

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

บริษัท ชับบ์สามัคคีประกันภัย จำกัด (มหาชน) 2/4 อาคารซับบ์ ชั้นที่ 12 โครงการนอร์ธปาร์ค ถนนวิภาวดีรังสิต แขวงทุ่งสองห้อง เขตหลักสี่ กรุงเทพฯ 10210

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Personal Accident, Health and Travel Claim Form

To avoid unnecessary delay in claim process by (1) Completed Claim form (2) Prepare the relevant documents and (3) Registered mail to company within In certain circumstances additional 30 days from the date of the event. Part 1-3 are the list of minimum documentation required to process claim. information may be required in order for further confirmation. We are unable to return original documents, but we will 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		
Address				
Occupation	Email			
Mobile / Telephone No.	Travel Agency			
Have you lodged the claim with the similar circumstance to other insurance company or other sources? If yes, state:				
For the claim under Credit or Debit card previlleges please specify issuing bank name(Please do not fill in card number)				
PAYMENT DETAILS				
Cheque Payment				
- To Address				
Direct Transfer to Savings Account				
- Please attached a copy of Insured's bankbook with account name and number				
DECLARATION, AUTHORIZATION & CUSTOMER'S DATA PRIVACY CONSENT				
[Declaration] I/We confirm that I'm/We're 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	Signa	ture of Claimant	Date	
FOR OFFICER ONLY				
Name	Branch			
Telephone no.	Date			
TDACK VOLID OLAIM 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. o 2555 9100 or Email to $\frac{\text{Claimmail} \text{A\&H@chubb.com}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim form for the following: Tel. o 2555 9100 or Email to <math display="block"> \frac{\text{Claimmail} \text{A\&H@chubb.com}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim form for the following: Tel. o 2555 9100 or Email to <math display="block"> \frac{\text{Claimmail} \text{A\&H@chubb.com}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim form for the following: Tel. o 2555 9100 or Email to <math display="block"> \frac{\text{Claimmail} \text{A\&H@chubb.com}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim form for the following: Tel. o 2555 9100 or Email to <math display="block"> \frac{\text{Claimmail} \text{A\&H@chubb.com}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim form for the following: Tel. o 2555 9100 or Email to <math display="block"> \frac{\text{Claimmail} \text{A\&H@chubb.com}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim for the following: Tel. o 2555 9100 or Email to <math display="block"> \frac{\text{Claimmail} \text{A\&H@chubb.com}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim for the following: Tel. o 2555 9100 or Email to <math display="block"> \frac{\text{Claimmail} \text{A\&H@chubb.com}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim for the following: Tel. o 2555 9100 or Email to <math display="block"> \frac{\text{Claimmail}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim for the following: Tel. o 2555 9100 or Email to \\ \frac{\text{Claimmail}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim for the following: Tel. o 2555 9100 or Email to \\ \frac{\text{Claimmail}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim for the following: Tel. o 2555 9100 or Email to \\ \frac{\text{Claimmail}}{\text{Claimmail}}. We suggest you make a copy of your bill(s) and your completed claim for the following: Tel. o 2555 9100 or Email to \\ \frac{\text{Claimmail}}{\text{Claimmail}}. We suggest you when$ your records. Delays can occur or claims may be denied because of missing information.

Part 1: Medical Expenses Hospital Income I	Protection / Broken Bone	Cancer Insurance		
Date and Time of Accident/Sickness ; Date / / Time	Date of tr	eatment / / Time		
Cause of Accident/Sickness (Please provide full details of symptoms/m	ause of Accident/Sickness (Please provide full details of symptoms/medical condition) Accident by vehicle type			
	☐ Car	☐ Car ☐ Motorcycle☐ Other		
	Driver	Passenger Other		
	Police Sta	ation		
Documents Required (Please tick against the documents you have submitted)				
Medical Expenses Hospital Income Protection / Broken Bone Cancer Insurance				
All original medical receipts - Total number of receipts Medical Certificate (Certified by related organization)				
Total amount of receipts Admission / Discharge Report (as the case may Pathology (Certified by related organization)				
Medical Certificate (Certified by related organization) Identity Card or Passport (Certified true copy) Identity Card or Passport (Certified true copy)				
☐ Identity Card or Passport (Certified true copy) ☐ X-Ray film and interpretation by physician				
☐ Insurance card (Certified true copy) (Broken Bone only)				
Employee Certificate (as the case may be)				
☐ Flight itinerary information (e.g. Copy of boarding pass or E-tickets)				
Part 2: Death Total Perman	ent Disability	Dismemberment		
Date and Time of Loss / Accident; Date / / Time	Place of L	oss / Accident		
Cause of Loss / Accident (Please provide full details of symptoms/medical condition)				
Documents Required (Please tick against the documents you				
Death		Total Permanent Disability and Dismemberment		
Insured Person's Identity Card and Census Registration (Certified true copy		Medical record (Certified by related organization)		
□ Beneficiary's Identity Card and Census Registration (Certified true copy) □ Death Certificate (Certified by related organization)		Medical report which comfirms Total Permanent Disability or Dismemberment		
Death Certificate (Certified by related organization) Autopsy Report (Certified by related organization)		Photograph which confirms permanent disability (if any) Insured Person's Identity Card and Census Registration		
Police Report (Certified by related organization)	_			
Folice Report (Certified by related organization)				
Part 3: Loss/Damage to Baggage&Personal Effect	Baggage Delay	Travel Delay Uther Please Specify		
Date and Time of Loss / Event; Date / / Time	Place of L	oss / 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 occures threat or use of violence				
☐ Photo of Damage or Loss of Baggage / Personal Effects				