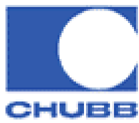
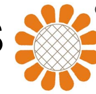


CHUBB GROUP OF INSURANCE COMPANIES
FEDERAL INSURANCE COMPANY



Sun Flower Insurance Brokers Limited
Room 1108, Hing Yip Commercial Centre
282 Des Voeux Road Central, Hong Kong
Tel: (852) 2521-1881 Fax: (852) 2521-1919
Web: www.sunflowervip.com www.sunflowermpf.com

Incorporated under the laws of Indiana, U.S.A., licensed to do business in the Hong Kong Special Administrative Region

2401, Harcourt House, 39 Gloucester Road, Wanchai, Hong Kong Tel: (852) 2861 3668 Fax: (852) 2861 2681
香港灣仔告士打道 39 號夏慤大廈 24 樓 2401 室 電話號碼: (852) 2861 3668 傳真號碼: (852) 2861 2681

旅 遊 保 險 索 償 申 請 書

茲此聲明,填寫本申請表不代表聯邦保險公司已承諾了保險責任。投保人/受保人或索償人應正確詳細填寫此申請表，並將後頁所列索償所需的資料于索償事由發生 30天內交回本公司賠償部。視案件性質，本公司有權要求進一步資料。 每份申請表僅限一位申請索償人填寫。 若此申請表的資料不足夠或提供之文件不完整有可能會導致您的索償處理受延誤或被拒絕。

投保人 / 受保人資料（此部份必須填寫）

投保人/雇主(如適用)		保險單號碼
受保人/雇員	職業/職位	身分證號碼
通訊位址	聯繫電話	電郵地址
派駐城市/國家(如適用)	原居地	派駐日期
索償人(如非受保人)	與受保人關係	身分證號碼

旅遊行程（此部份必須填寫）

旅遊性質 ☐ 公幹 ☐ 消閒度假 ☐ 其他, 請具體說明:	旅遊時段由	至
出發港口/機場	公共交通機構名稱/航班編號	日期及時間
過境港口/機場(如有)	公共交通機構名稱/航班編號	日期及時間
目的地/機場	公共交通機構名稱/航班編號	日期及時間

隨附文件
☐ 旅遊程表/電子機票/登機證

醫療費用/住院現金保障/入息津貼

發生意外或疾病開始的日期,時間及地點	傷勢/病況的診斷結果	索償金額（請注明貨幣單位)
損傷 – 事故是如何發生的? 疾病 – 疾病的徵狀初次出現的日期?		
主診醫生名稱及地址		
如曾住院，請列出醫院/診所名稱及地址	住院時段由	至
證人的姓名及聯絡電話號碼(如適用)		

隨附文件
❖ 醫療費用
☐ 由註冊醫生/醫院發出的醫療報告/收據正本，並注明診斷結果
❖ 住院現金保障/入息津貼
☐ 由註冊醫生填寫的醫療報告正本，注明住院日數
☐ 出院總結
☐ 入息津貼 – 雇主發出的受保人在受傷或患病期間受雇的證明及其工資收入金額

行李/旅遊證件及金錢遺失

遺失/損壞日期，時間及地點	警察局/酒店/航空公司等有關機構的名稱及聯絡地址/電話

詳細描述事件發生的經過(如：遺失物品擺放的位置,如何及何時發現物品已遺失等)

索賠項目詳情:

遺失/損壞物品	損失物品 購置日期	購買時價值 (請注明貨幣單位)	補領/更換/修理費用 (請注明貨幣單位)

隨附文件

- ☐ 有關機構(如警察局/酒店/航空公司等）發出的損失/損壞證明或報告正本;
- ☐ 顯示物品受損壞程度的相片(如適用)
- ☐ 購買收據/維修報價/旅遊證件補領收據等(請提供正本)
- ☐ 從其他保險/責任方（例如航空公司）獲得的補償細目(如有)

