Zurich Assurance Ltd
Zurich Life Insurance (Hong Kong) Limited
蘇黎世人壽
蘇黎世人壽保險（香港）有限公司

Accident insurance claim form – Attending physician statement
意外索償申請表 – 醫療報告

Private and confidential 私人及保密文件

No claims can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expense of the life insured.
此表格必須由合資格及註冊西醫填妥，所需費用由受保人自負，否則索償不會獲得受理。

Name of life insured 受保人姓名

HKID card no./Passport no.
香港身份證號碼／護照號碼

Age
年齡

Date of accident
意外日期 Day日 Month月 Year年

1. a. What is the exact diagnosis?

   b. Is there any external and visible evidence of injury at your **1st consultation** ◯ Yes ◯ No

   c. If "Yes", please specify type of injury

   d. Specify injured body part

   e. Describe the cause and extent of injury

2. Present condition of injury

3. a. Is there any treatment provided? ◯ Yes ◯ No

   b. If "Yes", please give details (such as suturing, physiotherapy, type of dressing, etc.)

   Date (DD/MM/YYYY)

   Time (am/pm) Treatment

4. a. Any other physicians who treated the life insured for the same injury? ◯ Yes ◯ No ◯ Unknown

   b. If "Yes", please give: Name(s) Address(s) Approximate date(s)

5. Did injury require:
   a. Hospitalization? ◯ Yes From ☐☐☐☐☐☐☐☐ to ☐☐☐☐☐☐☐☐ ◯ No
   b. X-ray? ◯ Yes ◯ No
   c. Special diagnostic procedures? ◯ Yes ◯ No
   d. Surgery? ◯ Yes ◯ No

   If any of the above is "Yes", please provide details of the investigation result and/or the name of hospital admitted.

6. Was the injury induced from or effected by any of the following which may contribute to the accident and/or lengthen the period of disability?
   a. Physical defects/congenital anomaly ◯ Yes ◯ No
   b. Unfavourable past medical history ◯ Yes ◯ No
   c. Degenerative changes ◯ Yes ◯ No
   d. Alcohol or drugs ◯ Yes ◯ No

   If any of the above is "Yes", please provide details of the investigation result.

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7. a. Was healing complicated? ◯ Yes ◯ No
   b. If so, specify resason(s) and any special treatment given

8. Bearing in mind the life insured's occupation as stated in item(1) of the employment particulars section, do you opine that the injuries would have prevented him/her from working?
   at your 1st consultation ◯ Yes ◯ No
   at your latest consultation ◯ Yes ◯ No
9. If absence from work of more than 7 days was necessary, please describe in detail the reasons why you opine the life insured could not return to work earlier.

I hereby certify that I have personally examined and treated the life insured for the above injury and that the facts as given above is my opinion of his/her condition.

The personal information collected from the physician in this form will be used by the Company for administration, verification and record purposes in respect of the subject matter of this form. The Company will not be able to process the request in the form, if the physician fails to provide the personal information as requested. For personal data access or change requests, please write to our Personal Data Privacy Officer, 26/F, One Island East, 18 Westlands Road, Island East, Hong Kong.

Name of physician (with stamp)	Signed
Qualification	Date signed Day ☐☐ Month ☐☐ Year ☐☐☐☐
Address	Contact no.

PLEASE DO NOT SIGN ON BLANK FORM.

Zurich Assurance Ltd (a company incorporated in England and Wales with limited liability)
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