

Domestic Worker Claim Form

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This form must be completed truthfully and accurately.

The list of documents required is not exhaustive and we reserve our right to request from you any additional information/documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

The completed form should be returned to us together with all supporting documents as soon as possible at the following address:

Claims Department
Chartis Insurance Hong Kong Limited
46/F, One Island East
18 Westlands Road
Island East Hong Kong
852 2838 9916 Facsimile

Claims Department
Chartis Insurance Hong Kong Limited (Macau Branch)
Unit 506, 5/F, AIA Tower
No 251A-301 Avenida Comercial de Macau
853 2835 5299 Facsimile

Section IA - General Information

Policy/certificate no.:	Name of insured:	ID card no./passport no.:
Telephone no. (Residential):	Telephone no. (Office):	Telephone no. (Mobile):
Mailing address:		E-mail address:
Name of agent/broker:	Telephone no.:	
Name of domestic worker:		

Section II A - Medical Expense Reimbursement/Hospital Income/Loss of Income

Documents required under SECTION IIA:

Medical Expense Reimbursement

- Original hospital/medical bill(s)/receipt(s)/medical report stating diagnosis and the date of the injury/sickness commenced and certified by a qualified medical practitioner.

Hospital Income/Loss of Income

- Medical certificate from a qualified medical practitioner certifying the number of days of hospitalization.
- Hospital discharge summary.
- Letter from employer/company stating that the insured is under employment during sick leave period as a result of injury/sickness and amount of the salary earned, if claiming loss of income.

Date (MM/DD/YYYY) and time of injury/sickness:

In the case of injury, where and how did the accident occur? In the case of sickness, how long have the symptoms existed?

Nature of injury/diagnosis of sickness:

Name and address of the attending doctor:		
If hospitalized, please state the name, address and the period of the hospitalization:		
From (MM/DD/YYYY):	To (MM/DD/YYYY):	Claim amount (Please indicate the currency) :

Section II B - Accidental Death and Disability

Date of accident (MM/DD/YYYY):	Time of accident:	Place of accident:
Description of how the accident occurred, and the injuries sustained:		
Name and address of the attending doctor:		
Full name and telephone no. of witness(es), if any:		
Cause of death, if applicable:	Permanent disability (degree and extent), if applicable:	

Section II C - Domestic Worker Liability

Full description of the incident:	
Full name and telephone no. of the third party claimant:	Full name and telephone no. of the witness(es), if any:
Remarks: <ul style="list-style-type: none"> Any lawsuit, demand, claim or proceeding of any types relating to the incident of which the claimant becomes aware of, and received from the third party claimant, should be immediately forwarded to us. No liability should be admitted and no settlement or promise of payment should be reached or made to the third party without our prior approval. 	

Section III - Declaration and Authorization

The undersigned Claimant(s) HEREBY DECLARE that to the best of the Claimant(s)' knowledge and behalf, the above statement and particulars contained are true and complete in every respect and are made without reservation of any kind. The Claimant(s) agree that any of my/our personal information collected or held by Chartis Insurance Hong Kong Limited and/or Chartis Insurance Hong Kong Limited (Macau Branch) ("the Company"), (whether contained in this Claim Form or otherwise obtained) is provided and be held, used, and disclosed by the Company to individuals/organizations associated with the Company or any selected third party (within or outside of Hong Kong and Macau, including reinsurance, claims adjusting or investigation companies, police, airlines and industry associations/federations) for the purposes of processing the Claims herein and providing subsequent services, direct marketing, and data matching, and to communicate with the Claimant(s) for such purposes. The Claimant(s) understand(s) that (i) the Company may be unable to process the Claims herein if the Claimant(s) fail(s) to provide any information requested in this Claim Form and (ii) the Claimant(s) has/have the right to obtain access to and to request correction of any personal information held by the Company concerning the Claimant(s). Such request can be made to any of the Company's Data Privacy Officer at G.P.O. Box 456, Hong Kong. The Claimant(s) understand(s) that the submission and completion of this claim form is not an admission of liability on the part of the Company.

The Claimant(s) hereby irrevocably authorize:

- a. any organization, institution, or individual that has any information, record or knowledge of the Claimant(s)' health and medical history or any treatment or advice rendered thereto to disclose to the Company such information, record and knowledge;
- b. the Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate the Claimant(s)' health status in relation to the Claims therein and any matter arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites;
- c. the police that has any of my/our information to provide the Company with the information including but not limited to the police reports, witness statements, investigation and/or prosecution results;
- d. airline(s) that has/have any of my/our information to provide the Company with the information including but not limited to flight details, booking details, irregularities reports and all information related to my/our bookings; and
- e. any organization institution or individual that has any information, record or knowledge of the Claimant(s) travel record to disclose to the Company such information, record and knowledge.

This authorization shall bind the Claimant(s)' successors and assigns and remain valid notwithstanding the Claimant(s)' death or incapacity in so far as legally permissible. A photocopy of this authorization shall be as valid as the original.

Signature of insured:	Name of insured:
ID card no./passport no.:	Date (MM/DD/YYYY):
Signature of domestic worker:	Name of domestic worker:
ID card no./passport no.:	Date (MM/DD/YYYY):