Globe Gadget Care

Claim Form

CHUBB®

Policy and Claimant Details	
Name of Insured	
Address (Unit No., Street, Brgy/Town, City and Postcode)	
Policy No.	
Name of Claimant	
Address (Unit No., Street, Brgy/Town, City and Postcode)	
Date of Birth	
Occupation	
Tel. No.(House)	( )
Tel. No.(Business)	( )
Email Address	

Device Details	
Mobile No.	
Make and Model	
Date of Purchase	
Store/Branch	
IMEI/Serial No.	

Important Information

1. In order to submit your claim, please complete the relevant sections.
   - This first page must be completed for all claims.
   - The privacy consent must be completed for all claims.

2. The supporting documentation required for your claim is detailed in each section.

3. The issuance and acceptance of this form does not constitute an admission of liability by Chubb or a waiver of its rights.

4. Fraud Warning:
   Section 251 of the lnsurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

Chubb Globe Gadget Care Claim Form. Philippines. Published 03/2017.

Section 1 – Claim Details

Documents Required for Claims Processing:
(Note that failure to provide these documents may result in claims processing delays)

- Two (2) Latest Globe Statements of Account showing monthy recurring fee of Gadget Care Plan
- Any proof of payment of Globe account outstanding balance covering claim period

(Additional) For Theft Claims:
- Original copy of Police Report (secured within 7 days of discovery)
- Certified true copy of two (2) valid IDs
- Notarized Affidavit of Ownership and Loss with Undertaking (NTC Form for Handset Blocking)

(Additional) For Accidental Damage Claims:
- Photo of the damaged device
- Notarized Affidavit of Ownership and Loss with Undertaking (for device which cannot be retrieved)

1. Please provide details of how the incident occurred.

_____

_____

_____

_____

2. Date of Incident _____/_____/_____
3. Time of Incident _____ ☐am ☐pm
4. Place of Incident

_____

5. Where was the device at the time of the incident?

_____

6. Please describe the damage to, or the fault with, your device: (e.g. cracked screen)

_____

7. Have you reported the incident to your network operator? If Yes, please indicate date reported to network operator.
   ☐ Yes_____/_____/_____☐ No
8. If theft, have you reported the incident to the police? If Yes, please indicate date reported to the police.
   ☐ Yes_____/_____/_____☐ No
   Please provide name of police station theft was reported to. _____
   If No, please state reason why the incident was not reported.

_____

9. Are you the sole user of the device? ☐ Yes ☐ No
10. Is the device covered by any other insurance? If Yes, which company?
    ☐ Yes_____☐ No
11. Is the device still under warranty? ☐ Yes ☐ No

Section 2 – Bill Protect Benefits

Documents Required for Claims Processing:
(Note that failure to provide these documents may result in claims processing delays)

- Two (2) Latest Globe Statements of Account showing monthy recurring fee of Gadget Care Plan
- Any proof of payment of Globe account outstanding balance covering claim period
- Attending Physician's Report, specifying the number of days/months that the Insured is not allowed to or capable of returning to work and/or attending to his daily duties
- Birth Certificate of the Insured
- Original Copy of Police Report
- Notarized Affidavit of Witness

(Additional) For Accidental Death Claim:
- Death Certificate
- Autopsy Report or Medico-Legal Statement
- Proof of Relationship to Beneficiary

1. If injury, date of Accident _____ / / _____
2. Time of Accident _____ ☐am ☐pm _____
3. Please state nature of accident (e.g. fracture, cut, bruise, etc.)

_____

4. Please explain exactly how the accident occurred

_____

5. If sickness, date symptom first noticed _____ / / _____
6. Please state nature of illness (describe the symptoms suffered)

_____

7. If hospitalized: Name and address of the hospital

_____

8. Period of hospitalization: From: To:
9. Date of first consultation with a medical practitioner for this condition:

_____

10. Details of Temporary Disability:
    When did you cease work? If illness, house confinement date
    / / / /

    When did or will you resume any part of your work? All work?
    / / / /

11. Describe fully the duties of your occupation

_____

12. Are you claiming from any other insurance company or other sources in respect of accidental death?
    If Yes, please provide Name of Insurance Co.:

_____

Policy No.: Date insurance affected / /

Amount of benefits: _____

Attending Physician's Statement

Patient Details	
Name of Patient	
Date of Birth	
Primary Diagnosis	
Secondary Diagnosis	
Period of hospitalization	From: / / To: / /
Complete admitting history	
Past Medical History	Date of Diagnosis: / / Medical Condition: Date of Diagnosis: / / Medical Condition: Date of Diagnosis: / / Medical Condition:
Patient physical examination findings	
Significant diagnostic procedure findings	
Date of services	From: / / To: / /
Description of surgical or medical services rendered/procedure	
Is condition due to injury or sickness arising out of patient's employment?	
Is condition due to injury or sickness arising out of patient's pregnancy?	If Yes, approximate date pregnancy commenced: / /
Date symptoms first appeared or accident happened	/ /
Date condition was diagnosed	/ /
Has the patient ever had the same or similar condition?	If Yes, please state when: / / Please state details of the condition:
Patient was continuously disabled	From: / / To: / /
Patient was partially disabled	From: / / To: / /
Patient was house confined	From: / / To: / /
If still disable, date patient should be able to return to work	/ /

Certification

I hereby certify that I have personally examined and treated the patient for the above injury and that the facts as given above present my opinion of his/her condition.

Signature Over Printed Name

License and PTR No.

/ /
Date

Privacy Consent - Claim Assessment

Protection of My Privacy
Acknowledgement and Consents

By signing this form, I agree that Chubb will use the information supplied during the formation and performance of my policy for policy administration, customer services, paying claims and fraud prevention.

Chubb may disclose this information to its service providers and its agents for these purposes. Chubb will keep this information for a reasonable period. Where sensitive personal data has been disclosed, including any criminal record information, Chubb will also use this information for the above purposes. Chubb may also transfer certain information to countries that do not provide the same level of data protection for the above purposes so a contract will be in place to ensure the information transferred is protected. Individuals whose information has been supplied to Chubb have a right to ask for a copy of that information and to have any inaccuracies corrected.

Chubb may record telephone calls to make sure it follows instructions correctly and for staff training purposes. When personal or sensitive data is supplied to Chubb about third parties other than the Insured, both during the formation and performance of this policy, Chubb assumes that those third parties consent to the supply of this information to Chubb, to Chubb processing this data, including sensitive personal data, and to the transfer of their information abroad. Chubb will also assume that the supplier of the information is authorized to receive, on their behalf, any data protection notices.

I declare that, I understand that by investigating my claim or by accepting proof of my claim, Chubb has made no acceptance of liability, or waived any of its rights in defense of any claim arising under the policy.

I agree to Chubb using and disclosing my personal information pursuant to Chubb's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to Chubb.

I authorize any person or entity, including but not limited to the parties referred to above, to provide to Chubb such personal information as Chubb in its absolute discretion considers relevant for its assessment of my claim.

I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim. I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint Chubb to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorizations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent.

Signature Over Printed Name	Date / /

Contact Us

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