



CLAIM FORM

Business Travel

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:
AIG Asia Pacific Insurance Pte. Ltd.
AIG Building 78 Shenton Way #09-16 Singapore 079120

The acceptance of this Form is NOT on admission of liability on the part of AIG Asia Pacific Insurance Pte. Ltd. ('the Company'). Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

Please note that information you provide in this claim form will be used for the purposes of claims administration as outlined in this form and will not be used to update any of your existing records that our organization holds. If you wish for us to update any of your information in our records, please contact our customer service representatives at 6419 3000, Mondays to Fridays, between 9am and 5pm. Alternatively, you may contact us at www.aig.sg/contact-online.

General Information

Documents required: For all travel claims please submit air tickets and boarding pass. For all annual plans, please provide a copy of the passport showing duration of trip.

Policy Holder Information

Product Name and Plan			
Certification / Policy No.			
Policy Holder's Name			
Contact Details	Office	Email	Mobile
Nature of Business			

Claimant Information

Claimant's Full Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		
Identity Card / Passport No.			
Are You a US Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If 'Yes', Please Provide Your Social Security No. (SSN).	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married		

Date of birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Contact Details	Residential		Mobile
	Email		
Designation/Title			
Class Type (e.g. Category)			
Employment country-based/country of residence			
Date Insured Person Joined the company	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		
Name of Company			
Plan and/or Category of Employee			
Relation to Policy Holder			

1. Please indicate your case number, if you have contacted AIG Travel Protect before :

Others (Please Specify):

To be Completed by Agent/Broker (if applicable)

Producer Code		Branch	
Name of Producer / Company Name			
Contact Person		Mobile No.	
Email Address			

Flight Details

Purpose of Travel (Select more than one where appropriate)	<input type="checkbox"/> Leisure	<input type="checkbox"/> Business / Conference	<input type="checkbox"/> Home Leave
	<input type="checkbox"/> Others (Please Specify):		
Date & Time of Departure from Singapore	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="H"/> <input type="text" value="H"/> <input type="text" value=":"/> <input type="text" value="M"/> <input type="text" value="M"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM
Date & Time of Return to Singapore	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="H"/> <input type="text" value="H"/> <input type="text" value=":"/> <input type="text" value="M"/> <input type="text" value="M"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM

Accident Related Claim Only

a) Date & Time of Accident	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="text"/> AM <input type="text"/> PM
(b) Where did the accident occur?	
(c) How did the accident occur?	
(d) Injuries Sustained	
(e) If you had a history of similar injury, which you have experienced in the past, please give details as to when, where and from whom you received medical diagnosis, treatment, consultation or prescribed drug.	
(f) Disablement Commencement	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="text"/> AM <input type="text"/> PM
(g) Date of Death	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
(h) Are you still suffering the above stated disability?	If yes, please advise the expected date & time of returning to work. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="text"/> AM <input type="text"/> PM
	If no, please advise the date & time of returning to work. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="text"/> AM <input type="text"/> PM
(i) Have you sustained any fractures from this accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please advise the type of fracture:
(j) Have you sustained a burn injury from this accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information: <input type="checkbox"/> Head <input type="checkbox"/> Body
	Degree of burn
(k) Have you lodged a police report?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of report <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Police Station that you lodged report?
(l) Name and address of any witness of the incident	
(m) Was the sum insured or benefits of your policy based on your monthly salary?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please advise the last drawn salary prior to the accident.

(n) Please furnish the details of any hospitalisation in connection with this injury.

Name of Hospital	Admission Date (DD-MM-YYYY)	Date Discharged (DD-MM-YYYY)	Admission No.	Type of Ward

(o) Please provide information on your first consultation.

Doctor Consulted			
Doctor's Address			
Doctor's Contact No.		Doctor's File Ref No. (If applicable)	

(p) Please provide information of your regular doctor.

