MPI GENERALI

MPI Generali Insurans Berhad (14730-X)

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TRAVEL PERSONAL ACCIDENT CLAIM FORM

Policy	Policy No.: ..... Claim No.: ..... Insured: .....
Flight Details	Flight No.: ..... Name of Airline Co.: ..... Period of Travel: ..... (To) ..... Destination: .....
Particular of Insured Person	Name: ..... Age: ..... NRIC No.: ..... Occupation: ..... Purpose of Travel: ..... Gender: ..... Home Address: ..... E-mail Address: .....Tel. No.: .....(Home).....(H/P) GST Registered: ( ) Yes ( ) No / GST Registration No.: .....
Accident / Incident / Loss	Date, Time and Place of accident: ..... Describe how accident occurred: .... Name and address of any witness: ..... Nature and extent of injuries: ..... Place of police report made: .....Police Report No.: .....
General Information	Are you / the injured person entitled to claim compensation for accidental injury from any other company or companies? If so, please provide details. ....

Please tick in the box to indicate the type of benefits you are claiming:	**Amount Claimed**
☐ **Personal Accident Benefit**	
☐ Accidental Death	.....
☐ Permanent Disability	.....
☐ **Medical Expenses**	.....
☐ **Emergency Medical Evacuation & Repatriation**	.....
☐ **Funeral Expenses**	.....
☐ **Hospital Confinement**	.....

	Amount Claimed
☐ **Compassionate Allowance** (reimbursement for a reasonable travel fare and hotel accommodation incurred up to two (2) relatives)	.....
☐ **Child Education Fund Benefit** (Child Education Fund Benefit for each legally Dependent Child in the event of death to Insured person relatives)	.....
☐ **Baggage & Personal Effects** (cover loss or damage of check-in luggage and clothing, registered personal effect relatives) **Description** ..... **Date & Place Purchased** ..... **Original Cost**	....
☐ **Other Common Carrier Delay** (flat payment for every complete 6 hours period of delay in scheduled public transport)	.....
☐ **Loss of Personal Money** (compensates for loss of coins, banknotes, postal and money orders, signed travelers and other cheques, letter of credit, travel tickets)	.....
☐ **Loss of Travel Documents** (reimbursement for reasonable travel fare, hotel accommodation and the cost of obtaining relevant travel documents)	.....
☐ **Trip Cancellation / Curtailment** (reimbursement for cost of flight if you must cancel an insured trip for covered reasons)	.....
☐ **Travel Delay** (state number of hours ……..) (flat payment for every complete 6 hours and consecutive hours of delay calculating from the original scheduled departure flight time)	.....
☐ **Damage or Loss of Laptop Computer**	.....
☐ **Missed Travel Connection** (state number of hours ……..) (no onwards flight connection is available within 6 consecutive hours from the previous missed scheduled departure flight)	.....
☐ **Rental Vehicle Excess**	.....
☐ **Personal Liability** (indemnify Insured Person in respect of legal liability up to the benefit amounts stated)	.....
☐ **Aircraft Hijacking** (flat payment for every 12 consecutive hours period of hijacking)	.....
☐ **Replacement Expenses** (reimbursement for reasonable travel fare and other essential travel expenses incurred in sending a substitute person to complete the original Insured Person's journey)	.....

☐ **Terrorism**	**Amount Claimed** ……
☐ **Legal Expenses** (legal fees incurred as a result of false arrest or wrongful detention by any government)	……
☐ **Home Care** (compensates for physical loss or damage caused by burglary to household contents within Insured Person residence in Malaysia that was left vacant	……
☐ **Political & Natural Disaster Expenses**	……

I / We hereby warrant that the above statements are true and correct and that I / We have not withheld from the Company any material information in connection with this claim. I / We further authorise the release of further medical information by the doctor should the Company require it. Any photostat copy of this authorisation shall be as effective and valid as the original.

Date: ……..... Signature of Insured: ……..……

Name: ……..

Company's Stamp: ……..……

MEDICAL CERTIFICATE

To be completed by the attending medical practitioner

1. Name of patient: .....

2. Date Admitted: …….. Date Discharged: .....

3. Profession, business or occupation of the patient: .....

4. Region injured (If limb, state whether right or left): .....

5. Nature and extent of injuries (please state in details): .....

   .....

6. a) State as fully as possible the cause of the accident: .....

   .....

   b) Is the appearance of the injury consistent with the accident? ☐ Yes ☐ No
   If no, please provide details: .....

7. Is there any connection between the present disablement and any disease or previous disability? ☐ Yes ☐ No
   If yes, please provide details: .....

8. Is surgical interference necessary or likely to become so? ☐ Yes ☐ No
   If yes, please provide details: .....

9. Is there anything in his / her medical history which may likely retard his/her recovery? ☐ Yes ☐ No
   If yes, please provide details: .....

10. Have you any reason to suppose that he / she was under the influence of intoxicants at the time of the accident? ☐ Yes ☐ No
    If yes, please provide details: .....

11. Are the injuries as such will prevent the patient from performing the followings without any assistance in the next 12 months:

    a) Toileting: The ability to use toilet, including getting in and out of it ☐ Yes ☐ No

    b) Mobility: The ability to get in and out of bed and a chair ☐ Yes ☐ No

    c) Continence: The ability to control bowel or bladder functions ☐ Yes ☐ No

    d) Dressing: Putting on and taking off clothing ☐ Yes ☐ No

    e) Bathing / Washing: The ability to take bath or shower (including getting in or out of the bath or shower) or wash by any other means ☐ Yes ☐ No

    f) Feeding: The ability to get food from a plate into the mouth ☐ Yes ☐ No

12. Are you his / her usual medical attendant? If yes, how long have you know him/her and for what other ailment have you treated him / her? .....

13. When did you first see and examine the injured person after the Accident described herein? .....

Signature of doctor: …… Name and Qualification of doctor: .....

Date: …… Name and Address of Hospital / Clinic / Medical Centre: ……

Email address: ……