redefining / standards

AXA INSURANCE SINGAPORE PTE LTD
8 Shenton Way #27-01 AXA Tower,
Singapore 068811
Customer Service Centre #B1-01
☎ 1800 880 4741
6880 4570
www.axa.com.sg
Co. Reg No. 196900406D
GST Reg No. M2-0009922-2

Travel Claim Form

This form is issued without admission of liability. Please complete the General Section (Questions 1 to 4) followed by the relevant section(s) to which your claim(s) relate(s). Please submit documentary evidence as stated in each section.

GENERAL SECTION (To be completed for all claims)

Please submit (for all claims)
- Original completed claim form.
- Original Certificate of Insurance
- Proof of travel, i.e. original boarding passes, air ticket or copy of passport

1. Policyholder's Name: ❑ Mr ❑ Ms ❑ Mrs ❑ Mdm ❑ Dr ____________________

   Claimant's Name: ❑ Mr ❑ Ms ❑ Mrs ❑ Mdm ❑ Dr ____________________

   NRIC / Passport No.: ____________ Sex: ______ Date of Birth: ____________ Occupation: ____________

   Address(Home): ____________________

   Email: ____________________

   Home Tel. No.: ____________ Office Tel. No.: ____________ Mobile No.: ____________

2. Policy / Certificate No.: ____________ Broker / Agent / Travel Agency: ____________

   Period of Insurance: From ____________ To ____________ Location: ____________

3. 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:

4. 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 AND OTHER EXPENSES

Please submit
- All original medical invoices and receipts
- Medical reports, Death Certificate if applicable
- Accident report and/or Police Report

1. Date, time and place of accident / illness	
2. Cause of accident / illness	
3. Nature and extent of injuries / illness (please describe the injury or illness if you are unsure of the medical term)	

4. State period during which you have been totally disabled from attending to your business as the sole and direct result of the accident / illness.	
5. Names and contact details of any witness(es)	

6. Have you suffered from the same condition before? ❑ Yes ❑ No

if yes, please state: Date(s) of Consultation(s):
Name and address of doctor consulted:

7. Name and address of your usual Doctor

8. Amount claimed in respect of Medical expenses and similar expenses

B. TRIP CANCELLATION / CURTAILMENT

Please submit

- Medical report, Death Certificate, written advice from the 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
- 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)
- Original booking invoice with terms and conditions, and payment receipts
- Written confirmation of the amount of refund from the travel agents or any other sources
- Detailed itinerary
- Original invoice & receipt for charges incurred in amending or purchasing additional air ticket (for trip curtailment)

1. Date of event leading to the cancellation or curtailment	
2. Reason(s) for trip cancellation or curtailment	
3. When was the holiday booked	
4. Where was the holiday booked	
5. Intended date of departure	
6. Date of cancellation of holiday	
7. Breakdown of amount claimed	Total amount paid by you : Total refund : Net amount claimed :

8. If trip cancellation / curtailment was caused by medical condition, has the patient suffered from this condition before? ❑ Yes ❑ No

If yes, please state: Date(s) of Consultation(s):
Name and address of doctor consulted:

C. TRAVEL DELAY / BAGGAGE DELAY / OVERBOOKED FLIGHT / FLIGHT MISCONNECTION

Please submit
- Written confirmation from carrier on the duration and reason(s) for delay
- Overbooked flight / Flight misconnection: Written confirmation from carrier on the overbooked flight and flight misconnection details and when the next alternative transportation is made available to the Insured
- Original receipts in respect of hotel accommodation and restaurant meals or refreshments (if any)
- Documents stating amount of compensation from airlines or other sources

TRAVEL DELAY / OVERBOOKED FLIGHT / FLIGHT 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:	

D. BAGGAGE, PERSONAL EFFECTS, MONEY, TRAVEL DOCUMENTS

Please submit
- Police report lodged at the place of loss within 24 hours
- Property Irregularity Report for losses in carriers' custody
- Any other loss reports
- Original purchase receipts and/or warranty cards for lost items
- Original receipts for replacement of lost items
- Photographs to show extent of damage and original repair invoices
- Documents stating amount of compensation from airlines or other sources

1. Date, time and place of loss or damage	
2. Give full details of circumstances leading to the loss or damage. (Please retain damaged articles for inspection if necessary)	
3. State total value of baggage, personal effects and money accompanying you.	

4. If the loss or damage occured whilst baggage was in transit or otherwise in the custody or control of others, have any steps been taken to claim against these persons?

❑ Yes. Please identify them and attach any correspondence and advise outcome of your claim against them.

❑ No. Please state reason(s):

5. If claim is in respect of articles lost or stolen, has a thorough search been made and notification sent to Airlines, Ship Owners, Hotel Proprietors, Police or other parties who may be able to assist in the recovery?

❑ Yes. Please give details:

❑ No. Please state reason(s):

DESCRIPTION OF ITEMS AND AMOUNTS CLAIMED

Description (Make & Model)	Date Purchased	Place of Purchase	Original Purchase Price	Amount Claimed
TOTAL AMOUNT CLAIMED				

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 authorise any hospital, physician or other person who has attended to me or examined me or is authorised to maintain medical records, to disclose when requested to do so by **AXA INSURANCE SINGAPORE PTE LTD**, or its authorised representative, any and all information with respect to any illness, or injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I hereby request & authorize AXA Insurance Singapore Pte Ltd to pay benefit due in respect of this claim to:

____

(Payee name spelt out in FULL as per bank a/c)

____

Signature of Claimant

Date:

____

Signature of Policyholder
(& Name, Designation and Company's Stamp, if applicable)
Date: