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Co. Reg. No.: 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。

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
Patient's Name _____ 保険期間 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 Date symptoms first commenced / Date of Accident: _____ (治療）初診日 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？ Has the claimant ever seen a doctor or been treated for any similar condition in the past? ☐ Yes ☐ No
それはいつですか？ (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？ Are you still receiving treatment ☐ Yes ☐ No
この他にも請求書はありますか？ 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

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

担当医師ご記入用

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? Or when did patient sustain injury? dd mm yy	When did patient first consult you for this condition? dd mm yy

Has patient had same or similar symptoms 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 treatment is a continuing condition for this consultation?	☐ Yes	☐ No
Is the cause of the condition or sickness congenital?	☐ Yes	☐ No
Does the treatment relate to pregnancy, childbirth, premature birth, miscarriage, or infertility?	☐ Yes	☐ No
Has patient suffered any other disease or infirmity affecting this condition?	☐ Yes	☐ No

If "Yes", please provide details :

Nature of disease or infirmity : (Date:)

Period of hospitalization From To

Encircle those days when patient consulted you as outpatient

Month of		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Month of		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Month of		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

For reference: How long was patient supposed to be entirely unable to go to work?

For ( ) Days From To

Date of recovery or transfer dd mm yy ☐ Recovery ☐ Transfer

Details of residual disability, if any

Date :

Tel No:

Signature of Attending Physician