



Policy Number

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# CRITICAL ILLNESS/DISABILITY/ ACCIDENT/HOSPITALISATION CLAIM FORM I

## Simple steps for your claim submission:

- (1) Complete this form. Please do not sign blank form
- (2) Prepare the relevant documents listed on page 3
- (3) Prepare the Insured/ Policy Owner ID copy with signature (if not provided before), and
- (4) Submit the form with above documents to your financial consultant or AXA Customer Service Centre

## 1. INSURED INFORMATION

Full Name	<b>1. INSURED INFORMATION</b>		
Macau ID/Passport No.		Nationality	
Residential Address (if different from policy owner address)			
Permanent Address (if different)			

## 2. TYPE OF CLAIMED BENEFIT

<input type="checkbox"/> Major/Minor/ Early Stage Illness Benefit	<input type="checkbox"/> Accident Benefit	<input type="checkbox"/> Disability Income Benefit (DI)/ Waiver of Premium Benefit (WP)	<input type="checkbox"/> Hospital Benefit
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## 3. ABOUT CURRENT CLAIM

General information	First consultation/accident date	dd ___ mm ___ yyyy _____
	Name and address of the doctor	
	Name and address of usual doctors	
<input type="checkbox"/> If caused by illness	Symptoms/Diagnosis	
<input type="checkbox"/> If caused by accident	Place and date of accident	Place: _____ Date: dd ___ mm ___ yyyy _____
	Description (Part of body injured and type of injury)	

**4. SUPPLEMENTARY DETAILS FOR DI/WP CLAIMS ONLY**

Employer's name and address			
Occupation prior to disability/accident		Main duties prior to disability/accident	
Date of absent from work	dd ___ mm ___ yyyy _____	Date of returning to work	dd ___ mm ___ yyyy _____

**5. SUPPLEMENTARY DETAILS FOR MAJOR/MINOR/EARLY STAGE ILLNESS BENEFIT CLAIMS ONLY**

Have any immediate family members suffered from a similar illness?	<input type="checkbox"/> Yes	Date of diagnosis	dd ___ mm ___ yyyy _____
		Relationship with insured	
		Nature of illness	
	<input type="checkbox"/> No		

**6. SETTLEMENT METHOD**

Please "✓" this box for return of certified true copy ("CTC") of your original document after claim is processed. Original document will not be returned.

Cheque and CTC doc. (If needed) collection method	<input type="checkbox"/> Delivery through Financial Consultant <input type="checkbox"/> By mail to the correspondence address <input type="checkbox"/> Collection at the Macau Service Centre
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**7. US CITIZENSHIP DECLARATION**

Applicable to individual as Claimant	Is the claimant an US citizen or US tax resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please submit "Supplement - Tax Residency Self-Certificate for Individual (For Claims)". If No, you must notify us if you become a US citizen or US tax resident immediately (and in any event within 30 days of you becoming a US citizen or US tax resident).
Applicable to non-individual as Claimant	Is the claimant an US entity/trust? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please submit "Supplement - Tax Residency Self-Certificate for Non-Individual (For Claims)", and provide (a) IRS Form W-8 (for Entities) if you are a non-US entity or trust with income generated in the US or (b) IRS Form W-9 if you are a US entity or trust.

**8. PERSONAL INFORMATION COLLECTION STATEMENT**

Please visit our website ([www.axa.com.hk](http://www.axa.com.hk) > Legal and Privacy Statement > Personal Information Collection Statement (Macau)) and read carefully the details of the Personal Information Collection Statement ("PICS") which can also be made available upon request.

**9. DECLARATION AND AUTHORISATION**

I HEREBY DECLARE AND AGREE on behalf of myself and other person referred to this form that all statements and answers to all questions are to the best of my /our knowledge and belief complete and true.

I HEREBY AUTHORISE that (1) any employer, registered medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of me/us to disclose such information to the Company as the Company may request; (2) the Company or any of its appointed medical examiners, paramedical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of myself/ourselves in relation to this application and any claim arising therefrom. This authorisation shall bind the successors and assignees of the Relevant Persons and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.

Signature of Claimant	Date (dd/mm/yyyy)

Financial Consultant Detail			
Full Name	Code	Mobile No.	


## 10. DOCUMENT CHECKLIST

Below is a list of minimum documents required to proceed your claim. In certain circumstances, more information may be required to substantiate the claim.


Documents Required (Please ✓ against the documents you have submitted.)		CI	ADW	HB
<b>CI</b> = Major/Minor/Early Stage Illness Benefit <b>ADW</b> = Accident Benefit Or Disability Income Benefit/Waiver of Premium Benefit <b>HB</b> = Hospital Benefit				
Basic	<input type="checkbox"/> Claim Form I and II <input type="checkbox"/> Copy of ID or passport of the Insured/Policy Owner with signature (If not provided before) <input type="checkbox"/> Laboratory/x-ray/CT Scan/MRI report/Pathology report <input type="checkbox"/> Doctor's referral for specialist or therapeutic treatment	✓	✓	✓
	<input type="checkbox"/> Supplement – Tax Residency Self-Certification for Individual/ Non-Individual (For Claims)(Applicable to Major/Minor/Early Stage Illness Benefit)	✓		
	<input type="checkbox"/> Sick leave certificate <input type="checkbox"/> Original medical expenses receipt(s) <input type="checkbox"/> Original hospital receipt(s) and Statement of charges <input type="checkbox"/> Physiotherapy/Occupational therapy report		✓	✓
	If applicable below:			
Hospitalised in private hospital	<input type="checkbox"/> Private hospital discharge summary	✓	✓	✓
Settlement has been arranged by other insurer	<input type="checkbox"/> Claims settlement advice from other insurer/party		✓	✓
Caused by accident	<input type="checkbox"/> Police report/Traffic accident report	✓	✓	
Employee compensation	<input type="checkbox"/> Certificate of Compensation Assessment and the Certificate of Assessment issued by the Labour Department		✓	
Claiming on behalf of insured	<input type="checkbox"/> Written notification if the insured is unable to sign the claim form	✓	✓	✓
Claimant as an US citizen/ US tax resident or Entity or trust	<input type="checkbox"/> Supplement - Tax Residency Self-Certification for Individual/ Non-Individual (For Claims) <input type="checkbox"/> IRS Form W-8 (for non-US entity/trust) <input type="checkbox"/> IRS Form W-9 (for US entity/trust)	✓		✓ Applicable to HealthSure Hospital Income only
Macau/Hong Kong/ China tax residency	<input type="checkbox"/> Macau/Hong Kong/China Identity Card number is equivalent to TIN	✓		

## 11. CONTACT US

If you have any questions on your request, please reach us at

 (853) 8799 2812

 [www.axa.com.mo](http://www.axa.com.mo)

 [ma.enquiry@axa.com.mo](mailto:ma.enquiry@axa.com.mo)

**AXA is committed to making your insurance process as easy and stress-free as possible. Thank you for insuring with us. We are always glad to be of service.**

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