Section 1 – Details of injury and 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 (The details of outpatient /hospitalization caused by accident)

Location of accident _____ Date and time of accident (DD/MM/YY, HH:MM) _____

Details of accident _____

Was the above accident reported to the police? ☐ No ☐ Yes, please provide copy of the police statement or police report

Injured part(s) ☐ Right leg ☐ Left leg ☐ Right upper limb ☐ Left upper limb ☐ Upper body ☐ Head Injury diagnosis _____

Nature of Injury ☐ Minor ☐ Moderate ☐ Severe ☐ Dead Medical fee(s) (HKD) _____

Do you need to attend follow up treatment/consultation?

☐ No ☐ Yes, please specify how long will the treatment last / follow up consultation date (DD/MM/YY) _____

Part II (The details of outpatient /hospitalization caused by sickness)

Symptom(s) before admitted to hospital/consultation: CHANGE IN BOWEL HABIT & EPIGASTRIC PAIN

Date of symptom(s) first appeared (DD/MM/YY): 01/08/17

Date of first consultation (DD/MM/YY): 19/09/17

Diagnosis: POLYPS FOUND IN COLON & STOMACH

Do you need to attend follow up treatment/consultation?

☑ No ☐ Yes, please specify how long will the treatment last / follow up consultation date (DD/MM/YY) _____

Medical fee(s) (HKD): 36,8xx

Section 2 (Applicable to hospitalization/surgery claim only)

Name of hospital / medical provider: BAPTIST HOSPITAL

Date of surgery (DD/MM/YY): 28/09/17 Date of admission (DD/MM/YY): 27/09/17 Date of discharge (DD/MM/YY): 28/09/17

	The name of doctor(s)	The address of doctor(s)
The doctor of the first consultation		
The doctor recommending admission to hospital	- ditto -	- ditto -
The doctor consulted for the same sickness/accident	- ditto -	- ditto -

During hospitalization period, did you have any home leave period?

☑ No ☐ Yes, please specify the period from (DD/MM/YY) _____ To _____

Do you need to attend follow up treatment/consultation?

☑ No ☐ Yes, please specify how long will the treatment last / follow up consultation date (DD/MM/YY) _____

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
      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.

Name of insured person (Name of father or mother of the insured under 18 years old)	Signature of insured person (Signature of father or mother of the insured under 18 years old)
HKID / Passport no.	Date of signature
	9.10.2017

Section 3 Employer-approved sick leave certificate (to be completed by claimant's employer)

This certificate is shown as proof of (name of claimant) _____

being the employee of our company (Position) _____

who sustained injury due to (reason(s)) _____ happening on (DD/MM/YY) _____.

This caused him/her to have sick leave period from (DD/MM/YY) _____ to (DD/MM/YY) _____.

I / our company confirm the monthly salary (excluding bonus, commission, overtime allowance and other allowances) is HKD _____

Name of employer _____ Position of employer _____

Address of employer _____

Employer's signature and date

_____

Company chop

_____

Claimant's signature and date

_____

(I hereby declare that the above information is true to my fullest understanding)

Section 4 Attending Physician Statement (This section should be completed by the insured person's attending doctor during patient's hospitalization at the insured person's cost)

第四部份 主診醫生報告 (此欄須由受保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 甲部 - 醫療資料

Full name of patient 病人姓名 _____ HKID no. 香港身份證號碼 /Passport no. 護照號碼: _____ Age 年齡 J-1 Sex 性別 F

(a) Treatment period (DD/MM/YY) 診治日期 (日/月/年) From 由 27/8/2017 To 至 28/8/2017

(b) Diagnosis of conditions 病況診斷 ① colonic polyp ② gastric polyp

(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：

① colonoscopy + polypectomy ② gastroscopy + polypectomy

(d) Prior to this consultation, did patient first consult you for the related signs and symptoms? If so, 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？

☐ No 否 ☑ Yes 是, the first consultation was since (DD/MM/YY) 第一次求診日期自 (日/月/年) 18/8/2017

(e) 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？

① change in bowel habit ② epigastric pain

(f) Were there any external visible signs of bodily injury were 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？

No

(g) 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？

No

(h) According to the patient, for how long had such symptom(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？

_____ year(s) 年 1 month(s) 月 _____ day(s) 日

(i) Was the patient referred to you by another doctor for further management? 病人是否由另一位醫生轉介予您在進一步治療？

☑ No 否 ☐ Yes 是, the name of referral doctor is 該醫生姓名是 _____

(j) Was there any hospitalization for the patient? 病人有否住院？

☐ No 否, the patient does not require to stay at hospital for treatment 病人不需要住院接受治療

☑ Yes 有, Hospitalization period from (DD/MM/YY) 住院日期(日/月/年) 由 27/8/2017 to 至 (DD/MM/YY) (日/月/年) 28/8/2017

(k) Did the patient have any home leave period during hospitalization period? 病人在住院期間有否請假外出？

☑ No 否 ☐ Yes 有, from (DD/MM/YY) 由 (日/月/年) _____ to 至 (DD/MM/YY) (日/月/年) _____

(l) 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 ☑)?

No

☐ 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 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 _____

Signature of attending doctor 主診醫生簽署 _____

Signature Date (DD/MM/YY) 簽署日期 (日/月/年) 28/8/2017

Chop of hospital / clinic 醫院或診所蓋印

Address of hospital / clinic 醫院或診所地址

MBBS (UK) FRCS RCPS (Glasg) FCSHK FHKAM (Surgery)

Tel: _____ Fax: _____

香港浸信會醫院
Hong Kong Baptist Hospital
九龍滑打老道二百二十二號
222 Waterloo Road, Kowloon, HK
Tel: 2339 8888

IN: 1237992

EN: 11715211

正本
ORIGINAL

正式收據
Official Receipt

CLM-Original

收據號碼
Receipt No.: RCIP-00820724

醫院/入院編號
Hospital / Episode No.: 1237992 / 11715211

日期
Date: 28/09/2017 15:02

茲收到
Received from

繳交港幣
the sum of Hong Kong Dollars 36,822.00

(THIRTY SIX THOUSAND EIGHT HUNDRED AND TWENTY TWO ONLY)

支付
in payment of BILL DIIP-00476764

付款方式
Payment Method

VISA / MASTER	DBS Bank (Hong Kong) Limited	36,822.00	01/08/2021

注意 Note:

1 支票付款須待兌現後作實。
This Receipt is not valid unless cheque, if used in payment, is cleared.

2. 按金將在出院結帳單中自動扣除。出院請連同收費單。按金收據，前往繳費處繳費。如有餘款，退款條件如下：
If this is a Receipt for payment of deposit, please present this Receipt to the Cashier for deduction of this amount from the discharge invoice upon settlement on the date of discharge. Balance of deposit, if any, will be refunded subject to the following conditions:
   a. 支票繳費者須待四個工作天才退回。
   Allow four days for clearance of any prior payment by cheque.
   b. 以信用咭 / 銀聯咭繳付按金者，退款只會退回該付款咭之賬戶。
   If deposit was paid by Credit Card / China Union Pay Card, refund will only be reimbursed to the same card account.
   c. 本港居民/ 外籍人士啟消產科預約者，按金一概不予退回。
   For Hong Kong resident/ foreigner, the maternity booking deposit will be forfeited on cancellation of booking.
   d. 中國內地人士產科預約按金為分娩服務最低收費，出院如有餘款一概不予退回。
   For Mainland maternity client, maternity booking deposit is the minimum charge for delivery service. Balance of the maternity deposit, if any, will not be refunded.