TRAVEL INSURANCE CLAIM FORM

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AIG

PLEASE COMPLETE ALL SECTIONS TO FACILITATE THE PROCESSING OF YOUR APPLICATION

Required documents – For all travel claims please submit air tickets and boarding pass. For annual plans, please provide a copy of the passport showing duration of trip. We reserve the right to request for additional information. To enable us to process your claim expeditiously, please return the duly completed Claim Form with supporting documents.

Please direct the claim form and all correspondence to:

AIG Asia Pacific Insurance Pte. Ltd.
AIG Building 78 Shenton Way #07-16 Singapore 079120

The acceptance of this Form is NOT an admission of liability on the part of AIG Asia Pacific Insurance Pte. Ltd. ("the Company"). Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

Any information collected or held by Us whether contained in the Application / Proposal or Claim Form or otherwise obtained in any other manner, may be used and disclosed to Our associated individuals / companies or any independent third parties (within or outside Singapore) for any matters related to your claim and to communicate with You for any purpose.

General Information: Documents required: For all travel claims please submit air tickets and bording pass. For all annual plans, please provide a copy of the passport showing duration of trip.

POLICY HOLDER INFORMATION

Product Name and Plan			
Certification / Policy No.		Master Policy No.	
Policy Holder's Name	☐ Mr. ☐ Mrs. ☐ Ms.		
Contact Details	_____ (Residential) _____ (Fax) _____ (Mobile)		
Occupation		Nature of Business:	
Preferred Method of Communication	☐ Mail ☐ Email Email Address: _____		

CLAIMANT INFORMATION

Claimant's Full Name	☐ Mr. ☐ Mrs. ☐ Ms.	Identity Card / Passport No.	
First Name		Last Name	
Are You a US Citizen?	☐ Yes ☐ No If 'Yes', Please Provide Your Social Security Number (SSN): _____	Marital Status	☐ Single ☐ Married
Date of birth	D D M M Y Y Y Y	Sex	☐ Male ☐ Female
Contact Details	_____ (Residential) _____ (Fax) _____ (Mobile) _____ (Email)		
Occupation			
Date Insured Person Joined the company	D D M M Y Y Y Y		
Name of Company			
Plan and/or Category of Employee			
Relation to Policy Holder			

1. Please indicate your case number, if you have contacted Travel Guard before: _____
2. Have you submitted any claims to / through Travel Guard? ☐ Yes ☐ No
3. If yes, please select the type of claims submitted: ☐ Medical Expense ☐ Medical Evacuation / Repatriation ☐ Others (Please Specify): _____

Cheque made payable to	

PREFERRED MAILING ADDRESS

Preferred Mailing Address	

TO BE COMPLETED BY AGENT/BROKER (if applicable)

Producer Code		Branch	
Name of Producer / Company Name			
Contact Person		Telephone No.	
Mailing Address			
Preferred Method of Communication	☐ Mail ☐ Email Email Address: _____		

FLIGHT DETAILS

Purpose of Travel	☐ Leisure ☐ Business / Conference ☐ Home Leave ☐ Others (Please Specify): _____

PLPF100-04/13

Was a Credit Card used to purchase some or all of the journey arrangement? ☐ Yes ☐ No

- If yes, please state the first six digits of the credit card used: _____
- If yes, please advise the amount settled by the credit card: _____

- Date & Time of Departure from Singapore D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM
- Date & Time of Return to Singapore D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM

ACCIDENT RELATED CLAIM ONLY

(a) Date & Time of Accident	D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM
(b) Where did the accident occur?	
(c) How did the accident occur?	
(d) Injuries Sustained	

(e) If you had a history of similar injury, which you have experienced in the past, please give details as to when, where and from whom you received medical diagnosis, treatment, consultation or prescribed drugs

