® **Sun Flower Insurance Brokers Limited**
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Tel: 2521 1881 Fax: 2521 1919 Email: vip@sunflowergroup.com.hk www.sunflowerVIP.com

Thank you for considering Sun Flower to be one of your selected intermediaries.
We are pleased to get in touch should you have any enquiry regarding the captioned insurance.

旅遊保險索償表
Travel Insurance Claim Form

STARR INSURANCE COMPANIES

如果表格空間不足或沒有適用之欄位，請以附件補充資料。If the space is not enough or no applicable field available, please supplement information by attachment.

保單持有人及受保人資料 POLICYHOLDER AND INSURED PERSON INFORMATION

保單號碼 Policy number	保單持有人姓名 Name of Policyholder	
受保人姓名 Name of Insured Person	索償人姓名 (如不是受保人) Name of claimant (if not Insured Person)	與受保人關係 Relationship to Insured Person
索償人身分證號碼 Claimant HKID number	聯絡電話 Contact phone number	電郵地址 E-mail address
通訊地址 Correspondence address		

索償類別及金額 TYPES OF CLAIMS AND AMOUNT

☐ 意外死亡 / 永久傷殘 / 燒傷
Accidental Death / Permanent Disablement / Burns

☐ 醫療費用 / 海外住院津貼
Medical Expenses / Overseas Hospital Cash

☐ 個人行李 / 個人錢財 / 證件遺失
Personal Baggage / Personal Money / Document Loss

☐ 旅程延誤 / 行程更改 / 行李延誤
Travel Delay / Re-Route / Baggage Delay

☐ 取消 / 提早結束旅程
Trip Cancellation / Trip Curtailment

☐ 個人責任
Personal Liability

☐ 其他
Others_____ 索償金額 Claim Amount: _____

意外詳情 DETAILS OF ACCIDENT

意外發生日期及地點 Date and place of accident	傷勢及受傷部位 Nature of injury and affected part of body
意外發生的詳情 Circumstances of accident	
證人姓名 Name of witness(es)	證人聯絡電話 Contact phone number of witness(es)

疾病詳情 DETAILS OF SICKNESS

首次出現病徵日期 Date of symptom first appeared DD 日 MM 月 YYYY 年	首次求診日期 Date of first consultation DD 日 MM 月 YYYY 年	病症 Diagnosis
醫生姓名、地址及電話 Name, address & contact phone number of doctor	醫院名稱及地址 Name and address of hospital	

遺失或損壞行李/錢財/證件詳情 DETAILS OF LOSS OF OR DAMAGE TO BAGGAGE/MONEY/DOCUMENT

遺失或損壞的日期及地點 Date and place of loss or damage	是否向有關機構(如警方、公共交通工具營運商等)報告此損失或損壞事件? Was the loss reported to relevant authorities (e.g. Police, Common Carrier Operator, etc.) ☐ 有 Yes ☐ 沒有 No
遺失或損壞的詳情 Circumstances of loss or damage	

遺失或損壞的物品 Lost or damaged Items	購買日期 Date of purchase DD 日 MM 月 YYYY 年	購買價錢 Purchase cost	維修價錢 Repair cost

行李/行程延誤或更改詳情 DETAILS OF BAGGAGE/TRAVEL DELAY OR RE-ROUTE

原定啟程/抵達時間 Original departure/arrival time	實際啟程/抵達時間 Actual departure/arrival time
延誤的原因 Reason for delay	有否購買緊急必需品 Any emergency purchase of essential replacement items of clothing and toiletries? ☐ 是 Yes ☐ 否 No
原定的行程 Original itinerary	更改後的行程 Re-routed itinerary

