

## Overseas Travel Accident Insurance Claim Form 海外旅行保険金請求書 兼 状況報告書

### Important Notice

1. The acceptance of this form is NOT an admission of liability on the part of the Company.
  2. All original final bills, certificates, supporting documents should be provided to substantiate your claim.
  3. All medical reports must be submitted at the claimant's expense before a claim can be admitted.
  4. Please answer in full all applicable questions as incomplete answers may delay claims settlement
- 1 当該書類の受理をもってお支払いできる保険金のが確約できるものではありません。
  - 2 保険金請求の際には領収書や診断書等は原本をご用意下さい。
  - 3 ご提出いただく書類のうち診断書等の交付費用は、お客様のご負担となりますので予めご了承下さい。
  - 4 ご提出いただいた書類を確認し、ご記入漏れや書類不備等ございましたらご連絡させていただきます。お支払いできるか否かの判断及び内容の決定までにお時間を頂くことがありますので予めご了承下さい。

ご契約者様ご記入用

Agency \_\_\_\_\_ 証券番号 \_\_\_\_\_  
Policy No \_\_\_\_\_

### 1. To be completed by Policyholder

契約者（会社）名  
Name of Policyholder \_\_\_\_\_

患者氏名 保険期間  
Patient's Name \_\_\_\_\_ Period of Insurance \_\_\_\_\_

### 2. To be completed by Patient / Guardian

けがまたは病気の内容 (Details of Accident or Sickness)  
状況 (Circumstances) \_\_\_\_\_

傷害または疾病名及び症状 (Nature & Condition of Injury or Sickness) (eg, fracture, cut, bruise etc.)  
\_\_\_\_\_

症状が最初に現れた日（発症日／傷害が起こった日） (治療) 初診日  
Date symptoms first commenced / Date of Accident: \_\_\_\_\_ First date of treatment: \_\_\_\_\_

以前に本症状に関して治療を受けたことがありますか？ それはいつですか？  
Has the claimant ever seen a doctor or been treated for any similar condition in the past?  Yes  No (If yes, please advise date of treatment) \_\_\_\_\_

請求金額 Please attach original medical bill & invoice -合計 Total amount claimed \_\_\_\_\_

病院名 Name of hospital \_\_\_\_\_ 医師名・電話番号 Name / Tel of doctor \_\_\_\_\_

現在も治療継続中ですか？ この他にも請求書はありますか？  
Are you still receiving treatment  Yes  No Anymore bills to submit  Yes \_\_\_\_\_  No

もし保険金請求が認められた場合の、保険金受取人の名前  
Please confirm payee name if claim is payable  Pay to Employer  Pay to employee \_\_\_\_\_

他の同種保険契約の有無 If you have any other insurance policy please fill in below  
保険会社名 (insurer) \_\_\_\_\_ 証券番号 (Policy No.) \_\_\_\_\_

同意書 (AUTHORIZATION) – to be signed by the claimant

私を診察または治療したすべての病院、医師及び関係者が保険会社又はその指名する者に、私に関するすべての疾病、傷害の記録を提供することを下記署名人は承認いたします。なお、本書の写も本書と同じ効力があるものと認めます。

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish the company or to authorized representative, any and all information with respect to any sickness or injury, medical history, consultation prescriptions or treatment and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and valid as the original.

私（達）は、上記内容が事実と相違ないことを確認し、保険金を請求致します。

私（達）は、Sompo が、Personal Data Protection Act 2012 に沿って制定された個人情報の取り扱いに関する会社規定に則り、業務委託・提携先、保険仲立人、またその他の関係先に対して個人情報の提供を行い、またはこれらの者から提供を受けることに同意致します。

I/We declare that the above is true and accurate to the best of my/our knowledge and belief. I acknowledge and agree (in case of corporate policy, I represent that I have obtained the consent of the individuals in relation to this policy) that Sompo may collect, use, disclose and/or process my personal data (in case of corporate policy, personal data of individuals in relation to this policy) in accordance with the Personal Data Protection Act 2012 for the purposes and uses described in Sompo's Privacy Policy (including the provision of protection, services related to this insurance policy, screening activities in accordance with legal/regulatory obligations/risk management procedures). This may include disclosure to Sompo's business partners, intermediaries, third party service providers and industry associations. Sompo's Privacy Policy can be found at [www.sompo.com.sg](http://www.sompo.com.sg)

患者氏名  
(Patient's Name in BLOCK LETTERS)

患者の署名  
(Patient's Signature)  
(未成年の場合は親権者 Guardian's Signature if patient is under age of 20)

\_\_\_\_\_  
Name of Claimant

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date