旅程取消/旅程縮短/旅程更改

	由: 地點 日期	至: 地點 日期
原定行程		
旅程取消/縮短/更改		

旅程取消/縮短/改變的原因

如旅程取消或縮短的原因是因爲受保人本人或受保人的直系親屬或親密生意夥伴死亡，受傷或患病,請提供以下資料:

死亡,受傷或患病人名稱	與受保人關係

傷病診斷	索償金額（請注明貨幣單位)

隨附文件

❖ **旅程取消/旅程縮短**

- ☐ 顯示**已付費用/按金**或於行程開始後支付的額外公共交通工具費用/住宿費用的收據正本
- ☐ 旅行社/旅運當局發出之證明文件以確認
- ☐
  - 受保人取消行程
  - 不獲退回的未使用旅費 /已獲退款之金額
- ☐ 醫生證明受保人本人或受保人的直系親屬或親密生意夥伴身體狀況不宜旅遊(如適用)
- ☐ 死亡證(如適用)
- ☐ 傷患病人與受保人的關係證明(如適用)

❖ **行程更改**

- ☐ 行程開始後支付的額外交通費用之正本
- ☐ 公共交通機構/旅行社發出的書面證明注明行程更改的原因

旅程及行李延誤

旅程/行李延誤的原因:

航班於　　　　　　　港口/機場遭延誤	航班編號	日期及時間
在　　　　　　　港口/機場錯過接駁航班	航班編號	日期及時間
行李於　　　　　　　港口/機場遭延誤	收回行李的地點	日期及時間

購買緊急必需物品（如適用）	購買日期	金額（請注明貨幣單位）	收據正本(有/沒有)

隨附文件

- ☐ 公共交通機構發出的書面證明注明行程或行李延誤的時間及原因
- ☐ 購買緊急必需物品的收據正本(如適用)

人身意外（死亡、傷殘或嚴重燒傷）

意外發生的日期,時間及地點

詳敍述意外發生的經過及所遭受的損傷

主診醫生名稱及地址

永久傷殘的程度(如適用)	死亡原因(如適用)

證人的姓名及聯絡電話號碼(如適用)

隨附文件

- ☐ 有關機構的意外報告(如警察局/酒店/航空公司/活動主辦單位等)（如有）
- ☐ 註冊醫生簽發受傷及永久傷殘程度的證明(如適用)
- ☐ 死亡證/解剖報告副本(如適用)

家屬探望 / 員工替代

家庭成員 / 替代員工姓名	與受保人的關係
探望時段由　　　由　　　　　　　至	索償金額（請注明貨幣單位）

隨附文件

- ☐ 與受保人的關係證明
- ☐ 公共交通工具費用/住宿費用的收據正本

個人責任

詳細描述意外發生的經過，日期,時間及地點

第三索償者姓名及聯絡電話號碼	證人的姓名及聯絡電話號碼(如有)

重要事項：

- ❖ 如收到任何第三方對有關事件的索償要求，法庭傳票，通告及書命令或涉及任何法律訴訟,應立即轉交本公司處理。
- ❖ 未經本公司同意，不得向第三方承認任何責任或達成和解或付款承諾。

隨附文件

- ☐ 有關機構的意外報告(如警察局/其他地方當局/酒店/體育活動中心等)
- ☐ 第三者要求賠償的文件、發票等
- ☐ 其他文件 － 請注明:

其他有關的生效保險（此部份必須填寫）

是項索償是否受保於其他保險合約(例如旅遊保險、家居保險、財物保險等) ？ 如有， 請說明：

保險公司	保險單號碼
索賠項目	索償/已賠付金額 HK$

收款人（如非受保人/索償人）

如果索賠受理，除非注明如下,否則賠付金額的收款人即爲受保人/索償人。本公司有權要求進一步資料以確認收款人姓名及與受保人/索償人之關係。

收款人姓名:	與受保人/索償人關係	索償項目

☐ 受保人/索償人未滿十八歲
☐ 遺失/損壞物品爲投保人/雇主所有
☐ 開支費用由投保人/雇主支付
☐ 其他原因 – 請注明:

