# TRAVEL HEALTH INSURANCE POLICY CLAIM FORM

(The issuance of this form does not imply admission of liability)

| | | | | |
|---|---|---|---|---|
| NAME OF THE CLAIMANT (IN FULL) | | POLICY NUMBER | | |
| ADDRESS | | PLAN TYPE | | |
| | | PERIOD OF INSURANCE | FROM | DD/ MM/ YY |
| | | | TO | DD/ MM/ YY |
| OCCUPATION | | DATE TRIP COMMENCED | DD/ MM/ YY | |
| RELATIONSHIP OF THE CLAIMANT WITH THE INSURED PERSON | | DATE OF SCHEDULED RETURN | DD/ MM/ YY | |

**SECTION TO WHICH CLAIM PERTAINS:** (PLEASE TICK WHICHEVER ONE IS APPLICABLE)

- ❑ Health Cover:
  - ○ Medical Expenses (Incl. Dental Treatment)
  - ○ Hospital Daily Allowance
  - ○ Transportation
- Personal Liability
- ❑ Baggage:
  - ○ Total Loss of Checked Baggage
  - ○ Delay of Checked Baggage
- ❑ Financial Emergency Assistance
- ❑ Personal Accident

ALL CLAIMS HAVE TO BE SUPPORTED WITH ORIGINAL DOCUMENTS OF EXPENSES / COSTS INCURRED, WHEREVER APPLICABLE

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**HEALTH COVER ( Please attach original Doctor's Certificate, Test Reports and Hospital Papers including Discharge Card )**

A. Medical Expenses ( including dental treatment )

| | | | |
|---|---|---|---|
| NAME OF DISEASE CONTRACTED | | TREATING DOCTOR / CLINIC / HOSPITAL | |
| | | *NAME* | |
| WHEN DISEASE FIRST MANIFESTED | DD/ MM/ YY | *ADDRESS* | |
| DATE WHEN TREATMENT STARTED | DD/ MM/ YY | *CONTACT NUMBER* | |
| DATE WHEN TREATMENT ENDED | DD/ MM/ YY | NATURE OF DISEASE / INJURY ( PLEASE DESCRIBE BRIEFLY ) | |
| DATE OF ADMISSION | DD/ MM/ YY | | |
| DATE OF DISCHARGE | DD/ MM/ YY | | |
| HOSPITAL EXPENSES ( PLEASE SHOW EACH HEAD SEPARATELY ) | | | |
| *ROOM RENT* | | *ROOM RENT IN WORDS* | |
| *CONSULTANCY CHARGES* | | *CONSULTANCY CHARGES IN WORDS* | |
| *COST OF TESTS* | | *COST OF TESTS IN WORDS* | |
| *OTHER COSTS* | | *OTHER COSTS IN WORDS* | |
| OUTPATIENT EXPENSES | | OUTPATIENT EXPENSES IN WORDS | |
| ***TOTAL CLAIM AMOUNT*** | | ***TOTAL CLAIM AMOUNT IN WORDS*** | |

B. Hospital Daily Allowance

| | | | |
|---|---|---|---|
| TOTAL NUMBER OF DAYS FOR AMOUNT BEING CLAIMED FOR | | TOTAL NUMBER OF DAYS FOR AMOUNT BEING CLAIMED FOR IN **WORDS** | |
| ***TOTAL CLAIM AMOUNT*** | | ***TOTAL CLAIM AMOUNT IN WORDS*** | |

C. Transportation

| | | | |
|---|---|---|---|
| IF YOU ARE CLAIMING FOR EXTRA COSTS OF TRANSPORTATION HOME( FOR SELF AND / OR ACCOMPANYING PERSON ), MORTAL REMAINS OR BURIAL EXPENSES PLEASE SPECIFY THE NAME OF AIRLINES, BURIAL DETAILS, EXPENSES INCURRED AND OTHER INCIDENTAL COSTS WITH BIFURCATION OF EXPENSES IN AN ATTACHED SHEET | | | |
| ***TOTAL CLAIM AMOUNT*** | | ***TOTAL CLAIM AMOUNT IN WORDS*** | |

**PERSONAL LIABILITY (Please attach Judgment of the Court)**

| | | | | | |
|---|---|---|---|---|---|
| DATE | DD/ MM/ YY | TIME | | PLACE OF ACCIDENT | |
| NATURE OF CLAIM BEING MADE | | | | COURT WHERE THE CASE IS BEING PURSUED | |
| ***TOTAL AMOUNT OF AWARD INCLUDING CLAIMANT COST*** | | | | ***TOTAL AMOUNT OF AWARD INCLUDING CLAIMANT COST IN WORDS*** | |

**LOSS OF CHECKED BAGGAGE / DELAY OF CHECKED BAGGAGE (Please attach Police Report, Property Irregularity Report from the Carrier, Claim Lodged on the Carrier, Baggage Receipt, Money Receipts of essential items purchased)**

| **TOTAL LOSS OF CHECKED BAGGAGE** | | | **DELAY OF CHECKED BAGGAGE** | | |
|---|---|---|---|---|---|
| PROPERTY IRREGULARITY REPORT BY CARRIER ATTACHED | | □ Yes □ No | NAME OF THE AIRLINE | | |
| CLAIM LODGED ON CARRIER | | □ Yes □ No | FLIGHT NUMBER | | |
| | | | FROM | | |
| | | | TO | | |
| POLICE REPORT LODGED | | □ Yes □ No | SCHEDULED DEPARTURE | DATE | DD/ MM/ YY |
| | | | | TIME | |
| NUMBER AND DESCRIPTION OF ITEMS LOST | | | SCHEDULED ARRIVAL | DATE | DD/ MM/ YY |
| | | | | TIME | |
| | | | ACTUAL DEPARTURE | DATE | DD/ MM/ YY |
| | | | | TIME | |
| DESCRIPTION OF ITEMS LOST WITH REGARDS TO NO, NATURE AND COST OF EACH SUCH ITEMS. | | | ACTUAL ARRIVAL | DATE | DD/ MM/ YY |
| | | | | TIME | |
| | | | DESCRIPTION OF ITEMS PURCHASED WITH REGARDS TO NO, NATURE AND COST OF EACH SUCH ITEMS | | |
| COST OF ITEMS LOST | | | COST OF ITEMS PURCHASED | | |
| ***TOTAL CLAIM AMOUNT*** | | | ***TOTAL CLAIM AMOUNT*** | | |
| ***TOTAL CLAIM AMOUNT IN WORDS*** | | | ***TOTAL CLAIM AMOUNT IN WORDS*** | | |

**PERSONAL ACCIDENT (Please attach Police Report, Post Mortem Report, Death Certificate, Medical Report)**

| | | | | | |
|---|---|---|---|---|---|
| DATE | DD/ MM/ YY | TIME | | PLACE OF ACCIDENT | |
| TREATING DOCTOR / CLINIC / HOSPITAL | | | | POLICE REPORT LODGED | □ Yes □ No |
| NAME | | | | | |
| ADDRESS | | | | FULL DESCRIPTION OF ACCIDENT CAUSE | |
| CONTACT NUMBER | | | | | |
| NATURE OF INJURY SUSTAINED | | | | | |
| | | | | | |
| ***TOTAL CLAIM AMOUNT*** | | | | ***TOTAL CLAIM AMOUNT IN WORDS*** | |

## Declaration

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect. I/We agree that if we have made already or if I/We make in any of my/our further statements in respect of the said incident or any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect the present or future claim shall be forfeited.

**Place:**

**Date:**

**Signature of Claimant/Insured**