QBE HONGKONG & SHANGHAI INSURANCE LIMITED
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FOR AGENT USE:

Agent name:
Tel no.:
Email:

DOMESTIC HELPER INSURANCE CLAIM FORM 家傭保險索償申請表

A. NOTES 注意事項

1. All questions must be answered. If not applicable, write "n/a".
   所有問題必須作答。如不適用者，請填上「不適用」。
2. The issue of this claim form is not an admission of liability by QBE Hongkong & Shanghai Insurance Ltd.
   發出此索償申請表並不代表昆士蘭聯保保險有限公司承認任何責任。
3. If there is insufficient space or further comment on any area is considered necessary, please use additional pages.
   若填報資料的位置不足，請填寫於附加紙上。
4. Please attach original medical advice, admission and discharge slips, hospital bills, doctor receipts and all other supporting documents.
   請遞交正本醫生建議書、入院及出院證明、醫院發票、醫生收據及其他一切有關文件。
5. Original receipt will not be returned. A copy of the original receipt will be returned upon request.
   正本收據將不獲發還，如需取得收據的副本，請與本公司聯絡。

B. DETAILS OF THE INSURED 保戶資料

Policy no. 保單號碼：	Name of the insured 保戶姓名：	
Correspondence address 通訊地址：		
Tel. no. 電話號碼：	Mobile tel. no. 手提電話號碼：	Email 電郵：

C. DETAILS OF THE HELPER 家傭資料

Name of the helper 家傭姓名：	
Are there any other policies of insurance covering the helper? 家傭是否擁有其他保險？	☐ NO 否 ☐ YES 是 (Please give details 請詳述)
Name of insurance company 保險公司名稱：	
Policy no. 保單號碼：	Amount recoverable 可領回金額：

D. THE ACCIDENT / SICKNESS 意外 / 疾病

Description of accident / sickness 意外或疾病詳情：	Name of hospital 醫院名稱：	
Date of accident / sickness 意外或疾病日期： / /	Date of admission 入院日期： / /	Date of discharge 出院日期： / /
Has the helper ever suffered from this or similar condition or a recurrence of a previous injury or illness? 家傭曾否患上類似之疾病，或舊傷 / 病復發？	☐ NO 否 ☐ YES 是 (Please give details 請詳述)	
Disease / Injury 疾病 / 損傷：		Date 日期： / /
Attending doctor's name and address 診治醫生姓名及地址：		

E. STATEMENT OF CLAIM 索償單

Type of Benefits 類別	Per Day (HK$) 每日（港元）	Total (HK$) 總額（港元）	Office Use Only 由保險公司填寫
Clinical expenses 門診費用			
Bonesetter / physiotherapist expenses (first treatment is received from registered doctor) 跌打 / 物理治療費用（首次治療由註冊西醫提供）			
Room, board & miscellaneous hospital charges 房租及醫院雜費			
Surgical fee 手術費			
Anaesthetist's fee 麻醉師費			
Operating theatre 手術室費			
Others (please specify) 其他（請註明）			

F. DECLARATION 聲明

I declare that all particulars and answers given above are true and complete to the best of my knowledge and belief.
本人聲明根據本人所知及深信表格填報之一切資料均屬確實完整。

Signature of the insured
保戶簽名：

Signature of helper
家傭簽名：

(Please sign with company chop, if incorporated 如屬法團請蓋章)

Date
日期： / /

G. AUTHORISATION 授權

I hereby agree and authorise any Doctor, Hospital, Clinic, Insurance Company or organisation who has been or may hereafter be consulted to disclose to QBE Hongkong & Shanghai Insurance Ltd. any and all information concerning my medical history for the purpose of assessment of an insurance claim, such authorisation to survive me in so far as legally possible. A photocopy of this authorisation shall be as valid as the orginal.
本人現授權任何醫生、醫院、診所、保險公司或機構提供有關本人所有疾病、受傷、病歷等資料，醫療或醫院記錄予昆士蘭聯保保險有限公司，以便評估本人的保險索償。如法律上可行，此授權書在本人身故後仍然生效。此授權書的影印本與正本同樣有效。

Signature of helper
家傭簽名：

Date
日期： / /

TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT'S OWN EXPENSES 由主診醫生填寫，其費用由索償者支付。

H. CERTIFICATE OF HOSPITALIZATION (please complete in block letters)

Name of patient:

Date of admission: / /	Date of discharge: / /	Diagnosis: / /

Name of hospital:

The first date and subsequent dates of your treatment of this illness

The last date of your treatment for this illness

According to the patient, how long had he / she been experiencing these symptoms before the first date of your treatment for the above illness?

Was the patient referred to you by another doctor? ☐ YES ☐ NO
If "Yes", please give name(s) and address(es) of the doctor(s).

Are there any of the conditions treated due to pregnancy? ☐ YES ☐ NO
If "Yes", please advise the commencement date of pregnancy

Details of Treatment / Operation

Date performed: / /	Name of surgeon:

To the best of your knowledge, has the patient previously been treated or hospitalized for this or any other disorder? ☐ YES ☐ NO
If "Yes", please give details.

Date	Disease / Disorder	Details of treatment / hospitalization	Doctor's / hospital's name

Are conditions due to or associated with the following:	YES	NO
i. drug addition or alcoholism?	☐	☐
ii. AIDS, venereal disease, sexually transmitted disease?	☐	☐
iii. infertility or sterilization?	☐	☐
iv. cosmetic or plastic surgery?	☐	☐
v. mental or nervous disorder?	☐	☐
vi. congenital deformities or anomalies?	☐	☐
vii. suicide, insanity or self-infliction?	☐	☐
viii. heart disease?	☐	☐
ix. cancer?	☐	☐

Name of attending physician

Signature of attending physician

Qualifications

Date: / /