(f) Disablement Commencement	D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM	(g) Date of Death	D D M M Y Y Y Y
(h) Are you still suffering the above stated disability?	☐ If yes, please advise the expected date & time of returning to work: D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM ☐ If no, please advise the date & time of returning to work: D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM		
(i) Have you sustained any fractures from this accident?	☐ Yes ☐ No If yes, please advise the type of fracture: _____		
(j) Have you sustained a burn injury from this accident?	☐ Yes ☐ No If yes, please provide the following information: ☐ Head ☐ Body Degree of burn: _____		
(k) Have you lodged a police report	☐ Yes ☐ No	Date of report: D D M M Y Y Y Y	Police Station that you lodged report?
(l) Name and address of any witness of the incident			
(m) Was the sum insured or benefits of your policy based on your monthly salary?	☐ Yes ☐ No If yes, please advise the last drawn salary prior to the accident: _____		

(n) Please furnish the details of any hospitalization in connection with this injury

Name of Hospital	Admission Date (DD-MM-YYYY)	Date Discharged (DD-MM-YYYY)	Admission No.	Type of Ward

(o) Please provide information on your first consultation

Doctor Consulted			
Doctor's Address			
Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

(p) Please provide information of your regular doctor.

Family Doctor			
Family Doctor's Address			
Family/ Regular Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

ILLNESS RELATED CLAIM ONLY

Claim Description (fill in items that apply)

(a) Give a brief description of the illness suffered

(b) Answer the questions pertaining to your condition stated above.

i) Are there any symptoms which are or were evident for this condition? If yes, please advise the date of onset of the symptoms. D D M M Y Y Y Y

ii) Have you been recommended to receive or received treatment, advice or diagnosis for this condition? If yes, please advise the date of your 1st consultation. D D M M Y Y Y Y

(iii) Please describe the symptoms you experienced.

(c) Please provide information on your first consultation.

Doctor Consulted			
Doctor's Address			
Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

(d) Please provide information of your regular doctor.

Family Doctor			
Family Doctor's Address			
Family/ Regular Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

(e) Please furnish the details of any hospitalization in connection with this illness

Name of Hospital	Admission Date (DD-MM-YYYY)	Date Discharged (DD-MM-YYYY)	Admission No.	Type of Ward

(f) Have any of your family members experienced this similar or related illness? If yes, please provide details.

Relationship of Family Member	Nature of Illness	Date Diagnosed (DD-MM-YYYY)	If Deceased, Date (DD-MM-YYYY)	Age

(g) Are there any other illness/complaints suffered by you prior to this event? If yes, please provide details.

TRAVEL CANCELLATION / CURTAILMENT / POSTPONEMENT

Please tick the appropriate box: ☐ Travel Cancellation ☐ Travel Curtailment ☐ Postponement

Travel Booking Date	D D M M Y Y Y Y	Date of event that resulted in the cancellation/ curtailment	D D M M Y Y Y Y
Original Scheduled Departure/ Return Date	D D M M Y Y Y Y	Location of Incident Causing Claim	

Cancellation/ Curtailment Reasons

☐ Earthquake ☐ Fire ☐ Tsunami ☐ Volcano Eruption ☐ Extreme Weather ☐ Airspace/Multiple Airport Closures

☐ Strike Riot, Civil Unrest, Civil Commotion resulting in cancellation of scheduled flights ☐ Epidemic/ Pandemic ☐ Travel Agent Insolvency

☐ Death, Serious Sickness, Injury (please specify illness/sickness/injury): _____

☐ Others (please specify): _____

Was a home government warning issued?	☐ Yes ☐ No	Amount Paid by you	
Has compensation been made by other parties?	☐ Yes ☐ No	If yes, please state amount compensated by other parties.	