Regular Doctor			
Regular Doctor's Address			
Regular Doctor's Contact No.		Doctor's File Ref No. (If applicable)	

Sickness Related Claim Only

Claim Description (fill in items that apply)

(a) Give a brief description of the sickness suffered.	
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(b) Answer the questions pertaining to your condition stated above.

(i) Are there any symptoms which are or were evident for this condition? If yes, please advise the date of onset of the symptoms.	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
(ii) Have you been recommended to receive or received treatment, advice or diagnosis for this condition? If yes, please advise the date of your 1st consultation.	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
(iii) Please describe the symptoms you experienced.									

(c) Please provide information on your first consultation.

Doctor Consulted			
Doctor's Address			
Doctor's Contact No.		Doctor's File Ref No. (If applicable)	

(d) Please provide information of your regular doctor.

Regular Doctor			
Regular Doctor's Address			
Regular Doctor's Contact No.		Doctor's File Ref No. (If applicable)	

(e) Please furnish the details of any hospitalisation in connection with this sickness.

Name of Hospital	Admission Date (DD-MM-YYYY)	Date Discharged (DD-MM-YYYY)	Admission No.	Type of Ward

(f) Have any of your family members experienced this similar or related sickness? If yes, please provide details.

Relationship of Family Member	Nature of sickness	Date Diagnosed (DD-MM-YYYY)	If Deceased, Date (DD-MM-YYYY)	Age

(g) Are there any other sickness/ complaints suffered by you prior to this event? If yes, please provide details.

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Travel Cancellation/ Curtailment/ Postponement / Re-arrangement

Please tick the appropriate box	<input type="checkbox"/> Travel Cancellation	<input type="checkbox"/> Travel Curtailment	<input type="checkbox"/> Postponement	<input type="checkbox"/> Re-arrangement
Travel Booking Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Date of event that resulted in the cancellation/ curtailment	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	
Original Scheduled Departure/ Return Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Location of Incident Causing Claim		
Cancellation/ Curtailment Reasons	<input type="checkbox"/> Earthquake <input type="checkbox"/> Fire <input type="checkbox"/> Tsunami <input type="checkbox"/> Volcano Eruption <input type="checkbox"/> Extreme Weather <input type="checkbox"/> Airspace/Multiple Airport Closures <input type="checkbox"/> Strike Riot, Civil Unrest, Civil Commotion resulting in cancellation of scheduled flights <input type="checkbox"/> Epidemic/ Pandemic <input type="checkbox"/> Travel Agent Insolvency <input type="checkbox"/> Death, Serious Sickness, Injury (please specify illness/sickness/injury): <input type="checkbox"/> Others (please specify):			
Was a home government warning issued?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount Paid by you		
Has compensation been made by other parties?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state amount compensated by other parties		

If travel cancellation is due to death, serious sickness of the insured's immediate family member/ Travel companion please state their:

Full Name	
Insured	

Did you need to cancel / curtail your trip because of a relative who is not traveling with you or because of a traveling companion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate which	<input type="checkbox"/> Relative <input type="checkbox"/> Traveling Companion
Please advise their name	
If a Relative, please advise their Relationship to you	
Date you became aware of the need to cancel / curtail your trip	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Date you informed your carrier/ travel agent/tour operator	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

Name, address and contact number of your usual doctor (if you need to cancel / curtail your trip on medical grounds, including death)	
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Details of trip costs, refunds due or paid and additional expenses incurred (continue on a separate sheet if necessary)

Item	Amount	Refund Due or Paid	Additional Expenses (for Curtailment)

