

Claim Form – Travel Insurance

This Form is issued without prejudice to any of the Stipulations or Conditions of the Company’s Policy, and is not to be taken as an admission of liability on the part of the Company.

This Form should be completed and returned within SEVEN (7) days of its receipt by the Insured.

IT IS ESSENTIAL THAT EACH QUESTION SHOULD BE ANSWERED AS FULLY AND ACCURATELY AS POSSIBLE.

PARTICULARS OF CLAIM

Insured	: _____	Insured Person	: _____
		NRIC/ Passport No.	: _____
Address	: _____	Policy/ Certificate No	: _____

	Singapore _____	Contact Number	: Home _____
Email	: _____		: Mobile _____

1.	Description of the incident of loss or injury or illness	
2.	Are you any other insurance policies in force covering you in respect of this event? If “Yes”, please provide the name and address of the Insurance Company.	<input type="checkbox"/> No <input type="checkbox"/> Yes, please specify

Documents Required for All Claims

- Original Certificate of Insurance
- Tour Operators Confirmation of booking invoices, Airline ticket counterfoil(s)/ Booking Pass(es)
- Copy of actual travel itinerary of Trip
- Copies of your other insurance policy

Claim Form – Travel Insurance *Cont'*

MEDICAL & OTHER EXPENSES/ EMERGENCY MEDICAL EVACUATION/ HOSPITAL ALLOWANCE/ REPATRIATION EXPENSES																											
<p><i>Please tick accordingly</i></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Medical & Other Expenses <input type="checkbox"/> Emergency Medical Evacuation </div> <div style="width: 45%;"> <input type="checkbox"/> Hospital Allowance <input type="checkbox"/> Repatriation Expenses </div> </div>																											
1	Name of Claimant _____																										
2	Date and Place of Accident/ or onset of illness _____																										
3	Nature and cause of accident/ illness _____ _____																										
4	Period in hospital From _____ To _____																										
5	Name and Address of other Insurance Company covering your medical expense(s) _____																										
	Policy reference no _____																										
<table border="1" style="width: 100%; border-collapse: collapse; margin: 0 auto;"> <thead> <tr> <th style="width: 25%; padding: 5px;">Nature of expenditure</th> <th style="width: 25%; padding: 5px;">To whom paid/ payable</th> <th style="width: 25%; padding: 5px;">Amount (state currency if not S\$)</th> <th style="width: 25%; padding: 5px;">Indicate if any bill is unpaid</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Nature of expenditure	To whom paid/ payable	Amount (state currency if not S\$)	Indicate if any bill is unpaid																				
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Documents Required:

- Medical Report showing nature of injury/ sickness
- Original Medical Bills/ Receipts for the full amount of the claim
- If hospital benefit is claimed, a letter confirming the date of admittance and the date of discharge from hospital is required.
- Death Certificate and Burial/ Cremation Permit (if death occurred)

Claim Form – Travel Insurance *Cont'*

MEDICAL CERTIFICATE <i>This certificate is to be furnished at the claimant's expenses and must be completed by the claimant's usual doctor</i>							
1.	Patient's name : _____						
2.	(a) Are you this patient's usual doctor <input type="checkbox"/> Yes <input type="checkbox"/> No (b) If "Yes", for how long? _____						
3.	Describe (a) accidental injuries (b) cause of death (c) illness of patient _____ _____						
4.	Date medical treatment first sought for this condition _____ _____						
5.	History of this condition or any relevant condition with date(s) of treatment. If none, please state so _____ _____						
6.	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> If you were treating the patient prior to the holiday, was he/she fit to travel at date of booking? </td> <td style="width: 50%; border: none; vertical-align: top;"> Date of Booking: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table>	If you were treating the patient prior to the holiday, was he/she fit to travel at date of booking?	Date of Booking: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No				
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<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> _____ Doctor's signature </td> <td style="width: 33%; border: none;"> _____ Doctor's name and Qualifications </td> <td style="width: 33%; border: none;"> _____ Date </td> </tr> <tr> <td colspan="3" style="border: none; padding-top: 10px;"> Clinic Address _____ </td> </tr> </table>		_____ Doctor's signature	_____ Doctor's name and Qualifications	_____ Date	Clinic Address _____		
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Clinic Address _____							

Claim Form – Travel Insurance *Cont'*

PERSONAL ACCIDENT/ PERMANENT TOTAL DISABLEMENT		
1	Date and Place of Accident	_____
2	State cause of Accident and Nature of Injury	_____
3	Give name of attending Physician	_____
4	Address of registered medical institution that you were admitted.	_____ _____

Documents Required:

- Death Certificate and Burial/ Cremation Permit
- Letter of Probate or Letter of Administration
- Medical Report (Permanent Total Disablement)
- Police Report (for accident-related cases)

