MSIG Insurance (Hong Kong) Limited
9/F Cityplaza One 1111 King's Road
Taikoo Shing Hong Kong
Tel: (852) 2894 0555 Fax : (852) 2902 9109
Website : www.msig.com.hk

Macau Branch
Avenida Da Praia Grande No. 693
Edif Tai Wah, 13th Andar A & B, Macau
Tel : (853) 2892 3329
Fax : (853) 2893 3349

Helper Insurance – Hospitalisation Claim Form

THE POLICYHOLDER

Policy Number: _____

1. Policyholder (name) : _____
2. Address :_____

   _____
3. Tel. No. (Work): _____ Tel. No. (Mobile): _____

For claim payment (if any) direct credit to Policyholder's bank account, please complete all of the following:

Account Holder's Name (Must be the same as the Policyholder) : _____

Bank Name : _____

Bank Code : _____ Branch No. : _____ Bank A/C No. : _____

THE EMPLOYEE

Passport / ID Card No. : _____

1. Full Name : _____
2. Nationality : _____ 3. Sex : _____

HOSPITALISATION EXPENSES – SECTION A (TO BE COMPLETED BY THE EMPLOYER)

1. State the nature of the injury, illness or medical condition : _____
2. On what dates did : (a) the symptoms first occur? _____
   (b) your Domestic Employee last attend work prior to the onset of the condition described above? _____
3. Is treatment related to an accident? YES / NO

   If YES (a) on what date did the accident occur? _____

   (b) give brief details of where and how the accident happened : _____

   _____
4. Which Doctor does your Domestic Employee normally attend?

   Address : _____

   _____ Tel. No : _____
5. Has your Domestic Employee previously consulted the above Doctor or any other Doctor for the medical condition for which you are now claiming, or related condition? YES / NO

   If YES, for each Doctor and hospital consulted, state :

   Name(s) : _____

   Full Address(es) : _____

   _____ Tel. No(s) : _____
6. In the event that we require an independent medical examination :

   (a) Where is the patient now located? _____

   (b) Who should be contacted to make the necessary arrangements? _____
7. If you think that your Domestic Employee may need to be repatriated due to inability to complete his / her contract, please advise the destination of repatriation : _____

   In the event of repatriation being necessary, you should contact the Claims Department immediately.

HOSPITALISATION EXPENSES – SECTION A (CONTINUED)

8. Please list below expenses incurred (original receipts must be enclosed)

Date of treatment	Description of expenses for which reimbursement is being claimed	Currency and amount paid

HOSPITALISATION EXPENSES – SECTION B

(TO BE COMPLETED BY THE ATTENDING DOCTOR)

1. Name of patient: _____

2. Correspondence address : _____

_____ 3. Tel. No : _____

4. How long have you been the patient's Doctor? _____

5. How far back in time do your records go? _____

6. Please give name and address of the referring physician : _____

_____

7. What date were you first consulted for the injury, illness or medical condition concerned, or for any related condition? _____

8. Please give your diagnosis of injury / illness / condition : _____

_____

9. If an accident is involved, how did it happen? _____

_____

10. Please give details of the treatment given or prescribed : _____

_____

11. Please give a brief history of this or any related condition, with dates on which any previous consultations or treatment took place :

_____

_____

12. Have you any reason to believe that the same or any related medical condition has been diagnosed or treated previously by any other Doctor or hospital? YES / NO

If YES, please give details : _____

_____

Signature : _____

Date : _____

Company Chop (if applicable)

DECLARATION

I hereby declare that above particulars are true and complete to the best of my knowledge and belief and authorise the release of any medical information necessary to process this claim. Photocopy of this authorisation shall be as valid as original.

Signature of Domestic Employee _____ Date _____