CHUBB®

Claims Department
Chubb Insurance Hong Kong Limited
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E A&HClaims.HK@chubb.com
www.chubb.com/hk

賠償部
安達保險香港有限公司
香港鰂魚涌英皇道979號
太古坊一座39樓
電話 +852 3191 6800
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Chubb Claim Centre
安達索償中心

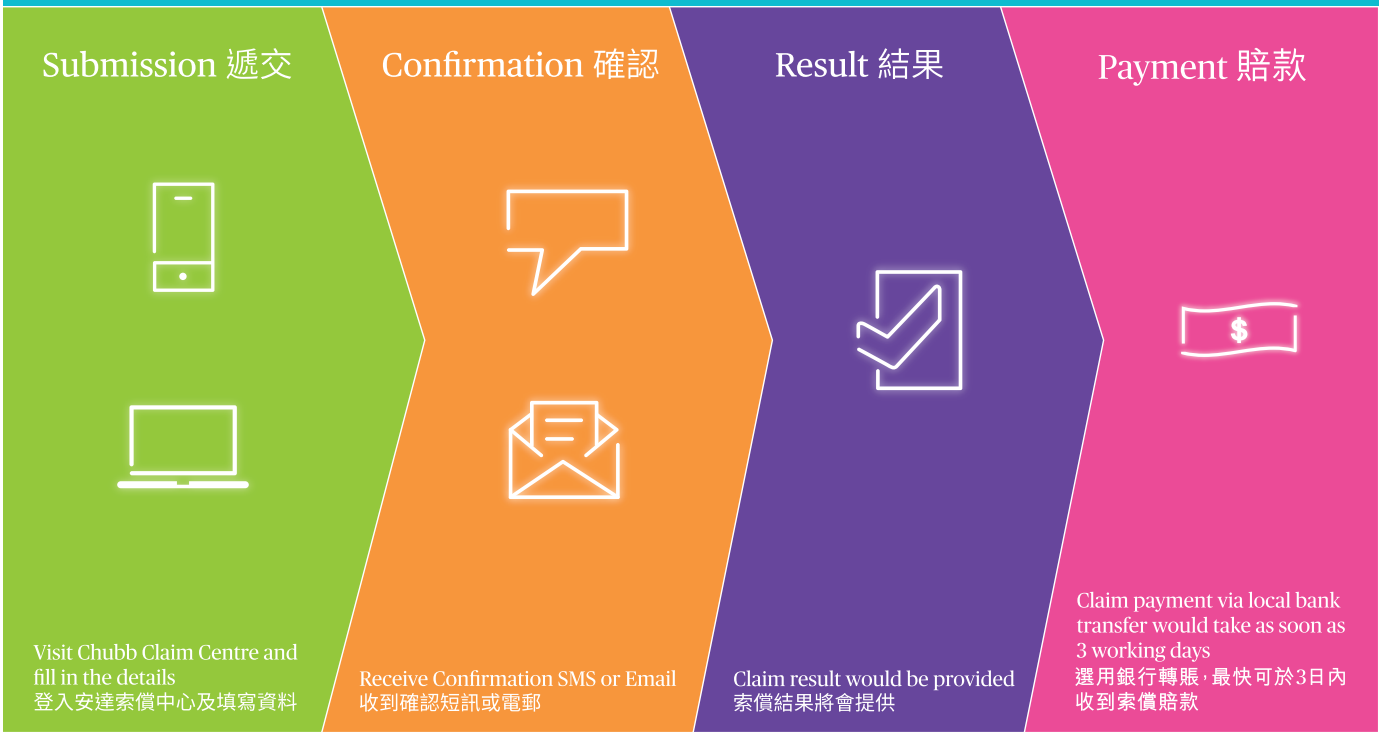
At Chubb, our aim is to process your claim efficiently. With this in mind, we have developed an easy-to-use online claims submission portal - **Chubb Claim Centre**.
安達保險致力為您提供有效率的理賠服務，有見及此，我們設計了一個易於使用的網上索償系統 – **安達索償中心**。

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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Dread Disease Claim Form