Claim Form – Travel Insurance *Cont'*

LOSS OF DEPOSIT/ CANCELLATION/ CURTAILMENT OR TRAVEL INCONVENIENCE <i>(Please tick accordingly)</i>			
	<input type="checkbox"/> Cancellation	<input type="checkbox"/> Curtailment	<input type="checkbox"/> Travel Delay
	<input type="checkbox"/> Missed Flight Connection	<input type="checkbox"/> Overbooked Flight	<input type="checkbox"/> Hijacking
1	Full name of all claimants	_____	
2	Date of Occurrence, Cancellation or Arrival home if curtailed	_____	
3	Reason for Cancellation/ Curtailment/ Travel Delay/ Missed Flight Connection/ Overbooked Flight/ Hijacking	_____	
4	Name of sick or injured person and relationship to Insured	_____	
5	Period of Delay	_____	
6	Period of Hijack (if applicable)	_____	
	Amount Claimed	_____	

Documents Required:

- Cancellation
 - ~ If due to own illness/ injury, doctor's letter is required
 - ~ If due to Immediate Family Member's death/ illness/ injury, Death Certificate or doctor's written advice respectively is required.
 - ~ Document confirming relationship if cancellation was due to Immediate Family Member death/ illness/ Injury
 - ~ Original cancellation invoice from Travel Agent stating the amount of refund.
 - ~ If there is no refund, please provide the original air ticket(s) for record.
- Curtailment
 - ~ Original letter from Travel Agent stating the amount of refund.
 - ~ If due to own illness or that of travelling companion, written advice or certificate from the treating doctor overseas confirming the advice for you or your travelling companion's return to Singapore is required.
 - ~ If due to Immediate Family Member's death/ illness injury, death certificate or doctor's written advice respectively is required.
 - ~ Document(s) confirming relationship if curtailment was due to Immediate Family Member's death/ illness/ Injury.
- Travel Delay/ Missed Flight Connection/ Overbooked Flight/ Hijack
 - ~ Written confirmation from operators of the airline, sea vessel or train stating the reason for departure delay and the duration of delay in number of hours
 - ~ Original receipt for meals, accommodations or refreshment expenses incurred if not provided for or compensated by the carrier or any third party.

Claim Form – Travel Insurance *Cont'*

DELAYED BAGGAGE				
	Flight Details		Collection of Delay Baggage	
1	Arrival Date and Time	_____	Arrival Date and Time	_____
2	Place of Departure	_____	Place of Departure	_____
3	Flight No	_____	Flight No	_____
4	Name of Airline	_____	Name of Airline	_____

Documents Required:

- Letter from Airline confirming reason for delay and duration
- Baggage delivery docket/ acknowledgement or Baggage Irregularity report.

Claim Form – Travel Insurance *Cont'*

LOSS OF BAGGAGE & PERSONAL EFFECTS/ LOSS OF PERSONAL MONEY & TRAVEL DOCUMENTS					
1	Did you report the loss to the police or airline or handling agents?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No	
2	If “Yes”, state to whom did you report the loss and date of loss reported.	Reported to: _____ Date: _____			
3	Details of item(s) lost or damaged				
	Item Description	Place Bought	Purchase Date	Purchase Price	Amount Claimed
4	Loss of Money				
	Amount in notes (S\$)	Amount in foreign currency notes	Amount in travellers cheques	Total amount claimed	

Documents Required:

- Original purchase receipt(s)/ Warranty card/ Instruction Manual (s)
- Photograph (s) of damaged baggage were applicable
- Property Irregularity Report for lost or damaged of baggage by an airline or carrier
- Police Report translated into English, where applicable, is required for Money and theft claim.

Claim Form – Travel Insurance *Cont'*

PERSONAL LIABILITY/ RENTAL VEHICLE EXCESS		
1	Date and Place of accident	_____
2	Please describe how the incident occurred	_____
3	What is the name of and address the other party?	_____
4	Was a police report made? If so, when and where was it made?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
5	Has a claim been made against you? If Yes, give details and attach all communication received.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Documents Required:

- Photographs of Damage
- Third Party's letter, if any, holding you liable for the incident
- A copy of rental vehicle agreement and repair invoice (applicable for Rental Vehicle Excess Claim)
- Related police report, if available

[Document(s) in foreign language except in the local working language, ie. English is to be translated at your own expense before submitting].

Claim Form – Travel Insurance *Cont'*

HOMESURE (FIRE INSURANCE COVER FOR HOUSEHOLD CONTENTS)				
1	Date and Place of accident			
2	Please describe how the incident occurred			
3	Is there other insurance covering the property concerned? If "Yes", please provide the insurance company and Policy reference no.		<input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Company _____ Policy reference no _____	
4	Details of item(s) lost or damaged			
		Item Description (including Make and Model)	Purchase Date	Purchase Price
				Amount Claimed

Documents Required:

- Photographs of Damage
- Original invoices/ Purchase receipt of items.
- Police report/ Results
- Quotation for repair/ replacement.

Declaration

I declare that the information given in this claim form is true and correct to the best of my knowledge and belief.

I hereby authorize any hospital physician, other person who has attended or examined me, to furnish to the Company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photostated copy of this authorization shall be considered as effective and valid as the original.

 Name and Signature of Claimant

 Date

Please mail the completed Claim Form and supporting documents to:
Crawford & Company International Pte Ltd
Travel Claims Department
No.8 Shenton Way
#03-01
Singapore 068811

Telephone: 6225 4211
Email: admin@crawford.com.sg
Singapore Company Reg No: 197101412E

Facsimile: 6222 8310