



Chubb Samaggi Insurance PCL.  
2/4 Chubb Tower, 12 Fl.,  
Northpark Project  
Vibhavadi-Rangsit Rd.  
Thung Song Hong, Laksi  
Bangkok 10210

บริษัท ชับบ์สามัคคีประกันภัย จำกัด (มหาชน)  
2/4 อาคารชัยบุรี ชั้นที่ 12  
โครงการนอร์ทปาร์ค  
ถนนวิภาวดีรังสิต แขวงทุ่งสองห้อง  
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## Personal Accident, Health and Travel Claim Form

You can help to avoid unnecessary delay in processing your claim by (1) Complete this form, (2) Prepare the relevant documents, and (3) Registered mail them to Chubb Samaggi Insurance PCL., within 30 days from the date of the event.

Part 1-3 are the list of minimum documentation required to process your claim.

In certain circumstances, additional information may be required in order for further confirmation.

We are unable to return original documents, but we will be happy to provide certified copies on request.

**The standard processing time is seven (7) business days after review and approval of all documents.**

### POLICY INFORMATION

Name of Insured Person		Policy No(s).	
ID / Passport No.	Gender	Date of Birth	
Correspondence Address			
Occupation	Email		
Mobile No.	Telephone No.		
Are you claiming from any other insurance company or other sources? If yes, state:			
CREDIT CARD TYPE _____	Number _____	Travel Agency :	

### PAYMENT DETAILS

- Cheque Payment.  
- To Address \_\_\_\_\_
- Direct Transfer to Savings Account.  
- Please attached a copy of saving account book bank first page of insured only.

### DECLARATION, AUTHORIZATION & CUSTOMER'S DATA PRIVACY CONSENT

**[Declaration]** I/We confirm that I am/We are the claimant and/or the Policyholder and I/We declare that all the particulars given above are to the best of my/our knowledge true and correct.

**[Authorization]** I / We hereby consent to and authorize the medical practitioner involved in the claimant's care to discuss and disclose treatment details and discharge arrangements with and to Chubb. I/We agree that a copy of this consent shall have the validity of the original.

**[Customer's Data Privacy Consent]** In connection with my/our and/or the claimant's claims, I/We give consent for Chubb and their respective representatives or agents to collect, use, store, transfer and/or disclose the information (including that provided by sources other than myself) concerning me/us and/or the claimant, to or with all such persons (including any member of the Chubb Group or any third party service provider, and whether within or outside of Thailand and the Policyholder when claiming under a Group Policy) for the purpose of enabling Chubb and their respective representatives or agents to provide me/us and/or the claimant (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/or managing my/our and/or the claimant's claims or the Policyholder Group Policy(ies) with Chubb .

\_\_\_\_\_  
Signature of Insured Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date

### FOR OFFICER ONLY

Name .....	Branch .....
Telephone no. ....	Date .....

### TRACK YOUR CLAIM STATUS

Once your claim is registered, you will be updated through e-mail. Should you have any query on your claim status, we would be pleased to assist you via the following:

Tel no. 02-555-9100 or Email : ClaimmailA&H@chubb.com

We suggest you make a copy of your bill(s) and your completed claim form for your records.

**Delays can occur or claims may be denied because of missing information.**

**Part 1 :  Medical Expenses  Hospital Income Protection / Broken Bone  Cancer Insurance**

**Date and Time of Accident/Sickness ; Date**      /      /      **Time**      **Date of treatment :**      /      /      **Time**

**Cause of Accident/Sickness (Please provide full details of symptoms/medical condition)**

**Accident by vehicle type**  
 Car     Motorcycle     other \_\_\_\_\_  
 Driver     Passenger     other \_\_\_\_\_  
 Police Station \_\_\_\_\_

**Documents Required (Please tick against the documents you have submitted)**

<u>Medical Expenses</u>	<u>Hospital Income Protection / Broken Bone</u>	<u>Cancer Insurance</u>
<input type="checkbox"/> All original medical receipts. Total number of receipts _____ Total amount of receipts _____	<input type="checkbox"/> Medical Certificate.(Certified by related organization)	<input type="checkbox"/> Medical record.(Certified by related organization)
<input type="checkbox"/> Medical Certificate.(Certified by related organization)	<input type="checkbox"/> Admission/Discharge Report. (as the case may be)	<input type="checkbox"/> Pathology.(Certified by related organization)
<input type="checkbox"/> Identity Card or Passport.(Certified true copy)	<input type="checkbox"/> Identity Card or Passport.(Certified true copy)	<input type="checkbox"/> Identity Card or Passport. (Certified true copy)
<input type="checkbox"/> Insurance card.(Certified true copy)	<input type="checkbox"/> X-Ray film and interpretation by physician. (Broken Bone only)	
<input type="checkbox"/> Proof of Work Letter. (as the case may be)		
<input type="checkbox"/> Proof of travel for Travel Insurance. (e.g.Boarding pass or Air tickets)		

**Part 2 :  Death  Total Permanent Disability  Dismemberment**

**Date and Time of Loss / Accident ; Date**      /      /      **Time**      **Place of Loss / Accident**

**Cause of Loss / Accident (Please provide full details of symptoms/medical condition)**

**Documents Required (Please tick against the documents you have submitted)**

<u>Death</u>	<u>Total Permanent Disability and Dismemberment</u>
<input type="checkbox"/> Insured Person's Identity Card and Census Registration.	<input type="checkbox"/> Medical record.(Certified by related organization)
<input type="checkbox"/> Beneficiary's Identity Card and Census Registration.	<input type="checkbox"/> Medical report which confirms Total Permanent Disability or Dismemberment.
<input type="checkbox"/> Death Certificate.(Certified by related organization)	<input type="checkbox"/> Photograph which confirms permanent disability (if any)
<input type="checkbox"/> Autopsy Report.(Certified by related organization)	<input type="checkbox"/> Insured Person's Identity Card and Census Registration.
<input type="checkbox"/> Police Report.(Certified by related organization)	<input type="checkbox"/> Beneficiary's Identity Card and Census Registration. (as the case may be)

**Part 3 :  Loss/Damage to Baggage&Personal Effect  Baggage Delay  Travel Delay  Other Please Specify.....**

**Date and Time of Loss / Event ; Date**      /      /      **Time**      **Place of Loss / Event**

**Please provide full details of Loss / Event**

**Original Flight Details**  
 Departure Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_ Arrival Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_ Flight No. \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**Actual Flight Details**  
 Departure Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_ Arrival Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_ Flight No. \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**Loss/Damage of Baggage or Personal Effects**

Description	Date&Place Purchased	Original Cost

**Documents Required (Please tick against the documents you have submitted)**

- Passport.(Certified true copy)
- Travel Itinerary and Proof of travel (e.g.Boarding pass or Air tickets)
- Document confirming(Irregularity Report) issued by Airport, Airline, Carrier or Hotel confirming the data, reason for (and duration of the delay).
- Original receipt of Damage or Loss of Baggage / Personal Effects
- Local Police Report, if loss or damage occurs threat or use of violence
- Photo of Damage or Loss of Baggage / Personal Effects

\*\*\*Third Party Liability Benefit ; Forward all correspondence & documents from third parties to us for our handling\*\*\*