

# Accident & Health Claim Form

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This form must be completed truthfully and accurately.

The list of documents required is not exhaustive and we reserve our right to request from you any additional information/documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

The completed form should be returned to us together with all supporting documents as soon as possible at the following address:

**Claims Department**  
**Chartis Insurance Hong Kong Limited**  
46/F, One Island East  
18 Westlands Road  
Island East Hong Kong  
852 3666 7090 Telephone  
852 2834 8962 Facsimile

## Section IA - General Information

Policy/certificate no.:	Name of policyholder (English):	Relationship between claimant & policyholder:
Name of claimant (English):	Name of claimant (Chinese):	Claimant's ID card no./passport no.:
Claimant's occupation:	Mobile no.:	E-mail address:
Mailing address:		Is the current mailing address same as the one in your policy application? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of incident (MM/DD/YYYY):	Time of incident:	Place of incident:
Describe how the incident happened:		
Result of incident: <input type="checkbox"/> Death <input type="checkbox"/> Disability <input type="checkbox"/> Injury <input type="checkbox"/> Sickness	Part of body affected:	Severity of the injury:
Name of witness:	Address of witness:	Telephone of witness:
Do you have any other insurance policies covering the loss or expenses incurred? (e.g. travel insurance policy, household policy, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide the following information:		
Name of the insurance company: _____		
Nature of risk covered: _____		
Policy no.: _____ Claim amount (Please indicate the currency): _____		
Has the said insurance company rejected your claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please state the reason(s). _____ _____		
If no, please state the amount payable/paid by the said insurance company (please provide the payment details). _____ _____		

## Section IB - Attending Physician Statement

(REQUIRED for Accidental Death and Disablement, Hospitalization/Surgery, Critical Illness/Cancer and must be completed by attending physician)

Patient's information		
Name:	Age:	ID card no./passport no.:
Patient's medical history		
Date of injury occurred or symptom first appeared (MM/DD/YYYY):	Date of first consultation (MM/DD/YYYY):	Date of first treatment (MM/DD/YYYY):
Diagnosis:		
To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please state dates and describe. _____		
Is the diagnosis due to or associated with the following?		
(a) Congenital anomalies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(e) Refractive error or correction of eyesight? <input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Heredity condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(f) Cosmetic or plastic surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Pregnancy, contraception, infertility or sterilization?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(g) Routine medical check-up? <input type="checkbox"/> Yes <input type="checkbox"/> No
(d) The influence of drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(h) Mental or nervous disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the patient was hospitalized, please fill in the boxes below		
Name of hospital:	Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY):
Major complaints of the patient:		
Brief discharge summary (including treatments, investigation procedures, results, and/or any complications and follow-up plan):		
If the patient had a surgical procedure, please fill in the boxes below		
Name and nature of procedure:		Date of operation (MM/DD/YYYY):
Remarks		
Declaration		
I hereby certify that the facts given above are true to the best of my knowledge.		
Signed with chop:	Name of attending physician / specialist:	Date (MM/DD/YYYY):
Qualifications:	Hospital (if applicable):	Telephone no.:

## Section II - Nature of Risk and Amount Claimed (REQUIRED)

Section IIA - Accidental Death and Disablement (ADD)	Amount (Please indicate the currency)
<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

### Documents required under SECTION IIA:

- Completion of Section IA and IB
- Police report, if applicable
- Documentary proof certifying the claimant is suffering from permanent disability (applicable for permanent disability claim)
- Copy of Death Certificate indicating the cause of death (applicable for death claim)
- Grant of Probate / Letters of Administration
- Letter issued by the Immigration Department confirming surrender of ID card

Section IIB - Out-Patient Medical Expenses Reimbursement	Amount (Please indicate the currency)
<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

### Documents required under SECTION IIB:

- Completion of Section IA
- Original medical receipts    No. of medical receipts submitted: \_\_\_\_\_ pieces
- Diagnosis

Section IIC - Hospital Income	Amount (Please indicate the currency)
<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

### Documents required under SECTION IIC:

- Completion of Section IA and IB
- Copy of hospital statement of account
- Sickness certificate / discharge summary

Section IID - Hospitalization/Surgery Expenses	Amount (Please indicate the currency)
<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

### Documents required under SECTION IID:

- Completion of Section IA and IB
- Original medical receipts
- Sickness certificate / discharge summary
- Copy of hospital statement of account

Section IIE - Critical Illness (CI) / Cancer	Amount (Please indicate the currency)
<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

### Documents required under SECTION IIE:

- Completion of Section IA and IB
- Detailed medical reports provided by attending physicians (e.g. hospital / clinical notes, examination reports, etc.)

Section IIF - Other	Amount (Please indicate the currency)
Please specify. _____	\$ _____

Remark: Additional documents may be required after initial assessment.

## Section III - Declaration and Authorization

The undersigned Claimant(s) HEREBY DECLARE that to the best of the Claimant(s)' knowledge and behalf, the above statement and particulars contained are true and complete in every respect and are made without reservation of any kind. The Claimant(s) agree that any of my/our personal information collected or held by Chartis Insurance Hong Kong Limited ("the Company"), general agent of American Home Assurance Company, National Union Fire Insurance of Pittsburgh, PA and New Hampshire Insurance Company in Hong Kong, (whether contained in this Claim Form or otherwise obtained) is provided and be held, used, and disclosed by the Company to individuals/organizations associated with the Company or any selected third party (within or outside of Hong Kong and Macau, including reinsurance, claims adjusting or investigation companies, police, airlines and industry associations/federations) for the purposes of processing the Claims herein and providing subsequent services, direct marketing, and data matching, and to communicate with the Claimant(s) for such purposes. The Claimant(s) understand(s) that (i) the Company may be unable to process the Claims herein if the Claimant(s) fail(s) to provide any information requested in this Claim Form and (ii) the Claimant(s) has/have the right to obtain access to and to request correction of any personal information held by the Company concerning the Claimant(s). Such request can be made to any of the Company's Data Privacy Officer at G.P.O. Box 456, Hong Kong. The Claimant(s) understand(s) that the submission and completion of this claim form is not an admission of liability on the part of the Company.

The Claimant(s) hereby irrevocably authorize:

- a. any organization, institution, or individual that has any information, record or knowledge of the Claimant(s)' health and medical history or any treatment or advice rendered thereto to disclose to the Company such information, record and knowledge;
- b. the Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate the Claimant(s)' health status in relation to the Claims therein and any matter arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites;
- c. the police that has any of my/our information to provide the Company with the information including but not limited to the police reports, witness statements, investigation and/or prosecution results;
- d. airline(s) that has/have any of my/our information to provide the Company with the information including but not limited to flight details, booking details, irregularities reports and all information related to my/our bookings; and
- e. any organization institution or individual that has any information, record or knowledge of the Claimant(s) travel record to disclose to the Company such information, record and knowledge.

This authorization shall bind the Claimant(s)' successors and assigns and remain valid notwithstanding the Claimant(s)' death or incapacity in so far as legally permissible. A photocopy of this authorization shall be as valid as the original.

Signature of claimant:	Name of claimant:
ID card no./passport no.:	Date (MM/DD/YYYY):
Signature of guardian (If claimant is under the age of 18):	Name of guardian:
ID card no./passport no.:	Date (MM/DD/YYYY):

Producer's Information		
Name:	Code:	Mobile no.: