® Sun Flower Insurance Brokers Limited
Placing through Sun Flower Insurance Agency Limited
Room 1105-08, Hing Yip Commercial Centre, 282 Des Voeux Road Central, Hong Kong
Tel: 2521 1881 Fax: 2521 1919 Email: vip@sunflowergroup.com.hk www.sunflowerVIP.com
Thank you for considering Sun Flower to be one of your selected intermediaries.
We are pleased to get in touch should you have any enquiry regarding the captioned insurance.

FAMILY PERSONAL ACCIDENT INSURANCE CLAIM FORM
家庭個人意外索償申請表

NOTE: Please complete this form in block letters and submit it together with all relevant documents to Claims Department at "Allied World Assurance Company, Ltd 22/F One Island East, Taikoo Place, 18 Westlands Road, Quarry Bay, Hong Kong".

注意事項: 請用正楷填寫表格，連同有關證明文件，送交 Allied World Assurance Company, Ltd 世聯保險有限公司理賠部，
地址為香港鰂魚涌太古坊華蘭路 18 號港島東中心22樓。
Tel 電話：+852 2968 3221 Fax 傳真： +852 2917 6179 Email 電郵： hk_claims@awac.com

Use separate sheet if not enough space on this form. We may request for further information for handling the claim application.
倘本表格不敷填寫，請另加紙張。本公司有權要求索償人提供更多資料以處理賠償申請。

Part I 第一部份

Insured's Information 受保人資料

Name of Insured 受保人姓名		Policy No. 保單號碼	
Name of Claimant 索償人姓名		Email 電郵	
HKID No. 香港身份證號碼		Daytime Contact No. 日間聯絡電話號碼	
Correspondence Address 通訊地址			
Name of Employer 僱主名稱		Present Business or Occupation 現時業務	
Business Address 辦公室地址			

Benefits Claimed 索償項目 Please ☑ the appropriate box(es) 請☑ 選適合空格

- ☐ **Accidental Death 意外死亡**
- ☐ **Education Fund 教育基金**
- ☐ **Loss of Limbs or Sight or Hearing or Speech 四肢傷殘或失明或失聰或喪失說話能力**
- ☐ **Permanent Total Disablement 永久完全傷殘**
- ☐ **Disfigurement / Scarring of the Face 毀容 / 面部傷疤**
- ☐ **Temporary Total Disablement 短期完全失去活動能力**
- ☐ **Coma 昏迷**
- ☐ **Hospitalization Allowance 住院現金津貼**
- ☐ **Medical Expenses 醫療費用**
- ☐ **Bonesetters' Fee 跌打費用**

Description of the Accident 事故詳情

Date 日期:	Time 時間:	Location 地點:
Circumstances 事件發生的經過:		
Description of Injury 受傷情況:		

Please indicate your current status. 請指出你現在的情況	Fully recovered from this injury 完全康復 / Still under treatment 治療中 (Please delete the inappropriate one(請刪除不適用者)
Currency/Claim Amount 索償金額 (Please list items & indicate the amount of your claim in details. 詳細列出索償之內容及數目)	
Have you applied for claims in another insurance company for this event/accident? If "Yes", please specify. 就此事件/意外，你有否向其他保險公司索償？如「有」者，請列明有關詳情。	

Authorization and Declarations 授權及聲明

For the purpose of assessing my claim, I hereby authorize Allied World Assurance Company, Ltd or its authorized representative to collect any and all information with respect to my loss, disability, medical history, police statement made and the like from any hospital, physician, person, party and/or authority that has any records or is holding any information of me; and authorize any hospital, physician, person, party and/or authority that has any records or is holding any information of me to disclose to Allied World Assurance Company, Ltd or its authorized representative, any and all information with respect to my loss, disability, medical history, police statement made and the like. A photocopy of this authorization shall have the same effect as the original.

I declare to the best of my knowledge and belief that the information given is true in every respect. I agree that any concealment or incorrect statement in connection with this claim may result in legal liability and the policy shall become void.

