Domestic Helper Insurance (Hospitalization) Claim Form

Claims procedure

1. Claim submission

All claim types (including in-patient and out-patient medical expenses):

- Visit eClaim platform at the following website: www.zurich.com.hk/eclaim/en

In-patient medical expenses:

- Submit this claim form by email/post
  Email: claims@hk.zurich.com
  Post: Claims Department, Zurich Insurance Company Ltd, 26/F, One Island East,18 Westlands Road, Island East, Hong Kong

Out-patient medical expenses:

- Scan the QR code on the right and download "Zurich HK" App to submit

2. Claim acknowledgement

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

3. Claim result

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

^Subject to the completeness of documents

Remarks:

- Please report your claim to us within **30 days** from the date of incident.
- If your claim included third party liability, please also complete and submit the **Third Party Liability Claim Form**. If your claim included loss of property, please also complete and submit the **Property Damage Claim Form**.
- 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.
- For inquiry, please call our Claims Hotline at +852 2903 9388 or email to claims@hk.zurich.com or fax to +852 2968 1660.

Policy no.

Personal details of the insured person (employer)

Name of insured person (employer)

Name of contact person

HKID/Passport no. of the insured person (employer)

*Mobile no. of contact person

(If the same as insured person (employer), please ignore this field)

*Email address of contact person

*Please fill in the mandatory fields as our company will send you the **claim acknowledgement and claim settlement** by SMS and/or email

*Postal address of contact person

Flat/Room* Floor Block Building

Estate name/No. & name of street/Lot no.* District HK/KLN/NT* ☐ ☐ ☐

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, our company will contact you via insurance intermediary/agent.)

Domestic helper's details

Name

HKID/Passport no.

Sex

Age

Payment method

☐ **By direct credit/wire transfer** (only applicable to the banks listed below and for claim amount less than HKD 100,000)

Please provide your bank details below:

Account holder's name _____

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 or 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's postal address, please fill in the mandatory field in "**Personal details**" section above)

Claim items and documentation

Please submit the required documents listed below together with this form to our company. Our company may request for additional documents.

Claim items	Claim documents checklist
Hospitalization medical expenses	1. Copy of hospital admission and discharge summary issued by registered medical practitioner (applicable to Hong Kong public hospital)
	2. 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
	3. 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)

Section 1 – Details of injury/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 – Details of hospitalization caused by accident

Date and time of accident Day Month Year Hour Minute (☐ a.m./☐ p.m.) Location of accident _____

Details of accident _____

Injury part(s) (please✓) ☐ Right leg ☐ Right upper limb ☐ Left leg ☐ Left upper limb ☐ Upper body ☐ Head ☐ Others, please specify _____

Nature of Injury (please✓) ☐ Slight ☐ Moderate ☐ Serious ☐ Death

Injury diagnosis _____ Medical fee(s) (HKD) _____

Part II – Details of hospitalization caused by sickness

Diagnosis _____ Date of symptom(s) first appeared Day Month Year

Doctor(s) consulted during hospitalization/first consultation _____ Date of first consultation Day Month Year

	Name of doctor(s)	Address of hospital/clinic	Consultation date
All other doctor(s) consulted for the same symptom(s)			Day Month Year
The doctor recommended admission to hospital			Day Month Year

Medical fee(s) (HKD) _____

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
      Zurich Insurance Company Ltd
      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.

Signature of insured person (employer)	Signature of the domestic helper
Name of insured person (employer)	Name of the domestic helper
Date Day Month Year D D M M Y Y Y Y	Date Day Month Year D D M M Y Y Y Y

1DH-1CF-02-2019E

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
24-hour emergency hotline: +852 2886 3977 Claims hotline: +852 2903 9388
Fax : +852 2968 0639 Website : www.zurich.com.hk

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Section 2 Attending Physician Statement (This section should be completed by the domestic helper's attending doctor during hospitalization at the insured person's cost)

第二部分 主診醫生報告 (此欄須由家傭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./Passport no.
香港身份證號碼 / 護照號碼

Age
年齡

Sex
性別

Treatment period
診治日期

From 日 月 年
由 D D M M Y Y Y Y

To 日 月 年
至 D D M M Y Y Y Y

Diagnosis of conditions
病況診斷

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

Prior to this consultation, did patient first consult you for the related signs and symptoms? If so, when was the first consultation? ☐ No 否 ☐ Yes 是
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？

The first consultation was since 日 月 年
第一次求診日期自 日期 D D M M Y Y Y Y

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？

Were there any external visible signs of bodily injury 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?

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？

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

Was the patient referred to you by another doctor for further management? ☐ No 否 ☐ Yes 是 The name of referral doctor is
病人是否由另一位醫生轉介予您作進一步治療? 該醫生姓名是

Was there any hospitalization for the patient? ☐ No 否 ☐ Yes 有
病人有否住院？

Hospitalization period 住院日期 from 由 日期 日 月 年 D D M M Y Y Y Y to 至 日期 日 月 年 D D M M Y Y Y Y

Did the patient have any home leave period during hospitalization period? ☐ No 否 ☐ Yes 有
病人在住院期間有否請假外出？

Hospitalization period 住院日期 from 由 日期 日 月 年 D D M M Y Y Y Y to 至 日期 日 月 年 D D M M Y Y Y Y

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 is to the best of my knowledge, 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

Chop of hospital/clinic
醫院或診所蓋印

Address of hospital/clinic
醫院或診所地址