

# Elite Health Plans

## Maternity Claim Form

Please complete Section A of this claim form yourself, and ask your physician to complete Section B.

Submit the completed form, with the fully itemised invoices for all treatment you have received, to [hkclaims@william-russell.com](mailto:hkclaims@william-russell.com). We can only reimburse your claim when we have received copies of the fully itemised invoices, which give us a complete breakdown of all treatment you have received and any medication you have been prescribed. We also reserve the right to request original documentation relating to your medical treatment, so please retain all original invoices and receipts for a period of 12 months.

### A SECTION A

Section A is to be completed by the claimant, or the claimant's guardian or legal representative.

#### Claimant's personal details

Full name: ..... Title: .....  
 Address: ..... Policy number: .....  
 ..... Date of birth: .....  
 Email address: ..... Telephone number: .....

#### Details of your pregnancy

On what date did you discover that you were pregnant? .....  
 Please provide the name of the physician who confirmed that you are pregnant: .....  
 .....  
 What is your estimated due date? .....  
 Please confirm how many previous pregnancies you have had: .....  
 At which hospital do you plan to give birth? .....  
 Do you plan to give birth by Caesarean Section?  Yes  No

#### Please list the bills for which you are seeking reimbursement

Date(s) of treatment	Details of the bills you have enclosed for reimbursement	Please state currency and amount paid

#### How you wish to be reimbursed

**Payment will be made to your bank account.**  
 Currency in which you would like to be reimbursed:  US Dollars  HK Dollars  Other: .....  
 If you have previously submitted a claim, and you wish to receive reimbursement to the same bank account as before, please confirm the last four digits of your account number: .....  
 If you have not submitted a claim before, or if you have submitted a claim before but you wish to receive your reimbursement in a different account, please provide your account details below.  
 Bank name and address: .....  
 .....  
 .....

## How you wish to be reimbursed (continued)

Account holder's name: ..... Account number: .....  
Swift code: .....

## Personal Information Collection Statement

**1. Purpose:** Sompo Insurance (Hong Kong) Co., Ltd. and William Russell Ltd. (collectively the “Company”) is committed to protecting the personal data of our customers. The Company is also committed to the implementation of the data protection principles set out in Schedule 1 of Personal Data (Privacy) Ordinance (“the PDPO”) (Chapter 486 of the laws of Hong Kong). From time to time it is necessary for you to supply the Company with your personal data which may be used, stored, processed, transferred, disclosed or shared by the Company for the following purposes:

- (a) processing and evaluating your application or request for and any alterations, variations, cancellation, renewals and reinstatements of any insurance products and / or services offered by the Company;
- (b) administering your insurance policy and providing services in relation to your insurance policy;
- (c) any purposes in connection with any claims made by or against or otherwise involving you in respect of any products and / or services provided by the Company, including processing and / or investigating any claims;
- (d) invoicing and collecting premiums and / or outstanding amounts from you;
- (e) exercising any right of subrogation, if applicable;
- (f) conducting statistical analysis;
- (g) contacting you for any of the above purposes;
- (h) meeting the requirements to make disclosure (i) under any law binding on the Company; or (ii) under any applicable rules, regulations, codes or guidelines or to assist in law enforcement purposes, investigation by police or other government or regulatory authorities; or (iii) for complying with any requirements, policies or measures for using data and information within Sompo Japan Nipponkoa Holdings, Inc. (“the Group”) in accordance with any Group-wide programmes from time to time for compliance with sanctions or prevention or detection of money laundering, terrorist financing or other unlawful activities / misconducts;
- (i) other purposes directly related to any of the above purposes.

For using the personal data provided by you for promotional / marketing purposes, please refer to the section titled “Use of Personal Data in Direct Marketing”.

The failure of providing the Personal Data by you may result in the Company being unable to provide products and services, assess your policy application, process claims under insurance policies issued by us, or process any other requests, enquiries, or complaints from you, or any of the purposes listed above.

**2. Transfer:** The Company may disclose your personal data to the following transferees in Hong Kong or overseas for the above purposes:

- (a) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist the Company to carry out the above purposes (including medical service providers, emergency assistance service providers, mailing houses, IT service providers and data processors);
- (b) in the event of a claim, loss adjusters, claims investigators and medical advisors;
- (c) in the event of default, debt collectors and recovery agents;
- (d) insurance reference bureaus or credit reference bureaus;
- (e) reinsurers and reinsurance brokers;
- (f) financial services intermediaries that are authorized by the Company for the distribution of products and services provided by the Company including your insurance agents, intermediaries or brokers, if applicable;
- (g) legal and professional advisors of the Company;
- (h) associated companies of the Company;
- (i) the policyholder, when none of the insured person(s) of that policy is the policyholder, for the purpose of policy application, administration, renewal and / or claims administration (if applicable);
- (j) relevant industry association and federation that exists or is formed from time to time;
- (k) government and authorities within or outside HKSAR as required or permitted by law. The Company may also use and disclose your personal data otherwise with your consent;
- (l) any third party in connection with a transfer or potential transfer of all or part of the business of the Company that some of the

**Personal Information Collection Statement (continued)**

transferees may be located within or outside of HKSAR.

**3. Access:** You have the right to ascertain what type of personal data the Company holds, whether the Company holds your personal data and, if so, the right to request access to and to request correction of any personal data concerning you held by the Company. Such request can be made to the Data Protection Officer, Sompo Insurance (Hong Kong) Co., Ltd, 19/F, Lincoln House, Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong. The Company reserves the right to charge a reasonable fee for processing a request to access your personal data access request.

