Domestic Helper

AXA China Region Insurance Company (Bermuda) Ltd.
(incorporated in Bermuda with limited liability)
GENERAL INSURANCE Claims Dept 36/F Tower One Times Square 1 Matheson Street Causeway Bay Hong Kong
Tel (852) 2828 3725 Fax (852) 2511 9851 Website www.axa.com.hk

Outpatient / Dental Claim

- Original medical expenses receipt(s) issued by registered medical practitioner and/or bonesetter showing, among others, the name of patient, type of treatment, the diagnosis, etc.
- The policy number and the name of the Insured shown at the back of the original medical expenses receipt(s).

Hospitalisation Claim

- A completed “Hospitalisation Claim Form”.
- Original hospital medical bill(s), receipt(s) with itemised breakdown of all expenses incurred.
- All medical records, report(s) showing the diagnosis and/or the operation(s) performed, certified by the attending medical practitioner.
- Medical practitioner’s written referral for laboratory tests / X-ray / treatment of physiotherapy or chiropractor, if applicable.

HOSPITALISATION CLAIM FORM
住院索償表格

No fees, commission or charges of whatever nature are payable to Agents or Employees of the Company in respect of this claim.
有關本索償，客戶無需支付任何手續費，佣金或其他任何性質的費用予本公司的營業員或其他僱員。

Part I - To be completed by the Claimant 第一部份 - 由索償人填寫

Name of Insured 被保人姓名 | HKID Card No 身份證號碼 | Date of Birth 出生日期 | Policy No 保單編號

Claim payment to be made in 賠償款項請用： ❑ HK$ 港幣 ❑ Policy currency 保單貨幣

Please provide your Bank Account Number if the claim payment is to be made in Hong Kong dollars and/or through Autopay. The account holder must be the Insured. If the insured is under 18 years of age the account holder must be the policy owner.
如採用港幣賠款，請填寫收受賠款之自動轉賬戶口號碼。戶口持有人必須為被保人。十八歲以下之被保人，戶口持有人則須為保單持有人。

|_|_|_|—|_|_|_|—|_|_|_|_|_|_|_|_| Bank 銀行名稱：

1) Nature of Disability 傷病性質
   a) If disability is related to illness 若傷病由疾病導致 —
   Symptoms of Illness 病徵：
   Date symptoms were first noticed 首次出現病徵日期：
   Name & Address of attending doctor 主診醫生姓名及地址：
   First Consultation Date 首次求診日期：

   b) If disability is related to an accident 若傷病由意外導致 —
   Nature of the Accident 意外情況：
   Date 日期：
   Place 地址：
   Time 時間：
   Description 詳情：

2) Have you previously suffered from or been treated for the above symptoms or disability? Please provide the Dates, Address & Name of the Doctor/Hospital.
閣下曾否患有上述傷病或就上述傷病求診？請提供詳情如日期、就診醫生／醫院、地址及情況。

3) Name & Address of your usual doctor 經常求診之醫生姓名及地址：

4) Employment Details 工作資料：
   a) Occupation & Nature of duties prior to the above disability
   傷病前的工作職務及性質

   b) Name & Address of the Employer 僱主名稱及地址

   c) Date of cessation of work as a result of this disability
   因是次傷病而停止工作的日期：

   d) Expected date of returning to work
   恢復或預計恢復工作的日期

5) Other Details 其他資料：
   Are you also making insurance claims with any other insurance company? 閣下是否同時或曾經就是次住院申請其他保險？
   Name of Insurer 保險公司名稱 | Policy No 保單編號 | Amount of Benefit 賠償金額 | Benefit Period 賠償日期

Declaration & Authorisation

I HEREBY DECLARE AND AGREE on behalf of myself/the insured and all Covered Person[s] and other Persons referred to in this claim form ("Relevant Persons") that (1) all statements and answers to all questions whether or not written by my own hand are to the best of my knowledge and belief complete and true; (2) any personal data of the Relevant Persons collected or held by the Company (whether contained in this claim form or otherwise), may be used in connection with matching for whatever purpose (whether or not with a view to taking any adverse action against the Relevant Persons) with such other personal data and/or may be used, stored, disclosed, transferred (whether within or outside Hong Kong) to such persons as the Company may consider necessary including without limitation any of its affiliated companies, reinsurers or any individuals/organisations associated with the Company to (i) process and deal with this claim and underwrite and evaluate any other existing policies and/or application for insurance (ii) provide all services related to this claim and underwrite and evaluate any other existing policies and/or application for insurance and promote, improve and further promotion of services by the Company and its affiliated companies (iii) communicate with the Relevant Persons for any other purpose and/or comply with the laws of any applicable jurisdiction.

If the Relevant Persons fail to provide any information requested in this claim form, it may result in the Company's inability to process and deal with this claim.

I DECLARE AND AGREE that I have the full authority from and consent of the Relevant Persons to make the above declarations and agreements.

The Relevant Persons have the right under the Personal Data (Privacy) Ordinance to request access to and correct any of the personal data held by the Company concerning the Relevant Persons. Any request may be made in writing and addressed to the head of the Policyowners' Service Department.

I HEREBY AUTHORISE on behalf of myself/the insured and all Covered Person[s] (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of me/the insured or any of the Covered Person[s] and who has attended or may hereafter attend to myself/the insured and any of the Covered Person[s] to disclose such information to the Company; (2) the Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessments and tests to evaluate the health status of myself/the insured or any Covered Person[s] in relation to this claim. This authorisation shall bind my successors and assignees and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.

