CHUBB®

**Claims Department**
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# Chubb Claim Centre
# 安達索償中心

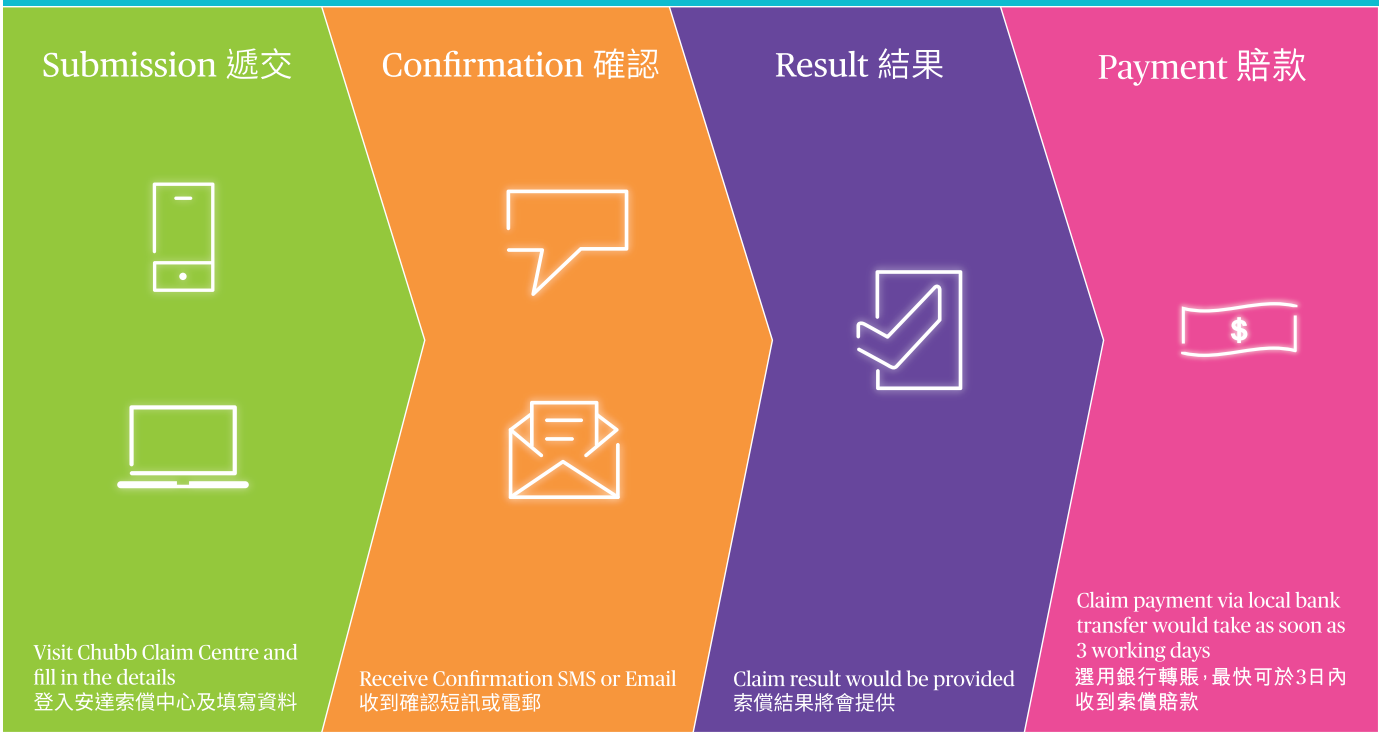
At Chubb, our aim is to process your claim efficiently. With this in mind, we have developed an easy-to-use online claims submission portal - **Chubb Claim Centre**.
安達保險致力為您提供有效率的理賠服務，有見及此，我們設計了一個易於使用的網上索償系統 – **安達索償中心**。

Every time Every where
隨時隨地

Faster Handling
快捷處理

Status Update
進度查詢

## Submission Procedure
## 索償程序




**Please submit your claim via the Chubb Claim Centre:**
**請即使用安達索償中心:**

www.chubbclaims.com.hk

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# Accident Claim Form
# 意外索償表格

