



Domestic Helper Insurance

家傭綜合保險

Medical Claim – Direct Credit Payment Application Form

醫療費用 – 賠款自動轉帳申請表格

Please fill in the details below and return to us via mail or fax No. 2533 7548. Your application would be completed within 3 working days.
請填妥以下資料後，寄回或傳真(傳真號碼：2533-7548)至本公司。此申請將會在收到表格後的三個工作天後生效。

Policy/Certificate No

保險證明書號碼 _____

Contact No.

聯絡電話號碼 _____

Email Address:

電郵地址: _____

Name of Policy Holder

投保人(僱主)姓名 _____ (in BLOCK letters)
(請以英文正楷填寫)

Name of Bank

銀行名稱 _____

Branch Office

分行名稱 _____

Account No

戶口號碼 _____

(N.B. The Bank Account Holder must be the same person as the Policy Holder; joint name account is also acceptable)
(註：銀行戶口持有人須為上述投保人；聯名戶口亦可)

Signature of policyholder/Bank Account Holder

投保人/銀行戶口持有人簽署

Date:

日期

Remarks: If there is any change of bank account information, please complete and return to us this Application Form by fax or post.
備註：如需更改以上戶口資料，請重新填寫此賠款自動轉帳申請表格寄回或傳真至本公司處理。