

CLAIM FORM - TRAVEL INSURANCE

General Information (To be filled in for all types of claim) Required information is mandatory and cannot be left blank

Policy Particulars:

Policy No. _____

Endt. No. (If any) _____

Insured's Name _____ CNIC No; _____

Date of Departure from Pakistan; _____ Date of Arrival in Pakistan; _____

Country of Residence; _____ Resident of Country other than Pakistan; _____

Insured's Contact No. _____

Loss Particulars:

Date of Loss _____

Type of Loss (Please Tick)

- Personal Accident (Death & Disability) Medical Expenses Medical Evacuation
- Death Repatriation Emergency Dental Care Total Loss of Checked-In Baggage
- Loss of Passport Baggage Delay Flight Delay Trip Cancellation & Curtailment
- Loss of Credit Card Emergency Return Home Travel & Stay Over of One Immediate Family Member
- Return of Dependent Children Dispatch of Medication Personal Liability

Please attach the following documents with all types of claims:

1. Original Policy.
 2. Original Endorsement (if any).
 3. Air Tickets and any other traveling documents proving actual travel period.
 4. Photo Copy of Full Passport.
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Claim Form - Personal Accident (Death or Permanent Disability)

1. Name of Loss Sustaining Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Circumstances of Loss {attach extra sheet(s), if required}

5. Cause of Death (for death claims only)

6. Cause and Extent of Disability (for disability claims only)

7. Name, Address and Telephone Nos. of Hospital/ Clinic where treatment was given

8. Name of Attending Doctor _____
9. Details of Any Third Party Involved in the Accident

10. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Death Certificate issued by Competent and Authorized Entity stating cause of death (for death claims only).
 2. Disability Certificate issued by Competent & Authorized Entity stating cause and extent of disability (for Permanent Disability claims only).
 3. Police Report stating cause of loss.
 4. Medical Treatment Documents.
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Claim Form - Medical Expenses Claim – Sickness or Injury

1. Name of Loss Sustaining Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Circumstances of Loss {for injury related claims only} {attach extra sheet(s), if required}

5. Name, Address and Telephone Nos. of Hospital/ Clinic where treatment was given

6. Name of Attending Doctor _____
7. Nature of Ailment _____
8. Was the Ailment/ Injury aggravated due to a pre-existing condition? Please give details

9. Details of Treatment Received & Expenses Incurred {attach extra sheet(s), if required}

10. Details of Any Third Party Involved in the Accident (for Injury related claims only)

11. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Medical Bills/ Invoices/ Receipts.
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2. Attending Physician's Original Prescriptions.
3. Attending Physician's Original Case Summary
4. Original Reports
5. Police Report (for Injury related claims only)

Claim Form - Medical Expenses Claim – Dental Treatment

1. Name of Loss Sustaining Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Circumstances of Loss {attach extra sheet(s), if required}

5. Name, Address and Telephone Nos. of Hospital/ Clinic where treatment was given

6. Name of Attending Doctor _____
7. Nature of Ailment _____

8. Was the Ailment/ Injury aggravated due to a pre-existing condition? Please give details

9. Details of Treatment Received & Expenses Incurred {attach extra sheet(s), if required}

10. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Medical Bills/ Invoices/ Receipts.
 2. Attending Physician's Prescriptions.
 3. Tooth/teeth treated.
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4. Treatment performed.



Claim Form - Repatriation of Mortal Remains

- 1. Name of Insured Person _____
- 2. Date of Death _____
- 3. Place of Death _____
- 4. Circumstances of Loss (attach extra sheet(s), if required)

- 5. Cause of Death for (for death claims only)

- 6. Name, Address and Telephone Nos. of Hospital/Clinic where treatment was given

- 8. Name of Attending Doctor _____
- 9. Total Amount Claimed _____

Please attach the following document in original for claim verification and assessment:

- 1. Death certificate.
- 2. Physician's statement stating cause of death.
- 3. Original bills/receipts for expenses incurred.



Claim Form - Total Loss of Checked - in - baggage

1. Name of Insured Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Detail of Loss (When & Where) attach extra sheet(s), if required

5. Name, Address and Telephone Nos. of Airline.

6. Total Amount Claimed _____

Please attach the following document in original for claim verification and assessment:

1. Property Irregularity Report Issued by the carrier.
 2. Proof of ownership of items valued in excess of USD,100/-
 3. Letter from the carrier stating compensation received for lost baggage.
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Claim Form - Delay of Checked - in - Baggage

1. Name of Insured Person _____

2. Date of Baggage Delay _____

3. Place of Loss Baggage Delay _____

4. Detail of Baggage Delay (When & Where) attach extra sheet(s), if required

5. Name, Address and Telephone Nos. of Airline.

6. Total Amount Claimed _____

Please attach the following document in original for claim verification and assessment:

1. Property Irregularity Report stating the date and time of baggage arrival.
2. Original bills/receipt of emergency items purchased.

Claim Form - Flight Delay (Excess First 12 Hours)

1. Name of Insured Person _____
2. Date of Delayed _____
3. Place of Delayed _____
4. Reason for Delaying _____

5. Name, Address and Telephone Nos. of Airline.

6. Total Amount Claimed _____

Please attach the following document in original for claim verification and assessment:

1. PNR (Passenger Name & Record) where should has the narration of Flight Delayed.
 2. List of Items purchased.
 3. Original bills/receipts of emergency items purchased.
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Claim Form - Loss of Passport

1. Name of Insured Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Detail of Loss (When & Where) attach extra sheet(s), if required

5. Total Amount Claimed _____

Please attach the following document in original for claim verification and assessment:

1. Police report obtained with 24 hours of becoming aware of the theft.
 2. Bills/receipts of expenses incurred in obtaining fresh of duplicate passport.
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Claim Form - Trip Cancellation & Curtailment

1. Name of Loss Sustaining Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Circumstances of Loss {attach extra sheet(s), if required}

5. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Original tickets of the traveling companion(if applicable)
2. Original bills/invoices of reasonable additional expenses incurred and/ or proof of cancellation charges levied by the carriers.



Claim Form - Travel and Stay Over of One Immediate Family Member

1. Name of Loss Sustaining Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Circumstances of Loss {for injury related claims only} {attach extra sheet(s), if required}

5. Name, Address and Telephone Nos. of Hospital/ Clinic where treatment was given

6. Name of Attending Doctor _____
7. Nature of Ailment _____

8. Was the Ailment/ Injury aggravated due to a pre-existing condition? Please give details

9. Details of Treatment Received & Expenses Incurred {attach extra sheet(s), if required}

10. Details of Any Third Party Involved in the Accident (for Injury related claims only)

11. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Medical reports, statement from Attending Physician.
 2. Doctor's statement indication the need for an attendant
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Claim Form - Emergency Return Home Following Death of Close Family Member

1. Name of Loss Sustaining Person _____

5. Date of Loss _____

6. Place of Loss _____

7. Circumstances of Loss {attach extra sheet(s), if required}

5. Cause of Death (for death claims only)

6. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Death Certificate of the deceased.
2. Documents (Passport/NIC) providing the relationship of the insured with the deceased.
3. Original bills/receipts for expenses incurred.

