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

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Medical/Hospital cash claim form – Attending physician statement
醫療／住院現金索償申請表– 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 patient _____ Identity card no _____

Date of admission (DD/MM/YYYY) _____ Date of discharge (DD/MM/YYYY) _____

Name of hospital _____

1. Clinical history of this patient

a. Date on which the patient first consulted you relating to this medical condition(s)/injury _____

b. If caused by injury, please describe the cause and extent of injury _____

c. Symptoms and complaints for this hospitalization/treatment _____

d. Underlying cause(s) of the hospitalization _____

e. According to the medical history given by the patient, how long had he/she been experiencing these symptoms before the first consultation and the date of the first consultation? _____

f. How long, in your opinion, has the patient been suffering from this illness/injury? _____

2. Hospitalization history of this patient

a. Final diagnosis _____

b. Date of operation _____

Operational procedure(s) performed _____

c. If the patient has consulted other doctor during this hospitalization, please provide the following:

Consulted doctor's name _____ Reason _____

What treatment(s) had the doctor performed _____

d. Please give brief discharge summary (including onset and duration of signs and symptoms/disease, etiology, types and results of major examination, treatment, complications and follow up plan _____

e. Has the patient taken any home leave during this hospitalization? If "Yes", please state the date, time and reason

_____

f. Was the patient confined in an Intensive Care Unit during this hospitalization or did he/she suffer from 3rd or 4th degree of burning? If "Yes", please

indicate the period/numbers of days stayed _____

g. Please provide reason(s) for hospitalization if this type of cases cannot be managed on day care _____

_____

3. Professional comment

a. In your opinion, was the hospitalized illness a recurrent episode or a chronic illness or related to a previous complaint/diagnosis? If "Yes", please provide date of the first episode and details _____

b. Has the patient ever had the same symptoms before/has the patient been treated or hospitalized for these same symptoms before?

_____

If "Yes", please state, to the best of your knowledge, on a separate sheet when and describe details (including a brief summary describing the onset date, duration of signs and symptoms, disease, etiology, types and results of major examination, treatments, complications and follow up plan)

_____

c. Was the condition due to or associated with the following (please circle the right answers)?
Accidental bodily injury, abuse of drugs or alcohol, AIDS/HIV related illness, venereal disease or sexually transmitted disease, pregnancy, childbirth, miscarriage, abortion, infertility or sterilization, correction of vision, refractive error, cosmetic or plastic surgery, mental or nervous disorder, congenital condition heredity condition, developmental condition, suicide, attempted suicide, ionizing radiation, self-inflicted injury, participation in any sports, general check up or vaccination or none of the above.

d. If you are referred by another doctor, please provide the referring doctor's full name and address

_____

_____

I hereby certify that all information given above is accurate and true to the best of my knowledge

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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