name of physician (with stamp)		Signed	
Qualification		Date signed	
Address		Contact no.	

Day Month Year

**PLEASE DO NOT SIGN ON BLANK FORM.**