If travel cancellation is due to death, serious sickness of the insured's immediate family member/ Travel companion please state their:

Full Name: _____ Relationship to Policyholder/ Insured: _____

Did you need to cancel / curtail your trip because of a relative who is not travelling with you or because of a travelling companion? ☐ Yes ☐ No

Please indicate which ☐ Relative ☐ Travelling Companion Please advise their name: _____ If a Relative, please advise their Relationship to you: _____

Date you became aware of the need to cancel / curtail your trip	D D M M Y Y Y Y	Date you informed your carrier/ travel agent/tour operator	D D M M Y Y Y Y

Name, address and contact number of your usual doctor (if you need to cancel / curtail your trip on medical grounds, including death)

Details of trip costs, refunds due or paid and additional expenses incurred (continue on a separate sheet if necessary)

Item	Amount	Refund Due or Paid	Additional Expenses (for Curtailment)

TRAVEL DELAY / MISCONNECTION / FLIGHT OVERBOOKING, DIVERSION

Please tick the appropriate box:	☐ Travel Delay ☐ Travel Misconnection ☐ Flight Overbooking ☐ Flight Diversion
Location of Incident causing the claim:	
Causes	☐ Earthquake ☐ Fire ☐ Tsunami ☐ Volcano Eruption ☐ Adverse Weather ☐ Airport Closure ☐ Terrorism ☐ Strike Riot, Civil Unrest, Civil Commotion ☐ Carrier Defect ☐ Others (please specify): _____
Carrier Type:	☐ Aircraft ☐ Bus ☐ Train ☐ Others (please specify): _____
Original Flight Details	Departure Date & Time: D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM Location: _____ Arrival Date & Time: D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM
Actual Flight Details	Departure Date & Time: D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM Location: _____ Arrival Date & Time: D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM
Actual Arrival of incoming connecting carrier from airport / ferry port, etc (For travel misconnection only)	D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM
Length of Delay	Hour : Minutes
Please state the reason provided by the tour operator, airline, cruise company, rail company etc for the cause of the delay:	
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	☐ Yes ☐ No If yes, please provide details on the compensation or cash settlement amount received : _____ If no, please provide evidence of denial of compensation from the service provider.

BAGGAGE DELAY

Planned Arrival Date	D D M M Y Y Y Y	Actual Arrival Date	D D M M Y Y Y Y
Planned Arrival Time	Hour : Minutes ☐ AM ☐ PM	Actual Arrival Time	Hour : Minutes ☐ AM ☐ PM
Place of Departure			
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	☐ Yes ☐ No If yes, please provide details on the compensation or cash settlement amount received : _____ If no, please provide evidence of denial of compensation from the service provider.		

BAGGAGE DAMAGE / LOSS OF PERSONAL EFFECTS, TRAVEL DOCUMENTS AND MONEY

Please tick the appropriate box:	☐ Baggage Loss ☐ Baggage Damage ☐ Damage/ Loss of Personal Effects ☐ Loss of Travel Document ☐ Loss of Money		
Cause of Loss	☐ Destroyed or Lost due to Natural Disaster: ☐ Earthquake ☐ Fire ☐ Tsunami ☐ Volcano Eruption ☐ Extreme Weather ☐ Others (please specify): _____ ☐ Robbery, Burglary, Theft ☐ Damage or Lost while held by Airline or Service Provider		
Please provide details on the circumstances surrounding the incident and the precautions taken to protect your property			
Where did the loss / theft / damage occur?			
Date and time of the loss / theft / damage	D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM		
To whom the incident was reported (e.g.: police, airline, cruise company, etc)			
Date and time reported	D D M M Y Y Y Y Hour : Minutes ☐ AM ☐ PM		
Were your items in the custody of the carrier / service provider?	☐ Yes ☐ No	Service Provider Contact No.	
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	☐ Yes ☐ No If yes, please provide details on the compensation or cash settlement amount received : _____ If no, please provide evidence of denial of compensation from the service provider.		
Where were the items located at the time of the loss, theft or damage?			
Any Action taken to attempt the recovert if your property?	☐ Yes ☐ No If yes, please provide details on the actions taken: _____ If yes, please provide details for not attempting recovery: _____		

Details of damaged, stolen, destroyed or lost personal effects (continue on a separate sheet if necessary). Please provide full details of each item claimed for. (For cameras, include the make and model number, lens details etc. For jewellery include nature and quality of metal content, type of stone etc.). Purchase receipts, valuations or other documentation to substantiate ownership should be provided whenever possible.

