



FEDERAL INSURANCE COMPANY – SINGAPORE

One of the Chubb Group of Insurance Companies

18 Cross Street #11-08 China Square Central Singapore 048423
 Telephone: 6333 8113 Facsimile: 6333 8112

OVERSEAS / BUSINESS TRAVEL INSURANCE CLAIM FORM®

The Insured is requested to state as fully and as accurately as possible the information asked for hereunder in order to expedite claim processing and to return the form immediately to the Company. Any documentary proof or reports required by the Company shall be furnished at the expense of the Policyholder or Claimant. Acceptance of this Form is not in itself and admission of liability on the part of the Company.

A POLICYHOLDER / CLAIMANT

1. Policyholder _____ Policy No. _____

2. Address _____

3. Tel/Mobile _____ Email _____

4. Employee/Claimant _____ Age _____ Sex F M

5. NRIC/Passport No. _____ Nationality _____

6. Occupation _____ Email _____

7. Commencement date of employment _____ Tel/Mobile _____

If employed less than 12 months, state name of prior medical insurer, if any/known:

8. Country of Posting (if applicable) _____ Home Country _____ Date of Posting _____

9. Insured Person (if not claimant) _____ NRIC/ Passport No. _____ Age _____ Relationship to Employee _____

10. Insured Person's prior medical insurer, if insured less than 12 months under this policy _____

11. Are there any other insurance which would cover this loss? Yes No

Name of Insurance Company & Policy No. _____

If Yes, please submit claim to the other insurance company and provide copies of policy and completed claim form for our review.

B CLAIM TYPE Please tick box accordingly

Flight Delay Baggage Delay Baggage Loss Trip Curtailment Trip Cancellation

Missed Connection Personal Liability Loss / Damage to Personal Effects Loss of Money / Documents Medical Expenses

Personal Insurance Others: _____

NOTE: If seeking reimbursement of medical expenses incurred, it is IMPORTANT that you let us know the doctor's diagnosis and/or the cause or reason for seeking medical treatment. Additional details are required in Section F.

C DESCRIPTION OF LOSS / EVENT (If space below is insufficient, please attach a separate sheet)

Date and Time: _____ Place: _____

D. TRAVEL DETAILS

Purpose of Trip: Business Vacation Personal Vacation Home Visit

If travelling with your spouse or children: Yes No Not Applicable
 were they insured under the policy?

Duration of Trip: From _____ To _____

The following may be omitted if you submit a copy of your travel itinerary prepared by the travel agent which clearly provides the necessary details.

- 1. Departure Airport _____ Carrier / Flight No. _____ Date and Time _____
- 2. Transit Airport, if any _____ Carrier / Flight No. _____ Date and Time _____
- 3. Arrival Airport _____ Carrier / Flight No. _____ Date and Time _____

E TRAVEL / BAGGAGE DELAY CLAIM INFORMATION

FLIGHT DELAY Airport _____ Actual Flight No./Date & Time: _____

BAGGAGE DELAY OR LOSS Airport _____ Date & time returned: _____

MISSED CONNECTION Airport _____ Alternative flight, date & time: _____

F MEDICAL / PERSONAL ACCIDENT CLAIM INFORMATION

Have you ever suffered this or a similar condition or was this recurrence of a previous illness or injury? If yes, please provide details, including dates. Yes No

Names and addresses of usual attending Physician(s): _____

Names and addresses of witnesses to the Accident, if any: _____

Name and address of the Police Station where the report was lodged. A copy of the report should be attached to this form.
 If report was not lodged, please advise reason. _____

G CLAIM QUANTUM

Description of Item claimed (For property claims, please include brand, make and model)	Date Purchased	Original Price Paid	Replacement or Repair Costs	Amount Claimed

(If space is insufficient, please attach separate list)

H. SUPPORTING DOCUMENTS

TO FACILITATE CONSIDERATION OF YOUR CLAIM, PLEASE ENSURE YOU SUBMIT ALL THE NECESSARY DOCUMENTS TOGETHER WITH THIS FORM AS SOON AS AVAILABLE:

1. **Baggage loss or delay at the airport:** Airline Property Irregularity Report and confirmation letter on when baggage was returned;
2. **Flight delay:** written confirmation from airline stating the period of delay and reason(s);
3. **Loss of money or baggage (other than in the custody of airline):** copy of police report;
4. **Lost or damaged items:** original purchase receipts or bills, photographs of damaged items and original repair bills or receipts;
5. **Medical expenses:** original detailed medical bills/receipts, medical report (if available) or certification from the attending Physician on the diagnosis.
6. **Permanent Disablement/Death:** Medical report; police report, accident report and/or newspaper report (if any); certified true copy of death certificate, coroner's report and/or post-mortem report (if available); claimants' identification documents (such as certified true copy of Grant of Letters of Administration or Grant of Probate and Estate Duty Schedule). Legal documents where and when required by law, must be submitted at the claimants' expense;
7. **Reimbursement of expenses incurred (if covered for flight or baggage delay or missed connection):** original receipts of expenses incurred and/or items purchased.
8. **Trip cancellation or trip curtailment:** medical report and/or other documents to substantiate the reason plus bills/receipts of advance payments and/or additional expenses incurred;

For all travel claims:

9. Air tickets and boarding passes for the entire trip;
10. A copy of travel itinerary for the entire trip;
11. Written confirmation from airline stating compensation paid or payable.

Additional information may be necessary for certain claims, in which case we will contact you as soon as possible.

DECLARATION

I hereby declare that to the best of my knowledge and belief, the statements and answers in this form are true and correct in every respect. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

I also hereby authorise any hospital, physician, or other person who had attended me or examined me, to disclose when requested to do so by **Federal Insurance Company** or its authorised representative, any and all information with respect to any illness, or injury, medical history, consultations, prescriptions or treatment, copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

Name & Signature
of Insured Person and/or Claimant _____ Date _____

Name, Signature & Designation
of Policyholder's Rep.
(with company stamp) _____ Date _____