CHUBB GROUP OF INSURANCE COMPANIES
FEDERAL INSURANCE COMPANY

Incorporated under the laws of Indiana, U.S.A., licensed to do business in the Hong Kong Special Administrative Region

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香港灣仔告士打道 39 號夏慤大廈 24 樓 2401 室 電話號碼: (852) 2861 3668 傳真號碼: (852) 2861 2681

ACCIDENT & HEALTH INSURANCE CLAIM FORM
疾病及意外保險索償申請表

This form is issued without admission of liability on the part of Federal Insurance Company and must be completed as truthfully and accurately by the Policyholder and/or Insured Person/Claimant and returned to our Claims Department together with the supporting documents within 30 days after the occurrence of the claimed condition. Further information/documents may be requested depending on the nature and extent of the claim. Separate forms must be used for different claimants.

茲此聲明,填寫本申請表不代表聯邦保險公司已承諾了保險責任。投保人/被保險人或索償人應正確詳細填寫此申請表，並將後頁所列索償所需的資料于索償事由發生 30 天內交回本公司賠償部。視案件性質，本公司有權要求進一步資料。 每份申請表僅限一位申請索償人填寫。

THE POLICYHOLDER 投保人資料

Name 名稱		Policy No. 保險單號碼
Correspondence Address 通訊位址		E-mail 電郵地址
Contact Person 聯繫人	Contact No. 聯繫電話	Facsimile No.傳真號碼

THE INSURED PERSON/CLAIMANT 受保人/索償人資料

Name 姓名	Relationship to Policyholder 與投保人關係	Occupation 職業	Identity Card Number 身分證號碼
Residential Address 現住地址		Contact No. 聯繫電話	E-mail 電郵地址

If Insured Person/Claimant is aged under 18, please specify 受保人/索償人如爲十八歲以下，請注明：
Name of Payee 收款人姓名: Relation to Insured Person 與被保險人關係：

CLAIM DETAILS 索償事由

Date of Incident 事件發生之日期	Time 時間 a.m./p.m. 上午/下午	Place of Incident 事件發生之確切地點

Describe in detail how the incident happened 請詳述事件發生的原因和經過

Result of Incident 事件導致的結果： ☐ Injury 受傷 ☐ Sickness 疾病 ☐ Permanent Disability 永久傷殘 ☐ Death 死亡	Part(s) of body affected 受影響的身體部位	Nature of Injury 受傷性質

Name of Witness 證人姓名	Address 地址	Contact Number 聯繫電話

HOSPITALIZATION / SURGERY EXPENSES CLAIM 住院 / 手術費用索償
（Please fill in this part for hospitalization / surgery claim. 因意外或疾病而入住醫院，須填寫此部分）

Symptoms and Diagnosis 傷病的名稱及症狀：

Date of the symptom first appeared 首次就診前該症狀已存在多久？	Date of first consultation for this condition or related illness 首次接受治療日期：	Attending Physician 主診醫生：

Name of Clinic/Hospital first attended 首次接受治療診所/醫院：	Name of In-patient Hospital 住院醫院名稱：	Date of Admission 入院日期：	Date of Discharge 出院日期：

OTHER APPLICABLE INSURANCE 其他有關的生效保險

Do you have any other insurance policies covering the loss or expenses incurred (e.g. Travel Insurance, Household Insurance)? If so, please state: 是項索償是否受保於其他保險合約(例如旅遊保險, 家居保險等) ？ 如有， 請說明：

Name of Insurer 保險公司:	Policy Number 保險單號碼:	Claimed Item 索賠項目:	Claimed / Settled Amount 索償/已賠付金額 HK$

