

TRAVEL INSURANCE CLAIM FORM

www.aig.sg



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 an 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 send us an email via 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.		Master Policy No.	
Policy Holder's Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		
Contact Details	(Residential)	(Fax)	(Mobile)
Occupation		Nature of Business:	
Preferred Method of Communication	<input type="checkbox"/> Mail <input type="checkbox"/> Email Email Address: _____		

CLAIMANT INFORMATION

Claimant's Full Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Identity Card / Passport No.	
	First Name	Last Name	
Are You a US Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please Provide Your Social Security Number (SSN): _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Date of birth	<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"/>	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Contact Details	(Residential)	(Fax)	(Mobile)
	(Email)		
Occupation			
Date Insured Person Joined the company	<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"/>		
Name of Company			
Plan and/or Category of Employee			
Relation to Policy Holder			
1. Please indicate your case number, if you have contacted Travel Guard before: _____			
2. Have you submitted any claims to / through Travel Guard? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. If yes, please select the type of claims submitted: <input type="checkbox"/> Medical Expense <input type="checkbox"/> Medical Evacuation / Repatriation <input type="checkbox"/> Others (Please Specify): _____			
Cheque made payable to			

PREFERRED MAILING ADDRESS

Preferred Mailing Address	
---------------------------	--

TO BE COMPLETED BY AGENT/BROKER (if applicable)

Producer Code	<input type="text"/>	Branch	<input type="text"/>
Name of Producer / Company Name			
Contact Person		Telephone No.	<input type="text"/>
Mailing Address			
Preferred Method of Communication	<input type="checkbox"/> Mail <input type="checkbox"/> Email Email Address: _____		

FLIGHT DETAILS

Purpose of Travel	<input type="checkbox"/> Leisure <input type="checkbox"/> Business / Conference <input type="checkbox"/> Home Leave <input type="checkbox"/> Others (Please Specify): _____
-------------------	---



Was a Credit Card used to purchase some or all of the journey arrangement? Yes No

• If yes, please state the first six digits of the credit card used: _____

• If yes, please advise the amount settled by the credit card: _____

• Date & Time of Departure from Singapore

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Hour : Minutes AM PM

• Date & Time of Return to Singapore

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Hour : Minutes AM PM

ACCIDENT RELATED CLAIM ONLY

(a) Date & Time of Accident

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Hour : Minutes AM 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 drugs

(f) Disablement Commencement

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Hour : Minutes AM PM (g) Date of Death

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

(h) Are you still suffering the above stated disability?
 If yes, please advise the expected date & time of returning to work:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Hour : Minutes AM PM
 If no, please advise the date & time of returning to work:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Hour : Minutes AM PM

(i) Have you sustained any fractures from this accident?
 Yes No If yes, please advise the type of fracture: _____

(j) Have you sustained a burn injury from this accident?
 Yes No If yes, please provide the following information: Head Body Degree of burn: _____

(k) Have you lodged a police report Yes No Date of report

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 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? Yes No If yes, please advise the last drawn salary prior to the accident: _____

(n) Please furnish the details of any hospitalization 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.

Family Doctor _____

Family Doctor's Address _____

Family/ Regular Doctor's Contact No.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Doctor's File Ref No. (if applicable)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

ILLNESS RELATED CLAIM ONLY

Claim Description (fill in items that apply)
 (a) Give a brief description of the illness suffered

(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.

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.

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.	<input type="text"/>	Doctor's File Ref No. (if applicable)	<input type="text"/>

(d) Please provide information of your regular doctor.

Family Doctor			
Family Doctor's Address			
Family/ Regular Doctor's Contact No.	<input type="text"/>	Doctor's File Ref No. (if applicable)	<input type="text"/>

(e) Please furnish the details of any hospitalization in connection with this illness

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 illness? If yes, please provide details.