Description of item	Owner's Name	Place of Purchase	Date of Purchase	Purchase Method	Purchase Price

Loss/Theft of Money

Amount of Cash & Travelers' cheques taken on trip				Amount of cash & travelers cheques damaged, stolen, destroyed or lost during the trip		
Owner's Name	Traveler's Cheque	Cash	Currency	Traveler's Cheque	Cash	Currency

Loss of Travel Documents Please detail the expenses you incurred in obtaining a replacement passport or travel document (continue on a separate sheet if necessary)

Owner's Name	Description	Date	Amount	Currency
	Additional Travel Expenses			
	Additional Accommodation Costs			
	Travel Documents Replacement Costs			
	Total expense			

PERSONAL LIABILITY ABROAD

Which of the following are you being held liable for?	☐ Damages ☐ Medical Compensation		
Please provide details of the circumstances			
Please provide details on the extent of damages or injuries sustained by the other party/person (please attach photos):			
Have you instructed solicitors to represent you at this time?	☐ Yes ☐ No If yes, please provide the name of solicitors : _____ Solicitors contact number:		
Was the accident due to carelessness or negligence on your part?	☐ Yes ☐ No	Have you in any way admitted liability?	☐ Yes ☐ No
Name and address of any witness to the incident		Name and address(es) of the other party / parties	_____
If any, which Police Officer and Police Station did you report the occurrence?			
If a claim has been made upon you, was the amount of such claim specified?	☐ Yes ☐ No If yes, please state the amount _____		
Please provide any additional information which you consider would help us in dealing with any claim that may be made against you.			

COMPASSIONATE VISIT / HOSPITAL VISITATION / STAFF REPLACEMENT / CHILD FRAUD

Reason for additional travel and accommodation expenses?	☐ Death ☐ Serious Sickness / Serious Injury		
Please provide description of loss			
Period of Hospitalization from	D D M M Y Y Y Y to D D M M Y Y Y Y		
Please state their name and relationship to you	Name:	Relationship:	
Details of accomodation expenses and additional travel expenses (continue on a seperate sheet if necessary)			

Item	Amount
Accommodation Costs	
Additional Travel Expenses	
Others, please specify	
Total amount	

OTHERS

In respect of any other claim, which does not fall within the sections stated above, please provide details of the claim you are submitting. If the space is insufficient for such details, please attach another page

DETAILS OF YOUR OTHER INSURANCE OR COMPENSATION CLAIMS

Details of your claims other than this insurance policy (i.e. other insurance policies, third party and others)

Name of Insurer / Third Party	Policy/ Reference Number	Type of Benefit	Have you filed a claim?	Amount Claimed

NOTE: If the space provided is insufficient for your answer, please continue on a separate sheet.

Have your other claims been paid by the other policies above? ☐ Yes ☐ No

ACKNOWLEDGEMENT AND DECLARATION

I declare that to the best of my knowledge and belief that the above particulars are true and accurate. If I made or shall make any false or fraudulent statements, or withhold material facts whatsoever in respect of this claim, the Policy shall be void and I shall forfeit all rights to recover therein. I agree to the conditions set out at the beginning of this claims form.

I authorise any hospital doctor, other person who attended or examined me, to furnish to the Company, and /or it's authorised representatives, any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Claimant: _____ Date Signed D D M M Y Y Y Y

Signature of Policy Holder: _____ Date Signed D D M M Y Y Y Y

Name		Designation	
Company Stamp			

AIG Bring on tomorrow

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