危疾保障索償表格

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 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 this local bank transfer will only be facilitated to the local bank HKD account 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 to the correspondence address provided. This information request should not be construed as an admission of our liability.
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,本公司方會轉賬至本地銀行港幣賬戶;否則,本公司將以支票支付此索償並郵寄至台端所提供之通訊地址。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 policies covering this event? If so, please state 台端有否其他保險保障此事件? 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 Disability 病性闡述

1. Please provide details of the type of disability you are suffering from. If the disability was caused by injury, please specify date, time, place and details of the accident which caused the injury: 請述所患疾病之種類。如病況乃因意外創傷造成，請述意外發生日期、時間、地點及起因:

DD日 MM月 YY年 HH時 MM分 am/pm

2. What symptom(s) are you suffering from, and please give an approximate commencement date of when you first became aware of such symptom(s) : 請述所患之病徵，並闡述在何時首次及發現此等病徵:

3. Please state all medical doctors consulted for the disability in chronological order:
請順序列述台端因此病而求診的所有醫生及醫療機構:

Name of Physician 醫生姓名:	Name & Address of Hospital / Clinic 醫院 / 診所名稱及地址:	Date of Consultation / Confirmation 求診 / 住院日期:

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 SAR 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特別行政區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:	Name of Insured Person 受保人姓名: (in BLOCK CAPITALS 請以正楷書寫)
Date Signed 簽署日期: / / DD 日 MM 月 YY 年	HKID Card No. of Insured Person 受保人香港身份證號碼:
Signature of Policyholder 保單持有人簽署:	Name of Policyholder 保單持有人姓名: (in BLOCK CAPITALS 請以正楷書寫)
Date Signed 簽署日期: / / DD 日 MM 月 YY 年	HKID Card No. of Policyholder 保單持有人香港身份證號碼:

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)

Patient's Particulars 病人資料		
Name 姓名:	HKID Card No. 香港身份證號碼:	Gender 性別: ☐ M 男 / ☐ F 女

Details of Disability 病性闡述

1. Please state patient's medical condition:
請提供上述病人之病況資料:

a. Exact final diagnosis:
最後診斷:

b. Stage / degree / severity of the disability and extent of area / organ affected:
病情階段 / 嚴重程度及所影響之部位 / 器官 / 機能:

c. What is the prognosis? According to your professional opinion, does the disability pose any life threatening signs or is there or will there be any permanent / irreversible loss of function?
據台端之專業意見，預計今後病情展望如何? 病人之生命會否因此病遭受脅 / 造成永久性之身體機能喪失?

2. Please state patient's medical history:
請提供上述病人之病歷資料:

a. At the first consultation of the above disability, what symptom(s) did the patient present?
於首次診治此病時，病人有那些徵狀?

b. When did the first consultation take place for such symptom(s)? 病人何時開始就上述病徵求診?	c. How long have such symptom(s) persisted before the first consultation? 上述病徵持續了多久才首次求醫?

d. Was the patient referred to you by another physician? If yes, please advise the name and address of that physician.
病人是否由其他醫生轉介予台端? 如是，請提供其姓名及地址。

e. Please list below all medical consultations, hospital confinements, surgical procedures and courses of medical therapy relating to the disability:
請於下面列出病人曾就此病況而求診，住院或接受手術及治療之有關紀錄及詳情:

Date / Period 日期 / 期間	Type of medical treatment 主要治療項目	Details 詳情

3. According to your professional opinion, is the disability a recurrent episode, chronic disease or related to a previous complaint / diagnosis? If yes, please provide the date of the first episode, details of previous complaint, diagnosis and treatments.
據台端之專業意見，此病是否為繼發性或慢性疾病或與以前的主訴診斷有關？如是，請提供首次發病日期及以往的主訴、診斷及診治詳情。

4. Please indicate if the disability is associated with any of the following:
如此病與下列情況有關，請註明:

☐ Congenital disease
先天性疾病

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

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

☐ Acquired Immune Deficiency Syndrome (AIDS)
後天免疫力缺乏病

5. Please attach copies of diagnostic / pathological / laboratory reports relating to the disability.
請附上所有有關此病之診斷 / 病理 / 化驗報告副本。

Signature 簽署

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

Chubb. Insured.™