取消或提早結束旅程詳情 DETAILS OF TRIP CANCELLATION OR CURTAILMENT

取消/提早結束行程的原因 Reason for Trip Cancellation or Curtailment

原定的行程 Original itinerary	提早結束後的行程 Curtailed itinerary

個人責任事故詳情 DETAILS OF PERSONAL LIABILITY INCIDENT

事故日期及地點 Date and place of incident

事故的詳情 Circumstances of incident

第三者索償人姓名及聯絡資料 Name and contact details of third party claimant	證人姓名及聯絡資料 Name and contact details of witness(es)

重要備註 Important Note: -

倘收到第三者就有關事件提出的索償要求、官司或法律訴訟，應即時通知 Starr International Insurance (Asia) Ltd. ("SIIA")處理。在未獲得 SIIA 書面同意之前，不可向第三者索償人承認責任、提出和解或作出賠償。

Any claim, demand, lawsuit or legal proceedings relating to the incident which the Insured Person becomes aware of or received from third party claimant should be forwarded to Starr International Insurance (Asia) Ltd. ("SIIA") unanswered immediately. No admission of liability, offer to settle or payment of claim with third party claimant is permitted without written consent of SIIA.

其他保險或賠償 OTHER INSURANCE OR COMPENSATION

索償項目是否受保於其他保險合約 Do you have other insurance policies covering this loss or expenses incurred? ☐ 否 No ☐ 是 Yes (請詳述如下 Please specify below)

保險公司之名稱 Name of Insurer	保單號碼 Policy number	保障項目 Benefit	保額 Sum insured

索償項目是否獲得公共運輸機構或酒店提供賠償或安排 Did you receive any compensation or offer from common carrier operator or hotel for this claim?

☐ 否 No ☐ 是 Yes (請詳述 Please specify) _____

收款方式 SETTLEMENT METHOD

請選擇以下其中一項收款方式

Please select one of the following settlement method

☐ 轉數快 FPS (只適用於香港註冊賬戶 Valid for Hong Kong registered account only)

轉數快帳戶類型 FPS payment method:

銀行户口持有人名稱 Full Name of Account Holder _____

手提電話號碼 Mobile No. _(+_____)_____ 或 OR 轉數快識別代號 FPS ID_____ 或 OR

電郵地址 Email Address _____

☐ 銀行轉帳 Bank Transfer

登記銀行名稱 Name of the Bank _____

銀行號碼 Bank Code _____

銀行户口號碼 Account No. _____

銀行户口持有人名稱 Full Name of Account Holder _____

☐ 非香港銀行户口 Bank account outside Hong Kong

本公司會盡快與閣下聯絡以獲取詳細資料，索償時間可能會因此而延長。

Our Staff will contact you shortly for details and it may take longer to settle your Claim.

聲明及授權 DECLARATION AND AUTHORIZATION

- 本索償表簽署人謹此聲明，就我/我們所知所信，本索償表上所填報之資料均屬實無訛。我/我們同意任何蓄意欺詐或隱瞞將會導致保單失效。我/我們並同意 Starr International Insurance (Asia) Ltd ("SIIA") 或其授權代理可保留，使用或透露 SIIA 所收集或保留之任何有關我/我們的個人資料給予 SIIA 有關人士/機構或任何被選定的機構，用作處理此索償申請及資料核對等用途，及因此等用途與我/我們聯絡。我/我們明白倘若未能提供索償表所需的資料，SIIA 將可能無法處理有關索償。我/我們同時有權向 SIIA 查閱及申請改正個人資料。有關的申請可致函 SIIA 的營運部經理，地址為香港灣仔港灣道 18 號中環廣場 19 樓 1901 室。
- 我/我們現授權 SIIA 或其代理人向醫生、醫院、診所、保險公司、政府機構或有關組織，提取我/我們與這意外或索償事件有關之病歷記錄。即使我/我們身故或喪失能力，此授權書仍然存有法律效力，而我/我們之繼承人也會受此約束，其副本與正本同屬有效。
- The undersigned hereby declares that to the best of my/our knowledge and belief, the above statement and particulars are fully and truly made. I/We agree that if any fraudulent means or devices are used in connection with obtaining any benefit under the Policy, the Policy shall be void against me/us. I/We agree that any of my/our personal information collected or held by Starr International Insurance (Asia) Ltd. ("SIIA") or its authorized representatives is provided and be held, used and disclosed by SIIA to individuals/organization associated with SIIA 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 SIIA may be able 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 and to request correction of my personal information held by SIIA. Such request can be made to SIIA's Operations Services Manager at Suite 1901, 19/F Central Plaza, 18 Harbour Road, Wanchai, Hong Kong.
- I/We hereby irrevocably authorize SIIA or its authorize representative to obtain my/our medical records from my/our treating physicians, hospitals, clinics, insurance companies, government agencies or other relevant organizations in relation to the accident or claim. This authorization is valid even I/we am/are deceased. My/our next of kin is also bound by this authorization. The original or copy of this authorization has the same effects.

