

Tenet Insurance Company Ltd

(A member of Sampo Japan Group)
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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 completion of the journey.
- 3 All documents provided to substantiate your claim must be **original documents**.
- 4 All medical reports must be submitted at the claimant's expense.

Agency _____ Policy / Certificate No _____

A. GENERAL SECTION - Please complete this section

1. Insured/Claimant's Particulars

a. Name

Dr/Mr/Mrs/Ms _____

b. Address

c. NRIC / Passport Number _____ Date of Birth _____

Occupation _____

d. Residence / Business Telephone Number

(Res) _____ (O) _____ (HP) _____

2. Circumstances of Claim

a. Date / Time of Accident/Illness

Date: _____ Time: _____

b. Please state exactly what happened (if insufficient space, please attach statement)

3. Claim History / Other Insurances

a. Have you or any Insured person ever previously sustained a loss of this nature or made any previous claim in respect of Travel Insurance? If so, please state details.

b. Is there any other insurance in force covering this loss? Yes No

If so, please state Insurance Company and Policy Number.

Insurance Company: _____ Policy Number: _____

PLEASE COMPLETE ONLY THE SECTIONS WHICH ARE RELEVANT TO YOUR CLAIM

B. PERSONAL ACCIDENT / MEDICAL EXPENSES / REPATRIATION EXPENSES

Please attach as applicable:

- 1) Medical Bills and Certificate 2) Medical Report 3) Boarding Pass/Air Ticket 4) Police or other reports as applicable

1a. Please give reasons for additional accommodation or traveling expenses incurred if any.

Person who incurred expenses _____ Relation to Insured _____

1b. Has claimant suffered from this complaint before? Yes No

Date of previous treatment: _____

1c. Treatment Details Overseas:

Out-patient In-patient Day Surgery Admit on _____ Discharged on _____ No. of Days _____

1d. Date of Return to Singapore _____ Amount Claimed _____

2. Will there be any more bills to be submitted? Yes No

If yes, please elaborate _____

C. TRIP CANCELLATION AND CURTAILMENT

Please attach as applicable:

- 1) Medical Report 2) Certified Original Death Certificate/Letter of Administration 3) Bills
4) Letter from Attending Doctor 5) Letter from Airline 6) Letter from Travel Agency Regarding Refunds

1a. If caused by illness, has the insured person suffered from this before? If so, please give details.

1b. Amount paid _____ Amount recovered _____

Amount claimed _____

D TRAVEL DELAY / FLIGHT MISCONNECTION

Please attach as applicable:

- 1) Air Ticket / Boarding Pass 2) Letter from Carrier explaining delay 3) Flight Itinerary

Original Flight Details	Delayed Flight Details
Date:	Date:
Time:	Time:
Place of Departure:	Place of Departure:
Conveyance No:	Conveyance No:
Name of Airline:	Name of Airline:

1a. State reason for delay

E. BAGGAGE DELAY / DELAY DUE TO HIJACK

Please attach as applicable:

- 1) Air Ticket / Boarding Pass 2) Property Irregularity Report 3) Receipts 4) Letter from Carrier

Flight Details	Collection of Delayed Baggage Details
Arrival Date:	Date:
Arrival Time:	Time:
Place of Departure:	Place:
Conveyance No:	
Name of Airline:	

F. RENTAL VEHICLE EXCESS

Please attach as applicable:

- 1) Police Report 2) Rental Agreement/Letter/Receipt from Rental Company 3) Bills showing amount paid

1a. Amount claimed _____

G. LOSS OF HOTEL FACILITIES

Please attach as applicable: 1) Letter from Hotel 2) Bills

1a. Number of days of loss of hotel facilities _____

1b. Amount claimed _____

H. LOSS OR DAMAGE TO BAGGAGE / PERSONAL EFFECTS / TRAVEL DOCUMENTS / MONEY

Please attach as applicable:

- 1) Purchase Receipts 2) Property Irregularity Report 3) Police or Other Reports

1a. If other parties are responsible for your loss, have you taken any steps to recover your loss from them?

DESCRIPTION OF ITEMS LOST OR DAMAGE

Description (Make & Model)	Date of Purchase	Name & Address from whom goods were purchased	Original Purchase Price	Amount Claimed

I. PERSONAL LIABILITY

NOTE: ANY COMMUNICATION RECEIVED REGARDING THIS INCIDENT SHOULD BE SENT TO THE INSURER IMMEDIATELY.
Please attach as applicable: 1) Police or Other Report 2) Any Other Supporting Documents

1. Was the accident due to carelessness or negligence on your part?

2. Have you in any way admitted liability?

3. Name and address of witnesses of the incident.

Name: _____

Address: _____

4. Name and address of the other party or parties

Name: _____

Address: _____

5. The nature of the personal injuries, if any, sustained by any person as a result of the occurrence

6. The extent of damage to property

7. Has any claim been made upon you. If so, was the amount of such claim specified.

J. PAYMENT DETAILS

1. Please confirm payee name if claim is payable _____

DECLARATION - to be signed by the Claimant

I declare that the particulars stated above are true and correct and I understand that if I have in this or in any further declaration in respect of this claim, made any false or fraudulent statement or suppress conceal or falsely state any material fact whatsoever my claim may be refused.

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 photostatic copy of this authorisation shall be considered as effective and valid as the original.

Signature

Date

Name

NRIC Number