

# Travel Insurance Claim Form

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**TRAVEL GUARD**  
CHARTIS

PLEASE COMPLETE ALL SECTIONS TO FACILITATE THE PROCESSING OF YOUR APPLICATION

Required documents – For all travel claims please submit air tickets and boarding pass. For annual plans, please provide a copy of the passport showing duration of trip. We reserve the right to request for additional information. To enable us to process your claim expeditiously, please return the duly completed Claim Form with supporting documents.

Please direct the claim form and all correspondence to:

**AHA Travel Claims Unit**

c/o Crawford & Co Int'l Pte Ltd, No. 5 Shenton Way #33-01 UIC Building, Singapore 068808

The acceptance of this Form is NOT an admission of liability on the part of American Home Assurance Company, Singapore Branch ("the Company"). Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

## General Information

### Documents required

For all travel claims please submit air tickets and boarding pass.

For annual plans, please provide a copy of the passport showing duration of trip.

Policyholder	Claimant (if it differs from the above)	Insurance Policy No.
Address		
Occupation	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Telephone No.	HP No.	Email Address :
Travel companion(s) is/are insured <input type="checkbox"/> Yes <input type="checkbox"/> No With AHA? If yes, please provide details.		
GST Registered : <input type="checkbox"/> Yes <input type="checkbox"/> No	Registration No.	Purpose of Trip <input type="checkbox"/> Business <input type="checkbox"/> Vacation
Place where accident, loss or illness occurred	Time	Date
Are there any other Policies of insurance in force covering you in respect of this event? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify : _____		
Description of the incident, loss or illness		

## Section A - Personal Accident/Illness – Medical And Additional Expenses

### Documents required for Section A

- original medical receipts and copy of discharge summary or available medical report

1. Have you suffered this illness or injury or a similar condition or a recurrence of a previous illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify : _____
2. State amount claimed \$ _____
3. Give name and address of your usual attending Doctor

## Section B - Cancellation/Curtailment/Postponement

### Documents required for Section B

- documents from carrier/travel agent and any relevant documents to support your claim

When and where was the trip booked?	Intended Departure Date	Date of cancellation
Why was the trip cancelled?		
Amount paid by you	Amount recovered from other sources	Amount Claimed

Section C - Luggage & Personal Effects

Documents required for Section C

- Police Report and original purchase receipts and/or warranty cards

Location of police station, name of airlines/carrier or other authorities where report is lodged.					
Give details of amount claimed					
Item	Description	When and where purchased	Original purchased price	Depreciation for wear and tear	Amount Claimed

Section D - Flight Delayed/Misconnection

Documents required for Section D

- letter from Airlines/Carrier stating the reason and duration of delay

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

Section E - Baggage Delay

Documents required for Section E

Boarding Pass, Baggage Irregularity Report, Baggage acknowledgement slip and any other correspondence from the Airlines.

Flight Details	Collection of Delay Baggage
Arrival Date :	Date :
Arrival Time :	Time :
Place of Departure:	Place :
Flight No. :	
Name of Airline :	

Section F - Others

In respect of any other claim, which does not fall within the sections stated above, please provide details of the claim you are submitting. If the space below is insufficient for such details, please attach another page.		
I declare that to the best of my knowledge and belief that the above particulars are true and accurate. If I made or shall make any false or fraudulent statements, or withhold material facts whatsoever in respect of this claim, the Policy shall be void and I shall forfeit all rights to recover therein.		
I authorise any hospital doctor, other person who has attended or examined me, to furnish to the Company, and/or its authorised representatives, any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.		
Date		Signed here (Claimant)
Date		Signed here (Policyholder)
Particulars of Agent	Mobile :	Email Address :
Name :		