受保人/索償人簽署 Signature of Insured Person/claimant	保單持有人簽署（請蓋公司印，適用於團體保單） Signature of Policyholder (with company chop, applicable to group policy)	日期 Date DD 日 MM 月 YYYY 年

醫療報告（需由主診醫生填寫）**MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIANS)**	
病人姓名 Name of patient	診斷 Diagnosis
首次求診日期 Date of first consultation DD 日 MM 月 YYYY 年	受傷或首次出現病徵日期 Date of occurrence of injury or first symptom DD 日 MM 月 YYYY 年
據你所知，病人以往曾否出現同樣或類似的病況? 如是，請提供日期及詳情。To the best of your knowledge, has the patient ever had the same or similar condition(s) or symptom(s)? If yes, please state the dates and conditions/symptom.	
是次情況是否由其他潛在疾病導致？如是，請提供詳情。Was the condition caused by any underlying disease? If yes, please specify.	
是次情況會否引致永久傷殘? 如是，請提供詳情。Will the current condition(s) or symptom(s) result in any permanent disability? If yes, please advise detail.	
如是次情況與燒傷有關，請評估燒傷程度及身體面積之百分比。If the current condition or symptom relates to burn injury, please advise (a) degree of burnt and (b) estimated % of burnt body surface.	

診斷是否由下列情況導致或有關連 Is the diagnosis due to or associated with any of the following?

(a)	先天性異常 Congenital anomalies	☐ 是 Yes ☐ 不是 No
(b)	視力矯正 Refractive error or correction of eyesight	☐ 是 Yes ☐ 不是 No
(c)	遺傳性疾病 Heredity condition	☐ 是 Yes ☐ 不是 No
(d)	美容或整形手術 Cosmetic or plastic surgery	☐ 是 Yes ☐ 不是 No
(e)	懷孕或分娩 Pregnancy or childbirth	☐ 是 Yes ☐ 不是 No
(f)	例行醫療檢查 Routine medical check-up	☐ 是 Yes ☐ 不是 No
(g)	酒精或藥物影響 Drugs or alcohol	☐ 是 Yes ☐ 不是 No
(h)	精神或心理病 Mental or nervous disorders	☐ 是 Yes ☐ 不是 No

手術日期及詳情，如適用。Date and details of operation, if applicable		
出院概況 (包括診治、檢查程序、結果、併發症及覆診計劃) Discharge summary (including investigation procedures, result, diagnosis, treatments, complications and follow-up plan)		
醫院名稱 Name of hospital	入院日期 Date of admission DD 日 MM 月 YYYY 年	出院日期 Date of discharge DD 日 MM 月 YYYY 年
醫院/診所地址 Address of hospital/clinic		
醫院/診所電話 Phone number of hospital/clinic	醫療報告日期 Date of medial report DD 日 MM 月 YYYY 年	
主診醫生姓名 Name of attending physician/specialist	主診醫生簽名及蓋章 Signature and stamp of attending physician/specialist	日期 Date DD 日 MM 月 YYYY 年

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