Travel Delay/ Misconnection / Flight Overbooking, Diversion

Please tick the appropriate box	<input type="checkbox"/> Travel Delay <input type="checkbox"/> Travel Misconnection <input type="checkbox"/> Flight Overbooking <input type="checkbox"/> Flight Diversion
Location of Incident causing the claim	
Causes	<input type="checkbox"/> Earthquake <input type="checkbox"/> Fire <input type="checkbox"/> Tsunami <input type="checkbox"/> Volcano Eruption <input type="checkbox"/> Adverse Weather <input type="checkbox"/> Airport Closure <input type="checkbox"/> Terrorism <input type="checkbox"/> Strike Riot, Civil Unrest, Civil Commotion <input type="checkbox"/> Carrier Defect <input type="checkbox"/> Others (please specify):
Carrier Type	<input type="checkbox"/> Aircraft <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/> Others (please specify):
Original Travel Details	Departure Date & Time <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="text"/> AM <input type="text"/> PM
	Location
	Arrival Date & Time <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="text"/> AM <input type="text"/> PM
Actual Travel Details	Departure Date & Time <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="text"/> AM <input type="text"/> PM
	Location
	Arrival Date & Time <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="text"/> AM <input type="text"/> PM
Actual Arrival of incoming connecting carrier from airport/ ferry port, etc (For travel misconnection only)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="text"/> AM <input type="text"/> PM

Length of Delay			
Please state the reason provided by the tour operator, airline, cruise company, rail company etc for the cause of the delay.			
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide details on the compensation or cash settlement amount received.	
		If no, please provide evidence of denial of compensation from the service provider.	

Baggage Delay

Planned Arrival Date	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	Actual Arrival Date	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y
Planned Arrival Time	<input type="text"/> H <input type="text"/> H : <input type="text"/> M <input type="text"/> M <input type="checkbox"/> AM <input type="checkbox"/> PM	Actual Arrival Time	<input type="text"/> H <input type="text"/> H : <input type="text"/> M <input type="text"/> M <input type="checkbox"/> AM <input type="checkbox"/> PM
Place of Departure			
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide details on the compensation or cash settlement amount received.	
		If no, please provide evidence of denial of compensation from the service provider.	

Baggage Damage/ Loss Of Personal Effects, Travel Documents and Money

Please tick the appropriate box:	<input type="checkbox"/> Baggage Loss <input type="checkbox"/> Baggage Damage <input type="checkbox"/> Damage/ Loss of Personal Effects <input type="checkbox"/> Loss of Travel Document <input type="checkbox"/> Loss of Money
Cause of Loss	Destroyed or Lost due to Natural Disaster: <input type="checkbox"/> Earthquake <input type="checkbox"/> Fire <input type="checkbox"/> Tsunami <input type="checkbox"/> Volcano Eruption <input type="checkbox"/> Extreme Weather <input type="checkbox"/> Robbery, Burglary, Theft <input type="checkbox"/> Damage or Lost while held by Airline or Service Provider <input type="checkbox"/> Others (please specify):
Please provide details on the circumstances surrounding the incident and the precautions taken to protect your property.	

Where did the loss/ theft/ damage occur?			
Date and time of the loss/ theft/ damage	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	<input type="text"/> H <input type="text"/> H : <input type="text"/> M <input type="text"/> M	<input type="checkbox"/> AM <input type="checkbox"/> PM
To whom the incident was reported (e.g.: police, airline, cruise company, etc)			
Date and time reported	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	<input type="text"/> H <input type="text"/> H : <input type="text"/> M <input type="text"/> M	<input type="checkbox"/> AM <input type="checkbox"/> PM
Name of Carrier/Service Provider			
Were your items in the custody of the service provider (e.g.: airline, cruise company, etc)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Carrier/Service Provider Contact	
Did you receive any compensation from the carrier/service provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide details on the compensation or cash settlement amount received	
		If no, please provide evidence of denial of compensation from the service provider.	
Where were the items located at the time of the loss, theft or damage?			
Did you take any steps to recover/repair your property?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide details on the steps taken.	
		If no, please state why no steps were taken.	

Details of damaged, stolen, destroyed or lost personal effects (continue on a separate sheet if necessary). Please provide full details of each item claimed for. For cameras, include the make and model number, lens details etc. For jewelry include nature and quality of metal content, type of stone etc. Purchase receipts, valuations or other documentation to substantiate ownership should be provided whenever possible.

