

## TRAVEL PERSONAL ACCIDENT CLAIM FORM

<b>Policy</b>	Policy No.: ..... Claim No.: ..... Insured: .....	
<b>Flight Details</b>	Flight No.: ..... Name of Airline Co.: ..... Period of Travel: ..... (To) ..... Destination: .....	
<b>Particular of Insured Person</b>	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.: .....	
<b>Accident / Incident / Loss</b>	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.: .....	
<b>General Information</b>	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:		<b>Amount Claimed</b>
<input type="checkbox"/> <b>Personal Accident Benefit</b>		.....
<input type="checkbox"/> Accidental Death		.....
<input type="checkbox"/> Permanent Disability		.....
<input type="checkbox"/> <b>Medical Expenses</b>		.....
<input type="checkbox"/> <b>Emergency Medical Evacuation &amp; Repatriation</b>		.....
<input type="checkbox"/> <b>Funeral Expenses</b>		.....
<input type="checkbox"/> <b>Hospital Confinement</b>		.....

<input type="checkbox"/> <b>Compassionate Allowance</b> (reimbursement for a reasonable travel fare and hotel accommodation incurred up to two (2) relatives)	<b>Amount Claimed</b> .....									
<input type="checkbox"/> <b>Child Education Fund Benefit</b> (Child Education Fund Benefit for each legally Dependent Child in the event of death to Insured person relatives)	.....									
<input type="checkbox"/> <b>Baggage &amp; Personal Effects</b> (cover loss or damage of check-in luggage and clothing, registered personal effect relatives)  <table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>Description</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Date &amp; Place Purchased</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Original Cost</u></th> </tr> </thead> <tbody> <tr> <td>.....</td> <td>.....</td> <td>.....</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>.....</td> </tr> </tbody> </table>	<u>Description</u>	<u>Date &amp; Place Purchased</u>	<u>Original Cost</u>	.....	.....	.....	.....	.....	.....	..... .....
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<input type="checkbox"/> <b>Other Common Carrier Delay</b> (flat payment for every complete 6 hours period of delay in scheduled public transport)	.....									
<input type="checkbox"/> <b>Loss of Personal Money</b> (compensates for loss of coins, banknotes, postal and money orders, signed travelers and other cheques, letter of credit, travel tickets)	.....									
<input type="checkbox"/> <b>Loss of Travel Documents</b> (reimbursement for reasonable travel fare, hotel accommodation and the cost of obtaining relevant travel documents)	.....									
<input type="checkbox"/> <b>Trip Cancellation / Curtailment</b> (reimbursement for cost of flight if you must cancel an insured trip for covered reasons)	.....									
<input type="checkbox"/> <b>Travel Delay</b> (state number of hours .....) (flat payment for every complete 6 hours and consecutive hours of delay calculating from the original scheduled departure flight time)	.....									
<input type="checkbox"/> <b>Damage or Loss of Laptop Computer</b>	.....									
<input type="checkbox"/> <b>Missed Travel Connection</b> (state number of hours .....) (no onwards flight connection is available within 6 consecutive hours from the previous missed scheduled departure flight)	.....									
<input type="checkbox"/> <b>Rental Vehicle Excess</b>	.....									
<input type="checkbox"/> <b>Personal Liability</b> (indemnify Insured Person in respect of legal liability up to the benefit amounts stated)	.....									
<input type="checkbox"/> <b>Aircraft Hijacking</b> (flat payment for every 12 consecutive hours period of hijacking)	.....									
<input type="checkbox"/> <b>Replacement Expenses</b> (reimbursement for reasonable travel fare and other essential travel expenses incurred in sending a substitute person to complete the original Insured Person's journey)	.....									

	<b>Amount Claimed</b> .....
<input type="checkbox"/> <b>Terrorism</b>	.....
<input type="checkbox"/> <b>Legal Expenses</b> (legal fees incurred as a result of false arrest or wrongful detention by any government)	.....
<input type="checkbox"/> <b>Home Care</b> (compensates for physical loss or damage caused by burglary to household contents within Insured Person residence in Malaysia that was left vacant)	.....
<input type="checkbox"/> <b>Political &amp; Natural Disaster Expenses</b>	.....

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: .....