



**閩 信 保 險 有 限 公 司**  
**MIN XIN INSURANCE COMPANY LIMITED**  
 (A WHOLLY OWNED SUBSIDIARY OF MIN XIN HOLDINGS LIMITED)  
 (INCORPORATED IN HONG KONG)

**香港總行** : 香港中環紅棉路8號東昌大廈17樓  
 Head Office 17/F, Fairmont House, 8 Cotton Tree Drive, Central, Hong Kong.  
 電話 Tel: (852) 2521 5671 傳真 Fax: (852) 2526 7364, 2179 5078  
 電子郵箱 E-mail: mxic@mxic.com.hk

**澳門分行** : 澳門羅保博士街1-3號國際銀行大廈27樓  
 Macau Office 27/F, Luso International Bank Bldg., 1-3 Rua Dr. Pedro Jose Lobo, Macau.  
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**福州代表處** : 福建省福州市古田路121號華福大廈25層C2  
 Fuzhou Representative Office C2, 25/F, Hua Fu Bldg., 121 Gu Tian Road, Fuzhou, Fujian Province, P.R.C.  
 電話 Tel: (86-591) 8333 3611 傳真 Fax: (86-591) 8333 3610

## 海外家傭保險索償表格

### Overseas Helper Insurance Claim Form

N.B. Please attach original medical advice, admission and discharge slips, hospital bills, doctor receipts and all other supporting documents.  
 注意 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。

| THE INSURED 保戶              |                    |               |                   |
|-----------------------------|--------------------|---------------|-------------------|
| Name of Insured 保戶姓名        | Policy Number 保單號碼 | Tel. No. 電話號碼 | Mobile No. 手提電話號碼 |
| Correspondence Address 通訊地址 |                    |               |                   |

| THE HELPER 家傭  |                 |                          |
|--|-----------------|--------------------------|
| Name of 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?<br>No 否 <input type="checkbox"/> Yes 是 <input type="checkbox"/> |                 |                          |
| If Yes, please give details. 如是，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 |
|  |                 |                          |

| THE ACCIDENT / SICKNESS 意外 / 疾病  |                                     |   |
|--|-------------------------------------|---|
| Description of Accident / Sickness 意外或疾病詳情   | Date of Accident / Sickness 意外或疾病日期 |   |
| Name of Hospital 醫院名稱  | 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?<br>家傭曾否患上類似之疾病，或舊傷 / 病復發?<br>No 否 <input type="checkbox"/> Yes 是 <input type="checkbox"/> |                                     |   |
| If Yes, please give details. 如是，請詳述。   |                                     |   |
| Disease / Injury 疾病 / 損傷   | 日期                                  | Attending Doctor's Name and Address 診治醫生姓名及地址 |
|  |                                     |   |

| STATEMENT OF CLAIM 索償單  |                      |                    | OFFICE USE ONLY<br>由保險公司填寫 |
|---|----------------------|--------------------|----------------------------|
| TYPE OF BENEFITS<br>類別  | PER DAY (HK\$)<br>每日 | TOTAL (HK\$)<br>總額 |                            |
| Clinical Expenses<br>費用   |                      |                    |                            |
| Bonesetter/Physiotherapist Expenses<br>跌打/物理治療費用<br>(First treatment is received from registered doctor<br>首次治療由註冊西醫提供) |                      |                    |                            |
| Room, Board & Miscellaneous Hospital Charges<br>房租及醫院雜費   |                      |                    |                            |
| Surgical Fee<br>手術費   |                      |                    |                            |
| Anaesthetist's Fee<br>麻醉師費  |                      |                    |                            |
| Operating Theatre<br>手術室費   |                      |                    |                            |
| Others 其他 (please specify 請註明)  |                      |                    |                            |
|   |                      |                    |                            |

### IMPORTANT 重要事項

I/We hereby authorize any hospital physician and any other person/s who has attended or examined me/us, to furnish to the Company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorization shall be considered as effective and valid as the original.

I/We the Insured do solemnly and sincerely declare that I/We have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or sought unjustly to benefit thereby by any fraud or wilful misrepresentation and that the information shown on this form is true and I/We have not concealed any information relating to this claim.

本人/吾等謹此授權任何曾診治本人/吾等之醫院、醫生或其他有關人士，向閩信保險有限公司或其授權代表，提供所有關於本人/吾等之患病、受傷資料、健康紀錄、診斷報告、藥方、醫院及醫生報告等。有關授權書之影印本其有效性與正本相同。

本人/吾等謹以摯誠，據實聲明，本人/吾等已遵守保單內所有載之條文及保證(如適用)及沒有蓄意導致上述之損失，毀壞或以欺詐，故意歪曲事實而索取利益，本人/吾等於此表格內所填報的資料均為真實，及並無隱藏任何與是次賠償有關的資料。

### PERSONAL INFORMATION COLLECTION STATEMENT

#### 收集個人資料聲明

The information you provide to us is collected to enable us to carry on insurance business and may be used for the purpose of:

- any insurance or financial related product or service or any alterations, variations, cancellation or renewal of such product or service;
- any claim or investigation or analysis of such claim; and
- exercising any right of subrogation

may be transferred to:

- any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
- any association, federation or similar organization of insurance companies "Federation" that exists or is formed from time to time for any of the above or related purposes or to enable the "Federation" to carry out its regulatory functions or such other functions that may be assigned to the "Federation" from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the "Federation", and
- any members of the "Federation" by the "Federation" for any of the above or related purposes.

