Overseas Secondment

Claim Form

SG020

CHUBB®

Important Notes

To facilitate the processing of your claim, you are required to complete Sections A, B and C for all claim submissions.

The issue and acceptance of this form does NOT constitute an admission of liability by Chubb Insurance Singapore Limited (Chubb) or waiver of its rights.

The information requested and documents mentioned in this form are a general guide. Further documents or information may be required depending on the circumstances of your claim. Note that failure to provide supporting documentation may result in delays in the processing of your claim.

Your Policy may not provide cover under every section shown in this Claim Form.

Section A: Particulars of Policyholder / Insured Person and Claimant

Name of Policyholder / Insured Person (as shown in NRIC / Passport)

_____

Address of Policyholder / Insured Person

_____

_____ Postal Code_____

Policy No.

_____

Period of Insurance From DD / MM / YYYY To DD / MM / YYYY

Tel No. (Office) _____ Name of Intermediary (if any) _____

Email _____

Name of Claimant (as shown in NRIC / Passport)

_____

Address of Claimant

_____

_____ Postal Code_____

Tel No. (Mobile) _____ Tel No. (Residence) _____

Tel No. (Office) _____ Relationship to Insured Person _____

NRIC / Passport No. _____ Gender ☐ Male ☐ Female

Nationality _____ Age _____

Date of Birth DD / MM / YYYY

Email _____

Occupation _____ Date of Employment DD / MM / YYYY

Name of Employer _____

Section B: Payment Details

Please provide details for payment of your claim in the event that the claim is deemed payable by Chubb.

I / We hereby authorise and request Chubb to pay benefit due in respect of this claim as follows (Name as per Identification Card and / or Bank Account):

☐ Cheque Payment

Payee Name (as per bank account name) _____

☐ Electronic Funds Transfer (for payments in SGD and to bank accounts in Singapore)

Payee Name (as per bank account name) _____

Name of Bank _____

Branch Code No. _____ Account No. _____

If no name is provided, settlement will be effected to the payee as provided for under the terms of the policy.

Section C: Details of The Incident / Loss / Illness

Chronology and Description of the Accident / Loss / Illness (Please use supplementary sheet if necessary)

_____

_____

_____

_____

Country of Secondment ☐ Singapore ☐ Others _____

Date of Secondment DD / MM / YYYY Has the Secondment Journey ended? ☐ Yes ☐ No

If the claim took place outside the city of secondment, please indicate the purpose of trip

☐ Business ☐ Leisure ☐ Business cum Personal Vacation ☐ Home Leave (Please specify duration: _____)

Duration and Itinerary of Trip _____

Place of Accident / Loss / Illness _____

Date of Accident / Loss / Illness DD / MM / YYYY Time of Accident / Loss / Illness : H H : M M

When and Who discovered the Accident / Loss _____

Relationship of person to the Insured _____

Were there witnesses to the incident? ☐ Yes ☐ No

If **Yes**, please provide the following details:

	Witness 1	Witness 2
Name		
Address		
NRIC		
Contact Number		

Section D: Personal Accident / Illness – Medical and Additional Expenses

Please note:

1) Personal Accident - please enclose Police Report (if any), Detailed Medical Report, Medical Certificate.
2) Medical, Dental or Post Journey Medical Expenses - please enclose Original Detailed Pre-Medical / Final Hospitalisation / Post-Medical Bills, Inpatient Discharge Summary, Detailed Medical Report / Memo from Attending Physician on the type of illness or injury sustained.
3) Emergency Travel Expenses - please enclose Certified True Copy of Death Certificate and Proof of Relationship or written advice of attending Physician indicating the need to travel to or remain with the Insured Person, with Original Bills and Receipts of travel and accommodation expenses incurred.

1. Was it due to illness? ☐ Yes ☐ No

   If **Yes**, please specify type of illness _____

   When did first symptoms appear? _____

   When did you receive medical attention for this condition? DD / MM / YYYY

   Please provide name & address of Attending Physician.

   _____

   _____

   _____

   _____

2. Have you ever had this or similar condition? ☐ Yes ☐ No

If **Yes**, please provide details, dates and name and address of the doctors.

3. Was it due to an Accident? ☐ Yes ☐ No

If **Yes**, please provide the date and details of the Accident and Injury

4. Is Claimant on Home Leave? ☐ Yes ☐ No

If **Yes**, please provide duration of Home Leave

The visit is: (Please tick all that applies and provide details below)

☐ a follow-up treatment requested by the doctor.

☐ a routine medical examination – Annual / Monthly / Others*. (* Delete where applicable.)

☐ an elective surgery / treatment.