Before sending in this form, please read below Important Information
請於交回此賠償申請表前先細閱下面之索償注意事項:

1. Please complete this form by the Policyholder.
   由保單持有人填寫。
2. If there is not enough space, please attach an additional page.
   如填寫位置不足,請另行附上資料補足。
3. Additional documents may be required and to be forwarded upon request of Chubb Insurance Hong Kong Limited.
   如有需要,安達保險香港有限公司將要求提供額外文件。

**Part I - To be completed by the Policyholder**
**第一部份 — 請由保單持有人填寫**

## Personal Particulars 個人資料

Name of Policyholder 保單持有人名稱:
(Eng) (中文)

Name of Insured Person 受保人姓名:
(Eng) (中文)

HKID Card No. of Insured Person 受保人香港身份證號碼:
( )

Policy No. 保單號碼:

Date of Birth 出生日期:
DD 日 MM 月 YY 年

Gender 性別#:
☐ M 男 / ☐ F 女

Occupation 職業:

Correspondence Address 通訊地址:

Email Address 電郵地址*:

Mobile Phone No. 手提電話號碼*:

Name of Current Employer 現任僱主名稱:

Position Held 受僱職位:

Address of Current Employer 現任僱主地址:

Office Tel No. 公司電話號碼:

## Local Bank Account Details 本地銀行賬戶資料

Account Holder's Name 賬戶持有人姓名 (Must be the Policyholder 必須為保單持有人):

Bank Name 銀行名稱:

Bank Code 銀行號碼:

Account Number 賬戶號碼:

Please note that claim settlement will only be made payable to the designated recipient mentioned in the terms and conditions of the relevant policy. Please provide the above information of the designated recipient accordingly. This local bank transfer will only be facilitated to the local bank HKD account of the designated recipient if all the information above has been accurately provided and the settlement amount is lower than HKD100,000. Otherwise, we will proceed with the claim settlement by delivering a cheque payable to the designated recipient according to the terms and conditions of the relevant policy. This information request should not be construed as an admission of our liability.
本公司只會支付此索償予有關保單條款指定的支付對象,故請提供該支付對象關於上述所要求的資料。當上述所要求的資料均正確提供,以及賠償金額少於港幣十萬元時,本公司方會轉賬至該支付對象的本地銀行港幣賬戶;否則,本公司將以支票支付此索償予有關保單條款指定的支付對象。此項要求並不代表本公司承認賠償責任。

* Correspondence may be sent to this email address and / or mobile phone no. 本公司或會以此電郵地址及 / 或手提電話號碼作聯繫用途
\# Please mark "X" in the appropriate box. 請於適當空格內填"X"

## Other Insurance Details 其他保險資料

Do you have other insurance covering this disability? If so, please state 台端有否其他保險保障此傷患? 如有，請述:

| Name of Insurance Company 保險公司名稱 | Type of Coverage 保障類別 | Policy Effective Date 保單生效日期 |
|---|---|---|
| | | |

## Details of Accident 意外詳情

1. Please state the following particulars of accident:
   請提供以下有關意外的資料:

| Date 日期 | Time 時間: | Place accident happened 意外地點: |
|---|---|---|
| DD日 MM月 YY年 | HH時 MM分 am/pm | |

2. Please state how the accident happened:
   請述意外發生經過:

3. Please describe the injuries sustained, indicating the part of the body injured and the type of injury (e.g.fracture, cut, bruise etc.):
   請述受傷部位及傷勢 (如：骨折、刀傷、瘀腫等):

4. Was the accident reported to the Police? If so, please state name of Police Station to which the accident was reported and case reference no.:
   上述意外有否通知警方？如有，請列明所辦理之警署地點及報案編號:

5. Please list all doctor(s) or hospital(s) consulted for the injury and date of consultation:
   請列出就上述意外而求診之所有醫生或醫院名稱及求診日期:

| Name of doctor / hospital 醫生 / 醫院名稱: | Date of First Consultation 初診日期: |
|---|---|
| | |

## Declaration & Authorization 聲明及授權

I / We declare that to the best of my knowledge and belief the above statements and particulars contained are in all respects true and complete and are made without reservation of any kind. I hereby authorize any physician, medical practitioner, hospital or clinic by whom or where I have been observed or treated to give full particulars about my health to Chubb Insurance Hong Kong Limited. A photocopy of this authorization shall be considered as effective and valid as the original.

