



ace insurance

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**TRAVEL CLAIM FORM**



\*SG013\*

**TO FACILITATE THE PROCESSING OF YOUR CLAIM, YOU ARE REQUIRED TO COMPLETE SECTION A & B FOR ALL CLAIM SUBMISSIONS.**  
The issue and acceptance of this form does NOT constitute an admission of liability by the Company or waiver of its rights.

**SECTION A: PARTICULARS OF POLICYHOLDER / INSURED PERSON AND CLAIMANT**

Name & Address of Policyholder/Insured Person:	Policy No.:	Period of Insurance:
	NRIC No.:	Tel No. (Office):
	Date of Birth:	Tel No. (Residence):
	Age:	E-mail Address:
	Nationality:	Name of Intermediary (if any):
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Occupation:	
	Date Of Employment:	
Name & Address of Claimant: (if different from Insured Person)	NRIC No.:	Tel. No. (Office):
	Date of Birth:	Tel. No. (Residence):
	Age:	E-mail Address:
	Nationality:	Relationship to Insured Person:
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Occupation:	
	Date Of Employment:	

**SECTION B: DETAILS OF THE INCIDENT/LOSS/ILLNESS**

Chronology Event of the Accident/Loss/Illness:	Period of Travel: _____	
	Country: <input type="checkbox"/> Singapore <input type="checkbox"/> Malaysia <input type="checkbox"/> Others: _____	
	Place of Accident/Loss/Illness:	
	Date of Accident/Loss/Illness:	Time of Accident/Loss/Illness:
	When and Who discovered the Accident/Loss:	Relationship:
Name & Address of any witnesses of the Accident/Loss:	NRIC/Passport:	
	Contact No.:	

**SECTION C: PERSONAL ACCIDENT/ILLNESS – MEDICAL AND ADDITIONAL EXPENSES**

**Please note:**

- 1) **Personal Accident** – please enclose **Police Report (if any), Detailed Medical Report, and Original Medical Certificate.**
- 2) **Medical or Post Journey Medical Expenses** – please enclose **Original Detailed Pre-Medical/Final Hospitalization/Post-Medical Bills, Detailed Medical Report/Memo from Attending Physician on the type of illness or injury sustained.**
- 3) **Emergency Travel Expenses** – please enclose **Certified True Copy of Death Certificate & Proof of Relationship or written advice from the Attending Physician indicating the need to travel to or remain with the Insured Person with Original Hospital Bill & Receipts of travel and accommodation expenses incurred.**

<p>1. Is it due to Illness:    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Type of Illness:</p> <p>_____</p> <p>2. Have you ever had this or similar condition?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Is this a Routine Check-up?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>3. Is it due to Accident:   <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Date of Accident: _____</p> <p>4. Is Claimant on Home Leave?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p>1. When did first symptoms appear? _____</p> <p>When did you first receive medical attention for this condition? Name &amp; Address of Attending Physician?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>2. If Yes, please provide details, dates and name &amp; address of the Attending Physician.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>3. If Yes, please provide details of the Accident &amp; Injury?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<b>AMOUNT PAID BY YOU:</b>	<b>AMOUNT RECOVERED FROM OTHER SOURCES:</b>	<b>AMOUNT CLAIMED:</b>

**SECTION D: CANCELLATION/CURTAILMENT**

**Please note:**

- 1) **Please enclose documentary proof on relevant expenses incurred as a result of this trip cancellation or curtailment, original booking invoice, Death Certificate, Medical Report &/or Written Memo from Attending Physician to cancel trip, Proof of Relationship, Travel Agents' confirmation of the amount of refund.**
- 2) **Original Invoice/Receipt of charges incurred in amending or purchasing additional air ticket (for Trip Curtailment).**

When and Where was holiday booked?	Intended Departure Date:	
Reason of Cancellation / Curtailment?	Date Cancelled:	
<b>AMOUNT PAID BY YOU:</b>	<b>AMOUNT RECOVERED FROM OTHER SOURCES:</b>	<b>AMOUNT CLAIMED:</b>

### SECTION E: PERSONAL EFFECTS

Please note: Losses must be reported to the Police Authority, responsible Hotel Management or responsible officer of any aircraft, vessel/ conveyance within 24 hours from the date of occurrence.