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

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

TRAVEL CANCELLATION / CURTAILMENT / POSTPONEMENT

Please tick the appropriate box: Travel Cancellation Travel Curtailment Postponement

Travel Booking Date	<input type="text"/>	Date of event that resulted in the cancellation/ curtailment	<input type="text"/>
Original Scheduled Departure/ Return Date	<input type="text"/>	Location of Incident Causing Claim	
Cancellation/ Curtailment Reasons	<input checked="" 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: _____ Relationship to Policyholder/ Insured: _____			
Did you need to cancel / curtail your trip because of a relative who is not travelling with you or because of a travelling companion?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate which	<input type="checkbox"/> Relative <input type="checkbox"/> Travelling 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"/>	Date you informed your carrier/ travel agent/tour operator	<input type="text"/>
Name, address and contact number of your usual doctor (if you need to cancel / curtail your trip on medical grounds, including death)			

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 Flight Details	Departure Date & Time: <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"/> Hour: <input type="text" value="H"/> : <input type="text" value="M"/> <input type="checkbox"/> AM <input type="checkbox"/> PM Location: _____ Arrival Date & Time: <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"/> Hour: <input type="text" value="H"/> : <input type="text" value="M"/> <input type="checkbox"/> AM <input type="checkbox"/> PM			
Actual Flight Details	Departure Date & Time: <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"/> Hour: <input type="text" value="H"/> : <input type="text" value="M"/> <input type="checkbox"/> AM <input type="checkbox"/> PM Location: _____ Arrival Date & Time: <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"/> Hour: <input type="text" value="H"/> : <input type="text" value="M"/> <input type="checkbox"/> AM <input type="checkbox"/> PM			
Actual Arrival of incoming connecting carrier from airport / ferry port, etc <small>(For travel misconnection only)</small>	<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"/> Hour: <input type="text" value="H"/> : <input type="text" value="M"/> <input type="checkbox"/> AM <input type="checkbox"/> PM			
Length of Delay	<input type="text" value="H"/> Hour : <input type="text" value="M"/> Minutes			
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" 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"/>	Actual Arrival 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"/>
Planned Arrival Time	<input type="text" value="H"/> Hour : <input type="text" value="M"/> Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM	Actual Arrival Time	<input type="text" value="H"/> Hour : <input type="text" value="M"/> Minutes <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	<input type="checkbox"/> 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"/> Others (please specify): _____ <input type="checkbox"/> Robbery, Burglary, Theft <input type="checkbox"/> Damage or Lost while held by Airline or Service Provider			
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" 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"/> Hour: <input type="text" value="H"/> : <input type="text" value="M"/> <input type="checkbox"/> AM <input type="checkbox"/> PM		
To whom the incident was reported <small>(e.g.: police, airline, cruise company, etc)</small>				
Date and time reported		<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"/> Hour: <input type="text" value="H"/> : <input type="text" value="M"/> <input type="checkbox"/> AM <input type="checkbox"/> PM		
Were your items in the custody of the carrier / service provider?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Service Provider Contact No.
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.		
Where were the items located at the time of the loss, theft or damage?				
Any Action taken to attempt the recover if your property?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details on the actions taken: _____ If yes, please provide details for not attempting recovery: _____		

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 jewellery 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 Money

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			0	

PERSONAL LIABILITY ABROAD

Which of the following are you being held liable for? Damages 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? Yes No If yes, please provide the name of solicitors : _____ Solicitors contact number: _____

Was the accident due to carelessness or negligence on your part? Yes No Have you in any way admitted liability? Yes 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? Yes 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 FRAUD

Reason for additional travel and accommodation expenses? Death Serious Sickness / Serious Injury

Please provide description of loss

Period of Hospitalization from

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 to

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Please state their name and relationship to you Name: _____ Relationship: _____

Details of accomodation expenses and additional travel expenses (continue on a sepearte sheet if necessary)

Item	Amount
Accommodation Costs	
Additional Travel Expenses	
Others, please specify	
Total amount	0

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 Number	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

ACKNOWLEDGEMENT 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 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 authorization 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 and 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 and 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 http://www.aig.sg/sg-privacy_1030_237853.html.

Signature of Claimant: _____

Date Signed

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Signature of Policy Holder: _____

Date Signed

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Name	Designation
Company Stamp	



AIG Asia Pacific Insurance Pte. Ltd.
 AIG Building
 78, Shenton Way #09-16
 Singapore 079120
www.aig.sg