ZURICH
蘇黎世

Domestic helper insurance claim form (for hospitalization claim)
僱傭保險索償申請表（住院索償）

Email 電郵：claims@hk.zurich.com

Clear form

Please tick 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。

For claims enquiry, please visit www.zurich.com.hk/claims 有關索償查詢，請瀏覽 www.zurich.com.hk/claims

1. Claim submission 申請索償

All claim types (including in-patient and out-patient medical expenses)
所有索償類別（包括住院及門診醫療費用）

- Visit eClaim platform at the following website 瀏覽e索償平台：
  www.zurich.com.hk/eclaim

In-patient medical expenses 住院醫療費用：

- Submit this claim form by email/post 填妥此索償申請表並電郵 / 郵寄至本公司
  Email 電郵：claims@hk.zurich.com
  Post 地址：Claims Department, Zurich Insurance Company Ltd,
  26/F, One Island East,18 Westlands Road, Island East, Hong Kong
  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賠償部

2. Claim acknowledgement 申請確認通知

- Receive acknowledgment SMS and/or email in two working days
  在兩個工作天內收到確認短訊及 / 或電郵

3. Claim result 索償結果

- Received claim result after claim assessment
  索償評估後收到索償結果

Remarks 注意事項：

- Please report your claim to us within 30 days from the date of incident. 索償申請表必須於事故發生後30日內遞交。
- If your claim included third party liability, please also complete and submit the Third party liability insurance claim form. If your claim included loss of property, please also complete and submit the Property insurance claim form. 如此索償申請涉及第三者責任保險索償申請，請另外填寫及遞交第三者責任索償申請表。如此索償申請涉及財物保險索償申請，請另外填寫及遞交財物損失索償申請表。
- If you would like to report any work injury or occupational disease sustained by your foreign domestic helper under the "Employee's Compensation Ordinance", please download and submit the prescribed form directly to the Labour Department for such incident. You do not need to fill in this claim form. 您正根據《僱傭補償條例》申報有關您的海外家傭因執行職務發生意外而蒙受身體損傷或患上職業病，請從勞工處直接下載指定表格並提交給他們以作通知之用，無需填寫此索償申請表。

Policy no.
保單號碼

1. General information 一般資料

Insured name (employer)
受保人姓名（僱主）

Contact person (if different from insured)
聯絡人姓名（如與受保人不同）

HKID/Passport no. of insured person (employer)
受保人（僱主）香港身份證 / 護照號碼

Mobile phone no. of contact person
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*

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

Name of domestic helper
家傭姓名

Gender of domestic helper ☐ Male 男 ☐ Female 女
家傭性別

HKID/Passport no. of domestic helper
家傭香港身份證 / 護照號碼

Age of domestic helper
家傭年齡

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。

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	☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐

- If the above fields are blanked/incorrect, we will issue cheque and post to the postal address of the contact person or your intermediary.
  如上述所填寫的銀行轉賬資料全留白或有誤，本公司會改發支票並郵寄至聯絡人通訊地址或您的保險代理或經紀。
- 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 submit the required documents listed below together with this form to our company. Our company may request for additional documents.

請連同以下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
Hospitalization medical expenses 住院醫療費用	☐ Copy of hospital admission and discharge summary issued by registered medical practitioner (applicable to Hong Kong public hospital) 由註冊醫生發出的入院紙及出院總結副本（適用於香港公立醫院） ☐ Original medical/clinic surgery expenses invoice(s) and/or diagnosis and/or treatment records and/or medical reports issued by Attending Physician/Specialist/Anesthetist/Surgeon/Physical therapists showing the patient's name, consultation date and diagnosis 所有主診醫生 / 專科醫生 / 麻醉師 / 外科醫生 / 物理治療師發出的醫療 / 手術費用收據及 / 或診斷証明及 / 或治療紀錄及 / 或醫療報告之正本，並註明病人姓名、求診日期及診斷結果 ☐ Copy of Attending Physician Statement completed by the attending physician (Section 2 of this form) if there was any surgery or hospitalization (applicable to Hong Kong private hospital) 如曾接受手術或住院，由主診醫生填妥的主診醫生報告副本（本表格的第二部分）（適用於香港私立醫院）

Section 1 第一部分 — Details of injury/sickness 傷病詳情

☐ This claim is caused by accident (Please fill in Part I)
是次索償是由意外引致（請填寫甲部）

☐ This claim is caused by sickness (Please fill in Part II)
是次索償是由疾病引致（請填寫乙部）

Part I 甲部 — Details of hospitalization caused by accident 由意外引致的住院詳情

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*

Injured part(s)
受傷部位

Nature of injury ☐ Slight 輕微 ☐ Moderate 普通 ☐ Serious 嚴重 ☐ Death 死亡
受傷程度

Injured diagnosis
受傷診斷結果

Medical fee (HKD)
醫療費用（港元）

Part I 乙部 — Details of hospitalization caused by sickness 由疾病引致的住院詳情

Diagnosis
疾病的診斷結果

Date of symptom(s) first appeared
該病徵於何時首次出現
Day日 Month月 Year年
D D M M Y Y Y Y

Doctor(s) consulted during hospitalization/first consultation
入住醫院 / 首次求診該病的醫生

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

	Name of doctor(s) 醫生姓名	**Address of hospital or clinic 醫院或診所地址**	**Consultation date 應診日期**
All other doctor(s) consulted for the same symptom(s) 所有其他應診該病的醫生			Day日 Month月 Year年 D D M M Y Y Y Y
The doctor recommended admission to hospital 建議病人入院的醫生			Day日 Month月 Year年 D D M M Y Y Y Y

Medical fee (HKD)
醫療費用（港元）

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。

Signature of insured person (employer) 受保人（僱主）簽署	Signature of domestic helper 家傭簽署
Name of insured person (employer) 受保人（僱主）姓名	Name of domestic helper 家傭姓名
Date 日期 Day日 Month月 Year年 D D M M Y Y Y Y	Date 日期 Day日 Month月 Year年 D D M M Y Y Y Y

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）
香港港島東華蘭路18號港島東中心25-26樓

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Attending physician statement
主診醫生報告

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(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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