聲明及授權（此部份必須填寫）

本索償申請表簽署人（等）謹此聲明， 就我等所知所信， 以上陳述絕無虛假和隱瞞。索償申請人並同意聯邦保險公司（下稱“貴公司”）或其授權代理可保留，使用或透露貴公司所收集或保留之任何有關索償申請人的個人資料給予貴公司有關之人士／機構或任何被選定的機構，用作處理與此索償申請及資料核對等用途，及因此等用途與索償申請人聯絡。索償申請人明白到倘若索償申請人未能提供申請書所需的資料，貴公司將可能無法處理有關申請。索償申請人同時有權向貴公司查閱及申請改正所有與索償申請人有關的個人資料。有關的申請可致函貴公司的營運部經理， 地址爲香港灣仔告士打道 39 號夏愨大廈 24 樓 2401 室。

本索償申請表簽署人（等）授權任何知悉或擁有本人/受保人之健康狀況及病歷或任何治療或諮詢記錄、意外或索償事件之細節及曾爲或將爲本人/受保人之診治之醫生，醫院，診所， 部門，保險公司或任何政府或私人機構、組織或人士，向聯邦保險公司或其代理人透露有關資料， 不得撤回，即使本人/受保人死亡或喪失能力，此受權書仍然存有法律效力，而本人/受保人之繼承人及轉讓人也會受此授權書約束。此授權之複印件與原件同屬有效。

索償申請人簽署 日期:	監護人姓名及簽署:（若索償申請人未滿十八歲） 日期:

投保人或雇主代表姓名，職位及簽署（加蓋公司印章）

姓名 職位	投保人簽署 / 公司印鑒(如適用) 日期:

CHUBB GROUP OF INSURANCE COMPANIES
FEDERAL INSURANCE COMPANY

Sun Flower Insurance Brokers Limited
Room 1108, Hing Yip Commercial Centre
282 Des Voeux Road Central, Hong Kong
Tel: (852) 2521-1881 Fax: (852) 2521-1919
Web: www.sunflowervip.com www.sunflowermpf.com

Incorporated under the laws of Indiana, U.S.A., licensed to do business in the Hong Kong Special Administrative Region

2401, Harcourt House, 39 Gloucester Road, Wanchai, Hong Kong Tel: (852) 2861 3668 Fax: (852) 2861 2681
香港灣仔告士打道 39 號夏慤大廈 24 樓 2401 室 電話號碼: (852) 2861 3668 傳真號碼: (852) 2861 2681

TRAVEL INSURANCE CLAIM FORM

This form is issued without admission of liability on the part of Federal Insurance Company and must be completed as truthfully and accurately by the Policyholder and/or the Insured Person/Claimant and returned to our Claims Department together with the FULL supporting documents within 30 days after the occurrence of the claimed condition. Further information/documents may be requested depending on the nature and extent of the claim. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim. Separate forms must be used for different claimants.

THE POLICYHOLDER / THE INSURED PERSON (REQUIRED)

Policyholder/Employer		Policy No.
Insured Person/Employee	Occupation/Position	Identity Card Number
Residential Address	Contact No.	E-mail
Stationed City/Country (if applicable)	Home & Residing Country	Date of Posting
Claimant (if not Insured Person)	Relationship to Insured Person	Identity Card Number

TRAVEL DETAILS (REQUIRED)

Purpose of Trip ☐ Business ☐ Personal Vacation ☐ Others, please specify:		Duration of Trip From To
Departure Airport	Carrier/Flight No.	Date & Time
Transit Airport, if any	Carrier/Flight No.	Date & Time
Arrival Airport	Carrier/Flight No.	Date & Time

Documents attached:
☐ Travel itinerary / e-ticket / boarding pass

MEDICAL EXPENSE REIMBURSEMENT / HOSPITAL INCOME / LOSS OF INCOME

Date, Time & Place of Injury/Sickness	Nature of Injury / Diagnosis of Sickness	Claimed Amount (Specify currency)
Injury – how did the accident occur? Sickness – when did the symptom(s) first appear?		
Name and address of the attending doctor		
If hospitalized, please state the name and address of the hospital.	Hospitalized From	To
Name and contact number of witness(es), if any.		