Moreover, MIN XIN INSURANCE COMPANY LTD. is hereby authorized to obtain access to and/or to verify any your data with the information collected by the "Federation" from the insurance industry.

You have the right to obtain access to and to request correction of any personal information concerning yourself held by MIN XIN INSURANCE COMPANY LTD. Requests for such access can be made to The General Administration Officer of MIN XIN INSURANCE COMPANY LTD. on Telephone No. 2521 5671 or Fax No. 2526 7364.

閣下提供的資料，為本公司提供保險業務所需，並可能使用於下列目的：

- 任何與保險或財務有關的產品或服務，或該等產品或服務的任何更改、變更、取消或續期；
- 任何索償或該等索償的調查或分析；
- 行使任何代位權；及

可能移轉予：

- 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；
- 現存或不時成立的任何保險公司協會或聯會或類同組織「聯會」，以達到任何上述或有關目的，或以便「聯會」執行其監管職能，或其他基於保險業或任何「聯會」會員的益而不時在合理要求下賦予「聯會」的職能；及
- 或透過「聯會」移轉予任何「聯會」的會員，以達到任何上述或有關目的。

此外，在此授權閩信保險有限公司由「聯會」從保險業內收集的資料中查閱及/或核對閣下任何資料。

閣下有權查閱及要求更正由閩信保險有限公司持有有關閣下的個人資料，如有需要，可向閩信保險有限公司行政事務主任提出。

(電話: 2521 5671 或傳真: 2526 7364)

### AUTHORIZATION 授權

I hereby agree and authorize any Doctor, Hospital, Clinic, Insurance Company or organization who has been or may hereafter be consulted to disclose to MIN XIN INSURANCE COMPANY LTD. Any and all information concerning my medical history for the purpose of assessment of an insurance claim, such as authorization to survive me in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

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，醫療或醫院紀錄予閩信保險有限公司，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有效。此授權書的影印本與正本同樣有效。

Signature of Insured 保戶簽名

Signature of Helper 家傭簽名

Date 日期

### AUTHORIZATION 授權

I hereby agree and authorize any Doctor, Hospital, Clinic, Insurance Company or organization who has been or may hereafter be consulted to disclose to MIN XIN INSURANCE COMPANY LTD. Any and all information concerning my medical history for the purpose of assessment of an insurance claim, such as authorization to survive me in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

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Signature of Insured 保戶簽名

Signature of Helper 家傭簽名

Date 日期

CERTIFICATE OF HOSPITALIZATION

(please complete in block letters)

|  |  |  |                          |
|--|--|--|--------------------------|
| Name of Patient:   |  |  |                          |
| Date of Admission:   | Date of Discharge:                               |  |                          |
| Name of Hospital:  | Diagnosis:                                       |  |                          |
| The first date and subsequent dates of your treatment for this illness   | The last date of your treatment for this illness |  |                          |
| Was the patient referred to you by another doctor?<br><input type="checkbox"/> No <input type="checkbox"/> Yes      If Yes, please give name(s) and address(es) of the doctor(s).<br>_____                           |  |  |                          |
| Are any of the conditions treated due to pregnancy?<br><input type="checkbox"/> No <input type="checkbox"/> Yes      If Yes, please advise the commencement date of pregnancy _____                                  |  |  |                          |
| Details of Treatment/Operation.<br>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?<br><input type="checkbox"/> No <input type="checkbox"/> Yes      If Yes, please give details. |  |  |                          |
|  |  |  |                          |
| Date   | Disease / Disorder                               | Details of Treatment / Hospitalization           | Doctor's / Hospital Name |
| _____  | _____  | _____  | _____                    |
| _____  | _____  | _____  | _____                    |
| _____  | _____  | _____  | _____                    |
| Are conditions due to or associated with the following:  |  | No   | Yes                      |
| i. Drug addiction or alcoholism?   |  | <input type="checkbox"/>                         | <input type="checkbox"/> |
| ii. AIDS, venereal disease, sexually transmitted disease?  |  | <input type="checkbox"/>                         | <input type="checkbox"/> |
| iii. Infertility or sterilization?   |  | <input type="checkbox"/>                         | <input type="checkbox"/> |
| iv. Cosmetic or plastic surgery  |  | <input type="checkbox"/>                         | <input type="checkbox"/> |
| v. Mental or nervous disorder  |  | <input type="checkbox"/>                         | <input type="checkbox"/> |
| vi. Congenital deformities or anomalies?   |  | <input type="checkbox"/>                         | <input type="checkbox"/> |
| vii. Suicide, insanity or self-infliction?   |  | <input type="checkbox"/>                         | <input type="checkbox"/> |
| viii. Heart disease?   |  | <input type="checkbox"/>                         | <input type="checkbox"/> |
| ix. Cancer?  |  | <input type="checkbox"/>                         | <input type="checkbox"/> |
| _____<br>Name of Attending Physician   |  | _____<br>Chop & Signature of Attending Physician |                          |
| _____<br>Qualifications  |  | _____<br>Date                                    |                          |