Description of item	Owner's Name	Place of Purchase	Date of Purchase	Purchase Method	Purchase Price

Loss/Theft of Cash & Traveler's Cheques

Amount of cash & travelers cheques taken on trip				Amount of cash & travelers cheques damaged, stolen, destroyed or lost during the trip		
Owner's Name	Traveler's Cheque	Cash	Currency	Traveler's Cheque	Cash	Currency

Loss of Travel Documents. Please detail the expenses you incurred in obtaining a replacement passport or travel document (continue on a separate sheet if necessary).

Owner's Name	Description	Date	Amount	Currency
	Additional Travel Expenses			
	Additional Accommodation Costs			
	Travel Documents Replacement Costs			
	Total expense			

Personal Liability Abroad

Which of the following are you being held liable for?	<input type="checkbox"/> Damages <input type="checkbox"/> Medical Compensation		
Please provide details of the circumstances.			
Please provide details on the extent of damages or injuries sustained by the other party/person (please attach photos).			
Have you instructed solicitors to represent you at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide the name of solicitors:	
		Solicitors contact no.:	
Was the accident due to carelessness or negligence on your part?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you in any way admitted liability?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name and address of any witness to the incident.			
Name and address(es) of the other party / parties.			
If any, which Police Officer and Police Station did you report the occurrence?			
If a claim has been made upon you, was the amount of such claim specified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state the amount:	
Please provide any additional information which you consider would help us in dealing with any claim that may be made against you.			

Compassionate Visit/ Hospital Visitation/ Staff Replacement/ Child Benefit

Reason for additional travel and accommodation expenses?	<input type="checkbox"/> Death <input type="checkbox"/> Serious Sickness / Serious Injury		
Please provide description of loss.			
Period of Hospitalisation from	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> to <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		
Please state their name and relationship to you	Name:		Relationship:
Details of accommodation expenses and additional travel expenses (continue on a separate sheet if necessary).			

Item	Amount
Accommodation Costs	
Additional Travel Expenses	
Others, please specify	
Total amount	

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 is insufficient for such details, please attach another page.

Details of your other Insurance or Compensation Claims

Details of your claims other than this insurance policy (i.e. other insurance policies, third party and others)

Name of Insurer / Third Party	Policy/ Reference No.	Type of Benefit	Have you filed a claim?	Amount Claimed

NOTE: If the space provided is insufficient for your answer, please continue on a separate sheet.

Have your other claims been paid by the other policies above?

Yes

No

Payment Details

Electronic Funds Transfer (Payment in SGD and to bank accounts in Singapore only)

Please provide details for the payment of this claim in the event that this claim is deemed payable by AIG. In such an event, this claim shall be payable to the relevant insured person only.

Payee Name (name as per bank account)					
Payee Address					
Name of Bank					
Bank Address					
Bank Code		Branch Code		Account No.	
Email address (if different from above) Notification of payment will be sent to this email address.					

Telegraphic Transfer (Payment in Overseas Currency for employment country-based out of Singapore)

Payee Name (name as per bank account)					
Payee Address					
Name of Bank					
Bank Address					
Bank Code		Branch Code		Account No.	
Swift Code		Bank Currency			
Email address (if different from above) Notification of payment will be sent to this email address.					

For Company / School / Kindergarten Use Only

Company Declaration

I / We hereby certify that _____ is / my our employee effective from _____
and is currently holding the position of _____

If no longer under employment, please advise the last date of employment.

D	D	M	M	Y	Y	Y	Y
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School / Kindergarten Declaration

I / We hereby certify that

is currently a student of my our school / kindergarten.

Name/ Designation									
Date Signed	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
Authorised signature of company / school/ kindergarten (Please also affix company / school kindergarten rubber stamp)									

Acknowledgment and Declaration

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 agree to the conditions set out at the beginning of this claims form.

I authorise any hospital doctor, other person who attended or examined me, to furnish to the Company, and /or it's authorised representatives, any end 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.

I, HEREBY DECLARE that to the best of my knowledge and belief, the above particulars as declared by me above are true and complete in every respect and are made without reservation of any kind.

