PERSONAL ACCIDENT INSURANCE
CLAIM REPORT FORM

NOTE: TO BE ACCOMPLISHED BY THE PRINCIPAL INSURED OR BENEFICIARY OR CLAIMANT

Principal Insured : _____ Policy No. : _____

Claimant's Name : _____ Relationship : _____

Address : _____ Email Address : _____

Birthday of Insured : _____ Tel. No. : _____

Occupation of Insured : _____ Fax. No. : _____

1. Date of Accident : _____
2. Place of Accident : _____
3. Nature of the injury of the Insured : _____
4. Briefly discuss how the accident occurred/happened : _____
5. Was the Insured confined? If yes, please indicate period of confinement and name of hospital : ☐ Yes ☐ No
   From: _____ To: _____
   Name of Hospital: _____
6. Details of physicians consulted: (use another sheet of paper if space is not enough) : Name: _____
   Address: _____
   Telephone Number: _____

   Name: _____
   Address: _____
   Telephone Number: _____
7. Do you have accident insurance or HMO with other companies? If yes, please indicate name & contact details of the company ☐ Yes ☐ No
   Company: _____
   Address: _____
   Company: _____
   Address: _____

Date: _____ Signature: _____
Insured/Claimant

AUTHORIZATION

I hereby authorize any hospital physician or other person who has attended or examined me to furnish to the Company or to its Authorized Representative any and all information with respect to any injury, medical history, consultation prescription or treatment and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____
Place Signature of Insured/Claimant

_____ _____
Place Signature of Insured/Claimant

INSTRUCTIONS TO CLAIMANTS

1. Ask the attending physician to accomplish the Attending Physician's Statement if no Medical Certificate is available.
2. Attach all the necessary documents as per Checklist below.
3. Submit the above documents for the nearest AXA/Charter Ping An Insurance Corporation office or to the servicing agent.

CHECKLIST

1) ACCIDENTAL DEATH CLAIM

a) Attending Physician's Statement or Medical Certificate (original or certified true copy)
b) Police investigation Report or Statement of Witness/es (original or certified true copy)
c) Birth Certificate (original or certified true copy)
d) Death Certificate with Post Mortem Examination (original or certified true copy)
e) Autopsy Report - if available (original or certified true copy)
f) Marriage Contract (original or certified true copy)
g) Burial & Funeral Services Contract (Photocopy only)
h) Official Receipts for the Burial & Funeral Services (original only) - if there is coverage and is claiming under Accidental Burial Expense coverage
i) Certificate of Employment (for Group Personal Accident Insurance - original or certified true copy)
j) Certificate of Bona-fide Student (for Student Personal Accident Insurance - original or certified true copy)
k) Official Receipts for Medical Expenses (original only)
l) Hospital Records (photocopy only) (if available)

2) MEDICAL REIMBURSEMENT CLAIM AND/OR DISABLEMENT CLAIM

a) Attending Physician's Statement or Medical Certificate (original or certified true copy)
b) Police Investigation Report or Statement of Witness/es (original or certified true) Police Investigation Report or Statement of Witness/es (original or certified true copy)
c) Official Receipts for Medical Expenses (original only)
d) Picture of disabled body part (for Disablement Claim only)
e) Hospital Records (photocopy only) (if available)

ATTENDING PHYSICIAN'S STATEMENT

In respect of the accident to _____

I DO HEREBY CERTIFY that I personally examined the injuries sustained by the above person named in the accident described herein, and that the said injuries are as follows:
Nature & extent of injury _____
_____
_____
State as fully as possible the cause of accident _____
_____
_____
Is the appearance of the injury consistent herewith? _____
_____
Is there any connection between the present disablement and any disease or previous accident? If so, please give details _____
_____
Is surgical interference necessary or likely to become so? _☑_ YES _☐_ NO. Please explain briefly: _____
_____
What was the medical management? _____
Is the patient now, or was he at the time of the accident, subject to or suffering from any illness or disease irrespective of the injury? _____ If so, state (a) the nature of the same (b) the probable duration thereof (c) the extent to which it has affected the patient's recovery _____
_____
Has the patient been confined to the hospital/house by your Instructions? _____
If so, state inclusive dates: from _____ to _____
Please state the date when the patient can resume work: _____
Is the patient permanently disabled? If yes, please indicate details: _____
_____

_____ _____ _____
Date Physician's Name (print please) Signature

_____ _____ _____
License No. Address Tel. No.

CHARTER PING AN INSURANCE CORPORATION
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