



# Domestic Worker Claim Form

## 家庭傭工保險索償申請表

This form must be completed truthfully and accurately. If the space is not enough or no applicable field available, please supplement information by attachment.  
請正確填寫此申請表。如果表格空間不足或沒有適用之欄位，請以附件補充資料。

The list of documents required is not exhaustive and we reserve our right to request from you any additional information/documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.  
各部份之「所需文件」只是概括要求，本公司保留權利在有需要時要求閣下提供更多文件以處理有關的索償申請。如所遞交的索償申請表未填妥或有關資料或文件不足，閣下的索償申請有可能會受延誤或被拒絕。

The completed form should be returned to us together with all supporting documents as soon as possible at the following address:

請填妥索償申請表並連同所有有關文件盡快寄回以下地址：

AIG Insurance Hong Kong Limited (Macau Branch)  
Claims Department  
Unit 506, 5/F, AIA Tower, No 251A-301 Avenida Comercial de Macau  
Facsimile: 853 2835 5299  
Telephone: 853 2835 5602 / 6321 3633  
Email address: claim.mo@aig.com  
www.aig.com.hk/macau

美亞保險香港有限公司 (澳門分行)  
賠償部  
澳門商業大馬路251A-301號友邦廣場5樓506室  
傳真: 853 2835 5299  
電話: 853 2835 5602 / 6321 3633  
電郵地址: claim.mo@aig.com  
www.aig.com.hk/macau

### Section IA - General Information 第一部份 一般資料

Policy/certificate no. 保單號碼	Name of Insured (Chinese & English) 受保人姓名 (中文及英文)	ID card no./passport no. 身份證/護照號碼
Telephone no. (Residential) 電話號碼 (住宅)	Telephone no. (Office) 電話號碼 (辦公室)	Telephone no. (Mobile) 電話號碼 (手提電話)
Mailing address 聯絡地址 (請盡量以英文填寫)		E-mail address 電郵地址
Name of agent/broker 經紀姓名	Agent / broker's email address 經紀電郵地址	Agent / broker's telephone no. (Mobile) 經紀電話號碼 (手提電話)
Name of domestic worker 家傭姓名		ID card no. / passport no. of the domestic worker 家傭身份證/護照號碼

### Section II A - Medical Expense Reimbursement/Hospital Income/Loss of Income 第二部份(甲) 醫療費用/住院現金/緊急入息援助

Documents required under SECTION IIA: 第二部份 (甲) 所需文件

Medical Expense Reimbursement 醫療費用

- Original hospital/medical bill(s)/receipt(s)/medical report stating diagnosis and the date of the injury/sickness commenced and certified by a qualified medical practitioner. 由註冊醫生發出的醫療報告/收據正本，並註明診斷結果及受傷或疾病發生日期

Hospital Income/Loss of Income 住院現金/緊急入息援助

- Medical certificate from a qualified medical practitioner certifying the number of days of hospitalization. 由註冊醫生發出的醫療證書證明住院日數
- Hospital discharge summary. 出院總結
- Letter from employer/company stating that the insured is under employment during sick leave period as a result of injury/sickness and amount of the salary earned, if claiming loss of income. 如屬緊急入息援助索償，請提供由公司/僱主發出之信件，證明受保人在受傷或疾病的病假期間仍然受僱及薪酬金額

Date of injury/sickness 發生意外或疾病的日期 DD 月 YYY年 日 月 年	Time of injury/sickness 發生意外或疾病的時間 □ □ A.M. / P.M. 上午 / 下午	Date of first consultation with doctor / hospital 首次求診日期 DD 月 YYY年 日 月 年
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In the case of injury, where and how did the accident occur? In the case of sickness, what were the symptom(s) and when did the symptom(s) first appear?  
如屬受傷個案，請詳述意外發生的地點及經過。如屬疾病個案，請詳述疾病的徵狀及首次出現病徵的時間。

Nature of injury/diagnosis of sickness  
傷勢/病況的診斷結果

Name and address of the attending doctor 主診醫生姓名和地址								
If hospitalized, please state the name, address and the period of the hospitalization 如曾住院，請列出住院地點、地址及期間								
From 由	DD 日	MM 月	YYYY 年	To 至	DD 日	MM 月	YYYY 年	Claim amount (Please indicate the currency) : 索償金額 (請註明貨幣) :
Was the injury due to any other party's fault? 意外是否第三者的責任?		If yes, please provide the details of the third party, including the name, address and contact number 如是，請提供第三者的資料，包括姓名、聯絡地址及電話						
<input type="checkbox"/> Yes 是  <input type="checkbox"/> No 否		<hr/> <hr/>						

## Section II B - Accidental Death and Disability 第二部份 (乙) 意外死亡及傷殘

Date of accident 意外發生日期	DD 日	MM 月	YYYY 年	Time of loss 時間	<input type="checkbox"/> A.M. / P.M. 上午 / 下午	Place of accident 地點
Full description of how the accident occurred and the injuries sustained 詳述意外發生的經過及所遭受的損傷						
Name and address of the attending doctor 主診醫生姓名及地址						
Full name and telephone no. of witness(es), if applicable 證人姓名及電話號碼(如適用)						
Cause of death, if applicable 死亡原因(如適用)				Permanent disability (degree and extent), if applicable 永久傷殘的程度(如適用)		
Name of the claimant (Chinese & English) in fatal case 索償申請人姓名(中文及英文)，僅適用於死亡個案			Claimant's relationship to the domestic worker (the deceased) 索償申請人與死者之關係		ID card no. / passport no. of the claimant 索償申請人身份證/護照號碼	

## Section II C - Domestic Worker Liability 第二部份 (丙) 家傭責任

Full description of the incident, including how, when and where it happened, and the extent of the damage/loss 詳細描述意外發生的時間、地點及經過，以及損失程度	
Full name and telephone no. of the third party / claimant 第三者 / 索償人姓名及電話號碼	Full name and telephone no. of the witness(es), if applicable 證人姓名及電話號碼 (如適用)
Remarks: Any lawsuit, demand, claim or proceeding of any types relating to the incident of which becomes aware of, and received from the third party claimant, should be immediately forwarded to us without acknowledgement. No liability should be admitted and no settlement or promise of payment should be reached or made to the third party without our prior approval. 備註 : 如收到任何第三者對有關事件的索償要求、法庭傳票、通告及書面命令，或涉及任何法律訴訟，切勿自行處理，應立即通知及提交本公司處理未得本公司事先同意前，不要向第三者承認任何責任或達成和解或付款承諾	

