

Sompo Insurance Singapore Pte. Ltd.

UEN: 198905490E GST Reg No: M200903196

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ございません。
- 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。

二米米口

ご契約者様ご記入用

こ矢利有塚こ記八片

Agency	皿分留り 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		
2. To be completed by Patient / Guardian		
けがまたは病気の内容 (Details of Accident or S		
·		
1/2/ (Circumstances)		
傷害または疾病名及び症状 (Nature & Condition	n 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	った日 (治療)初診日	
Date symptoms first commenced / Date of Accid	ident: 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		
Has the claimant ever seen a doctor or been tre any similar condition in the past? ☐ Yes		
請求金額 Please attach original medical bill & in	nvoice -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 $\ \square$ Yes	□ No Anymore bills to submit □ Yes	
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 他の同種保険契約の有無 If you have any other ir	☐ Pay to Employer ☐ Pay to employeeinsurance policy please fill in below	
保険会社名 (insurer)		

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

患者氏名	患者の署名	
(Patient's Name in BLOCK LETTERS)	(Patient's Signature) (未成年の場合は親権者 Guardian's Signatur	re if patient is under age of 20)
Name of Claimant	Signature of Claimant	Date

ATTENDING PHYSICIAN'S STATEMENT

Note : This Section is to be completed by the Claimant's attending physician/surgeon whose replies should be as full as possible 注:この欄は担当医師ができるだけ詳細にご記載ください。

Name of Patient		Date of Birth		Address			
		Age		Sex	Occupation		
Cause, nature, condition & progress of injury or sickness							
When did patient's symptoms first appear?				When did p condition?	When did patient first consult you for this condition?		
Or when did patient sustain in	jury? dd	mm	уу	dd	mm	уу	
Has patient had same or simil	lar sympton	ns before?		☐ Yes	(Date of Symptom)	□ No	
Has patient had prior treatment for this condition? (Including another hospital) □ Yes (Date of Symptom)					□ No		
If yes, whether the prior treatn	nent is a co	ontinuing cond	ition for this consult	ation? □ Yes		□ No	
Is the cause of the condition of	or sickness	congenital?		☐ Yes		□ No	
Does the treatment relate to p or infertility?	oregnancy, o	childbirth, prer	nature birth, miscar	riage, □ Yes		□ No	
Has patient suffered any other	r disease o	r infirmity affec	cting this condition?	' ☐ Yes		□ No	
If "Yes", please provide details	s :						
Nature of disease or infirmity	:				(Date:)	
Nature of disease or infirmity	:			From	(Date:)	
		ted you as out	patient	From)	
Period of hospitalization Encircle those days when pati	ient consult					28 29 30 31	
Period of hospitalization Encircle those days when pati Month of 1 2 3 4	ient consult	9 10 11 12	13 14 15 16 17	18 19 20 21	То		
Period of hospitalization Encircle those days when pati Month of 1 2 3 4 Month of 1 2 3 4	ient consult 4 5 6 7 8 4 5 6 7 8	9 10 11 12	13 14 15 16 17 13 14 15 16 17	18 19 20 21 18 19 20 21	To 22 23 24 25 26 27	28 29 30 31	
Period of hospitalization Encircle those days when pati Month of 1 2 3 4 Month of 1 2 3 4	ient consult 4 5 6 7 8 4 5 6 7 8 4 5 6 7 8	9 10 11 12 9 10 11 12 9 10 11 12	13 14 15 16 17 13 14 15 16 17	18 19 20 21 18 19 20 21 18 19 20 21	To 22 23 24 25 26 27 22 23 24 25 26 27	28 29 30 31	
Period of hospitalization Encircle those days when pati Month of 1 2 3 4 Month of 1 2 3 4	ient consult 4 5 6 7 8 4 5 6 7 8 4 5 6 7 8 ras patient s	9 10 11 12 9 10 11 12 9 10 11 12	13 14 15 16 17 13 14 15 16 17 13 14 15 16 17	18 19 20 21 18 19 20 21 18 19 20 21	To 22 23 24 25 26 27 22 23 24 25 26 27	28 29 30 31	
Period of hospitalization Encircle those days when pati Month of 1 2 3 4 Month of 1 2 3 4 Month of 1 2 3 4	ient consult 4 5 6 7 8 4 5 6 7 8 4 5 6 7 8 ras patient s	9 10 11 12 9 10 11 12 9 10 11 12 supposed to be	13 14 15 16 17 13 14 15 16 17 13 14 15 16 17	18 19 20 21 18 19 20 21 18 19 20 21 go to work?	To 22 23 24 25 26 27 22 23 24 25 26 27 22 23 24 25 26 27	28 29 30 31 28 29 30 31	
Period of hospitalization Encircle those days when pati Month of 1 2 3 4 Month of 1 2 3 4 Month of 1 2 3 4 For reference: How long w For (ient consult 4 5 6 7 8 4 5 6 7 8 4 5 6 7 8 ras patient s	9 10 11 12 9 10 11 12 9 10 11 12 supposed to be	13 14 15 16 17 13 14 15 16 17 13 14 15 16 17 e entirely unable to	18 19 20 21 18 19 20 21 18 19 20 21 go to work? From	To 22 23 24 25 26 27 22 23 24 25 26 27 22 23 24 25 26 27 To	28 29 30 31 28 29 30 31	
Period of hospitalization Encircle those days when path Month of 1 2 3 4 Month of 1 2 3 4 Month of 1 2 3 4 For reference: How long water for (Date of recovery or transfer	ient consult 4 5 6 7 8 4 5 6 7 8 4 5 6 7 8 ras patient s	9 10 11 12 9 10 11 12 9 10 11 12 supposed to be	13 14 15 16 17 13 14 15 16 17 13 14 15 16 17 e entirely unable to	18 19 20 21 18 19 20 21 18 19 20 21 go to work? From	To 22 23 24 25 26 27 22 23 24 25 26 27 22 23 24 25 26 27 To	28 29 30 31 28 29 30 31	
Period of hospitalization Encircle those days when path Month of 1 2 3 4 Month of 1 2 3 4 Month of 1 2 3 4 For reference: How long water for (Date of recovery or transfer	ient consult 4 5 6 7 8 4 5 6 7 8 4 5 6 7 8 ras patient s	9 10 11 12 9 10 11 12 9 10 11 12 supposed to be	13 14 15 16 17 13 14 15 16 17 13 14 15 16 17 e entirely unable to	18 19 20 21 18 19 20 21 18 19 20 21 go to work? From	To 22 23 24 25 26 27 22 23 24 25 26 27 22 23 24 25 26 27 To	28 29 30 31 28 29 30 31	