

Please note the following: 請注意以下事項:

It is not necessary to fill in 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（例如你的家僱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。

Domestic Helper Insurance (Hospitalization) Claim Form
家庭傭工保險(住院)索償書

Name of Insured:	Policy No.	
投保人姓名:	保單號碼	
Correspondence Address:		
通訊地址:		
E-mail Address:		
電郵地址:		
Phone No.: (Day)	(Night)	Fax No.
電話號碼: (日)	(夜)	傳真號碼
Name of Patient:	Sex	Age
病者姓名:	性別	年齡
Patient's ID/Passport No.:		
病者身份證/護照號碼:		

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 extent of injury. 請描述受傷部位及傷勢

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, Pafoong Insurance Company (Hong Kong) Limited ("the Company) 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，寶豐保險(香港)有限公司("貴公司")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/余等作出書面指示為止。
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 person, that has any records or knowledge of the patient or his/her health, to disclose to Pafoong Insurance Company (Hong Kong) 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寶豐保險(香港)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)

Insurer : Pafoong Insurance Company (Hong Kong) Limited
A subsidiary of Shanghai Commercial Bank Ltd.
承保公司 : 寶豐保險(香港)有限公司
上海商業銀行附屬公司

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.					
<u>Dates</u>	<u>Disease / Disorder</u>	<u>Details of treatment / hospitalization</u>	<u>Name of Physician / Hospital</u>		
Name of Physician _____			Qualification _____		
Date _____			Name and address of Hospital _____		
Signature _____			Hospital Stamp _____		