Sun Flower Insurance Brokers Limited
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ZURICH 蘇黎世

Private & Confidential 私人及保密文件

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 ☐ 不是
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
Bank A/C No. |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

戶口持有人簽署
Signature of Account Holder: _____

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Declaration and authorization
聲明及授權

1. 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。

2. I/We hereby declare and agree that any personal information in this claim form or otherwise obtained is provided by me/us and may be held, used and disclosed to enable the Company to carry on insurance and financial services business; and may be transferred to any individuals, related companies, any other organizations, any independent third party and other service providers for the purpose of (i) processing this application and providing subsequent services for this or other products and services, and or (ii) direct marketing, and/or (iii) data matching, and/or (iv) communication with me/us for such purposes.
本人/余等同意一切由 貴公司在本索償書或以其他方式獲取而所收集或持有本人/余等的個人資料均由本人/余等提供,並可由 貴公司持有、使用及披露作其保險及金融服務業務上所需,並可能轉予任何個人、與 貴公司關連公司、其他的組織、其他獨立第三者及其他服務提供者(i)能夠處理本人/余等此項申請及提供與此項申請或其他產品有關之服務,(ii)用作直銷,(iii)用作資料配合,並(iv)就任何事宜與本人/余等聯絡,直至本人/余等作出書面指示爲止。

3. I/We understand that I/we have the right to obtain access and request correction of any personal information concerning myself/ourselves held by the Company. Request for such access can be made to the Data Protection Officer of the Company.
本人/余等明白本人/余等有權查閱及要求更正由 貴公司持有有關本人/余等的個人資料,如有此項要求,可向 貴公司的資料保護主任提出。

4. 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。

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

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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.

Dates	Disease / Disorder	Details of treatment / hospitalization	Name of Physician / Hospital

Name of Physician _____ Qualification _____

Date _____ Name and address of Hospital _____

_____

_____

_____
Signature

_____
Hospital Stamp