TRAVEL INSURANCE CLAIM FORM

143 Cecil Street
#13-01 GB Building
Singapore 069542

Tel: 1800 327 1356 (Toll Free within Singapore) /
+65 6327 1356 (reverse call charge from overseas)
E-Mail: pricelineclaims@mondial-assistance.com.sg

This policy is underwritten by Tokio Marine Insurance Singapore Ltd., with services provided by the Mondial Assistance Group

Please note:-
In order for your claim to be dealt with promptly, please ensure that the General Section and the relevant section(s) to which your claim(s) relate are duly completed and returned to us by post together with all original invoices/documents in support of the claim. A separate claim form must be completed for each Insured Person who is claiming under the policy.

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

The acceptance of this form is NOT an admission of liability on the part of the Company. Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

GENERAL SECTION (To be completed for ALL claims)

Please submit:

- Original completed claim form
- Original travel itinerary
- Copies of front page of passport / the page indicating entry and exit stamp to the country of destination
- VISA
- Original Boarding passes / Air tickets
- Original Certificate of Insurance

1. Policyholder's name: _____

Claimant's name: _____

Date of Birth: _____Sex: _____ Occupation: _____

Address: _____

Email: _____

Home Tel. No.: _____Mobile No.: _____

2. Policy / Certificate No.: _____ Effective Date of policy: _____

Period of Travel: _____ to _____Destination: _____

3. Is there any other insurance in force covering this loss? * Yes / No

If yes, please furnish the details: Insurance Company: _____

Type of policy : _____

Policy No. : _____

Compensation Amount: _____

4. Have you ever had previous claims in respect of travel insurance? * Yes / No

If yes, please furnish the details: Insurance Company: _____

Type of claim: _____

Date of claim: _____

Compensation Amount: _____

A. MEDICAL, HOSPITAL AND DENTAL EXPENSES

Please submit:

- Original medical invoices
- Original Medical Report and discharge summary or duly completed Appendix A
- Original police report / accident report (if due to road traffic accident)

1. Date and place of injury / illness: _____

2. Cause of injury / illness: _____

3. Have you suffered from similar condition before? * Yes / No

If yes, kindly state: Date of consultation: _____

Name and address of doctor consulted: _____

4. Total amount you are claiming for this claim: _____

B. BAGGAGE, PERSONAL EFFECTS, TRAVEL DOCUMENTS AND PERSONAL MONEY

Please submit:

- Police report lodged at the place of loss within 24 hours
- Report from carrier if losses / damages are incurred while the item(s) is/are in their custody
- Original purchase receipts and/or warranty cards for lost item(s)
- Original replacement receipts – (a*pplicable for loss of travel docs and money only)*
- Photographs to show extent of damage and original repair quotations
- Documents stating amount of compensation from airlines or other sources

1. Date, Time and Place of loss or damage: _____

2. Please state in full, the circumstances leading to the loss / damage

3. If the loss or damage occurred whilst baggage was in transit or otherwise in the custody or control of others, have any steps been taken to claim against these persons?

If yes, kindly identify them and attach any correspondence with them.

If no, please state reason: _____

4. If claim is in respect of lost or stolen items, has a search been made and notification sent to the relevant parties who may be able to assist in the recovery?

If yes, please give details: _____

If no, please state reason: _____

5. Details of Items Claimed

Description (Make and model)	Purchase Date	Place of purchase	Original Price	Amount claimed
Total Claim Amount				

C. TRAVEL OR BAGGAGE DELAY / OVERBOOKED FLIGHT / TRAVEL MISCONNECTION

Please submit:

- Written confirmation from carrier on the duration and reason for delay
- Written confirmation from carrier on the overbooked flight and travel misconnection details and when the next alternative transportation is made available to the Insured – *(applicable for overbooked flight and travel misconnection only)*
- Original receipts in respect of hotel accommodation and meals
- Original receipts of essential purchases
- Documents stating amount of compensation from airlines or other sources

TRAVEL DELAY / OVERBOOKED FLIGHT / TRAVEL MISCONNECTION

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

BAGGAGE DELAY

Original Flight Details	***Receipt of delayed baggage***
Date of departure:	Date of receipt:
Time of departure:	Time of receipt:
Place of departure:	Place of receipt:
Flight No(s):	
Name of airline(s):	

If claiming for travel or baggage delay, kindly state the reason that gives rise to the delay.

Reason: _____

D. TRIP CANCELLATION / CURTAILMENT

Please submit:

- Medical report or Appendix A, death certificate, written advice from attending medical practitioner confirming advisability to cancel or curtail the trip due to illness or injury sustained by you, your relatives or travel companion
- Proof of relationship to Insured if claim is incurred due to illness or injury sustained by relative
- Original booking invoice with terms and conditions and payment receipts
- Written confirmation of the amount of refund from the travel agents or any other sources
- Original air ticket (if completely non-refundable)
- Original invoice for additional ticket purchase – *(applicable for trip curtailment only)*

1. When and where was the trip booked : _____

2. Intended departure date: _____ 3. Date of cancellation: _____

4. Kindly state in full the reason that gives rise to the cancellation / curtailment

5. Breakdown of amount claimed: Total amount paid $_____

Total refund $ _____

Net amount claimed $_____

6. If trip cancellation / curtailment was caused by medical condition, has the patient suffered from this condition before? * YES / NO

If yes, kindly state: Date of consultation: _____

Name and address of doctor consulted: _____

CLAIM PAYMENT AND DECLARATION (to be completed for ALL claims)

If the Payee differs from the Claimant detailed in the General Section, please provide us with the following:

Name of Payee: _____

Address of Payee: _____

_____

_____

NRIC / Passport No.: _____

Relationship with Claimant: _____

Please read the declaration carefully before signing

DECLARATION

I declare that all statements contained on this claim form is true and correct. I acknowledge that the underwriter or its agent may give to and obtain from other insurers and / or other authorities personal information relating to this claim.

Signature of claimant / Date

_____

APPENDIX A – MEDICAL CERTIFICATE (to be completed by attending physician)

1. Name of Patient: _____

2. Are you the patient's usual medical attendant? *YES / NO

If yes, for how long? _____

3. Please provide details of the nature of the illness or injury that gave rise to this claim.

5. Date you first investigated or were consulted by the patient for this condition: _____

6a. Has patient been investigated, diagnosed or treated previously in respect of the same, similar or related illness/injury as described in question 3 and is there any indication that the condition was pre-existing?

* YES / NO

b. If yes, when was the last time, prior to the occurrence of this claim, treatment was being rendered and what medication was prescribed?

7. Is there any indication that the condition suffered was due to alcohol or drug abuse?

*YES / NO

8. Was the patient advised to continue with the treatment / medication during the trip?

*YES / NO

9. Can you confirm that patient was compelled to cancel the travel arrangement solely due to the condition described in question 3?

*YES / NO

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

Doctor's name: _____

Address: _____

_____

Tel No.: _____

Fax No.: _____

Doctor's signature / Clinic Stamp / Date