I / We further hereby declare and agree, that the personal information collected or held by Chubb Insurance Hong Kong Limited, whether contained in this claim form or otherwise obtained, may be used by Chubb Insurance Hong Kong Limited or disclosed to any individual or organization such as legal firms, accountants, actuaries, loss adjudicators and claims investigators, doctors and other medical service provider within or outside Hong Kong and as more particularly set out in the Chubb Privacy Information Collection Statement for the following purposes: (1) to assess and process this application, (2) to provide insurance and customers services, (3) to conduct insurance claims or analysis. I / We understand that if I / We do not provide such consent, or revoke my / our consent, Chubb Insurance Hong Kong Limited may not be able to process or assess my / our claim. A copy of the Chubb Privacy Information Collection Statement can be found at www.chubb.com/hk.

Any persons from whom Chubb Insurance Hong Kong Limited has collected information as aforesaid shall have the right of access to and to request correction of any personal information concerning themselves held by Chubb Insurance Hong Kong Limited. A request for such access may be made to the Personal Data Privacy Officer of Chubb Insurance Hong Kong Limited at 39/F, One Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong.

本人 / 吾等謹此聲明本人確信以上所填報之資料及所列各項之事件乃屬完全真確並無作任何資料之保留。本人茲授任何曾替本人作診治之醫生、醫務人員、醫院或診所提供有關本人病歷之資料予安達保險香港有限公司。此授權書之副本亦屬有效。

本人 / 吾等亦在此聲明及同意由安達保險香港有限公司所收集或持有的個人資料，不論包含在這索償表格或以其他方式獲取，均可供安達保險香港有限公司使用或各在香港境內或境外之任何人士或機構例如律師事務所、會計人員、精算師、公證人、索償調查員、醫生及其他醫護服務提供者及其他已載於安達收集個人資料聲明之人士及機構披露作以下用途：(1) 評核此項申請，(2) 提供保險及客戶服務，(3) 處理保險的索償或有關之分析。本人 / 吾等明白如本人 / 吾等不同意或撤回此聲明，安達保險香港有限公司或未能處理及評核本人 / 吾等之索償。安達收集個人資料聲明之副本已載於www.chubb.com/hk。

就提供上述資料的任何人士有權查閱及要求更改安達保險香港有限公司所持有有關他們的任何個人資料。任何關於個人資料查閱或更改之要求，可向安達保險香港有限公司之個人資料私隱主任提出，地址為香港鰂魚涌英皇道979號太古坊一座39樓。

| | |
|---|---|
| Signature of Insured Person 受保人簽署:<br><br>Date Signed 簽署日期: / /<br>DD 日 MM 月 YY 年 | Name of Insured Person 受保人姓名:<br>(in BLOCK CAPITALS 請以正楷書寫)<br><br>HKID Card No. of Insured Person 受保人香港身份證號碼: |
| Signature of Parent / Legal Guardian 受保人父母 / 合法監護人簽署:<br>(if Insured Person is below 18 years old 如受保人未滿18歲)<br><br>Date Signed 簽署日期: / /<br>DD 日 MM 月 YY 年 | Name of Parent / Legal Guardian 父母/合法監護人姓名:<br>(in BLOCK CAPITALS 請以正楷書寫)<br><br>HKID Card No. of Parent / Legal Guardian 父母/合法監護人香港身份證號碼: |
| Signature of Policyholder* 保單持有人簽署*:<br><br>Date Signed 簽署日期: / /<br>DD 日 MM 月 YY 年 | Name of Policyholder# 保單持有人姓名#:<br>(in BLOCK CAPITALS 請以正楷書寫)<br><br>HKID Card No. of Policyholder 保單持有人香港身份證號碼: |

*Authorized Signature and stamp if Policyholder is a company 如保單持有人為公司，請由授權人簽署及蓋章

#Name and title of the authorized signatory if Policyholder is a company 如保單持有人為公司，請提供授權簽署人姓名及職銜

**Part II – Attending Physician Statement (to be completed by the Insured Person's attending doctor at the Insured Person's cost)**
**第二部份 — 主診醫生報告 (此欄須由受保人之主診醫生填寫，而費用須由受保人負責)**

## Personal Particulars 個人資料

| Name 姓名: | HKID Card No. 香港身份證號碼: | Gender 性別:<br>☐ M 男 / ☐ F 女 |
|---|---|---|

## Details of Injury 損傷詳情

| 1. Date of Injury<br>受傷日期: | 2. According to the patient, under what circumstances was the patient injured?<br>據傷者自述，其損傷是如何發生? |
|---|---|
| /  /<br>DD 日 MM 月 YY 年 | |

3. Diagnosis of condition, please locate and describe the injured area:
傷勢診斷，請述受傷部份及其傷勢:

4. Did you notice any visible signs of injury such as bruising or external wound at your examinations? If yes, please state:
請問受傷部位有沒有可見之表面傷痕，如傷口或瘀痕? 如有，請述:

5. Investigation, treatment, therapy and surgical procedures done:
因意外而接受之檢查、治療及手術項目:

| Date / Period 日期 / 期間 | Type of medical treatment 治療項目 | Details 詳情 |
|---|---|---|
| | | |

6. Were there any complications associated with the injured area? If yes, please state:
請問受傷部份有否引致任何併發症? 如有，請述:

7. Is the condition related to any previous injury or medical conditions? If yes, please state:
請問上述之傷勢是否與傷者過去之病歷有任何關連? 如有，請述:

8. Did you recommend any sick leave for the patient? If yes, please state the period:
台端有否就上述之傷勢建議病假予傷者? 如有，請述所建議之期段:

9. Please indicate if the medical condition and its subsequent treatment is associated with any of the following:
請指出上述狀況及其治療是否與以下情況有關:

☐ Congenital anomalies, infertility or sterilization
先天性不正常情況、不育或絕育情況

☐ Under the influence of drugs or alcohol
受酒精或藥物影響

☐ Self-inflicted injuries or suicidal attempt while sane or insane
不論在神志清醒與否下之自我損傷或自殺行為

☐ Pregnancy conditions or any related complications
懷孕或由此引發之病況

☐ Dental care
牙科治療

☐ Rest cure, rehabilitation, convalescence or extended care
休養、復康或延拓護理

☐ Psychiatric problems
精神病科

## Details of Hospitalization 住院資料

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

1. Investigation, treatments, therapy and surgical procedures done during hospitalization:
住院期間曾接受之檢查、治療及手術項目:

2. Please provide the reason(s) for this hospitalization if this type of case can be managed on day care / outpatient basis:
若此症能在日間護理 / 診所進行治療，請說明住院原因:

3. According to your professional opinion, does the aforesaid duration of hospitalization appear usual for the average patient with a similar condition? If not, please advise the reason:
據台端之專業意見，上述之住院日數與一般同類傷患之平均住院日數是否相乎？如否，請說明其原因:

4. Did the patient take any home leave during this hospitalization? If yes, please state the date and time:
患者有否於上述住院期間離開醫院? 如有，請詳列日期及時間:

## Signature 簽署

| Signature of Physician: 醫生簽署:<br><br>Date Signed: 簽署日期:<br>/ /<br>DD 日 MM 月 YY 年 | Hospital / Physician Stamp: 醫院 / 醫生蓋印: |
|---|---|
| Physician Name: 醫生姓名:<br>(in BLOCK CAPITALS 請以正楷書寫) | Clinic Address of Physician: 註診地址: |

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