本人謹此授權 Allied World Assurance Company, Ltd 世聯保險有限公司或其授權代表，向任何持有本人之任何記錄或資料的醫院、醫生、人仕、有關人等、及/或有關當局，索取任何或所有有關本人之損失、損傷、病歷、口供或任何相關資料，並授權任何持有本人任何記錄或資料的醫院、醫生、人仕、有關人等、及/或有關當局，向 Allied World Assurance Company, Ltd 世聯保險有限公司或其授權代表，提供任何或所有有關本人之損失、損傷、病歷、口供或任何相關資料，作評估賠償申請之用途。此授權書之正本及副本皆具同等效力。

本人謹此聲明，根據本人所知及所信，本索償表格上填報之資料均實屬無訛。本人並同意， 任何蓄意欺騙或隱瞞將構成法律責任並導致保單失效。

Signature of the Insured 受保人簽署 _____ Date 日期 _____

Signature of the Claimant 索償人簽署 _____ Date 日期 _____
(Not applicable if claimant aged below 18 不適用於 18 歲 以下的索償人)

Please submit the following documents together with the form for more efficient processing of your claim.

為更有效率地處理您的申請，請連同以下文件提交索償表格

Documents Required 所需文件	Types of Benefits 保障類別			
	Accidental Death 意外死亡	Loss of Limbs or Sight or Hearing or speech 四肢傷殘或失明或失聰或喪失說話能力	Temporary Total Disablement 短期完全失去活動能力	Hospitalization Allowance 住院現金津貼
	Education Fund 教育基金	Permanent Total Disablement 永久完全傷殘		Medical Expenses 醫療費用
		Disfigurement / Scarring of the Face 毀容 / 面部傷疤	Coma 昏迷	Bonesetters' Fee 跌打費用
Birth Certificate of Insured's Children (if applicable)受保人子女之出生證明書(如適用)	✓			
Death Certificate 死亡證明書	✓			
Medical Report 醫療報告	✓	✓		
Medical Certificate (Part II of the claim form) 醫療證明 (索償申請表的第二部份)			✓	✓
Original Medical Receipt 醫療費用之單據正本				✓
Police Report (if applicable) 警方報告 (如適用)	✓	✓		
Original Medical Certificate showing the Period of Sick-Leave 醫生批准之病假証明書正本			✓	
Confirmation from Employer stating the Leave Period that Insured has taken and Monthly Salary 僱主發出之信件證明受保人因病請假之日期及月薪證明			✓	
Original Receipts of Travel Expenses and Air Ticket (If applicable) 旅程費用及機票之收據正本(如適用)	✓			

Personal Information Collection Statement

Purpose of Collection
Allied World Assurance Company, Ltd ("Allied World") may collect and use your personal data to enable it to carry on its insurance business and to serve the purposes of:

- Processing your insurance application;
- Arranging a contract of insurance with you and administering the policy issued;
- Claims handling, investigation and analysis;
- Designing products and/or services for customers;
- Promoting, improving and furthering the provision of products and/or services by Allied World and its group companies; and
- Complying with any legal or regulatory requirements applicable to Allied World.

In general it is voluntary for you to provide Allied World with your personal data. However, if you do not provide sufficient information, Allied World may not be able to provide insurance services to you.

Transferee
Data held by Allied World relating to you will be kept confidential but Allied World may, for the purposes set out above, transfer your personal data to:

- Allied World's group companies;
- Reinsurers;
- intermediaries including insurance brokers and insurance agents;
- claims investigators, loss adjusters and other professional advisors;
- Allied World's other appointed service providers, including for the following services: telecommunications, information technology, administration, data processing, payment processing, emergency assistance, legal, and medical;
- any insurance industry association or federation and their respective members; and
- any other person necessary to comply with applicable legal or regulatory requirements, or orders of competent authorities,

in each case both within and outside of the Hong Kong Special Administrative Region.

Marketing and Promotion
Treating you as a valued customer, Allied World and its group companies may use the personal data, including name and contact details, collected from you for the purposes of direct marketing of Allied World and its group companies' general insurance products, services or offers and for sending you the promotional materials or updates of such products, services or offers when they become available.

Allied World may not use your personal data for direct marketing if you have indicated objection to such use by ticking the box next to the statement above the proposer's signature block in the proposal form. You may also, at any time, request Allied World to cease the use of your personal data for direct marketing purposes, by informing Allied World's Compliance Officer at the contacts set out below.

Access Requests and Corrections
You have the right to obtain access to and to request correction of any personal information concerning yourself held by Allied World. Requests can be made to the Compliance Officer of Allied World Assurance Company, Ltd by mail to 22/F One Island East, Taikoo Place, 18 Westlands Road, Quarry Bay, Hong Kong or fax to +852 2968 5111, or email to hkcompliance@awac.com.

個人資料收集聲明

資料收集目的
Allied World Assurance Company, Ltd 世聯保險有限公司 (「本公司」)可能收集並使用閣下的個人資料，作為營運其保險業務及下列目的之用：

- 處理閣下的保險申請；
- 安排保險合約及管理已發出的保單；
- 索償處理、調查及分析；
- 為客戶設計產品或服務；
- 推廣、改善及進一步提供本公司及其集團公司的產品、服務；及
- 遵守適用於本公司的法律或規則要求。

一般而言，閣下向本公司提供個人資料屬自願性質。如閣下未能給予足夠的資料，本公司可能無法提供所需保險服務。

資料轉移
本公司持有的客戶資料將予保密，但本公司可能會把閣下的個人資料提供給下列各方作上述用途：

- 本公司的集團公司；
- 再保險公司；
- 中介人包括保險代理人及保險經紀；
- 索償調查者、公證行及其他專業顧問；
- 本公司其他指定服務提供者，提供包括以下服務：電訊、資訊科技、行政、數據處理、付款處理、緊急援助、法律及醫療；
- 任何保險業組織或聯會及其成員；及
- 任何必要人士以符合任何相關的法律或規則要求，或監管機構之命令，

以上各項適用於香港特別行政區境內及境外。

市場推廣
貴為本公司的重要客戶，本公司及其集團公司可能會透過閣下所提供的個人資料如姓名及聯絡方法，向閣下推廣本公司及其集團公司的一般保險產品、服務或優惠，及為閣下提供該等產品、服務或優惠的市場推廣資料和最新消息。

如閣下已於投保書勾選位於投保人簽署上方的空格表示不願接收任何市場推廣資料和最新消息，本公司將不會使用閣下的個人資料作直接推廣用途。閣下亦可隨時要求本公司停止使用閣下的個人資料作直接推廣用途。屆時請按照下述聯絡方式通知本公司的條例事務主任。

資料查閱要求及更改
閣下有權要求查閱及更改本公司所持有的任何有關您之個人資料。有關申請可循下列途徑向本公司之條例事務主任提出：郵寄至香港鰂魚涌太古坊華蘭路18號港島東中心22樓，或傳真至+852 2968 5111，或電郵至hkcompliance@awac.com。

Part II 第二部份

Medical Certificate (To be completed by the attending physician/surgeon at the claimant's own expenses) 醫療證明 (由主診醫生填寫，所需費用由索償人自行承擔)	
Full name of patient (please fill in English BLOCK letters) and HKID number 病人全名（請以英文正楷填寫）及香港身份證號碼	
Date of Accident 意外日期 (DD日/MM月/YY年)	
Upon what date did you first examine the patient after the accident described herein? 於上述意外發生後，閣下何時替病人作首次檢查？	
To your knowledge, what was the cause of the injuries? 據閣下所知，是什麼原因引致受傷?	
Regions injured (If a limb, state right or left) 受傷部位 (如肢體，說明右或左)	
Nature and extent of injuries 受傷性質及其程度	
Is the patient's condition solely due to the accident herein? 病人的情況是否唯一由上述意外引起?	Yes是 ☐ No 否 ☐ If no, state other cause 若否，說明其他原因
From what injuries or illnesses is the Patient now suffering? 現在的傷勢或病情詳解	
Did injury required 傷勢是否需要 a. Hospitalization? 住院?	Date admitted 入院日期 a. Yes 是 ☐ No 否 ☐ Date discharged 出院日期
b. X-rays? X光?	(if yes, please give details) 若有，請詳述: b. Yes 是 ☐ No 否 ☐
c. Special diagnostic procedures? 特別診斷測試?	c. Yes 是 ☐ No 否 ☐
d. Surgery? 手術?	d. Yes 是 ☐ No 否 ☐
Has any circumstance, irrespective of the accidental injuries, such as cardiac affection, gout, rheumatism, paralysis, disease or otherwise, tended to produce or prolong disablement? 除以上所述受傷情況外，有否其他情形，例如：心臟病、痛風、風濕病、癱瘓或其他疾病可能會導致或延長其傷殘時間？	Yes 是 ☐ No 否 ☐ If yes, please give particulars若有，請詳述
If the patient was referred by another doctor, please provide the referring doctor's name and address. 如病人為其他醫生轉介，請提供該轉介醫生之姓名及地址	
Are you the patient's usual physician? 你是否病人慣常之醫生？	Yes 是 ☐ No 否 ☐

I hereby certify that all information given above is accurate and true to the best of my knowledge.
本人證明上述的資料根據本人所知皆為正確無訛。

_____

Signature and chop of attending physician/surgeon 主診醫生簽署及蓋章

Address and telephone no. 地址及聯絡電話

_____

Date 日期 _____