CLAIMED ITEM, AMOUNT & SUPPORTING DOCUMENTS 索償項目，金額及所需理賠資料：

Claimed Item 索償項目	Supporting Documents Attached (Please √) 隨附理賠資料（請打√）	Claimed Amount 索償金額
Medical Expenses 醫藥費用補償	☐ Original Medical Expense Receipt(s) with diagnosis 醫藥費收據(附診斷證明)正本 ☐ Original Medical Record or Discharge Summary issued by in-patient, out-patient or emergency unit; 完整的門、急診病歷或出院總結正本 ☐ Original Medical Examination Report; 醫院出具的所有檢查報告正本	
In-hospital Services 住院費補償	☐ Original Medical Record from in-patient/out-patient/emergency units with attending doctor's diagnosis 完整的門、急診病歷正本，或主診醫生的診斷證明正本	
Surgical Fees 手術費補償	☐ Original Hospital Record / Discharge Summary 出院總結及住院清單正本 ☐ Original In-hospital Services Bills 住院醫療正式收據正本	
Daily Hospital Income 每日住院現金津貼	☐ Medical Examination Reports issued by the Hospital 醫院出具的所有檢查報告 ☐ Sickness Certificate 病假證明	
Temporary Total Disablement 暫時完全傷殘	☐ Letter from employer stating that the insured person is under employment during the sick leave period as a result of the injury and amount of the salary earned, if claiming loss of income 如索償入息補償，請提供由僱主發出之信件，證明受保人在受傷休假期間仍然受僱及薪酬金額	
Accidental Disablement 意外殘疾給付	☐ Documentary proof certifying the claimant is suffering from permanent disability 證明索償人永久傷殘的有關文件	
Accidental Death 意外身故保險金索償	☐ Death Certificate 死亡證明正本 ☐ Grant of Probate / Letters of Administration 授予遺囑認證書 / 遺產管理書 ☐ Identity documents of the beneficiary and relationship proof 身故保險金受益人的身份證件或其他相關類似證明，以及受益人關係證明	
Compassionate Death Benefit 恩恤死亡金		
All Claims 所有索償	☐ Police Report, if applicable 警方報告, 如適用 ☐ Other documents in relation to this claim 其他與索償相關的證明和資料	

DECLARATION & AUTHORISATION 聲明及授權

The undersigned hereby declare that to the best of my/our knowledge and belief, the above statements and particulars are fully and truly made. I/We agree that any of my/our personal information collected or held by Federal Insurance Company ("Company") or its authorized representatives is provided and be held, used and disclosed by the Company to individuals/organizations associated with the Company or any selected third party for the purpose of processing the claims herein, providing data matching, and to communicate with me/us for such purposes. The undersigned understand that the Company may be unable to process the claims herein if I/we fail to provide any information requested in this Claim Form. The undersigned further understand that I/We have the right to obtain access to and to request correction of any personal information held by the Company concerning me/us. Such request can be made to the Company's Operations Services Manager at 2401, Harcourt House, 39 Gloucester Road, Wanchai, Hong Kong.
本索償申請表簽署人（等）謹此聲明， 就我等所知所信， 以上陳述絕無虛假和隱瞞。索償申請人並同意聯邦保險公司（下稱"貴公司"）或其授權代理可保留，使用或透露貴公司所收集或保留之任何有關索償申請人的個人資料給予貴公司有關之人士／機構或任何被選定的機構，用作處理與此索償申請及資料核對等用途，及因此等用途與索償申請人聯絡。索償申請人明白到倘若索償申請人未能提供申請書所需的資料，貴公司將可能無法處理有關申請。索償申請人同時有權向貴公司查閱及申請改正所有與索償申請人有關的個人資料。有關的申請可致函貴公司的營運部經理， 地址爲香港灣仔告士打道 39 號夏慤大廈 24 樓 2401 室。

The undersigned hereby irrevocably authorize any governmental or private organization / institution, insurance company or individual that has any information, record or knowledge of the Insured Person's health and medical history or any treatment, advice, accident or loss details that has been or may hereafter be consulted to disclose to Federal Insurance Company or its authorized representatives such information. This authorization shall bind my / the Insured Person's successors and assigns and remain valid notwithstanding my / the Insured Person's death or incapacity in so far as legally permissible. A photocopy of this authorization shall be considered as effective and valid as the original.
本索償申請表簽署人（等）授權任何知悉或擁有本人/受保人之健康狀況及病歷或任何治療或諮詢記錄、意外或索償事件之細節及曾爲或將爲本人/受保人之診治之醫生，醫院，診所， 部門，保險公司或任何政府或私人機構、組織或人士，向聯邦保險公司或其代理人透露有關資料， 不得撤回，即使本人/受保人死亡或喪失能力，此受權書仍然存有法律效力，而本人/受保人之繼承人及轉讓人也會受此授權書約束。此授權之複印件與原件同屬有效。

Signature of Policyholder (Position, Department and with Company Chop, if applicable): 投保人簽署(職位，部門及公司印鑑，如適用)： Date: 日期：	Signature of Insured Person / Claimant: 受保人/索償申請人簽署： Date: 日期：	Signature of Guardian (If Insured Person / Claimant is under the age of 18): 監護人簽署（若受保人/索償申請人未滿 18 歲）： Date: 日期：