



ace insurance

ACE Insurance Limited

Co Regn No: 199702449H

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TRAVEL CLAIM FORM

The acceptance of this Form is NOT an admission of liability on the part of the Company.

SECTION (A) : PARTICULARS OF INSURED / INSURED PERSON			
Name & Address of Insured:	Tel. No. (Office):	Tel. No. (Residence):	
	Policy No.:	Period of Insurance:	
	E-mail Address:	Name of Intermediary (if any):	
Name & Address of Insured Person:	Tel. No. (Office):	Tel. No. (Residence):	
	Date of Birth:	Occupation: Date Of Employment:	
	E-mail Address:	Sex: Male Female	
SECTION (B) : PARTICULARS OF LOSS / OCCURRENCE			
Explain exactly on how did the loss occur:	Country of occurrence: Singapore Malaysia Others: _____		
	Place of loss or occurrence:		
	Date of loss:	Time of loss:	
	On when and by whom was the loss discovered:	Relationship:	
	Name & Address of any witnesses of the Incident:	NRIC/Passport:	
		Contact No.:	
SECTION (C) - PERSONAL ACCIDENT / ILLNESS – MEDICAL AND ADDITIONAL EXPENSES			
(Please attach original medical receipts)			
Please state the type of Diagnosis:	If yes , please specify dates & circumstances of similar medical condition or previous injury and name & address of the doctor concerned:		
Have you ever suffered similar medical condition or is this medical condition related to a previous injury? Yes No			
AMOUNT PAID BY YOU:	AMOUNT RECOVERED FROM OTHER SOURCES:	AMOUNT CLAIMED:	

SECTION (D) : CANCELLATION / CURTAILMENT (Please attach documents from Carrier/Travel Agent)				
When and where was holiday booked?			Intended Departure Date:	
			Date Cancelled:	
AMOUNT PAID BY YOU:		AMOUNT RECOVERED FROM OTHER SOURCES:	AMOUNT CLAIMED:	
SECTION (E) : PERSONAL EFFECTS (Please furnish relevant Report from relevant authorities or Carrier/Airlines <u>AND</u> original purchase receipts)				
Give details of amount claimed				
DESCRIPTION OF ITEM	WHEN AND WHERE PURCHASED	ORIGINAL PURCHASE PRICE	AMOUNT RECOVERED FROM OTHER SOURCES	AMOUNT CLAIMED
				<i>(Please use supplementary sheet if necessary)</i>
SECTION (F) : PERSONAL MONEY / TRAVEL DOCUMENTS (Please furnish relevant Report from relevant authorities or Carrier/Airlines)				
Details of amount claimed				
AMOUNT LOST	AMOUNT RECOVERED FROM OTHER SOURCES		AMOUNT CLAIMED	
				<i>(Please use supplementary sheet if necessary)</i>
SECTION (G) : FLIGHT DELAY / BAGGAGE DELAY (Please attach letter from Carrier/Airlines and Boarding Pass)				
ORIGINAL FLIGHT DETAILS	DELAYED FLIGHT DETAILS	COLLECTION OF DELAYED BAGGAGE		
Date:	Date:	Date:		
Time:	Time:	Time:		
Place of Departure:	Place of Departure:	Place of collection:		
Flight No.:	Flight No.:			
Name of Airline:	Name of Airline:			
EXPENSES INCURRED BY YOU:	AMOUNT RECOVERED FROM OTHER SOURCES:	AMOUNT CLAIMED:		
SECTION (H) : PERSONAL LIABILITY (Please attach letter from Third Party, Police or Court)				
Was the accident due to carelessness, or negligence on your part?				
Have you in any way admitted liability?				
To which Police Officer and Police Station (if any) did you report the occurrence?				

Names & addresses of the other party(s)		
Nature of personal injury sustained by any person	Name/Age	Nature of Injury
Extent of damage to property belonging to other party(s)		
Whether any claim has been made upon you. If so, was the amount of such claim specified?		
Please give any additional information which you consider would help the Insurer in dealing with any claim that may be made against you.		
SECTION (I) : OTHERS (Please specify details of any claim other than (C) to (H))		
Name of Police Station, Carrier/Airline or other authorities where Report lodged (if applicable)		
DETAILS OF CLAIM	AMOUNT CLAIMED	
	<i>(Please use supplementary sheet if necessary)</i>	
SECTION (J) : ANY OTHER INSURANCES		
Are there any other Policies of insurance in force covering you in respect of this event?	Yes	No
If yes, please specify below:		
NAME & ADDRESS OF INSURANCE COMPANY(S)	POLICY NO(S).	
	<i>(Please use supplementary sheet if necessary)</i>	
SECTION (K) : CLAIMS HISTORY		
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	
	<i>(Please use supplementary sheet if necessary)</i>	

(1) I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and *I/We agree that if *I/We have made or in any further declaration in respect of the said claim shall make any false or fraudulent statements of suppress conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

(2) I/We hereby authorize any hospital physician, other person who has attended or examined me, to furnish to the company, or its authorized representatives, 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 photostatic copy of this authorization shall be considered as effective and valid as the original.

(3) I/We hereby authorize and request ACE Insurance Ltd to pay benefit due in respect of this claim to : _____

Date _____

Signature of Insured _____
(Please affix company stamp if applicable)

Signature of Insured Person _____