Avo WFH Protection
Avo 在家工作保障

Claim Form 索償申請表

Please complete this Claim Form in Block Letters and provide all supporting documentation to the Company within 30 days after the incident discovered to avoid delay in claim process. The Company is entitled to request for further information, documents or other specific claim form to be completed, and assign a loss adjuster for investigation. Completion and submission of this Claim Form shall not be construed as admission of liability on the part of the Company.

請以正楷填妥並簽署此索償申請表，連同有關證明文件於事件發現後30天內交回本公司，以免延誤索償進程。本公司有權要求索償人 / 受保人提供更多資料、文件或填寫其他專用索償表格，以及委派公證人進行調查。填寫及遞交此索償申請表並不表示本公司承擔賠償責任。

Policy Holder Details 保單持有人資料

Policy No.: 保單號碼：		Name of Policy Holder: 保單持有人姓名：
HKID No.: 香港身份證號碼：	Mobile Phone Number: 流動電話號碼：	Email Address: 電郵地址：
Correspondence Address: 通訊地址：		

Claimant Details 索償人資料 (Please fill in if different from Policy Holder 請填寫如非保單持有人)

Name of Claimant (if different from Policy Holder): 索償人姓名 (如非保單持有人):		Relationship with Policy Holder: 與保單持有人關係：
HKID No.: 香港身份證號碼：	Mobile Phone Number: 流動電話號碼：	Email Address: 電郵地址：
Correspondence Address: 通訊地址：		

Claims Payment Method (The request for payment method is not an admission of our liability) 賠償支付方式 (本公司特此聲明此項要求並不代表本公司承認賠償責任)

☐ Cheque 支票 ☐ Bank Autopay 銀行自動轉賬 (Please fill in the bank details as below 請填寫以下銀行資料)

Attention: The bank account holder must be the Policy Holder if chose Bank Autopay
請注意：如選擇銀行自動轉賬，必須為保單持有人持有的銀行帳戶

Account Holder's Name: 戶口持有人姓名：		
Bank Name: 銀行名稱：	Bank Code: 銀行編號：	Branch Code: 分行編號：
Bank A/C No.: 銀行帳戶號碼：		

General Information 一般事項

Is there any other insurance covering the loss / damage ? 閣下是次索償申請之損失是否同時受其他保險保障 ?
If "Yes", please provide the following information 如是，請提供以下資料:- ☐ Yes 是 ☐ No 否

(a)	Name of the insurance company: 保險公司名稱：
(b)	Relevant policy number and policy type: 有關之保險號碼及保險類別：
(c)	Whether the claim will be submitted to them? 會否向該公司提出索償 ? ☐ Yes 是 ☐ No 否
(d)	Claim Amount / Settlement Amount (HKD): 索償金額 / 賠償金額 (港幣) ：

Part 1 is to be completed by the claimant/ insured person, please fill in the relevant claim item column

第 1 部分須由索償人 / 受保人填寫，請在相關的索償項目欄內填上資料

Ergonomic Injury / Mental Health Therapy / Accidental Hospitalization Medical Expenses / Accident Death and Permanent Disablement / Food Poisoning 人體工學受傷 / 精神健康治療 / 意外住院醫療費用 / 意外身故及永久傷殘 / 食物中毒

Please ☑ the applicable option
請在索償項目空格內填上☑號

☐ Ergonomic Injury 人體工學受傷
☐ Mental Health Therapy 精神健康治療
☐ Accidental Hospitalization Medical Expenses 意外住院醫療費用
☐ Accident Death and Permanent Disablement 意外身故及永久傷殘
☐ Food Poisoning 食物中毒

Date of sickness / accident (DD/MM/YYYY, hh:mm):
患病 / 意外日期及時間（日 / 月 / 年，時：分）:

Condition (please ☑ the box)
狀況（請於空格內填上☑號）

☐ Sickness 患病 ☐ Injury 受傷 ☐ Death 死亡

Place of sickness / injury:
患病 / 受傷地點：

Diagnosis of sickness / Nature of injury:
所患為何種疾病 / 受傷性質：

Please describe how you got sick / injured and when does the symptom first appear:
請描述患病 / 受傷經過並提供何時首次出現病徵：

Name and address of Registered Medical Practitioner:
診治的註冊醫生姓名及地址：

If hospitalization is required, please state 如需留院治療，請提供 (DD/MM/YYYY 日 / 月 / 年):-

Date of admission 入院日期： Date of discharge 出院日期：

Is further follow-up treatment required?
仍需要覆診？

☐ Yes 需要 ☐ No 不需要

Have you ever had such sickness / injury before? If yes, please state when (DD/MM/YYYY):
以前有否患過該種疾病 / 受過同樣傷患？如有，請提供患過該種疾病 / 傷患的日期（日 / 月 / 年）:

Is this accident reported to police? If yes, please provide
是否就意外向警方報案？如有，請提供

Police Report Number:
警方報案號碼：

Name of Police Station:
報案警署名稱：

Home Office Equipment 辦公室設備

Date & time of loss / damage (DD/MM/YYYY, hh:mm):
遺失 / 損毀日期及時間（日 / 月 / 年，時：分）:

Place of loss / damage:
遺失 / 損毀地點：

Please describe how the loss / damage occurred:
請詳述財物遺失 / 損毀的經過：

Date & time of loss reported (DD/MM/YYYY, hh:mm):
向警方報告遺失日期及時間（日 / 月 / 年，時：分）:

Name of Police Station:
報案警署名稱：

Reference no. of the loss reported to the police:
警方檔案編號：

Please give details if you have lodged complaint against any other parties concerning the damage / loss:
如有就遺失 / 損毀一事向任何有關人士作出投訴，請提供詳情：

Loss / Damaged Items 遺失 / 損毀之物件	Conditions after the loss / damage 該物件遺失 / 損毀時之狀況	Date of Purchase (DD/MM/YYYY) 購買日期（日 / 月 / 年）	Original Purchase Price (please state the currency) 購買價值（請註明貨幣）	Repairing / Replacement Cost (please state the currency) 維修 / 重置費用（請註明貨幣）

Total amount claimed (please state the currency):
總索償額（請註明貨幣）:

Authorization and Declaration 授權及聲明

I/We hereby authorize any person, party, police and/or authority that has any records or is holding any information of the policy holder or me /us to disclose to Avo Insurance Company Limited ("the Company") or its authorized representative, any and all information with respect to the policy holder's or my/our loss, police statement made and the like for the purpose of assessing my/our claim request(s). A photocopy of this authorization shall have the same effect as the original.

I/We hereby declare that all the above information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief.

I/We have not withheld any material information and acknowledge that failure to supply true and accurate answers to this request or inform the Company of all material information may render the Company unable to accept or process this request and all rights to recover under the Policy shall be forfeited. I/We understand that the issuance or completion of this application does not constitute admission of liability or guarantee payment of the claim on behalf of the Company.

I/We confirm having read and understand and agreed to all the Declarations, terms and conditions and the Company's Personal Information Collection Statement as accompanied with this form.

本人 / 我們謹此授權任何持有受保人或本人 / 我們之任何記錄或資料的人士、有關人等、警方、及/或有關當局，向安我保險有限公司 (「貴公司」) 或其授權代表提供任何或所有有關受保人或本人 / 我們之損失、口供或任何相關資料作評估賠償申請之用途。此授權書之正本及副本皆具同等效力。

本人 / 我們謹此聲明，上述所有問題的答案包括所有資料及細節均是準確無誤，真實及為事實之全部，並且是盡本人 / 我們所知及所信而作答的。

本人 / 我們並沒有隱瞞任何重要資料及確認如未能提供真實及準確無誤之資料或通知貴公司任何有關此索償申請之重要資料，將可能導致貴公司不能接受或處理此索償申請及喪失所有追討保單權益之權利。本人 / 我們明白此索償申請表之發出及填妥並不代表貴公司確認責任或保證賠償。

本人 / 我們確認已閱讀及明白並同意所有聲明、條款及細則及隨本表格附上有關貴公司的收集個人資料聲明。

Signature of Policy Holder 保單持有人簽署	Signature of Claimant 索償人簽署
Signed Date (dd/mm/yyyy) 簽署日期 (日 / 月 / 年)	Signed Date (dd/mm/yyyy) 簽署日期 (日 / 月 / 年)

Personal Information Collection Statement 收集個人資料聲明

It is the policy of Avo Insurance Co., Ltd. ("Avo Insurance") to safeguard and keep confidential the personal data of all our customers. Avo Insurance shall at all times observe and ensure our staff strictly adhere to all the requirements under the Personal Data (Privacy) Ordinance ("the Ordinance").

1. Personal Data collected and/or held by Avo Insurance
   Personal data such as first name, last name, HKID Card, date of birth, email address, telephone number, policy number, medical and health records, and question or comment will be collected by us when you make enquires or submit any forms for products or services provided by Avo Insurance.
2. Importance of Personal Data Collection
   From time to time, you will be requested to provide your personal data to Avo Insurance. Provision of personal data to Avo Insurance by you is voluntary. However, Avo Insurance may not be able to provide or continue to provide products and services to you if you fail to provide your personal data as requested by us.
3. Purposes of Personal Data Collection and Usage
   Your personal data held by Avo Insurance may be used for the following purposes:-
   a. Administration of insurance or reinsurance related business, which include underwriting, processing and evaluation of applications, identity and credit checking, suitability checking, policy servicing, claims processing, investigation, account/debt collection, litigation, communications, preparing statistics, data analysis and research, internal and external audit, maintaining quality services, sales and marketing;
   b. Avo Insurance will collect, use and disclose my personal information (including claims history) for the purposes necessary to process my application, investigate and settle claims and detect and prevent fraud (whether or not relating to the policy issued in respect of this application);
   c. Make disclosure to any applicable regulators, governmental bodies or industry recognized bodies as required by any law, rule, regulation, code of practice or guideline, binding on Avo Insurance or our affiliates including without limitation the laws and regulatory requirements of Hong Kong SAR.
4. Personal Data Confidentiality
   The personal data you provide to Avo Insurance will be kept confidential, except that it may be shared with following parties:-
   a. Avo Insurance will transfer personal information to the following persons who may collect and use this information only as reasonably necessary to carry out the purposes described above: insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organisations that consolidate claims and underwriting information for the insurance industry; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information;
   b. any subsidiary, holding company, associated company or affiliates of Avo Insurance for any of the purposes set out in section 3a and b;
   c. Any agent, contractor or third party service provider, including but not limited to providers of risk intelligence, loss adjustors, private investigators, letter shopping service providers and debt collectors who provides administrative, telecommunications, computer, internet, payment or other services to Avo Insurance for any of the purposes set out in section 3a;
   d. Any actual or proposed reinsurers of Avo Insurance for any of the purposes set out in section 3a;
   e. Any co-branding partners and our business partners for any of the purposes set out in section 3a and b; and
   f. Any person to whom Avo Insurance is under an obligation to make disclosure under the requirement of any law or regulation binding on or applicable to Avo Insurance or any of our group companies.
5. Personal Data Access / Correction Request
   a. You have the right to check whether Avo Insurance holds personal data about you and of access to and correction of your personal data.
   b. Avo Insurance has the right to charge a reasonable fee for the processing of any personal data access request.
   c. Requests shall be made in writing to our Personal Data Protection Officer, Avo Insurance Company Limited, 5/F, 160 Des Voeux Road West, Sai Ying Pun, Hong Kong SAR.
6. We reserve the right to change this Statement.

