HL Assurance

Travel Claim Form

The acceptance of this Form is NOT an admission of liability on the part of HL Assurance Pte. Ltd.. Any documentary proof or report required by HL Assurance Pte. Ltd. shall be furnished at the expense of the Policyholder or Claimant.

PARTICULARS OF POLICYHOLDER / INSURED PERSON / CLAIMANT (to be completed for all claims)

Please submit (for all claims):
1) Original completed claim form.
2) Original Certificate of Insurance.
3) Proof of travel, i.e. original boarding passes, air ticket or copy of passport.

Name & Address of Policyholder	Policy No.	Period of Insurance
	NRIC/Passport No. Date of Birth Age Nationality Gender ☐ Male ☐ Female	Tel No. H/P No. E-mail Name of Intermediary (if any) Occupation Date of Employment
Name & Address of Insured Person / Claimant (if different from Policyholder)	NRIC/Passport No. Date of Birth Age Nationality Gender ☐ Male ☐ Female	Tel No. H/P No. E-mail Relationship to Policyholder Occupation Date Of Employment

Is there any other insurance in force covering this loss? ☐ Yes ☐ No

If yes, please state:

Name of Insurance Company	Type of Policy	Policy / Certificate No.	Amount of Compensation

Have you or the Claimant ever had previous claims? ☐ Yes ☐ No

If yes, please state:

Date	Circumstances	Insurance Company Involved	Amount Claimed

DETAILS OF THE ACCIDENT / LOSS / ILLNESS (to be completed for all claims)

Description of Accident / Loss / Illness (please retain damaged articles for inspection, if necessary)	Country: ☐ Singapore ☐ Malaysia ☐ Others: _____	
	Place of Accident / Loss / Illness	
	Date of Accident / Loss / Illness	Time of Accident / Loss / Illness
	When and Who discovered the Accident / Loss	
	Name & Address of any witnesses of the Accident / Loss	NRIC/Passport No. Contact No.

A. PERSONAL ACCIDENT / ILLNESS, MEDICAL AND OTHER EXPENSES

Please note:

1) **Personal Accident – please enclose Police Report (if any), Detailed Medical Report, and Original Medical Certificate.**
2) **Medical or Post Journey Medical Expenses – please enclose Original Detailed Pre-Medical / Final Hospitalization / Post-Medical Bills, Detailed Medical Report / Memo from Attending Physician on the type of illness or injury sustained.**
3) **Emergency Travel Expenses – please enclose Certified True Copy of Death Certificate & Proof of Relationship or written advice from the Attending Physician indicating the need to travel to or remain with the Insured Person with Original Hospital Invoices & Receipts of travel and accommodation expenses incurred.**

1. Date, time and place of Accident / Illness	1.
2. Is it due to Illness ☐ Yes ☐ No Type of Illness: _____	2. When did first symptoms appear? When did you first receive medical attention for this condition? Name & Address of Attending Physician?
3. Have you suffered from the same condition before? ☐ Yes ☐ No	3. If yes, please provide details. Date(s) of Consultation(s) Name & Address of the Attending Physician
4. Is it due to Accident ☐ Yes ☐ No Date of Accident: _____	4. If yes, please provide details of the accident & injury.
5. Name and Address of your usual Physician	
6. Amount paid by you	
7. Amount recovered from other sources	
8. Amount claimed in respect of medical expenses and similar expenses	

B. LOSS OF DEPOSIT / CANCELLATION / CURTAILMENT

Please note:

1) **Personal Accident Trip Cancellation & Curtailment – please enclose documentary proof on relevant expenses incurred as a result of this trip cancellation, original booking invoice, Death Certificate, Medical Report &/or Written Memo from Attending Physician to cancel trip, Proof of Relationship, Travel Agents confirmation of the amount of refund.**
2) **Trip Curtailment – please enclose Original Invoice / Receipt of charges incurred in amending or purchasing additional air ticket.**

When and Where was the trip booked?	Intended Date of Departure
Reason(s) for trip cancellation / curtailment?	Date of Cancellation of Trip
Breakdown of amount claimed	Total amount paid by you Total amount recovered from other sources Net amount claimed

If trip cancellation / curtailment were caused by medical condition, has the Patient suffered from this condition before? ☐ Yes ☐ No
If yes, please state:

Date(s) of Consultation(s)

Name and Address of Attending Physician consulted

C. BAGGAGE / PERSONAL EFFECTS / MONEY / TRAVEL DOCUMENTS

Please note: Losses must be reported to the Police Authority, responsible Hotel Management or responsible officer of any aircraft, vessel / conveyance within 24 hours from the date of occurrence.

