

# TRAVEL INSURANCE CLAIM FORM

**Important Notice:**

1. This form is issued without admission of liability
2. Claims should be submitted within thirty (30) days after the occurrence of any event.
3. All documents provided to substantiate your claim must be original documents.
4. All medical reports must be submitted at the claimant's expense.
5. Complete the General Section followed by the relevant section (s) to which your claim (s) relate(s)
6. Submit documentary evidence as stated in each section.

**GENERAL SECTION (To be completed for all claims)**

Documents required for all claims:

- (a) Original completed claim form
- (b) Air tickets and boarding pass
- (c) Copy of the passport showing the duration of trip

1.	Name of Policyholder		Policy No.	
	Name of Claimant			
	Relationship to Policyholder		Occupation	
	NRIC / Passport No.	Sex:	Date of Birth	
	Email Address:	Mobile No.	Home/Office No.	
	Home Address:			
2.	Is there any other insurance in force covering this loss?			
		Yes	No	
	If Yes, please state:	Insurance Company:		
		Type of Policy:		
	Policy / Certificate No:			
	Amount of Compensation			
3.	Have you or the Claimant ever had previous claims?			
		Yes	No	
	If Yes, please state:	Date:		
		Circumstances:		
		Insurance Company involved:		
	Amount Claimed:			

**A. PERSONAL ACCIDENT / MEDICAL EXPENSES / REPATRIATION EXPENSES**

Please submit:	<ol style="list-style-type: none"> <li>1. All original medical invoices and receipts</li> <li>2. Medical reports, Death Certificate if applicable</li> <li>3. Accident report and / or Police Report if applicable</li> </ol>		
1.	Date, time and place of accident / illness		
2.	Cause of accident / illness:		
3.	Nature and extent of injuries / illness:		
4.	Have you suffered from the same condition before:	Yes	No
	Date of previous treatment		
5.	Amount claimed in respect of Medical expenses and similar expenses:		
<b>Amount paid by you</b>		<b>Amount recovered from other sources</b>	
<b>Amount Claimed</b>			

**B. TRIP CANCELLATION / POSTPONEMENT / CURTAILMENT**

Please submit:	<ol style="list-style-type: none"> <li>1. Medical Report, Death Certificate, written advice from attending Medical Practitioner confirming advisability to cancel or curtail the trip due to the illness or injury sustained by you / your relatives (as defined in the policy) or travel companion.</li> <li>2. Documentary proof of relationship between claimant and patient if trip cancellation or curtailment is due to illness or injury of relative (as defined in the policy).</li> <li>3. Original booking invoice with terms and conditions and payment receipts.</li> <li>4. Written confirmation of the amount of refund from the travel agents or any other sources.</li> <li>5. Detailed Itinerary</li> <li>6. Original invoice and receipt for charges incurred in amending or purchasing additional air ticket (for trip curtailment).</li> </ol>
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1.	When and where was the trip booked?	
2.	Why was the trip cancelled?	
3.	Intended Date of Departure:	
4.	Date of cancellation of trip:	
Amount paid by you		Amount recovered from other sources
		Amount Claimed

**C. LOSS OR DAMAGE TO BAGGAGE / PERSONAL EFFECTS / TRAVEL DOCUMENTS / CASH**

Please submit	<ol style="list-style-type: none"> <li>1. Police report lodged at the place of loss.</li> <li>2. Property Irregularity Report for losses in carriers' custody.</li> <li>3. Any other loss reports.</li> <li>4. Original purchase receipts and / or warranty cards for lost items.</li> <li>5. Original receipts for replacement of lost items.</li> <li>6. Photographs to show extent of damage and original repair invoices.</li> <li>7. Documents stating amount of compensation from airlines or other sources.</li> </ol>
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1.	Date, time and place of loss or damage:	
2.	Give full details of circumstances leading to the 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 person / parties concerned	

**DESCRIPTION OF ITEMS AND AMOUNTS CLAIMED**

Description (Make & Model)	Date of Purchase	Place of Purchase	Original Purchase Price	Amount Claimed

**D. BAGGAGE DELAY / TRAVEL DELAY / TRAVEL MISCONNECTION**

 Please submit: 1. Written confirmation from carrier on the duration and reason (s) for delay.  
 2. Documents stating amount of compensation from airlines or other sources.

**TRAVEL DELAY / 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:		Flight No:	
Name of Airlines:		Name of Airlines:	

**BAGGAGE DELAY**

Original Flight Details		Receipt of Delayed Baggage	
Date of Arrival:		Date of Receipt:	
Time of Arrival:		Time of Receipt:	
Place of Arrival:		Place of Receipt:	
Flight No:			
Name of Airlines:			

**E. PERSONAL LIABILITY**

Please note: In no circumstances should the issue of legal liability be admitted to any third party claimant (s). Please enclose letters / writs / summons from third party / police / court.

1	Date, time and location of incident:	
2	Please describe what happened:	
3	Was the accident due to carelessness or negligence on your part?	
4	Have you in any way admitted liability?	
5	To which Police Officer and Police Station (if any) did you report the occurrence?	
6	Names and addresses of the other party (s):	
7	Nature of personal injury sustained by any person:	
8	Extent of damage to property belonging to other party (s):	
9	Whether any claim has been made upon you. If so, was the amount of such claim specified?	
10	Please give any additional information which you consider would help the Insurer in dealing with any claim that may be made against you.	

**F. OTHERS**

Name of Police Station, carrier/Airline or other authorities where Report lodged (if applicable)

Details of Claim *(Please use supplementary sheet if necessary)*

Amount Claimed

**G. PAYMENT DETAILS**

Please confirm payee name if claim is payable

**H. DECLARATION – to be signed by the Claimant**

I **HEREBY DECLARE** that I warrant the truth of the foregoing particulars in every respect and I agree that if I have made, or if I shall make, any false or untrue statement, suppression or concealment, the Policy shall be void and all rights to compensation shall be absolutely forfeited.

I hereby authorize any hospital physician, other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorization shall be considered as effective and valid as the original.

**DATA PRIVACY STATEMENT**

In accordance with the Personal Data Protection Act 2012, I consent to the collection, use, disclosure of and/or process of my personal data (whether contained in the Claim Form or otherwise obtained) by China Taiping Insurance (Singapore) Pte Ltd, its affiliates and service providers (within or outside Singapore), for the purpose relating to the evaluation of the claim and to provide advice and information relating to the claim to me by Short Message Service (SMS), Multimedia Messaging Service (MMS) and fax messages (notwithstanding the registration of my telephone or mobile number in the Singapore's Do Not Call Registry)

Yes, I have read and agreed to the above Data Privacy Statement.

Date

Signature of Claimant

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Date

Signature of Policyholder

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