



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

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

โทรศัพท์ +66 0 2555 9100
โทรสาร +66 0 2955 0205
www.chubb.com/th

Personal Accident, Health and Travel Claim Form

Claim Instructions

Please complete all information and attach the claim documents listed at the end of each coverage section to help expedite the assessment of your claim.

Please provide your current address and contact telephone number. The company will respond within 5 business days after receiving the documents.

Once you have completed all information, you may submit the claim documents through the following channels:

- By registered mail to: Accident and Health Claims Department Chubb Samaggi Insurance Public Company Limited
2/4 Chubb Building, 12th Floor, North Park Project, Vibhavadi Rangsit Road, Thung Song Hong, Lak Si, Bangkok 10210
- Through any branch office of Chubb Samaggi Insurance Public Company Limited nationwide / agents / insurance brokers

General Information (Please complete this section in full)

Insured Name		Policy Number
National ID Number or Passport Number	Gender	Date of Birth
Current Contact Address		
Occupation	Email	
Mobile Phone Number	Home/Office Phone Number	
If the insured name and the person completing the form are not the same, please specify the insured's name.	Have you made a claim with any other company? ☐ Yes ☐ No If yes, please specify the company name	

If the claim is under credit card or debit card benefits, please specify the issuing bank: _____ (Please do not provide your credit or debit card number)

Claim Payment Method via Bank Transfer: Please attach a copy of the insured's savings account passbook (first page).

Declaration / Consent Form

I hereby consent to any physician, healthcare provider, other insurance company, or any related person who possesses my personal data, health data, disability data, sexual behaviour data, biometric data, genetic data, racial data, and past or future medical history to disclose such information to the company in connection with the relevant insurance policy.

I hereby consent to the company collecting, using, and disclosing my personal data, health data, disability data, sexual behaviour data, biometric data, genetic data, racial data, and medical history to any competent authority, reinsurance broker, reinsurer, the company's representative, policyholder, and/or insurance broker for the purpose of applying for insurance, payment of benefits under the insurance policy, medical purposes, or any other matter relating to the insurance policy.

I and/or my lawful representative hereby consent to the Office of Insurance Commission (OIC) disclosing information relating to my insurance policy and/or that of the minor, whether existing in the past or arising in the future, including both general personal data and sensitive personal data, to the company for the purpose of considering compensation or claim payment under the insurance policy, or for providing any services related to the insurance policy. Such disclosure shall be in accordance with the personal data protection policy of the OIC, including the rules, procedures, and conditions prescribed by the OIC as published on www.oic.or.th. Any withdrawal of this consent shall not affect the consideration of compensation or claim payment under the insurance policy, or any services related to the insurance policy, and shall not relieve the company from performing in accordance with the terms and conditions of the insurance policy.

In the event of a claim submitted through a hospital, I consent and agree that the company may pay medical expenses directly to the healthcare facility where I receive treatment, and such payment shall be deemed as payment duly made to me in accordance with the terms and conditions of the insurance policy. Any medical expenses not covered under the insurance policy shall be paid by me directly to the healthcare facility. I understand and accept that the company reserves all rights under the hospital direct billing arrangement if it is subsequently determined that my illness or accident falls within an exclusion under the insurance policy, notwithstanding any initial approval for inpatient admission. In the event that the company has advanced payment of medical expenses on my behalf, I agree to reimburse the company in full within 7 days from the date of receipt of the company's written notice.

I hereby certify that I have read and fully understood the contents, conditions, and procedures set forth in this document, and confirm that the same are accurate and in accordance with my intention. Accordingly, I agree to give my consent and to be bound by the company's terms, conditions, and procedures in all respects.

Note: If the insured is a minor, a parent or legal guardian must sign on their behalf and specify the relationship. If signing by fingerprint, two witnesses are required.

Insured: Date : Witnesses: Witnesses:
(.....) (.....) (.....)

Consent Provider: as ☐ parent ☐ legal guardian of the insured (if the insured is a minor)

Section 1: ☐ Medical Expenses ☐ Hospital Income / Fracture Compensation ☐ Cancer / Critical Illness

Date and time of injury or illness

Date and time of first medical consultation

Describe the circumstances of the incident, place of incident and symptoms

If the accident involved a vehicle:

Was the insured ☐ driving ☐ passenger ☐ pedestrian walkway

Type of vehicle ☐ car ☐ motorcycle ☐ other.....

Police report filed at:.....

Supporting documents for claim assessment

Medical Expenses

☐ Original medical receipt.....

Total amount: _____ baht

☐ Medical certificate

☐ Copy of insured's ID card or passport

☐ Employee certificate (for group employee insurance)

☐ Travel confirmation documents (for travel insurance)

Hospital Income / Fracture Compensation

☐ Medical certificate

☐ Copy of invoice or copy of receipt

☐ Copy of insured's ID card or passport

☐ X-ray film and the doctor's interpretation

(for fracture compensation only)

Cancer / Critical Illness

☐ Medical certificate

☐ Copy of insured's ID card or passport

☐ Pathology report

☐ Medical history

Section 2: ☐ Death ☐ Total Permanent Disability ☐ Dismemberment

Date of incident

Time

Place of incident

Please describe the cause and circumstances of the incident

Supporting documents for claim assessment

Death

☐ Copy of insured's ID card and household registration

☐ Copy of beneficiary's ID card and household registration

☐ Copy of insured's death certificate

☐ Copy of autopsy report (certified true copy by the relevant authority)

☐ Copy of death certificate (certified true copy by the relevant authority)

☐ Copy of police report (certified true copy by the relevant authority))

Total Permanent Disability/ Dismemberment

☐ Medical certificate

☐ Medical history

☐ Current full-body photograph

☐ Copy of insured's ID card and household registration

(If payment is made to the beneficiary, please attach a copy of the beneficiary's ID card and household registration.)

Section 3: ☐ Loss or Damage to Baggage ☐ Baggage Delay ☐ Flight Delay ☐ Other

Date of incident

Time

Place of incident (City/Country)

Please describe the cause and circumstances of the incident. If baggage was delayed, please specify the date and time it was received.....

Original Flight schedule: Date_____Departure time_____Arrival time_____Flight number_____

Actual Flight schedule: Date_____Departure time_____Arrival time_____Flight number_____

Details of lost or damaged baggage / expenses incurred due to travel delay or baggage delay

Item lost / damaged / expense	Date of purchase	Purchase price or repair cost

Supporting documents for claim assessment

☐ Copy of the insured's passport

☐ Travel booking documents and actual travel documents

☐ Proof of compensation from the carrier or accommodation provider

☐ Original receipt showing the actual expenses incurred

☐ Airline certificate (for travel delay, baggage delay, flight cancellation, or reduction in travel days, stating the reason and duration)

☐ Loss or damage report issued by the police / accommodation / airline / transport company

Note: The Company reserves the right to request additional documents or information as necessary.

Please check that all documents are accurate and complete, and sign to certify true copies on all photocopies.