維護和保密所有客戶的個人資料是安我保險有限公司 (「本公司」) 的政策。本公司會一直遵守和確保員工嚴格遵守《個人資料 (私隱) 條例》(「條例」) 的所有規定。

1. 本公司所收集及 / 或持有的個人資料
   在閣下查詢或提交由本公司提供的產品或服務的表格時，本公司將會收集個人資料如姓名、身份證、出生日期、電郵地址、電話號碼、保單號碼、醫療及健康紀錄、以及問題或意見。
2. 個人資料收集的重要性
   本公司會不時地要求提供閣下的個人資料。向本公司提供閣下的個人資料是自願的。若閣下沒有按照本公司的要求提供該等資料，可能會令本公司無法向閣下提供或繼續提供保險產品及服務。
3. 個人資料收集和使用的目的
   閣下的個人資料可能會用於以下目的:-
   a. 保險管理或再保險業務有關的用途，其中包括承保、處理和評估申請、身份和信用檢查、適用性檢查、保單服務、理賠處理、調查、賬戶 / 債務追收、訴訟、通訊、編制統計、數據分析和研究、內部 / 外界審計、保持優質的服務、銷售和營銷；
   b. 安我保險有限公司將收集、使用和披露我的個人資料 (包括以往申索紀錄)，以用作處理我的申請、調查和解決申索、以及偵測和防止欺詐行為 (無論是否與就此申請而發出的保單有關) 所需的目的。
   c. 在對本公司或其附屬機構具有約束力的任何法律、法規、規例、實務守則或指引的要求下(包括但不限於香港法例及監管的要求)，向任何適用的監管機構、政府機構或相關行業的認可機構進行披露。
4. 個人資料保密
   本公司會對閣下的個人資料加以保密，但可能會與下列各方透露該等資料:-
   a. 安我保險有限公司將把個人資料轉移給以下人士，而他們只能在有合理需要履行上述目的之情況下才可收集和使用這些資料：保險理算人、代理和經紀；僱主；醫護專業人士；醫院；會計師；財務顧問；律師；整合保險業申索和承保資料的組織；防欺詐組織；其他保險公司 (無論是直接地，或是通過防欺詐組織或本段中指名的其他人士)；警察；和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊 (及其運營者)；
   b. 任何本公司的附屬公司、控股公司、聯營公司或聯屬公司作在第3a和b段中所列出的任何用途；
   c. 任何本公司的代理人、承包商或會向本公司提供行政、電訊、電腦、網際網路、付款或其他服務的第三方服務供應商(包括但不限於風險分析顧問、公證行、私人調查員、信函裝封服務機構及財務公司) 作在第3a段中所列出的任何用途；
   d. 任何本公司的實際或建議再保險公司作在第3a段中所列出的任何用途；
   e. 任何品牌合作伙伴及本公司生意伙伴作在第3a和b段中所列出的任何用途；及
   f. 在對本公司或其任何集團公司具有約束力或適用性的任何法律或法規的要求下而使本公司有責任對其進行披露的任何人士。
5. 個人資料的查閱 / 改正要求
   a. 閣下有權查詢本公司是否持有關於閣下的個人資料及查閱這些資料及改正不準確的資料；
   b. 本公司有權就處理任何個人資料查閱要求收取合理的費用；
   c. 有關要求須以書面提交香港西營盤德輔道西160號5樓安我保險有限公司的個人資料保護主任。
6. 我們保留更改本聲明的權利。

(If any conflict or inconsistency between the English and Chinese versions, the English version shall prevail. 中文譯本內容如與英文本有歧異，一概以英文為準。)

Appendix: Checklist for Claim Items Documentation
附錄：索償項目文件清單

Ergonomic Injury 人體工學受傷

- ✓ Full medical report
  詳細醫療報告
- ✓ Complete Claim Form Part 2a by attending Registered Medical Practitioner
  請主診註冊醫生填寫索償申請表第 2a 部分
- ✓ Original medical receipt(s)
  醫療費用單據正本

Mental Health Therapy 精神健康治療

- ✓ Full medical report
  詳細醫療報告
- ✓ Original receipt(s) for professional psychiatric or psychological counselling or consultation expenses
  精神科或心理輔導或治療費用收據正本

Accidental Hospitalization Medical Expenses 意外住院醫療費用

- ✓ Full medical report
  詳細醫療報告
- ✓ Complete Claim Form Part 2a by attending Registered Medical Practitioner
  請主診註冊醫生填寫索償申請表第 2a 部分
- ✓ Original medical receipt(s)
  醫療費用單據正本

Accident Death and Permanent Disablement 意外身故及永久傷殘

- ✓ Copy of full medical report
  詳細醫療報告副本
- ✓ Copy of Police Statement for the accident (if the case reported to police)
  如有報案，請提供所有警方口供紙副本
- ✓ Relationship proof between Claimant & Insured Person (e.g. Certificate of Birth)
  索償人與受保人的親屬關係證明副本（例：出生證明書）
- ✓ Complete Claim Form Part 2b by attending Registered Medical Practitioner (if applicable)
  請主診註冊醫生填寫索償申請表第 2b 部分（如適用）
- ✓ Copy of Death Certificate and/or autopsy report (if applicable)
  死亡證及 / 或驗屍報告副本（如適用）

Food Poisoning 食物中毒

- ✓ Food order record related to suspected food poisoning
  與食物中毒有關的食物外送訂單紀錄
- ✓ Original medical receipt(s)
  醫療費用單據正本
- ✓ Copy of letter of hospital admission and discharge summary (if applicable)
  入院紙及出院紙副本（如適用）

Home Office Equipment 辦公室設備

- ✓ Your company letter requested your payment for the lost / damage items
  僱主要求賠償遺失 / 損毀物品通知書
- ✓ Receipts from your company for your payment for the lost / damage items
  僱主發出的收據確認收取就遺失 / 損毀物品賠償
- ✓ Copy of Police Statement for the accident (if the case reported to police)
  如有報案，請提供所有警方口供紙副本
- ✓ Photos to show the damage of lost / damaged items
  遺失 / 損毀物品的相片

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Part 2a is to be completed by the claimant's attending Registered Medical Practitioner at the claimant's own expense

第 2a 部分須由索償人之主診註冊醫生填寫，所需費用由索償人自行承擔

Please fill in this section when claiming for Ergonomic Injury or Accidental Hospitalization Medical Expenses Benefit

如閣下索償人體工學受傷或意外住院醫療費用保障，請填妥下表

Patient Basic Information 病人基本資料

Name of Patient
病人姓名 ______________________

HKID Number
香港身份證號碼 ______________________

Name of Hospital / Clinic admitted
入住醫院 / 診所名稱 ______________________

Hospitalisation Period (DD/MM/YYYY, hh:mm)
入院日期 (日 / 月 / 年，時 : 分)
From 由 ______________ To 到 ______________

Level of ward class 入住病房級別

☐ Day Centre / Clinic 日間中心 / 診所
☐ Semi-private 半私家房
☐ Ward 普通病房
☐ Private 私家房

Consultation Details 診症詳情

1. Clinical History 門診病歷

Symptom(s) or diagnosis(s) 病徵 / 診斷結果

First consultation date 首次求診日期 (DD/MM/YYYY 日 / 月 / 年)	How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前已患有此症多久？

2. Hospitalisation Details 住院詳情

Final diagnosis 最後診斷	Date of operation 手術日期 (DD/MM/YYYY 日 / 月 / 年)

Operation procedure(s) performed 手術詳情

If the patient has been referred to other Registered Medical Practitioner during this hospitalisation, please provide the following 如病人於是次住院期間曾被轉介向其他註冊醫生求診，請提供以下資料

Name of Registered Medical Practitioner consulted
求診註冊醫生姓名 ______________________

Reason(s) and treatment(s) performed by Registered Medical Practitioner
求診原因及治療詳情 ______________________

Please give a brief discharge summary (including onset and duration of sign and symptoms / disease, etiology, types and results of major examinations, treatments, complications and follow up plan)
請提供出院摘要 (包括病發及疾病徵狀、病因、類型及主要檢查、治療、併發症之結果及跟進計劃)

Please provide reason(s) of hospitalisation if this type of cases can be managed on day care / out-patient basis