I DECLARE AND AGREE that I have the full authority from and consent of the insured and all Covered Persons to make the above authorisations.

聲明及授權

本人謹此代表本人／被保人，所有受保人及其他在此索償申請表提及之人士（"相關人士"）聲明及同意 (1) 上述一切陳述及問題的所有答案，不論是否本人親手所寫，就本人所知所信，均為事實之全部並確實無訛；(2) 貴公司可以在任何情況下（不論是否打算對相關人士採取不利行動）核對貴公司所收集或持有之任何相關人士的個人資料（不論是否此索償申請表所載或其他途徑所取得）及／或可以使用、儲存、透露、轉移（不論在香港或海外）任何貴公司所收集或持有之任何相關人士的個人資料（不論是否此索償申請表所載或其他途徑所取得）給貴公司認為有需要之人士，不受限制地包括貴公司之任何關聯公司、再保公司或任何與貴公司有關之人士或機構，以 (i) 審核及處理索償申請及／或審核及評估任何其他保單或投保申請；(ii) 提供所有關於此索償申請及／或審核及評估任何其他保單或投保申請之服務及推廣、改善及進一步推廣關於貴公司及其關聯公司所提供之服務；(iii) 用於與相關人士作任何其他目的之溝通及／或遵守任何適用之司法區域之法律。

若相關人士不能提供任何此索償申請表所需的資料，貴公司可能因此不能審核及處理此索償申請。

本人聲明及同意已獲相關人士授權及同意本人作出上述聲明及協議。

所有相關人士有權依據個人資料（私隱）條例要求查閱及更正任何貴公司持有關於相關人士之個人資料，他們可以以書面向客戶服務部之主管提出要求。

本人謹此代表人／被保人及所有受保人授權 (1) 任何僱主、註冊西醫、醫院、診所、保險公司、銀行、政府機構，或其他機構、組織或人士、凡知道或持有任何有關本人／被保人或任何一位受保人之紀錄者，及／或曾診驗或可能將會診驗本人／被保人及任何一位受保人者，均可將該等資料提供給貴公司；(2) 貴公司或任何其指定之醫生或化驗所，可就此索償申請替本人／被保人及任何受保人進行所需之醫療評估及測試，作為審核本人／被保人及任何受保人之健康狀況。此授權對本人之繼承人及受讓人具有約束力；即便死亡或無行為能力時，此授權仍具效力。本授權書的影印本與正本均有同等效力。

本人聲明及同意已獲被保人及所有受保人授權及同意本人作出上述授權。

Name of the Insured/Claimant 被保人／索償人姓名	Relationship to Insured 與被保人關係
Signature of the Insured/Claimant 被保人／索償人簽署 Date 日期	HKID Card No of the Insured/Claimant 被保人／索償人身份證號碼
Mailing Address 聯絡地址	Contact Tel No 聯絡電話
Name of Witness/Agent Code 見証人姓名／營業員編號	Signature of Witness/Agent 見証人／營業員簽署

This form must be returned with the Original Receipts and Hospital Discharge Note for prompt claim processing.
此住院索償表格必須連同有關單據正本及出院證明書一併交回。

GENERAL INSURANCE 36/F Tower One Times Square 1 Matheson Street Causeway Bay Hong Kong 一般保險 香港銅鑼灣勿地臣街 1 號時代廣場 1 座 36 樓
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Part II - To be completed by the Attending Doctor at the Insured's expense
索償表格第二部份 - 必須由主診醫生填寫，費用由被保人支付

Name of the Patient 病者姓名 | HKID Card/Passport No 身份證／護照號碼 | Age 年齡

1) Hospitalisation 住院：
Name of Hospital 醫院名稱：

Date of Admission 入院日期： | Date of Discharge 出院日期：

2) Surgical Procedure 手術
Date of Operation 手術日期： | Name of the Procedure 手術或檢驗名稱：

Nature and the Results 性質：

3) Chief complaint of the Patient relating to this hospitalisation/surgery 此次住院／手術的主要原因：

4) Diagnosis of Condition: (Including the underlying cause and the date the Patient was informed)
診斷：(包括導致以上診斷原因及通知病人有關診斷之日期)

5) Brief discharge summary: (Including treatment, investigation procedures, results, and/or any complications and follow up plans)
出院撮要：(包括治療、診查辦法、結果、併發症及跟進計劃)

6) Date the accident occurred or when the symptoms first appeared 首次出現病徵日期或意外發生日期：

7) Date of the first consultation for this condition or related illnesses 病人首次求診日期：

8) To the best of your knowledge, has the Patient ever had the same or similar conditions or symptoms relating thereto?
據閣下所知，病人以前曾否患有同類病況？

❑ No 沒有 ❑ Yes 有 Please state Dates and Describe 請說明何時及當時情況

9) Was the Patient referred by another doctor? 病人是否經其他醫生轉介？

❑ No 不是 ❑ Yes 是 Name and Address of the Referral Doctor 轉介醫生的姓名和地址

Name of the Attending Physician/Specialist (with qualifications)
主診／專科醫生的姓名(資歷)

Address
地址

Tel No
電話

Signature of the Attending Physician/Specialist
主診／專科醫生簽名

Date
日期

This claim form is endorsed by the Hong Kong Medical Association and the Medical Insurance Association of the Hong Kong Federation of Insurers.