

TRAVEL CLAIM FORM

GENERAL SECTION (Attach copy of Travel Policy Schedule and Travel Itinerary when submitting your claim)							
۱.	Name of Policyholder/Insured	Trade/Occupation NRIC No					
	Name of Insured Person						
			Date of Birth				
	Relationship to Policyholder/Insured						
	Address (Home)						
	(Business)						
	(Email)						
	(Telephone No.) Office	Но	ome	Mobile			
2.	Policy/Certificate No.	r/Agent/Travel Agency—					
	Name of Contact Person/Email/Telephone No.						
	Period of Insurance From	To)				
3.	Is there any other insurance	Insurance Company					
٥.	in force covering this loss of	Address					
	expenses? If so please state						
4		Policy/Certificate No.					
4.	Have you or any insured person ever previously sustained a loss	Date					
	of this nature? If so please state	Insurance Company involved					
A. LOSS OF DEPOSITS AND TOUR CHARGES/CANCELLATION (Attach Medical Certificate, Death Letter of Administration, Letter from Doctor, Invoices or evidence of proof whichever is applicable)				te, Death Certificate,			
1.	Please state reason for cancellation holiday						
2.	Date of event leading to the cancel						
3.	If caused by illness, has the Insured this before? If so please give details						
4.	4. Amount claimed		Amount of Deposits	Less Refund	Net Amount Claimed		
5.	If "NIL" refund, please state why						
В.	. PERSONAL ACCIDENT (Attach Medical Certificates, please check with us if you are required to arrange for the completion of a Personal Accident Claim Form)						
1.	Date, time and place of accident						
2.	State cause of accident and nature of injuries						
3.	State the period during which you have been totally disabled from attending to your business as the sole and direct result of the accident						
	b) Are you still totally disabled? If were you able to attend to som						
	c) Has the same part been injured						
	 d) Give name, address and contact details of any witness of the accident 						

NOTE: The issuance of this form is not an admission of liability by the Insurer.

	e) Give name and address of Doctor who attended to you					
	f) Name and address of your ordinary Medical Attendant					
	g) State where and when a Medical or other Officer of the insurer can visit you, if necessary					
	h) Please state whether in respect of the accident you are entitled to receive compensation from any other source. If so, from what source and to what extent?					
C.	MEDICAL EXPENSES (Attach Medical Certificates and Invoice	s. If claim for dependent children, attach Certificate of Birth)				
Ι.	Nature and cause of illness or injury					
2.	Date of illness or injury giving rise to expenses					
3.	a) Medical and similar expenses involved					
	b) Number of days for Hospital Confinement					
4.	Have you ever had the same or similar condition or symptom Physician and date of previous treatment.	ns relating thereto? If yes, please state name and address of				
5.	Name and address of your usual Attending Physician (Family/Company)					
_						
		D. TRAVEL INCONVIENCE				
	MISSED CONVEYANCE / FLIGHT DELAY (Attach letter from Transport Provider stating the hours of delay and the reasons for such delay or reason for missing conveyance and purchase receipts, if applicable)					
Ι.						
Ι.	the reasons for such delay or reason for missing conveyance					
1.	the reasons for such delay or reason for missing conveyance	and purchase receipts, if applicable)				
1.	the reasons for such delay or reason for missing conveyance Original Flight Details	Rescheduled Flight Details				
1.	the reasons for such delay or reason for missing conveyance Original Flight Details Flight Number	Rescheduled Flight Details Flight Number				
1.	the reasons for such delay or reason for missing conveyance Original Flight Details Flight Number Date/Time	Rescheduled Flight Details Flight Number Date/Time				
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E.	Any communication received regarding the accident should be sent to	• • • • • • • • • • • • • • • • • • • •			
1.	Date, time and place of accident				
2.	State cause of accident				
3.	If the accident could have been prevented, state what precaution might have been taken?				
4.	Was the accident due to carelessness or negligence on your part?				
5.	Have you in any way admitted liability?				
6.	To which Police Officer or at which Police Station (if any) did you report the occurrence?				
7.	Name, address and contact details of any witness of the incident				
8.	Name and address of the other party or parties				
9.	The nature of the personal injuries, if any, sustained by any person as a result of occurrence. Name, age and address of the injured person. The type of injuries sustained by the injured person				
10.	The extent of the damage to property				
11.	Whether any claim has been made upon you. If so, was the amount of such claim specified?				
12.	Please give any additional information which you consider would help the Insurer in dealing with any claim that may be made against you				
F.	LOSS OF OR DAMAGE TO PERSONAL BAGGAGE/LOSS OF PERSONAL MONEY/LOSS OR TRAVEL DOCUMENT (Attach Purchase Receipts, Property Irregularity Report or Police Report whichever is applicable)				
1.	Give full particulars of circumstances giving rise to the loss or damage. (Please retain damaged articles and indicate address at which they may be inspected)				
2.	Date, time and place of loss or 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? Please identify them and attach any correspondence and advise outcome of your claim against them.				
4.	If claim is in respect of articles lost or stolen, has a thorough search been made and notification sent to Shipowners, Hotel Proprietors, Police or other parties who may be able to assist in the recovery? Please give details.				
5.	State the total value of money lost	Amount in Singapore Currency Amount in Foreign Currency Amount in Travellers' Cheque			

DESCRIPTION OF BAGGAGE LOST OR DAMAGED							
Description (Make & Model)	Date Purchased	Purchase Price	Deduction for Wear and Tear and Depreciation	Amount allowed for Salvage	Amount Claimed		
(A) MEDICAL INFOR (MUST BE COMPLET			D (B) PERSONAL D	ATA PROTECTION	ACT		
I,			NR	JC No.			
hereby authorise any hospital, surgeon, medical practitioner, clinic, insurance office or other person or organisation who has attended to me for any reason, to disclose to Allied World Assurance Company, Ltd any and all information with respect to any illness or injury and to provide copies of all hospital or medical records/certification including earlier medical history. A copy of this authorisation shall be considered as effective and valid as the original. The information given is true and correct to the best of my knowledge and belief.							
I/We declare and acknowledge that: (i) all information given in this form is true and correct to the best of my/our knowledge and belief; (ii) I/We have not concealed or suppressed any material fact or made any false statement in relation to the claim; and (iii) I/We acknowledge and consent to Allied World collecting, using, disclosing and processing my/our personal data for the purposes of managing and administering my/our claim including disclosing my/our personal data to third party service providers within or outside Singapore in accordance with the Allied World Singapore Personal Data Protection Policy available at https://www.awac.com/asiapacretail .							
Signature of Policyholder/Insured and Company's stamp, if applicable (18 years and above)							
DECLARATION							
I/We, the undersigned, do		=	_				
non-concealment or suppression of any material fact, and I/We further agree and undertake that I/We shall not hereafter make any false statement or conceal or suppress any material fact relating to the accident.							
Signature of Policyholder/Insured Date							
and Company's stamp, if ap	pplicable						