Documents attached:

❖ **Medical Expense Reimbursement**
- ☐ Original hospital/medical bill(s)/receipt(s)/medical report(s) certified by a Qualified Medical Practitioner stating the diagnosis and date of the Injury/Sickness.

❖ **Hospital Income/Loss of Income**
- ☐ Medical certificate from a Qualified Medical Practitioner certifying the number of days of hospitalization
- ☐ Hospital Discharge Summary
- ☐ Loss of Income claim – Letter from Employer stating that the insured person is under employment during sick leave period as a result of the Injury/Sickness and the amount of the salary earned.

LOSS OF BAGGAGE, TRAVEL DOCUMENTS AND PERSONAL MONEY

Date, Time & Place of Loss/Damage	Contact Information of the reported police station/common carrier/hotel, etc.

State how the Loss/Damage occurred or discovered (e.g. where the property was placed and where, when and how the loss was discovered).

Particulars of Items Claimed:

Lost /Damaged Items	Date when Lost / Damaged Items Purchased	Original Purchase Value (specify currency)	Replacement / Repair Cost (specify currency)

Documents attached:

- ☐ Original loss/damage report(s) issued by the relevant authorities or organizations (e.g. police, airline, hotel, etc.);
- ☐ Photos showing the extent of damage to the property, if applicable;
- ☐ Purchase receipt, repair quotation, replacement invoice, etc. where applicable;
- ☐ Compensation breakdown from other insurers/responsible parties (e.g. airline), if applicable.

JOURNEY CANCELLATION, CURTAILMENT AND RE-ROUTE

	From Location	Date	To Location	Date
Original Schedule				
Curtailed / Cancelled / Re-arranged Journey				

Reason for Journey Cancellation/Curtailment/Re-route

If the Journey Curtailment/Cancellation is due to Death, Serious Injury or Sickness of the insured person/immediate Family Member/Close Business Partner, please state clearly the following:

Full name of sick/injured/deceased person	Relationship to the insured person

Diagnosis	Amount Claimed:

Documents attached:

- ❖ **Journey Cancellation and Curtailment**
  - ☐ Original receipt(s) showing any pre-paid costs or deposits made OR additional travel and/or accommodation expenses incurred after the commencement of the insured Journey
  - ☐ Original documentation issued by travel agent or common carrier confirming:
    - Trip cancellation
    - Non-refundable/refunded amount
  - ☐ Medical certificate indicating diagnosis and reason that the insured person/immediate family member/close business partner is unfit for travel, if applicable.
  - ☐ Death certificate, if applicable.
  - ☐ Proof of relationship, if applicable.
- ❖ **Journey Re-route**
  - ☐ Original documentation/receipt(s) indicating the additional traveling expenses incurred after the commencement of the insured Journey outside Hong Kong.
  - ☐ Documentation from common carrier or travel agent indicating the reason for travel re-route.

TRAVEL DELAY AND BAGGAGE DELAY

Reason for Delay

Flight Delayed at Airport	Delayed Flight No.	Date & Time
Missed Connection at Airport	Delayed Flight No.	Date & Time
Baggage Delayed at Airport	Place of Receipt	Date & Time

Emergency essential items purchased (if applicable)	Date Purchased	Price Paid (specify currency)	Original Receipts (Y/N)

Documents attached:

- ☐ Documentation indicating the reason(s) for and the number of hours of delay (e.g. confirmation from common carrier/travel agent).
- ☐ Original receipt(s) for emergency purchase of essential items, if applicable.

