Mondial Assistance Insurance Claim Form.

This document is designed to help you submit a completed claim. By following the directions on this document you will help ensure that your claim will be assessed in a timely manner.

This document consists of two parts:

1. This page explaining how to complete the claim form
2. The claim form which must be completed and submitted

Please do not submit this page with your claim. This is for your reference only.

To complete the claim form you must:

1. **Complete your name and address correctly on the first page.**
2. **Supply your bank details so that we can submit payment to you.**
3. **Complete all of Step 2**, it is important that we have all of these details so that we can assess your claim and contact you if required.
4. **You only need to complete the section under which you would like to make a claim.**
5. If any of the above information is missing we may return your claim form to you, delaying your claim.

When completing the appropriate section please ensure that it is completely filled out. If you require more space, please submit an additional letter explaining your claim.

It is important that you list the amount that you are claiming and a clear reason why. If you do not list this information we will be unable to complete your claim.

Each section contains certain document requirements that are listed under the section heading, these documents are essential to the completion of your claim. Please submit all of the request documents as per the claim form.

Please ensure that you supply original receipts and proof of ownership for any claims relating to Luggage and Personal Effects.

If you are unable to submit one or more of the submitted documents, please explain why so that we can take your circumstances into consideration.

Once you have completed the form, please sign the claim form and submit it to our offices with your additional documentation. If you have any questions or require assistance completing the form, our call centre staff will be more than happy to assist you.

TRAVEL INSURANCE CLAIM FORM

Claims Enquiries call: Monday – Friday, 09:00 – 17:00
+(65) 6222 3350

E-Mail: Mhinsure-claims@mondial-assistance.com.sg

Mail: **MHinsure Claims**
#13-01 143 Cecil Street
GB Building Singapore 069542

STEP 1 – CLAIM FORM COMPLETION REQUIREMENTS

• Please read this claim form carefully and complete ALL steps outlined on this form.
• Please use block letters.
• Please retain a copy of ALL documents for your records. **We reserve the right to request the original receipts, reports or any other documentation be submitted in order to substantiate the claim.**
• Documents in a foreign language are required to be translated into English at your own expense.
• Please refer to the specified documentation requirements that you will need to provide when lodging your claim.
• **AS EACH CLAIM IS UNIQUE, FURTHER INFORMATION MAY BE REQUESTED BY US**.
• **We cannot process your claim if you do not supply the listed documentation with your fully completed and your email address.**
• **PLEASE SUPPLY A COPY OF THE ID PAGE OF YOUR PASSPORT.**
• **A COPY OF YOUR CERTIFICATE OF INSURANCE MUSTBE SUPPLIED.**
• **If any part of your claim is of a dishonest or fraudulent nature, your claim will be denied and referred to the appropriate authorities.**

STEP 2 – PERSONAL DETAILS

1. Travel Insurance Policy Number: _____
2. Name of policy holder/s (as on the Certificate of Insurance) please underline your family or last name:
( ) Mr ( ) Mrs ( ) Miss ( ) Ms ( ) Dr _____Date of Birth: ____/____/____
3. Name of person making the claim. Please underline your family or last name:
( ) Mr ( ) Mrs ( ) Miss ( ) Ms ( ) Dr _____Date of Birth: ____/____/____
5. Home Address: _____
_____
_____ Postcode: _____
6. Telephone Numbers: Home: _____ **Mobile:** _____
7. Email Address (please write clearly as all correspondence will be sent to this address):
_____
8. Travel Destination: _____

B. Insurance Arrangements

1. Did you pay for your travel arrangements using a credit card? ( ) Yes ( ) No If *Yes*, please complete the following:
Credit Card Provider (e.g. DBS Bank) _____Card Type (e.g. Visa) _____
Card Status: Gold ( ) Platinum ( ) Other: _____
2. Do you have a Travel Insurance Benefit under your credit card? ( ) Yes ( ) No
If *yes*, have you made a claim against this? ( ) Yes ( ) No
3. Is there any other insurance covering this loss, such as home and contents, medical or car insurance?
If yes, please provide details including policy number: _____

STEP 3 – CLAIM INFORMATION

In this Section we will ask you the circumstances of your claim and the amount that you are claiming.
Please tick the applicable box(s) relating to your claim and answer the corresponding Section. ***You only need to complete the sections that are applicable to your claim.***

( ) **A.** Overseas Medical and Dental Expenses Claim
( ) **B.** Luggage and Personal Effects Claim – please go to page 3
( ) **C.** Travel or Baggage Delay / Flight Misconnection – please go to page 4
( ) **D.** Cancellation Claim – please go to page 4
( ) **E.** Other – please go to page 5

A. Overseas Medical and Dental Expenses Claim

PLEASE PROVIDEALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

• The itemised receipts/ account(s) giving a breakdown and description of the costs claimed.
• The medical report/dental report/hospital records giving full details of the matter for which treatment was sought.
• PLEASE PROVIDE US WITH A COMPLETED MEDICAL CERTIFICATE.

