

# TRAVEL INSURANCE

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

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

## Claim Form *Confidential*

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

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

**Enclose** this Claim Form together with the following original documents:

- Copy of your insurance certificate or if your Credit Card was used the statement showing the trip ticket purchase
- Passport copies showing the exit & entry dates
- Original Invoices of Expenses Incurred
- Other documents mentioned under relevant sections

**Mail** your complete claim to American Home Assurance Company, Claims Department, Hamarain Centre, Gate # 4, 3<sup>rd</sup> Floor, P.O. Box 40569, Dubai, U.A.E

## A Claimant Information

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

2. Date of Birth :  /  /  (Day/Month/Year)

3. Insured Name: \_\_\_\_\_ 4. Telephone No. \_\_\_\_\_

5. Address: \_\_\_\_\_

6. E-mail: \_\_\_\_\_

7. Did you call the AIG IS:  no  yes, when: \_\_\_\_\_

## B Claim Information

### MEDICAL EMERGENCY: ILLNESS OR ACCIDENTAL

**Please attach following additional documents**

- Original prescriptions and invoices.
- Medical report and/or information clarifying the diagnosis & the treatment done.

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

1. Date at which first symptoms appeared:  /  /  (Day/Month/Year)

2. State nature of illness (exact nature of pathology): \_\_\_\_\_

3. 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 uses a separate sheet). PLEASE ATTACH POLICE REPORT WHERE APPLICABLE.

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 : \_\_\_\_\_ Email : \_\_\_\_\_

**Is the Claim regarding:**

1. ACCIDENTAL DISMEMBERMENT / DISABLEMENT

2. ACCIDENTAL DEATH

3. REPATRIATION OF REMAINS

4. MEDICAL EVACUATION

**Please attach the following additional documents**

- Medical report and/or information clarifying Dismemberment / Disability
- Death Certificate and Post Mortem Report, in case of Accidental Death
- Original invoices relating Repatriation / Evacuation
- Police Report where applicable

1. Date of Accident / Death:  /  / .(Day/Month/Year) 2. Place of accident: \_\_\_\_\_

3. Cause of Accident / Death: \_\_\_\_\_

4. Brief Description of Circumstances: \_\_\_\_\_

**Is the Claim regarding:**

1. **BAGGAGE DELAY/ LOSS**   
2. **TRAVEL DELAY**   
3. **TRIP CANCELATION / CURTAILMENT**   
4. **LOSS OF TRAVEL DOCUMENTS**

**Please attach following documents along with the claim form**

- Original invoices of the reasonable emergency expenses incurred due to travel inconvenience
- A dated official letter from the Airlines confirming the flight delay / baggage delay / baggage loss
- Copy of cheque or any compensation paid by the airlines
- Copy of Baggage Tags and PIR for baggage delay/ loss
- In case of flight delay: Copy of your ticket showing original itinerary and copy of boarding pass of actual travel

1 – Name of Airlines \_\_\_\_\_ 2- Date of departure \_\_\_\_\_

3 – Date, time and place of arrival \_\_\_\_\_

4 – Date and time when you received your baggage from Airlines in case of baggage delay \_\_\_\_\_

Date and time of actual departure in case of flight delay \_\_\_\_\_

Reason for Trip Cancellation or Curtailment / Loss of Documents \_\_\_\_\_

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

6 – In case of baggage loss, list of items in the bag and their price. Attach a separate sheet if necessary

Description	Date & Time of Purchase	*Purchase Price

**Statement and authorization:**

In order to process this claim, I authorize my physician, hospital or other medical provider to release to American Home Assurance Company or its representative, 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: \_\_\_\_\_

**Claims Contact Details:**

**KUWAIT:**

CHARTIS Mems Insurance Company (Kuwait Branch)

Country	Address	FAX / Tel	Email
KUWAIT	CHARTIS MEMSA Insurance Company (Kuwait Branch) 5th Floor, Al-Kharafi Tower Hamad Al Saqr St. Kuwait City - Kuwait	Fax: +965 - 2247 4264  Tel: +965 2247 4260 / 1 / 2 / 3	<a href="mailto:Mastercard.services@chartisinsurance.com">Mastercard.services@chartisinsurance.com</a>