CHUBB®

Claims Department
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賠償部
安達保險香港有限公司
香港鰂魚涌英皇道979號
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Chubb Claim Centre
安達索償中心

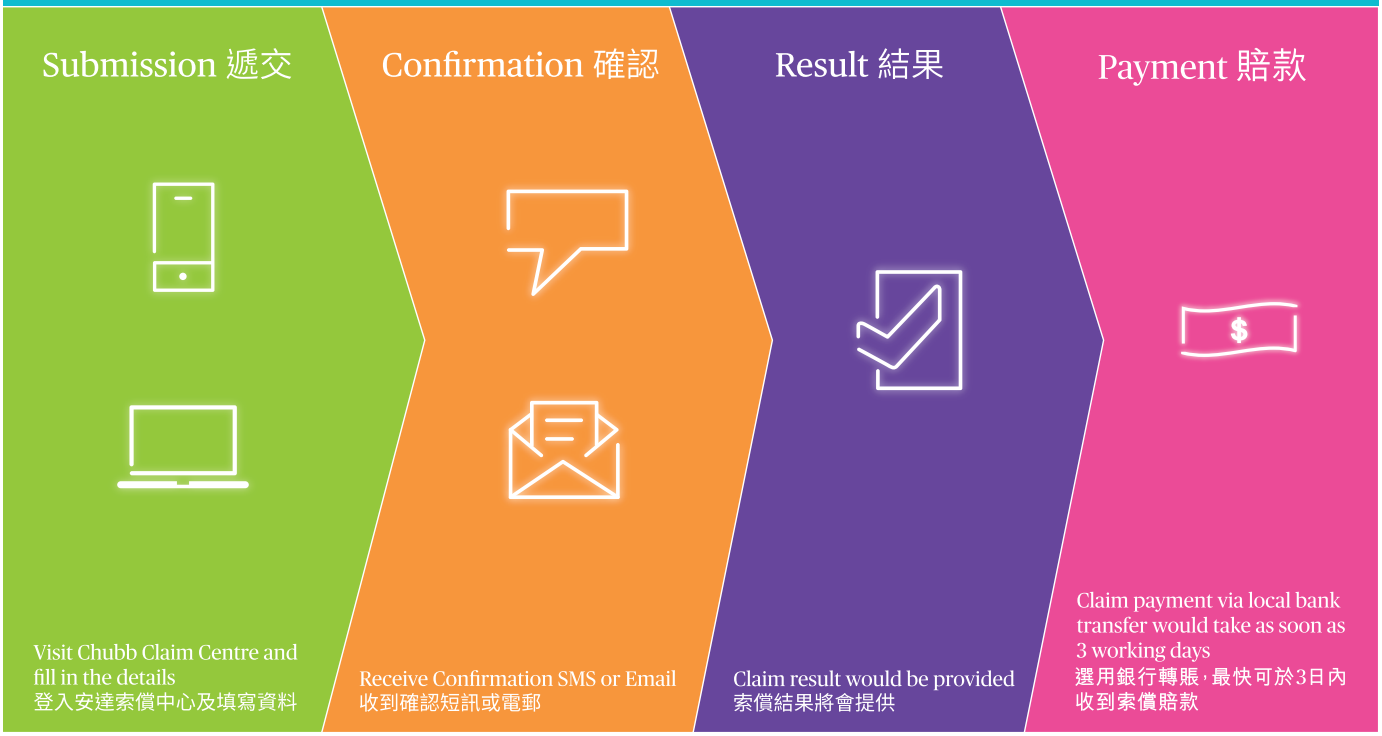
At Chubb, our aim is to process your claim efficiently. With this in mind, we have developed an easy-to-use online claims submission portal - **Chubb Claim Centre**.
安達保險致力為您提供有效率的理賠服務，有見及此，我們設計了一個易於使用的網上索償系統 – **安達索償中心**。

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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Hospitalization Claim Form

住院索償表格

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 covering this disability? If so, please state 台端有否其他保險保障此疾病? 如有，請述:

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

Details of Disability 病性闡述

Name of Hospital Admitted 醫院名稱:

Admission Period From 入院日期: DD日 MM月 YY年

To 出院日期: DD日 MM月 YY年

Reason for Admission 請註明住院原因
(Please ' X ' in the appropriate box and provide the relevant information 請在適當的空格內加「X」並提供相關資料):

☐ **A. Due to illness 由疾病所致**

1. Please indicate type of illness 請闡述所患何病:	2. When were you first aware of the manifestation of such symptons 上述疾病之徵狀始自何時?

☐ **B. Due to accident 由意外受傷所致**

1. Please state the following particulars of accident 請闡述意外詳情:

Date & Time 日期及時間: DD日 MM月 YY年	Location 地點:	How did the accident happen 意外怎樣發生?

2. 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:

Previous Consultation History 過往求診資料，請註明:

1. Name of doctors consulted for the above illness / accident during the past year: 請列出在住院前一年曾求診治療上述疾病 / 意外之醫生名稱:	Date of First Consultation: 初診日期:

2. Please list name and address of your usual consultant 請列出過去慣常求診之醫生名稱及地址:

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 個人資料

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

Details of Hospitalization 住院資料

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

1. Diagnosis of condition:
病況 / 傷患之診斷:

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

3. 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:

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:

History of Clinical Consultation 有關上述診斷之門診記錄

1. At the first consultation, what symptom(s) did the patient present?
於首次診治時，患者有那些徵狀?

2. When did the first consultation take place? 患者何時開始求醫?	3. How long have such symptom(s) persisted before the first consultation? 上述徵狀持續了多久才求醫?

4. 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。

Professional Comment 專業意見

1. According to your professional opinion, was the patient hospitalized as a result of 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，是次住院是否為繼發性或慢性疾病或與以往的主訴 / 診斷所引致? 如是，請提供首次發病日期及以往的主訴、診斷及診治詳情。

2. 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。

3. 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下列情況有關:

☐ Congential 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

☐ CoTMetic or plastic surgery
美容或整容手術

☐ Corrective of eye sight
視力改正

☐ Psychiatric problems
精神病科

☐ General check up
一般身體檢查

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

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:

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