EXCEPT IN THE CASE OF A MINOR ILLNESS OR INJURY YOUR CLAIM CANNOT BE PROCESSED WITHOUT A COMPLETED MEDICAL CERTIFICATE. WE MAY REQUEST ADDITIONAL INFORMATION IF REQUIRED.

1. Name of the person who incurred illness/injury: _____
2**.** The patient's relationship to the policy holder: _____
3. Nature of the illness/injury: _____
4**.** Did the illness/injury occur whilst the ill/injured person was working? ( ) Yes ( ) No
5. How did the illness/injury occur? _____
_____
_____
6. Date this condition first occurred: ____/____/____
7. Has the ill/injured person suffered from the same or similar illness/injury before? ( ) Yes ( ) No
If *Yes*, please provide details including dates: _____
_____
_____
8. Name and phone number of ill/injured person's usual Doctor/Dentist: _____
_____
9. Country where illness was treated: _____
10**.** Please list each receipt/bill separately in the table below:

Name of /Doctor/ Dentist/ Pharmacy/ Hospital	**Treatment received**	**Date of treatment**	**Amount charged (including currency)**	**Paid? (Yes/ No)**
e.g. Dr Lee	*e.g. Consultation*	*e.g. 22/03/2010*	*e.g. 100 SGD*	*Yes*

Claims will be converted to your relevant currency as per your Policy Wording using the currency rate applicable at the date and time the expenses were incurred.

B. Luggage and Personal Effects Claim

YOUR CLAIM WILL NOT BE PAID WITHOUT PROOF OF OWNERSHIP.
PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

• Proof of Ownership – This may be in the form of receipts or bank/ credit card statements.
• In the case of damaged items – please send us a quotation for repairs and the damaged items.
• A loss report from the authority you reported the loss to: e.g. Police Report, Letter from Hotel, or a Property Irregularity Report (PIR) from the Carrier.
• If applicable, a letter from the carrier outlining their compensation paid to you.
• Your travel tickets and baggage tags.

1. Date of Incident: ____/____/____ **2.** Time: _____ am/pm
3. Location: _____ **4.** Country: _____
5. Please state in full exactly what occurred (please attach a letter if you need more space): _____
_____
_____
_____
_____
_____
_____
6. Have you sought or received any compensation? _____
7. If yes, please detail: _____
8. Did you report the event to the police? ( ) Yes ( ) No If *Yes*, please attach the police report
9. Please complete the below schedule in full:

Item Description	Purchase Date	Place of purchase	Original Price	Amount claimed

C. Travel or Baggage Delay / Flight Misconnection

PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- Written confirmation from carrier on the duration and reason for delay including when the next alternative transportation was made available to the Insured – *(applicable for overbooked flight and flight misconnection only).*
- Have you received any compensation from the airline? If yes please provide details

_____

Original Flight Details	***Delayed Flight/ Luggage Details***
Date of departure:	Date of departure/ returned luggage:
Time of departure:	Time of departure/ returned luggage:
Place of departure:	Place of departure:
Flight No(s):	Flight No(s):
Name of airline(s):	Name of airline(s):

D. Cancellation Claim

PLEASE PROVIDE US WITH ALL OF THE FOLLOWING DOCUMENTATION RELATING TO YOUR CLAIM:

- The travel agent's letter detailing all cancellation charges AND your travel agent's contact details.
- This **MUST** show all amounts paid for your travel and amounts refunded.
- The complete terms and conditions for your booking arrangements.
- Any relevant documentation that which supports your reason for cancelling.
- If your travel was cancelled due to the unfortunate event of a death, a copy of the Death Certificate will be required.