**Use of Personal Data in Direct Marketing**

Apart from the aforementioned purpose, the Company may also use your name, contact details, demographic information, policy details, products and services portfolio information, transaction pattern and behavior, and financial background held by the Company to contact you with direct marketing communications regarding financial and insurance products by mail, email, telephone, facsimile or SMS. The Company may also provide your name, contact details, demographic information, policy details, products and services portfolio information, transaction pattern and behavior, and financial background held by the Company to the following transferees: (I) third party financial institutions, insurers, banks, credit card companies, securities and investment services providers; (II) third party reward, loyalty, privileges programme providers or merchants; and (III) charitable or non-profit making organizations for gain who may send you direct marketing communications regarding (1) insurance, banking, credit card, financial, provident fund scheme and related products and services; (2) reward, loyalty or privileges programmes and related products and services; and (3) donations and contributions for charitable and / or non-profit making purposes by mail, email, telephone, facsimile or SMS.

Before using your personal data for contacting you with direct marketing communications, the Company must obtain your written consent, and only after having obtained written such consent, the Company may use your personal data for any direct marketing purpose.

You may in future withdraw your consent to the use of your personal data for direct marketing purposes by the Company or the transferees and thereafter the Company shall, without charge to you, cease to use such data for direct marketing purposes. If you wish to withdraw your consent, please inform the Company by writing to the Data Protection Officer, Sompo Insurance (Hong Kong) Co., Ltd, 19/F, Lincoln House, Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong.

**Amendment to the Personal Information Collection Statement**

The Company reserves the right at anytime, with or without notice, amends this PICS which will be found in our website or in writing to notify you how the Company will collect, use and transfers your personal data. Should there be any amendment to this PICS in the future, such amendment will become effective with immediate effect.

I acknowledge and confirm that I have read and understood the PICS. I confirm that I have been advised to read carefully the PICS, and I have read it carefully about its effect and impact in respect of my personal data collected or held by the Company. I hereby give my acknowledgement and agree to the use and transfer of my personal data by the Company in accordance with the PICS, including the use and provision of my personal data for the purpose of direct marketing.

**If you do not agree to the use and provision of your personal data for direct marketing as set out in the PICS, please tick the box(es) below and we will not use your personal data for the purpose of direct marketing.**

- Please tick if you do not consent to receive direct marketing communications from us.
- Please tick if you do not consent to receive direct marketing communications from any transferees specified in the PICS.

**Name of applicant:** .....

**Signature of applicant:** ..... **Date:** .....

**Declaration for your claim**

Please read this section carefully and sign below.

- I hereby declare that all information provided in this form is accurate and complete, to the best of my knowledge.
- I confirm that I have read the above Personal Information Collection Statement and I understand that it will apply to the information provided in this claim form and any other information I may provide in connection with my claim.
- I hereby authorise any physician, doctor or other person who has attended to or examined me to furnish William Russell Ltd. and Sompo Insurance (Hong Kong) Co., Ltd. or to their authorised representatives any and all information with respect to my sickness, accident or injury, medical history, consultations, prescriptions or treatment, along with copies of all hospital and/or medical records relating to me.

**Declaration for your claim (continued)**

- I accept that my personal data may be passed on to selected third parties such as cost agents and claims administrators for the sole purpose of assisting with the administration of my claim. I understand that, if required, William Russell Ltd. and Somp Insurance (Hong Kong) Co., Ltd. will pass your information to legal and regulatory bodies and relevant third parties in the interests of fraud and money-laundering prevention.
- I hereby give William Russell Ltd. and Somp Insurance (Hong Kong) Co., Ltd. authorisation to correspond with me by email regarding my claim. I understand that these emails may contain reference to my medical condition(s) and/or financial payment information.

**Some important notes**

If the claimant is a child under the age of 18 years, this form should be completed by the claimant's parent or guardian. If the claimant is unable to complete the form due to cognitive disability or because the claimant is deceased, this form should be completed by the claimant's next of kin. If you are completing this form on behalf of the claimant, please state your relationship to the claimant below, along with your contact information.

**Name of claimant:** .....

**Signature of claimant:** ..... **Date:** .....

**B SECTION B**

**Section B is to be completed by the claimant's physician.**

**Patient's details**

Full name: .....

Date of birth: ..... Nationality: .....

**Dates**

Please confirm the date the patient first consulted you regarding this pregnancy: .....

Please confirm the date of the patient first registered at your facility: .....

Please state the expected delivery date: .....

Please state the date of the last monthly period: .....

**Medical information**

**Please state diagnostic tests performed, the test results and your reason for performing the tests.**

Date(s) of treatment	Tests performed	Reasons for tests

Was any medication prescribed?  Yes  No

If YES, please indicate which medication and why: .....

Are you aware of any complications that may arise during this pregnancy?  Yes  No

If YES, please provide details: .....

Please answer each of the following questions:

**Medical information (continued)**

- a **Has the patient ever received IVF or any other treatment to assist fertility?**  Yes  No
- b **Is this pregnancy as a result of IVF or assisted fertility?**  Yes  No
- c **Has the patient previously been treated or hospitalised for any termination of pregnancy, miscarriage, complications of pregnancy, or suffered any complications during childbirth?**  Yes  No

If you have answered YES to any of the above, please provide full details: .....

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**Declaration by physician**

I declare that I am the patient's treating physician, and that the details provided above are full, true, accurate, and complete.

**Signature of physician:** ..... **Date:** .....

Print your name and address: .....

.....

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Email address: ..... Telephone number: .....

Fax number: ..... Qualifications: .....

**PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP:**