PERSONAL ACCIDENT (FATAL / PERMANENT DISABILITY / BURNS BENEFIT)

Date, Time & Place of Accident

Describe how the accident occurred, and the injuries sustained.

Name and address of the attending doctor.

Permanent Disability (Degree & Extent), if applicable.	Cause of Death, if applicable.

Name and contact number of witness(es), if any.

Documents attached:

- ☐ Accident report(s) issued by relevant authorities/organizations (e.g. police, hotel, common carrier, activity organizer, etc.), if any.
- ☐ Original medical report stating the date of attendance and extent of injuries sustained as certified by a Qualified Medical Practitioner, if applicable.
- ☐ Copy of Death Certificate/Post Mortem Report, if applicable

CARE VISIT / STAFF REPLACEMENT

Name of Visiting Family Member / Replacement Staff	Relationship to Insured Person
Duration of Visit From: To:	Amount Claimed:

Documents attached:

- ☐ Proof of relationship
- ☐ Original receipts of traveling and/or accommodation expenses incurred.

PERSONAL LIABILITY

Full description of the incident, including Date, Time & Place

Full name and contact of the Third Party Claimant	Full name and contact of witness(es), if any.

Important:

- ❖ Any lawsuit, demand, claim or proceeding of any types relating to the incident of which the Claimant becomes aware of, and received from the Third Party Claimant, should be immediately forwarded to the Company.
- ❖ No liability should be admitted or no settlement or promise of payment should be reached or made to the third party without the prior consent of the insurance company.

Documents attached:

- ☐ Copy of incident report(s) from relevant parties (e.g. Police and other local authorities, Hotel, Sports Centre, etc.)
- ☐ Claim letter and invoice.
- ☐ Other documents – please state:

OTHER APPLICABLE INSURANCE (REQUIRED)

Do you have any other insurance policies covering the loss or expenses incurred (e.g. Travel Insurance, Household Insurance, Property Insurance, etc.)? If so, please state:

Name of Insurer	Policy Number
Claimed Item	Claimed / Settled Amount HK$

PAYEE NAME (Please complete if different from Insured Person)

If claim is admissible under the policy, the payment will be made to the Insured Person unless as stated below. Further proof might be requested by the Company to confirm payee name:

Payee Name:	Relation to Insured Person/Claimant	Particulars of Claimed Item(s)

- ☐ Insured Person / Claimant is aged under 18.
- ☐ Property owned by Policyholder/Employer.
- ☐ Expenses paid for by Policyholder/Employer.
- ☐ Other Reason(s) – Please state:

DECLARATION & AUTHORISATION (REQUIRED)

The undersigned hereby declare that to the best of my/our knowledge and belief, the above statements and particulars are fully and truly made. I/We agree that any of my/our personal information collected or held by Federal Insurance Company ("Company") or its authorized representatives is provided and be held, used and disclosed by the Company to individuals/organizations associated with the Company 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 the Company may be unable 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 to and to request correction of any personal information held by the Company concerning me/us. Such request can be made to the Company's Operations Services Manager at 2401, Harcourt House, 39 Gloucester Road, Wanchai, Hong Kong.

The undersigned hereby irrevocably authorize any governmental or private organization / institution, insurance company or individual that has any information, record or knowledge of the Insured Person's health and medical history or any treatment, advice, accident or loss details that has been or may hereafter be consulted, to disclose to Federal Insurance Company or its authorized representatives such information. This authorization shall bind my / the Insured Person's successors and assigns and remain valid notwithstanding my / the Insured Person's death or incapacity in so far as legally permissible. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Insured Person / Claimant: **Date:**	**Name & Signature of Guardian** **(If Insured Person / Claimant is under the age of 18):** **Date:**

Name, Signature & Designation of Policyholder's Representative / HR Personnel (with company stamp)

Name: **Position:**	**Policyholder Signature / Company Chop (if applicable)** **Date:**