TRAVEL PROTECTOR INSURANCE POLICY CLAIM FORM (FOR ALL PLANS)

(Please complete relevent sections of the Claim Form. If the space is insufficient please attach sheets to give full information)

Name of the Claimant (in full)		Policy Number	
Address		Plan Type	
		Period of Insurance	From
			To
Occupation		Date Trip Commenced	
Relationship of the Claiment with the Insured Person		Date of Scheduled Return	

Section to which Claim pertains : (Please tick whichever one is applicable)

- ❑ Health Cover:
  - -- Medical Expenses (Incl. Dental Treatment)
  - -- Hospital Daily Allowance
  - -- Transportation
- ❑ Hijack Distress Allowance
- ❑ Loss of Passport
- ❑ Baggage:
  - -- Total Loss of Checked Baggage
  - -- Delay of Checked Baggage
- ❑ Financial Emergency Assistance
- ❑ Personal Accident during travel
- ❑ Personal Liability

PLEASE NOTE : ALL CLAIMS HAVE TO BE SUPPORTED WITH ORIGINAL DOCUMENTS OF EXPENSES / COSTS INCURRED, WHEREVER APPLICABLE

HEALTH COVER (Please attach original Doctor's Certificate, Test Reports and Hospital Papers including Discharge Card)

A. Medical Expenses (including Dental Treatment)

Name of Disease contracted		Treating Doctor / Clinic / Hospital	
		Name	
When Disease first manifested		Address	
Date when Treatment started		Contact Number	
Date when Treatment ended		Nature of Disease / Injury (please describe briefly)	
Date of Admission			
Date of Discharge			
Hospital Expenses (please show each head separately)			
Room Rent		Room Rent in Words	
Consultancy Charges		Consultancy Charges in Words	
Cost of Tests		Cost of Tests in Words	
Other Costs		Other Costs in Words	
Outpatient Expenses		Outpatient Expenses in Words	
Total Claim Amount		Total Claim Amount in Words	

B. Hospital Daily Allowance

Total Number of Days for Amount being claimed for		Total Number of Days for Amount being claimed for in Words	
Total Claim Amount		Total Claim Amount in Words	

C. Transportation

IF YOU ARE CLAIMING FOR EXTRA COSTS OF TRANSPORTATION HOME (FOR SELF AND / OR ACCOMPANYING PERSON), MORTAL REMAINS OR BURIAL EXPENSES PLEASE SPECIFY THE NAME OF AIRLINES, BURIAL DETAILS, EXPENSES INCURRED AND OTHER INCIDENTAL COSTS WITH BIFURCATION OF EXPENSES IN AN ATTACHED SHEET			
Total Claim Amount		Total Claim Amount in Words	

HIJACK DISTRESS ALLOWANCE (Please attach necessary evidence such as Police Report, Airlines Reports, Media & TV coverage Reports)

Name of the Airline	Date of Commencement of Travel	Flight Number	Route being followed when Hijack took place				Arrival Time	
							Scheduled	Actual
			From		To			
Total Claim Amount			Total Claim Amount in Words					

FINANCIAL EMERGENCY ASSISTANCE (Please attach Police Report)

Amount of Funds Lost		Place of Loss	
Amount of Funds Lost in Words		Date of Loss	
Police Report Lodged	☐ Yes ☐ No	Time of Loss	
Total Claim Amount		Total Claim Amount in Words	

LOSS OF CHECKED BAGGAGE / DELAY OF CHECKED BAGGAGE (Please attach Police Report, Property Irregularity Report from the Carrier, Claim Lodged on the Carrier, Baggage Receipt, Money Receipts of essential items purchased)

Total Loss of Checked Baggage			Delay of Checked Baggage	
Property Irregularity Report by Carrier	☐ Yes ☐ No	Name of the Airline		
Claim Lodged on Carrier	☐ Yes ☐ No	Flight Number		
Police Report Lodged	☐ Yes ☐ No	Scheduled Departure	Date	
			Time	
Number and Description of Items Lost		Scheduled Arrival	Date	
			Time	
Cost of Items Lost		Actual Departure	Date	
			Time	
Description of Items Purchased		Actual Arrival	Date	
			Time	
		Cost of Items Purchased		
Total Claim Amount		Total Claim Amount in Words		

LOST OF PASSPORT (Please attach Police Report, Proof of Expenditure)

Date of Loss		Police Report Lodged	☐ Yes ☐ No
Application/ Documentation Fees		Incidental Costs	
Application/ Documentation Fees in Words		Incidental Costs in Words	
Total Claim Amount		Total Claim Amount in Words	

PERSONAL ACCIDENT (Please attach Police Report, Post Mortem Report, Death Certificate, Medical Report)

Date		Time		Place of Accident	
Treating Doctor /Clinic / Hospital				Police Report Lodged	☐ Yes ☐ No
Name				Full Description of Accident Cause	
Address					
Contact Number					
Nature of Injury Sustained					
Total Claim Amount				Total Claim Amonut in Words	

PERSONAL LIABILITY (Please attach Judgment of the Court)

Date		Time		Place	
Nature of Claim being made					
