TRAVEL INSURANCE CLAIM FORM

Postal Address:
Suites 403-11, 4/F, Cityplaza Four, 12 Taikoo Wan Road, Taikoo Shing, Island East, Hong Kong

Claims Hotline: 800 969 550 (Toll free within Hong Kong)
Fax: +8610-85355535
Email: claims@allianz-assistance.com.cn

In order for your claim to be dealt with promptly, please ensure ALL RELEVANT SECTIONS of this Claim Form are fully completed and returned to us by post together with all the required claims evidence. A separate claim form must be completed for each Insured Person who is claiming under the policy.

Please use BLOCK letters. Please retain a copy of all documents sent to us for your records.

Please note all expenses incurred in completing this claim form and providing all the necessary evidence to support this claim must be paid by you. Expenses incurred in providing evidence or translations are not covered under this policy.

SECTION 1 – INSURED DETAILS

Claim NO: ..... (AGA Use Only)

1. Policy Number: .....
2. Name of insured person: ..... Passport ID: .....
3. Date of birth: ..../..../..... Occupation: .....
4. Address of claimant to be used for correspondence: .....
5. Tel (Home/ Work): ..... Tel (Mobile): ..... Email: .....
6. Have you made any previous claims in respect to travel insurance? YES ☐ NO ☐
   If yes, please provide exact details of claim/s (date/amount/type of claim/insurance company involved): .....
7. Are you able to claim through any other source? YES☐ NO☐ If yes, please provide information: .....

SECTION 2 – MEDICAL EXPENSE CLAIM

1. Date of Incident: ..../..../..... Time (am / pm): ..... Location (City / Country): .....
2. Please advise (in detail) the nature of the illness contracted or injury sustained for which this claim is related:

   .....
3. Have you ever been hospitalized or advised to be hospitalized? YES☐ NO☐ If yes, please fill in the table below:

Hospitals Name	Admission Date	Discharge Date	NO. of Hospitalization	Diagnosis	Treatment/Medication

4. Have you ever suffered from any disorder which required that a) received more than 7 days treatment b) were off work/study for more than one week c) had specialized treatment (i.e. chem/radiotherapy and dialyse, etc.)?
   YES ☐ NO ☐ If yes, please describe the details: .....
5. Are you currently on treatment/medication or advised to have treatment? YES ☐ NO ☐
   If yes, please describe the treatment/medication. .....
6. Please provide details of the treatment provided:
   Name of hospital/clinic: ..... Address: .....
   Name of treating doctor: ..... Specifics of the treatment: .....
7. Has the illness or injury mentioned above occurred previously (prior to this specific incident)? YES ☐ NO ☐
   If yes, please provide details (date/location/previous treatment) .....
8. Please itemize all medical expenses that you are seeking reimbursement for:

Explanation of the Expense	Name of Hospital/Doctor	Currency	Amount Claimed
TOTAL			

SECTION 3 – DAILY INPATIENT CASH SUBSIDY CLAIM

Admission Date: ..../..../..... Discharge Date: ..../..../..... Duration: .....

SECTION 4 – BAGGAGE DELAY, TRAVEL DELAY AND/OR MISSED CONNECTION CLAIM

1. Please indicate the claim type: Baggage Delay☐ Travel Delay/Missed Connecting Flight ☐
   Scheduled Time of Arrival: ..... Actual Time of Arrival: .....
2. Flight/train number: ..... Reason for the delay: .....
3. Have you received any compensation for the delay from another source? YES☐ NO☐
   If yes, please advise from whom and the amount: .....

4. If you missed your connection, did you incur any additional overnight accommodation expenses (any costs that will be reimbursed by the airline/train company should not be included) : YES☐ NO☐
If yes, provide details of expenses .....

SECTION 5 – PERSONAL EFFECTS/MONEY (LOSS/DAMAGE) CLAIM

1. Date of Incident: ...../...../..... Time (am / pm): ..... Location (City / Country): .....
2. Please advise (in detail) exactly what happened (attach a letter if insufficient space) .....
.....
3. Please advise what action was taken to recover lost articles (if any): .....
4. Were the police or a responsible authority notified within 24 hours of the incident? YES☐ NO☐
If yes, state who: ..... Location: .....
If no, please provide the reason why: .....
5. Have you received payment from your travel/tour representative for the lost or damaged articles? YES☐ NO ☐
If yes, please advise from whom and the amount paid: .....
6. Please itemize all lost/damaged items that you are claiming for (please note which currency)

Full description of articles/money lost or damaged	Original price	Date & place of purchase	Amount claimed
TOTAL			

SECTION 6 – TRIP CURTAILMENT/CANCELLATION CLAIM

1. Please indicate the claim type: Trip curtailment ☐ Trip Cancellation ☐
2. Trip curtailment/cancellation time: ..... Reason: .....
3. Item claimed:

Description	Original Price	Time of Payment	Claimed Amount
TOTAL			

SECTION 7 – ADDITIONAL INFORMATION OR COMMENTS TO SUPPORT YOUR CLAIM

If you are claiming under a section of the policy not provided on this claim form, please provide details below:
We recommend that you contact us for advice on the documents required to support your claim.

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Please read the following declaration carefully and sign & date below:

I (the Claimant) declare that all statements and particulars contained on this claim form are true and correct.
I (the Claimant) acknowledge and authorize that the underwriter or its agent may give to and obtain from other insurers and / or other authorities, personal information relating to this claim.
I (the Claimant) authorize the insurer or its agent to get related information and documents in respect to this claim from any other persons, police offices, hospitals, etc.

Signature of Claimant: ..... Date: ..../..../.....