Amount Paid By You	Amount Recovered From Other Sources (Please provide details of settlement)	Amount Claimed

Section E: Personal Liability

Please note:
1) In no circumstances should the issue of legal liability be admitted to any third party claimant(s).
2) Please enclose letters / writs / summons from third party / police / court.

Was the accident due to carelessness or negligence on your part?		
Have you in any way admitted liability? If Yes, please advise why.		
To which Police Officer and Police Station (if any) did you report the accident / damage?		
Names and addresses of the other party(s)		
Nature of personal injury sustained by third party (if any)	Name and Age	Nature of Injury
Extent of damage to property belonging to other party(s)		
Whether any claim has been made upon you. If so, was the amount of such claim specified?		
Please give any additional information which you consider would help the Insurer in dealing with any claim that may be made against you.		

Section F: Family Security

Please note:
1) Please enclose Police Report, Certified True Copy of Death Certificate and Proof of Relationship.
2) Please enclose Proof of Enrolment in Kindergarten, Primary or Secondary School, Institution for Vocation or Tertiary Education licensed by the local government.

Date and Brief Details of Accident **(**Please use supplementary sheet if necessary)

_____

_____

_____

_____

Name of Dependent(s) and Name of School(s) currently attending

_____

_____

_____

_____

Section G: Legal Fees

Please note:
Please enclose all relevant documents issued by the government concerned or Foreign Power, all correspondence between your appointed solicitor and the government concerned or Foreign Power, each original bill for the legal fees incurred and official receipt issued by your appointed solicitor.

Name of Insured Person(s) involved in the False Arrest or Wrongful Detention:

_____

_____

Date of False Arrest or Wrongful Detention DD / MM / YYYY

Brief Details on Circumstances Surrounding the False Arrest or Wrongful Detention:

_____

_____

_____

_____

Amount of Legal Costs Incurred $_____

Section H: Cancellation / Curtailment

Please note:
Please enclose documentary proof on relevant expenses incurred as a result of this trip cancellation or curtailment, original booking invoice, Death Certificate, Medical Report and / or Written Memo from Attending Physician to cancel trip, Proof of Relationship, Travel Agents confirmation of the amount of refund, Original Invoice / Receipt of charges incurred in amending or purchasing additional air ticket (for trip curtailment).

When, where and with which Provider was the holiday booked?

_____

_____

_____

_____

_____

Intended Departure Date DD / MM / YYYY Intended Departure Date DD / MM / YYYY

Please state the reason for Cancellation / Curtailment

_____

_____

_____

_____

_____

Amount Paid By You	Amount Recovered From Other Sources (Please provide details of settlement)	Amount Claiming Against Chubb

Section I: Personal Effects

Please note:
1) Losses must be reported to the Police Authority, responsible Hotel Management or responsible officer of any aircraft, vessel / conveyance within 24 hours from the time of occurrence.
2) Please enclose Police Report or report issued by responsible Hotel Management or carrier evidencing such losses, Property Irregularity Report for losses in carriers' custody, Original Purchases Bills, Photographs of damaged items, Original Repair Bills for damaged items. If the responsible Hotel Management or carrier has made compensation for the damaged / lost items, please request them to issue a note or letter certifying the amount of compensation issued or will be issued to you.

Please provide details of Loss (Please use supplementary sheet if necessary)

Description Of Item	When And Where Purchased	Original Purchase Price	Amount Recovered From Other Sources (Please provide details of settlement)	Amount Claiming Against Chubb

Section J: Personal Money / Travel Documents

Please note:
1) Losses must be reported to the Police Authority, responsible Hotel Management or responsible officer of any aircraft, vessel / conveyance immediately, in any event within 24 hours from the time of occurrence.
2) Please enclose Police Report or report issued by responsible Hotel Management or carrier evidencing such losses, Original Receipts for replacement of travel documents, Original Transportation or Hotel Bills incurred for replacement of travel documents.

Please provide details of Amount Claimed (Please use supplementary sheet if necessary)

Amount Lost / Incurred	Amount Recovered From Other Sources (Please provide details of settlement)	Amount Claiming Against Chubb

Section K: Flight Delay / Baggage Delay

Please note:
1) Flight Delay - please enclose travel itinerary, boarding pass showing the actual take off time and date, written confirmation from carrier / airline or their agents specifying reason and hours of delay.
2) Baggage Delay - please enclose travel itinerary, written confirmation from carrier / airline or their agents specifying reason and the number of hours of baggage delay, Property Irregularity Report, Acknowledgement Receipt of baggage received.

Original Flight Details (Mandatory for all claims under this section)		
Original Departure Date, Time and Place:	Original Scheduled Arrival Date, Time and Place:	Flight No.: Name of Airline:
Delayed Flight Details		
Rescheduled Departure Date, Time and Place:	Rescheduled Departure Date, Time and Place:	Flight No.: Name of Airline:
Collection of Delayed Baggage		
Original Delay Date, Time and Place:		
Received Date, Time and Place:		
Expenses Incurred By You: (Please State Date and Item(s))	Amount Recovered From Other Sources:	Amount Claimed:

Section L: Get Well Benefit

Please note: Please enclose written note from the Physician certifying the number of days necessary to be recuperating at home and Medical Certificate.

Brief description of Medical Condition(s) or Injuries

_____

_____

_____

_____

_____

Date of Admission to Hospital DD / MM / YYYY Date Discharged DD / MM / YYYY

Period of Medical Leave as awarded by the Hospital From DD / MM / YYYY To DD / MM / YYYY

Section M: Loss or Damage to Home Contents

Please note:
1) Contents lost or damaged are to be described in detail.
2) The Insured person must promptly take all possible steps to trace / recover the contents lost.
3) Receipts showing date, price, and place of purchase of the articles set out below should accompany this form.
4) Police report should be lodged where the loss or damage is caused by third party and a copy is to be submitted to us.
5) A set of photograph depicting the damage is to be submitted to us.
6) In the case of damaged property, an estimate for repair should be submitted. If the content is not repairable, a letter from repairers to that effect should be forwarded. All salvage must be retained.

Please provide details of contents lost / damaged (Please use supplementary sheet if necessary)

Description of Contents	Quantity	Original Purchase Price	Purchase Date	Value At Time of Loss (After Deduction For Wear and Tear)	Deduction For Value of Salvage	Amount Claimed
					Total Amount Claimed $	

Did you remove or save any property immediately before or during the occurrence? ☐ Yes ☐ No

If **Yes**, how much and where is it located now? _____

Are you the sole owner of the property lost / damaged? ☐ Yes ☐ No

If **No**, please state name, address and relationship of other owner(s) _____

Section N: Others (Please specify Details of any Claim other than Section D to M)

Name of Police Station, Carrier / Airline or other Authorities where report was lodged (if applicable)

_____

_____

_____

(Please use supplementary sheet if necessary)

Details of Claim	Amount Claimed

Section O: Any Other Insurance

Are there any other policies of insurance in force covering you in respect of this event? ☐ Yes ☐ No
If **Yes**, please specify below (Please use supplementary sheet if necessary)

Name and Address of Insurance Company(s)	Policy No(s).

SECTION P: Claims History

Have you or any insured person previously made claim(s) under a travel, secondment, home, medical or accident policy? ☐ Yes ☐ No
If **Yes**, please specify below (Please use supplementary sheet if necessary)

Date(s) and Circumstances of Claim(s)	Name of Insurance Company(s) Involved

Section Q: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	NA
Travel Documents (i.e. Air Tickets and / or Boarding Pass)	☐	☐
Medical Bills (Original copy need to be submitted for Reimbursement claim)	☐	☐
Written notes from Physician on type of injury sustained / Inpatient Discharge Summary or Medical Report	☐	☐
Original purchase receipts and photographs (for Loss and / or Damage of personal property claim)	☐	☐
Overseas Police or relevant authorities concerned Report (for Loss of personal property and/or money claim)	☐	☐
Written confirmation issued by the transport service provider (for Baggage Delay, Flight Delay or Flight Misconnection claim)	☐	☐
Letter from the third party concerned (for Legal Liability claim)	☐	☐
Death Certificate, Post Mortem Report, Autopsy Report, Police Reports, Letter of Administration (if involves Fatalities)	☐	☐

By signing this form, I / We agree that Chubb will use the information supplied here and during the formation and performance of this policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I / We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined me, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of this claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I / We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I / we agree that if I / we have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

_____

Signature of Policyholder
(Please affix company stamp if applicable)

_____

Date

_____

Signature of Claimant
(if different from Policyholder)

_____

Date

_____

Name & Signature of Insured's Direct Manager (for corporate policies)

_____

Date

Note:

If your claim involves reimbursement of medical or other expenses (Sections D and H), kindly submit the completed claim form in person, through your Broker, or by mail to Chubb Insurance Singapore Limited at 138 Market Street #11-01 CapitaGreen Singapore 048946. Please ensure that the relevant original copies of supporting documents are submitted as well.

If your claim does not involve any reimbursement of medical or other expenses, you may email the completed claim form to A&H.Claims.Singapore@chubb.com. Please ensure that the relevant scanned copies of supporting documents are submitted as well.

Contact Us

Chubb Insurance Singapore Limited
Co Regn. No.: 199702449H
138 Market Street
#11-01 CapitaGreen
Singapore 048946
O +65 6398 8000
F +65 6298 1055
www.chubb.com/sg

Chubb. Insured.℠

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