1. Date of travel cancellation/change: ____/____/____
2. Date of the incident that caused you to cancel your trip: ____/____/____
3. Was your travel cancelled/changed for a medical reason? ( ) Yes ( ) No If *Yes*, Medical Certificate must be completed by the Doctor/Dentist who recommended cancellation. Option 2 on the Medical Certificate needs to be completed. Please answer questions from 4 to 8. If *No*, please answer questions 7 to 9.
4. Name of person who incurred the illness/injury: _____
5. What is the illness/injury: _____
6. Has the ill/injured person suffered from the same or similar illness/injury before? ( ) Yes ( ) No
7. Date your trip was originally booked: ____/____/____ 8. Date your trip was cancelled: ____/____/____
9. Please provide details of why you cancelled your trip: _____
_____
_____
_____
_____
_____
_____
_____
10. Please list each item separately in the table below:

Description	Purchase Date	Place of purchase	Price paid (less any refunds)	Amount claimed

E. Other

PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

• Please provide ALL relevant documentation relevant to the application of this claim.
• To process your claim more efficiently, please provide us with as much information as possible.

1. Please tell us in as much detail as possible what happened to you in order for you to make this claim, including dates and amounts paid. If there is not enough room in the space provided, you may continue your description of the events on a separate piece of paper.

_____
_____
_____
_____

CLAIM FORM SUBMISSION CERTIFICATE

I/We certify that this claim form has been completed in full and all required information and documentation as specified on this claim form is attached to this signed claim form.
I/We certify that the information given in this form is truthful, accurate and complete. No information that is likely to affect this claim has been withheld.
I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.
I/We understand that if this claim is fraudulent, it will be reported to the relevant authorities.
I/We consent to the collection, use and disclosure of personal information in order to handle my/our claim.
I/We acknowledge that if I/we do not agree to the collection of this personal information then Mondial Assistance will be unable to process my/our claim.
I/We acknowledge that I/we will provide all necessary assistance as required by Mondial Assistance to process this claim.
Name (PLEASE PRINT): _____
Signature: _____ Date: _____

PAYMENT DETAILS

Please note that ALL payments will be sent to your BANK ACCOUNT. If you do not provide us with your bank details we cannot process your claim. Please complete all of the following:

If you reside in Singapore:

Beneficiary Name: _____

Bank Code: _____
Branch Code: _____
Bank Account No: _____

If you reside outside Singapore

Beneficiary Name: _____
Beneficiary Address: _____
_____
Bank Name: _____
Bank Address: _____
Bank Account No: _____
Bank Swift Code: _____

MEDICAL CERTIFICATE

To be completed by the person's usual Doctor/Dentist (at the claimant's expense) in all cases of cancellation and medical claims resulting from accident, illness or death.

Name of person to whom this certificate applies (i.e. the person whose state of health caused the claim):
_____ Date of Birth: ____/____/____

Instructions to the Medical Professional:
Please complete this form in block letters, and provide as much information as possible, as this will accelerate this Travel Insurance claim. Thank you for your assistance.

1. (a) Are you the patient's usual medical attendant? _____
(b) If not, do you have access to their medical records? _____

The claimant must indicate which applicable, question 2 or 3 is.
2. Alteration to/cancellation of travel arrangements prior to travel.
(a) Did you recommend that travel be cancelled or postponed due to the patient's state of health? _____
(b) Please give precise details of the nature of the illness or injury which gave rise to this recommendation (including the final diagnosis): _____
_____
_____
_____
(c) On what date did you make this recommendation? ____/____/____
(d) On what date did the patient first become aware of their symptoms? ____/____/____
(e) On what date were you first made aware of the condition, or change in the condition? ____/____/____
(f) Has the patient previously been investigated, diagnosed or treated in respect for same/similar/related illness or injury?
_____
(g) If *Yes*, please provide details from the patient's history (e.g. dates of incidents, advice, treatment and/or medication):
_____
_____
_____
_____
(h) Did the patient make the travel arrangements against your advice (or the advice of another medical professional)?
_____
_____

OR

3. Treatment costs/ additional expenses incurred during travel.
(a) What do you understand to be the illness or injury which resulted in the need to seek medical care/ interrupt the patient's travel plans? _____
(b) Has the patient previously been investigated, diagnosed or treated in respect of the same/similar/related illness or injury? _____
(c) If *Yes*, please provide details from the patient's history (e.g. dates of incidents, advice, treatment and/or medication):
_____
_____
_____
(d) Was there any indication that medical care may be required on the journey? _____
(e) Was the patient non-compliant with medical advice whilst on the journey? _____
(f) Did the patient travel against your advice (or the advice of another medical professional)? _____
_____
_____

I certify that the statements contained in this Medical Certificate are true and correct.

Doctor's Signature: _____ Date: ____/____/____

Doctor's Stamp: