

# TRAVEL INSURANCE

## Claim Form *Confidential*

The issue of this claim form is in no way an acceptance of liability.

Policy No. : \_\_\_\_\_

Policy Type : \_\_\_\_\_

**To help us proceed with your claim quickly, please read carefully and answer all the questions below as applicable**

- Enclose** this form together with the following documents:
- Copy of the Insurance Certificate
  - Copy of the Passport including Immigration Exit/Entry stamps at Kuwait & a copy of Civil ID
  - Copy of the ticket showing the original itinerary
  - **Other documents mentioned under relevant sections**

### A Claimant Information

1. Policy No. & Type: \_\_\_\_\_ 2. Date of Birth : / /  (Day/Month/Year)
3. Claimant Name: \_\_\_\_\_ 4. Telephone No. \_\_\_\_\_
5. Address: \_\_\_\_\_
6. E-mail: \_\_\_\_\_ 7. Claim Amount. \_\_\_\_\_
8. Did you call the Travel Assist:  No  Yes, when \_\_\_\_\_
9. Do you have any other Insurance covering subject loss:  No  Yes, Detail \_\_\_\_\_
10. Date you left country of residence / /  & date of return / /  (Day/Month/Year)

### B Claim Information for accident or illness

#### ILLNESS (if necessary use a separate sheet)

##### Documents specific to Illness Claim: (In addition to the documents mentioned on the top of the form):

- Original prescriptions and invoices with payment proof
- Medical reports and/or information given on the site of the medical emergency showing diagnosis and treatment

1. Date at which first symptoms appeared: / /  (Day/Month/Year)
2. When did you make appointment with the hospital? / /  (Day/Month/Year)
3. State exact nature of illness: \_\_\_\_\_
4. Have you already been treated (including prescribed medicines) for this condition or any related condition prior to your subscription to the Plan? If yes, please specify: \_\_\_\_\_
- a- When? : / /  (Day/Month/Year)
- b- What treatment? : \_\_\_\_\_
- c- Name of physician who treated you : \_\_\_\_\_ d- Telephone No. \_\_\_\_\_
- e- Address : \_\_\_\_\_

#### ACCIDENT (if necessary use a separate sheet). PLEASE ATTACH POLICE REPORT WHERE APPLICABLE.

##### Documents specific to Accident Claim: (In addition to the documents mentioned on the top of the form):

- Original prescriptions and invoices with payment proof
- Medical reports and/or information given on the site of the medical emergency showing nature of injury and treatment

1. Date of accident: / /  (Day/Month/Year) 2. Place of accident: \_\_\_\_\_
3. Nature of injuries: \_\_\_\_\_
4. What happened? : \_\_\_\_\_
5. If any Third Party is involved, please specify, a- Name : \_\_\_\_\_
- b- Address : \_\_\_\_\_
- c- Telephone : \_\_\_\_\_ d- Fax : \_\_\_\_\_ e- Email : \_\_\_\_\_

Continued ..... Page (2)

**BAGGAGE DELAY/ LOSS**

**Please attach following documents along with the claim form in addition to the documents mentioned on the top of the form**

1. PIR / A dated official confirmation letter from the Airlines that the baggage is lost / delayed, and copy of Baggage Tags
2. Copy of baggage delivery receipt showing baggage delivery date and time
3. In case of baggage delay, please provide Original invoices/receipts for the emergency purchase of essential items due to delay
4. In case of baggage loss, please provide description of contents, cost determination of contents (in the table below / separate sheet)
5. Detail of the amount paid or payable by the Airline responsible for the delay/loss, and the correspondences exchanged with them

a – Date, Time of Departure \_\_\_\_\_ b- Name of Airlines \_\_\_\_\_

c – Date, Time and Place of Arrival \_\_\_\_\_

d – Date and time when you received your baggage from Airlines \_\_\_\_\_

e – Number of Bags in total and approximate weight \_\_\_\_\_

f – Number of Bags Delayed / Lost and approximate weight \_\_\_\_\_

**TRIP DELAY / TRIP CANCELLATION / TRIP CURTAILMENT**

**Please attach following documents along with the claim form in addition to the documents mentioned on the top of the form**

1. Copy of revised ticket booking and boarding pass of actual travel
2. A dated official confirmation letter from the Airlines stating the reason for delay and duration of delay (**Trip Delay only**)
3. Original invoices/receipts for the emergency reasonable essential expenses during delay hours due to the delay (**Trip Delay only**)
4. Detail of the amount paid or payable by the Airline responsible for the delay (**Trip Delay only**)
5. Supporting documents for the reason for **Trip Cancellation / Trip Curtailment**, such as Medical Certificate etc.
6. Supporting documents for non-refundable portion of prepaid travel and accommodation expenses (**Cancellation/Curtailment**)

**Planned Travel**

**Actual Travel**

a – Date & time \_\_\_\_\_ Date & Time \_\_\_\_\_

b – Brief Description: \_\_\_\_\_

**List of reasonable emergency expenses you incurred due to delay/ loss**

Description	Date & Time of Purchase	*Purchase Price

**Statement and authorization:**

*By executing this application, we, the Insurer, thank you for consenting to us processing data relating to you for the purpose of providing insurance products and services, legal, administrative and management purposes and in particular to the processing of any sensitive personal data relating to you.*

*You, the Insured, consent to the Insurer, where necessary making such information available to third parties including but not limited to any Group Company, those who provide products or services to the Insurer or any Group Company, and regulatory authorities, within and outside the Insured's country of domicile.*

*I hereby declare that the foregoing statements are made by myself and are true in all respect and that I have not attempted to conceal from the Company anything with which it ought to be made acquainted and I agree that if I have made, or in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue avowal whatever, the policy shall be void, and my right to compensation forfeited.*

*In order to process this claim, I authorize my physician, hospital or other medical provider to release to AIG MEA Limited - Kuwait Branch or their representatives, any information regarding my medical history, symptoms, treatment, examination result or diagnosis, invoices. A photocopy of this authorization shall be considered as effective and valid for the duration of the claim, but not to exceed one year from the date signed. I declare to the best of my knowledge that the above information is true.*

Date and Signature: \_\_\_\_\_

**Please forward to: AIG MEA Limited - Kuwait Branch  
Al-Kharafi Tower - 5<sup>th</sup> Floor, Hamad Al Saqr St, Area 7 Al-Qiblah - Kuwait City, Kuwait  
Tel: 00965 2247 4260 / 1 / 2 / 3, Fax: 00965 2247 4264**