CLAIM NOTIFICATION FORM
ACCIDENT/SICKNESS/TRAVEL RELATED

Directions: Please answer this application form as truthfully as possible. All sections must be completed using **BLUE** ballpen or sign pen. Please use block letters. Application forms without the appropriate signatures and dates will be returned.

I. POLICY HOLDER &/OR CLAIMANT

POLICY NO:		
Surname	First Name	Middle Name
Address:		
Company/Employer's Name:		
Tel. No.:	Mobile No.:	E-mail Address:
Date of Birth (dd/mm/yy):	Age:	Gender: ☐ Male ☐ Female

II. NATURE OF CLAIM

☐ ACCIDENT

Is the condition accident-related? ☐ Yes ☐ No

If yes: When did the accident happen? ______________________ At around what time? __________________

What was the cause of the accident? ____

Details of Accident: ____

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☐ SICKNESS/CONFINEMENT

Date:	Time :
Medical Findings/Diagnosis:	

☐ OTHER TRAVEL RELATED CLAIM

☐ Loss of Baggage	☐ Cancellation & Curtailment	☐ Personal Liability	☐ Emergency Repatriation
☐ Delayed Baggage	☐ Missed Travel Connection	☐ Hijack	☐ Emergency Evacuation
☐ Loss of Passport	☐ Delayed Departure	☐ Rental Vehicle Expense Cover	☐ Repatriation of Mortal Remains
☐ Loss of Documents or Samples	☐ Missed Departure	☐ Additional Cost or Rental Car	☐ Hospital Benefit

Travel Period :	Place and Date of incident:
Details of Incident:	

III.AUTHORITY AND DECLARATION STATEMENTS

Pursuant to IC Circular Letter No. 50-2016, Section 5: Fraud Warning

"Section 251 of the lnsurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim".

Data Privacy

Pursuant to the foregoing Claim, I consent to the collection, use, processing and transfer of my personal data as described in this paragraph. I understand that the Company and/or its related companies hold certain personal information about me (including my name, address and telephone number, date of birth, social security number, tax identification number, etc.) for the purpose of processing my/ the Claim. I also understand that the Company may transfer this Data amongst its related companies as necessary for the purpose of processing, administering and managing my/ the Claim, and that the Company may also transfer this Data to any third parties assisting the Company in the processing, administration and management of the Claim. I authorize them to receive, possess, use, retain and transfer the Data, in electronic or other form, for these purposes. I also understand that I may, at any time, review the Data, require any necessary changes to the Data or withdraw my consent in writing by contacting the Company. I further understand that withdrawing my consent may substantially affect my ability to further process and collect on my/ the Claim.

Declaration

I hereby declare that I am claiming compensation under the above policy in respect thereof. I hereby warrant that the above statements and facts are true and that I have not withheld from the Company any material information in connection with this claim.

Signature over Printed **Name of Claimant or of Policy Holder** (if Claimant is Minor) or the Beneficiary (if the Claimant/Policy Holder is incapacitated by illness)	Date

Note: For accidental death claims, or for medical claims leading to death, the signatory of this form should be the Claimant's Beneficiary.