In relation to the personal information collected in this claim form, I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority to provide that information to AIG Asia Pacific Insurance Pte. Ltd. ("AIG"), I have informed the individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by AIG, as set out in the contents of the consent clause below and the individual agrees and consents, that AIG may collect, use and process my/his/her personal information as follows:

- (a) the personal information collected in this form (or otherwise provided during the course of the claim process, including by way of call recordings) may be collected, used and disclosed by AIG to:
- (i) process and administer this insurance claim;
 - (ii) assess, investigate, adjust and make a decision on this claim;
 - (iii) administer my insurance policy (including pursuing recovery from reinsurers or other parties);
 - (iv) deal with disputes end complaints,
 - (v) respond to requests for information from public and governmental/ regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;
 - (vi) respond to requests from the policyholder;
 - (vii) carry out due diligence or other screening activities (including background check(s)) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by AIG;
 - (viii) compliance with legal or regulatory obligations, risk management procedures and AIG internal policies;
 - (ix) manage AIG's infrastructure end business operations; and
 - (x) for other purposes stated in AIG's Data Privacy Policy.
- (b) AIG may transfer the personal information to the following classes of persons (whether located in Singapore or elsewhere) for the purposes identified in (a) above:
- (i) third parties providing services related to the administration of my policy (including reinsurers) and processing of my claim;

- (ii) AIG's agents;
- (iii) brokers, my authorised agents or representatives or next-of-kin;
- (iv) the policyholder;
- (v) legal process participants and their advisors;
- (vi) governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums;
- (vii) other financial institutions for the purpose of administering this claim, obtaining policy payments;
- (viii) loss adjusters, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers, external auditors;
- (ix) another member of the AIG group (for all of the purposes stated in (a)) in any country; or
- (x) other parties referred to in AIG's Data Privacy Policy for the purposes stated therein.

Note: The full version of AIG's Data Privacy Policy can be found at www.aig.sg/privacy.

Signature of Claimant:		Date Signed	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Signature of Policy Holder:		Date Signed	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Name			
Company Stamp			

Documentation required for each benefit under the Business Travel are as follow:

Overseas Medical Benefits

1. Medical and Accidental Dental Expenses Incurred overseas
 - Copy of final medical invoices and receipts (as proof of payment)
 - Police report for road traffic accidents or other accidents (where applicable)
2. Return Treatment
 - Copy of final medical invoices and receipts (as proof of payment)
3. Treatment By Traditional Chinese Medicine (TCM)
 - Copy of final medical invoices and receipts (as proof of payment)
4. Hospital Confinement Benefit (overseas confinement)
 - Copy of hospitalisation bills
5. Double Hospital Confinement Benefit in ICU
 - Copy of hospitalisation bills
6. Hospital Visitation (for hospitalisation more than 5 days)
 - Copy of invoices and receipts for purchase of economy class air-ticket or first class rail ticket.
 - Copy of invoices and receipts of hotel accommodation expenses incurred.
 - Medical report showing details of admission and duration of hospitalisation.

Evacuation and Repatriation Benefits

7. Emergency Medical Evacuation
 - Please call our AIG Hotline at 6735 2221 for assistance
8. Repatriation of Mortal remains
 - Please call the AIG Hotline at 6735 2221 for assistance

Personal and Accidental Benefits

9. Accidental Death
 - Certified true copy of Death Certificate
 - Autopsy/Post Mortem and toxicology reports (where applicable)
 - Police report for road traffic accidents or other accidents (where applicable)
 - All relevant medical reports
 - Police investigation report
 - Coroner's inquiry (where applicable)
10. Accidental Permanent Disablement
 - Police report for road traffic accidents or other accidents (where applicable)
 - All relevant medical reports
 - Police investigation report
 - Copy of driver's license
 - For industrial or work-related accident: Work Injury Report lodged by the company
11. Simple Fracture Benefit
 - Medical report indicating type and location of fracture
 - Police report for road traffic accidents or other accidents (where applicable)
12. Compassionate Death Allowance / Burial Expenses / Funeral Expenses
 - Same as the documents required for Accidental death benefit
13. Child Education Fund
 - Birth Certificate as proof of relationship
 - Copy of student pass/documentary proof that the child is a full time student at a recognised tertiary institution.

Travel Inconvenience Benefits

14. Trip Cancellation
 - Certified True copy of death certificate for death cases (where applicable)
 - Medical report from the doctor certifying details of diagnosis and reason why the insured person is unfit to travel.
 - For cases where insured person is unable to travel due to serious injury/sickness of family members or Travel Companion, Business Partner or Co-director as defined in the policy, please provide a detailed medical report.
 - Copy of invoice from the travel agency and statement showing breakdown of tour package and amount refunded.
 - Proof of relationship to insured for death/serious injury/serious sickness/compulsory quarantine of family members, Business Partner/Co-director.
 - Proof of event for cancellation due to other insured perils.
15. Trip Curtailment
 - Certified True copy of death certificate for death cases (where applicable)
 - Medical report from the doctor certifying details of diagnosis and reason why the insured person is unfit to continue with his trip.
 - For cases where insured person is unable to travel due to unexpected death, serious injury/sickness of Insured's immediate family members, travel companion, business partner/co-director as defined in the policy, please provide a detailed medical report.
 - Copy of invoice from the travel agency and statement showing breakdown of tour package and amount refunded.
 - Proof of relationship to insured for death/serious injury/serious sickness of family members, Business Partner/co-director.
 - Proof of event for curtailment due to other insured perils.

16. Travel Delay
 - Letter from the airlines stating the cause and duration of delay
 - Air ticket and boarding pass
17. Travel Misconnection
 - Letter from the airlines
 - Air-ticket and boarding pass
 - Copy of receipts for accommodation, meal or travel expenses necessarily incurred.
 - Letter from airlines if any compensation provided.
18. Baggage Delay
 - Property Irregularity Report
 - Air ticket and acknowledgment receipt on when delayed baggage was recovered.
19. Damage or loss of Personal Baggage including golfing equipment & Portable business equipment
 - Certified true copy of police report/Property Irregularity Report/Hotel Management Report
 - Copy of purchase receipts and warranty cards (where applicable) of lost items
 - Copy of repair bills and photographs for damaged items
 - Letter of compensation from airlines/hotel management/any other parties.
 - If no original purchase receipts available for lost items, please provide estimated purchase price and year of purchase.
20. Loss of Travel Document
 - Certified true copy of police report/proof of event for loss due to natural disasters.
 - Copy of receipts of expenses incurred to obtain replacement passports or travel tickets
 - Copy of receipts for hotel accommodation expenses incurred
 - Copy of receipts of transportation expenses incurred
21. Loss of Money including credit card fraud
 - Certified true copy of police report/hotel management report
 - Letter from the credit card company for credit card fraud
22. Hijacking
 - Proof of event
 - Letter from the service providers

Other Travel Related Benefits

23. Staff Replacement Expenses
 - Certified true copy of Medical Certificate
 - Medical Report
 - Death certificate (for death of immediate family member)
 - Proof of relationship (for death of immediate family member)
 - Copy of receipts of air tickets & hotel accommodation
24. Credit Card Indemnity
 - Same documents as required under Accidental Death Benefit
 - Copy of outstanding credit card statement
25. Legal Fees
 - Please seek approval from AIG prior to taking any actions against a third party.
26. Bail Bond Facility (for road accident only)
 - Certified True Copy of the Police Report
 - Certified True Copy of the Letter from the authorities as proof of detention.
27. Personal Liability to Third Party
 - Do not make any offer or promise payment or admit fault to any other third party or become involved in any litigation without our prior consent
 - Forward all correspondence/documents from third parties to us for our handling



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Contact:

**AIG Asia Pacific Insurance Pte. Ltd.
AIG Building
78 Shenton Way #09-16
Singapore 079120**