1) **Please enclose Police Report or report issued by responsible Hotel Management or carrier evidencing such losses, Property Irregularity Report for losses in carriers' custody, Original Purchases Bills, Photographs of damaged items, Original Repair Bills for damaged items, If the responsible Hotel Management or carrier has made compensation to the damaged/lost items, please request them to issue a note or letter certifying the amount of money paid to you.**

2) **Please enclose Police Report or report issued by responsible Hotel Management or carrier evidencing such losses, Original Receipts for replacement of travel documents, Original Transportation / Hotel Bills incurred for replacement of travel documents.**

If the loss or damage occurred whilst baggage was in transit or otherwise in the custody or control of others, have any steps been taken to claim against these persons?	☐ Yes. Please identify them, attach any correspondence and advise outcome of your claim against them. ☐ No. Please state reason(s):
If claim is in respect of articles stolen or lost, has a thorough search been made and notification sent to the Airlines, Ship Owners, Hotel Proprietors, Police or other parties who may be able to assist in the recovery?	☐ Yes. Please give details ☐ No. Please state reason(s):

DETAILS OF CLAIM *(Please use supplementary sheet if necessary)*

DESCRIPTION OF ITEM (MAKE & MODEL)	WHEN AND WHERE PURCHASED	ORIGINAL PURCHASE PRICE	AMOUNT LOST	AMOUNT RECOVERED FROM OTHER SOURCES	AMOUNT TO BE CLAIMED

D. TRAVEL DELAY / BAGGAGE DELAY

Please Note: Departure and Arrival Point must be the Insured Person's Country of Residence.

1) **Travel Delay – please enclose travel itinerary, boarding pass showing the actual take off time & date, written confirmation from carrier/airline or their agents specifying reason and hours of delay.**

2) **Baggage Delay – please enclose travel itinerary, written confirmation from carrier/airline or their agents specifying reason and the number of hours of baggage delay, Property Irregularity Report, Acknowledgement Receipt of baggage received.**

<table>
<tr><th>ORIGINAL FLIGHT DETAILS</th><th>DELAYED FLIGHT DETAILS</th><th>COLLECTION OF DELAYED BAGGAGE</th></tr>
<tr><td>Original Departure Date, Time and Place</td><td>Rescheduled Departure Date, Time and Place</td><td rowspan="2">Original Arrival Date, Time and Place</td></tr>
<tr><td rowspan="2">Original Arrival Date, Time and Place</td><td rowspan="2">Rescheduled Date, Time and Place</td></tr>
<tr><td rowspan="2">Received Date, Time and Place</td></tr>
<tr><td>Flight No.
Name of Airline</td><td>Flight No.
Name of Airline</td></tr>
<tr><td colspan="3">Cause of Delay</td></tr>
<tr><td colspan="3">Amount recovered from other sources</td></tr>
<tr><td colspan="3">Amount to be claimed</td></tr>
</table>

E. PERSONAL LIABILITY

Please note: In no circumstances should the issue on legal liability be admitted to any third party claimant(s).
1) Please enclose letters/summons/writs from the third party/police/court.

Please provide details of the circumstances		
Was the accident due to carelessness or negligence on your part?	☐ Yes ☐ No	
Have you in any way admitted liability?	☐ Yes ☐ No	
Names & Addresses of any witnesses to the accident		
To which Police Officer and Police Station (if any) did you report the accident / damage?		
Names & Addresses of the other party(s)		
Nature of personal injury sustained by any person (please attach photographs, if any)	**Name / Age**	**Nature of Injury**
Extent of damage to property belonging to other party(s) (please attach photographs, if any)		
Whether any claim has been made upon you. If so, 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		

F. OTHERS (Please specify Details of any Claim other than Sections A to E)

Name of Police Station, Carrier / Airline or other authorities where Report is lodged (if applicable)

DETAILS OF CLAIM *(Please use supplementary sheet if necessary)*	**AMOUNT TO BE CLAIMED**

G. CLAIMS HISTORY *(Please use supplementary sheet if necessary)*

Have you or any insured person previously made a claim under a travel policy? ☐ Yes ☐ No

If yes, please specify below:

DATE & CIRCUMSTANCES OF SIMILAR CONDITION & RECURRENCE	**NAME OF INSURANCE COMPANY(S) INVOLVED**

BANK ACCOUNT DETAILS

Name of Account Holder (as per bank account)	Bank Code
Bank Name	Branch Code
Bank Account No.	Swift Code

* Important Notice: The Company shall (i) be discharged from all liability under this claim and (ii) not be liable for any and all losses incurred by you, as a result of you providing the Company with an inaccurate bank account number under this section for the payment of this claim.

1) *I/We do solemnly and sincerely declare that the information given is true and correct to the best of my/our knowledge and belief. *I/We understand that any false or fraudulent statements or any attempt to suppress or conceal any material facts shall render the Policy void and we shall forfeit our rights to claim under the Policy.

2) *I/We hereby authorise any hospital, physician or other person who has attended or examined me, to disclose when requested to do so by HL Assurance Pte. Ltd., or its authorised representative, any and all information with respect to any illness or injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

3) *I/We hereby authorise and request HL Assurance Pte. Ltd. to pay benefit due in respect of this claim to: _____
(Name as per Identification Card and/or Bank Account)

PERSONAL DATA

In addition to the declaration and authorisation provided above, I/we agree and consent to the Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents collecting, using, disclosing and sharing amongst themselves my/our personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate, admit, process and/or administer my/our claims.

These purposes are set out in HL Assurance Pte Ltd Privacy Statement, which is assessable at: https://www.hlas.com.sg/PolicyOnPersonalData.aspx and which I/we confirm I/we have read and understood.

_____
Signature of Policyholder / Insured Person / Claimant

_____
Company's Stamp (if applicable)

Name _____

Date _____

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