- 1) Please enclose Police Report or report issued by responsible Hotel Management or carrier evidencing such losses, Property Irregularity Report for losses in carriers' custody, Original Purchases Bills, Photographs of damaged items, Original Repair Bills for damaged items, If the responsible Hotel Management or carrier has made compensation to the damaged/lost items, please request them to issue a note or letter certifying the amount of money paid to you.

#### Details of Amount Claimed *(Please use supplementary sheet if necessary)*

DESCRIPTION OF ITEM	WHEN AND WHERE PURCHASED	ORIGINAL PURCHASE PRICE	AMOUNT RECOVERED FROM OTHER SOURCES	AMOUNT CLAIMED

### SECTION F: PERSONAL MONEY/TRAVEL DOCUMENTS

Please note: Losses must be reported to the Police Authority, responsible Hotel Management or responsible officer of any aircraft, vessel/ conveyance within 24 hours from the date of occurrence.

- 1) Please enclose Police Report or report issued by responsible Hotel Management or carrier evidencing such losses, Original Receipts for replacement of travel documents, Original Transportation / Hotel Bills incurred for replacement of travel documents.

#### Details of Amount Claimed *(Please use supplementary sheet if necessary)*

AMOUNT LOST	AMOUNT RECOVERED FROM OTHER SOURCES	AMOUNT CLAIMED

### SECTION G: FLIGHT DELAY/BAGGAGE DELAY

Please Note: Departure and Arrival Point must be the Insured Person's Country of Residence.

- 1) **Flight Delay** – to enclose travel itinerary, boarding pass showing the actual take off time & date, written confirmation from carrier/airline or their agents specifying reason and hours of delay.
- 2) **Baggage Delay** – to enclose travel itinerary, written confirmation from carrier/airline or their agents specifying reason and the number of hours of baggage delay, Property Irregularity Report, Acknowledgement Receipt of baggage received.

ORIGINAL FLIGHT DETAILS	DELAYED FLIGHT DETAILS	COLLECTION OF DELAYED BAGGAGE
Original Departure Date, Time and Place:	Rescheduled Departure Date, Time and Place:	Original Delay Date, Time and Place:
Original Arrival Date, Time and Place:	Rescheduled Date, Time and Place:	
Flight No.:	Flight No.:	Received Date, Time and Place:
Name of Airline:	Name of Airline:	
<b>EXPENSES INCURRED BY YOU:</b>	<b>AMOUNT RECOVERED FROM OTHER SOURCES:</b>	<b>AMOUNT CLAIMED:</b>

## SECTION H: PERSONAL LIABILITY

**Please note: In no circumstances should the issue on legal liability be admitted to any third party claimant(s)**

**1) Please enclose letters/writes/summons from the third party/police/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 accident / damage?		
Names & addresses of the other party(s)		
Nature of personal injury sustained by any person	<b>Name / Age</b>	<b>Nature of Injury</b>
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 Section C to H)

Name of Police Station, Carrier/Airline or other authorities where Report lodged (if applicable):

DETAILS OF CLAIM <i>(Please use supplementary sheet if necessary)</i>	AMOUNT CLAIMED

## SECTION J: ANY OTHER INSURANCES *(Please use supplementary sheet if necessary)*

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).

## SECTION K: CLAIMS HISTORY *(Please use supplementary sheet if necessary)*

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

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: \_\_\_\_\_  
(Name As Per Identification Card and/or Bank Account)

\_\_\_\_\_  
Signature of Insured  
(Please affix company stamp if applicable)

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Insured Person

Date: \_\_\_\_\_

\_\_\_\_\_  
Name & Signature of Insured's Direct Manager

Date: \_\_\_\_\_