

Power Mac Center Protect Plus Program

Claim Form

CHUBB®

Policy and Claimant Details	
Name of Insured	
Address (Unit No., Street, Brgy/Town, City and Postcode)	
Name of Claimant	
Address (Unit No., Street, Brgy/Town, City and Postcode)	
Date of Birth (mm/dd/yy)	
Occupation	
Mobile No.	()
Tel. No.(Home)	()
Tel. No.(Business)	()
Email Address	

Equipment Details	
Brand and Model	
Date of Purchase	
Store of Purchase	
Serial No.	

Important Information

- In order to submit your claim, please complete the relevant sections.
 - This first page must be completed for all claims.
 - The privacy consent must be completed for all claims.
- The supporting documentation required for your claim is detailed in each section.
- The issuance and acceptance of this form does not constitute an admission of liability by Chubb or a waiver of its rights.
- A Participation Fee equivalent to 20% of the equipment retail price cost should be settled prior to repair of the equipment.
- Chubb shall not be liable in respect of Equipment that have undergone unauthorized modification.
- Fraud Warning:**
Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

Section 1 – Accidental Damage Benefit

1. Please send a photo of the damaged equipment to ProtectPlus.PH@Chubb.com
 2. Please provide details of how the incident occurred.
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3. Date of Incident _____ / _____ / _____

4. Time of Incident _____ am pm

5. Place of Incident _____

6. Where was the equipment at the time of the incident?

7. Please describe the damage to, or the fault with, your equipment: (e.g. cracked screen)

8. Have you surrendered the damaged equipment to any Power Mac Center? If Yes, please indicate date surrendered.

Yes _____ / _____ / _____ No

9. Is the equipment covered by any other insurance? If Yes, which company?

Yes _____ No

10. Is the equipment still under manufacturer's warranty? Yes No

11. Which is your preferred Power Mac Center Authorized Service Provider for surrendering and pick-up of equipment?
Please check one from below list:

- Abreeza Mall Power Mac Center
2/L Abreeza Mall, Ayala Malls J.P. Laurel Ave., Bajada, Davao City
- Cebu Business Park Power Mac Center
Unit G2 G/Floor Mercedes- Benz Tower, Mindanao Ave. Cebu Business Park, Cebu City
- Festival Supermall Power Mac Center
4/L Festival Supermall Alabang Corp. Avenue, Filinvest Corporate City, Alabang, Muntinlupa City
- Glorietta 5 Power Mac Center
3L Glorietta 5, Ayala Center Ayala Avenue, Makati City
- KCC Power Mac Center
2L KCC de Zamboanga, Camino Nuevo, Zamboanga City
- Northeast Square Power Mac Center
2/L Northeast Square 47 Connecticut St., Northeast Greenhills, San Juan City
- SM Aura Premier Power Mac Center
3/L SM Aura Premier McKinley Parkway and C5 Road cor. 26th St. Bonifacio Global City, Taguig City
- SM City North EDSA Power Mac Center
4/L Cyberzone The Annex at SM City North EDSA North Avenue corner EDSA, Quezon City
- SM Megamall Power Mac Center
4/L Cyberzone, SM Megamall Building B, EDSA, Mandaluyong City
- SM Mall of Asia Power Mac Center
2/L Cyberzone, SM Mall of Asia, Pasay City

Section 2 – Accidental Death & Accidental Medical Expenses Benefits

Documents Required for Claims Processing:

(Note that failure to provide these documents may result in claims processing delays)

- Attending Physician’s Statement (please refer to the attached template)
- Original copy of Police Report
- Original notarized Affidavit of Witness

(Additional) For Accidental Death Claim:

- Photocopy of Death Certificate
- Photocopy of Autopsy Report or Medico-Legal Statement
- Proof of Relationship to the Beneficiary

(Additional) For Accidental Medical Expense Claim:

- Original copy of Medical Bills (Itemized Charge Slips & Professional Fees included)
- Original copy of the Official Receipts
- Prescription of Medicines

1. Date of Accident _____ / _____ / _____

2. Please explain exactly how the accident occurred

3. If hospitalized: Name and address of the hospital

Period of hospitalization: From: _____ / _____ / _____ To: _____ / _____ / _____

Attending Physician's Statement

Patient Details

Name of Patient	
Date of Birth (mm/dd/yy)	
Primary Diagnosis	
Period of hospitalization	From: / / To: / /
Patient physical examination findings	
Description of surgical or medical services rendered/procedure	
Date condition was diagnosed	/ /

Certification

I hereby certify that I have personally examined and treated the patient for the above injury and that the facts as given above present my opinion of his/her condition.

Signature Over Printed Name

_____/_____/_____
Date

License No.

PTR No. and Date Issued

Privacy Consent - Claim Assessment

Protection of My Privacy Acknowledgement and Consents

By signing this form, I agree that Chubb will use the information supplied during the formation and performance of my policy for policy administration, customer services, paying claims and fraud prevention.

Chubb may disclose this information to its service providers and its agents for these purposes. Chubb will keep this information for a reasonable period. Where sensitive personal data has been disclosed, including any criminal record information, Chubb will also use this information for the above purposes. Chubb may also transfer certain information to countries that do not provide the same level of data protection for the above purposes so a contract will be in place to ensure the information transferred is protected. Individuals whose information have been supplied to Chubb have a right to ask for a copy of that information and to have any inaccuracies corrected.

Chubb may record telephone calls to make sure it follows instructions correctly and for staff training purposes. When personal or sensitive data is supplied to Chubb about third parties other than the Insured, both during the formation and performance of this policy, Chubb assumes that those third parties consent to the supply of this information to Chubb, to Chubb processing this data, including sensitive personal data, and to the transfer of their information abroad. Chubb will also assume that the supplier of the information is authorized to receive, on their behalf, any data protection notices.

I declare that, I understand that by investigating my claim or by accepting proof of my claim, Chubb has made no acceptance of liability, or waived any of its rights in defense of any claim arising under the policy.

I agree to Chubb using and disclosing my personal information pursuant to Chubb's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to Chubb.

I authorize any person or entity, including but not limited to the parties referred to above, to provide to Chubb such personal information as Chubb in its absolute discretion considers relevant for its assessment of my claim.

I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim. I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint Chubb to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorizations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent.

Signature Over Printed Name

_____/_____/_____
Date

Contact Us

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