如這類個案可於日間護理 / 門診護理處理，請提供入住醫院原因

3. Professional Comment 專業意見

Is this a chronic/recurrent illness? 此情況是慢性 / 復發性疾病？	☐ Yes 是	☐ No 否
To the best of your knowledge, has the patient ever had the same or similar symptoms/medical conditions before? If yes, please state the date of consultation, details of conditions and diagnosis 據閣下所知，病人是否曾經患有同一或相似病徵？如有，請提供詳情	☐ Yes 是	☐ No 否

Was the condition due to / associated with the following? (Please tick the appropriate boxes)

上述情況是否由於或與以下問題相關？（請選擇適當空格）

☐ Accidental bodily injury 意外身體受傷	☐ Pregnancy 懷孕	☐ Congenital condition 先天性疾病/異常
☐ Developmental condition 發展障礙	☐ Self-inflicted injury 自我傷害	☐ Infertility or sterilisation 不育或絕育
☐ Contraception 避孕	☐ Hereditary condition 遺傳性問題	☐ Abuse of drugs or alcohol 濫用藥物或酒精
☐ Mental disorder 精神紊亂	☐ General check-up 一般身體檢查	☐ Refractive error 視力問題
☐ Treatment for cosmetic purpose 美容手術	☐ Vaccination 疫苗接種	☐ N/A 不適用

☐ Venereal disease, sexually transmitted disease or AIDS / HIV related illness 性病、性傳染病或愛滋病 / 與愛滋病毒有關的疾病

4. Others 其他

a. If the patient was referred by other Registered Medical Practitioner, please provide the referring Registered Medical Practitioner's name and address

如病人為其他註冊醫生轉介，請提供該轉介註冊醫生之姓名及地址

c. Are you the patient's usual Registered Medical Practitioner? ☐ Yes 是 ☐ No 否

閣下是否該病人的慣常註冊醫生？

Declaration 聲明

I hereby certify that all information given above is accurate and true to the best of my knowledge.
本人特此聲明，就本人所知，上述所有資料均準確無誤。

Contact Telephone Number 聯絡電話號碼	Email Address 電郵地址	Fax Number 傳真號碼
Signature of the Registered Medical Practitioner with Official Chop 註冊醫生簽署及蓋章	Name of Registered Medical Practitioner 註冊醫生姓名	Signature Date 簽署日期

Part 2b is to be completed by the claimant's attending Registered Medical Practitioner at the claimant's own expense.

第 2b 部分須由索償人之主診註冊醫生填寫，所需費用由索償人自行承擔

Please fill in this section when claiming for Permanent Disablement Benefit

如閣下索償永久傷殘保障，請填妥下表

Patient Basic Information 病人基本資料

Name of Patient
病人姓名 ____________________

HKID Number
香港身份證號碼 ____________________

Date of Injured
受傷日期 ____________________

Attending Registered Medical Practitioner's Statement 主診註冊醫生證明書

Diagnosis (in respect of the disability described in accident details) 診斷（有關索償申請表描述之殘疾）

Had the patient become permanently, totally and irrecoverably disabled? ☐ Yes 是 ☐ No 否

病人是否永久、完全及不可復原的傷殘？

If yes, please provide the details 如「是」，請提供詳情：

Part of disabled 傷殘部位：

☐ Hand 手 ☐ Leg 腳

☐ Head 頭 ☐ Eye 眼

☐ Others 其他：

Severity of disabled / injury 傷殘 / 受傷程度：

First consultation date (DD/MM/YYYY):

首次求診日期 (日 / 月 / 年) ：

Name of referring Registered Medical Practitioner (if any):

轉介註冊醫生姓名（如有）:

Has the patient ever had the same or similar symptoms / medical conditions before? 病人是否曾經患有同一或相似病徵？ ☐ Yes 是 ☐ No 否

If yes, please provide the details 如「是」，請提供詳情：

Declaration 聲明

I hereby certify that all information given above is accurate and true to the best of my knowledge.
本人特此聲明，就本人所知，上述所有資料均準確無誤。

Contact Telephone Number 聯絡電話號碼	Email Address 電郵地址	Address 地址
Signature of the Registered Medical Practitioner with Official Chop 註冊醫生簽署及蓋章	Name of Registered Medical Practitioner 註冊醫生姓名	Signature Date 簽署日期