



Thomas Smith Insurance Agency Ltd.

Travel Claim Form

(The Issue of this form is not an admission of Liability)

IMPORTANT NOTE

The Company, their Agents and Insurance Association share information with each other to prevent fraudulent claims and for underwriting purposes. In the event of a claim, some or all of the information you supply on this form and the proposal form together with other information relating to the claim may be provided to other Insurers, their Agents and Insurance Associations.

Kindly complete this form fully by ensuring that every question is answered

Name of First Insured	Policy Number Plan Operative
Claimant's Name Email Address	Telephone Number Mobile Number
Address	ID Card No Age Occupation
<p>Have you ever claimed under a travel policy? If yes please give details</p> <hr/> <p>Are you insured by any other policy in respect of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, kindly give name and address of Insurers and Policy Number</p> <hr/> <hr/>	

KINDLY COMPLETE SECTION 1 OR 2 AS APPLICABLE

Section 1 - Personal Accident

Accident: Date _____ Time _____ Place _____

Give full description of the circumstances and details of the injury _____

Name & addresses of witnesses _____

Have You been totally disabled as a result of this accident? _____

When did total disablement start? _____

Are You still totally disabled? _____

When do You expect to resume part, if not all, normal occupation/business? _____

Kindly also complete the MEDICAL INFORMATION section below

Section 2 - Medical & Incidental Expenses

Give full details of injury or illness necessitating medical attention, including date of commencement _____

Kindly complete the MEDICAL INFORMATION section below

Kindly detail all the expenses incurred and attach receipts _____

Section 3 - Hospital Cash Benefit

Kindly give full details why You have been admitted to hospital as an in-patient _____

Date & Time admitted to hospital _____

Date & Time discharged from hospital _____

Kindly attach letter from hospital confirming dates and times of both admittance & discharge

Section 4 – Cancellation Expenses

What is the reason for cancellation? _____

Date event leading to the Cancellation _____

In the event cancellation is due to death, injury or illness kindly complete the MEDICAL INFORMATION section below

Kindly advise the amounts being claimed and also attach receipts _____

Have any monies been recovered? Yes No

If Yes, state amount _____ IF NO WHAT STEPS HAVE BEEN TAKEN TO OBTAIN RECOVERY OF THESE MONIES – please enclose copies of all correspondence exchanged

Are these amounts non-recoverable? Yes No

(Kindly attach any relevant booking conditions If cancellation because of death please include copy of death certificate noting clearly the cause of death)

MEDICAL INFORMATION – this is to be completed for claims being made under Section 1,2 & 3

Name & address of doctor giving initial treatment in respect of the death injury or illness _____

a) Has the person concerned ever suffered from this type of illness or injury before? YES/NO

If YES, kindly give full details _____

b) If not claimant, give name, address and relationship _____

c) Give full Name & Address of usual doctor _____

d) Has he been consulted in respect of this illness or injury? [] Yes [] No

e) When and why was he consulted the last by the concerned? _____

Section 5 – Baggage & Loss of Money

Date of loss or damage _____ Time _____

Place _____

Give FULL details on the circumstances in which loss or damage occurred _____

Give Name & Address of Witnesses _____

Kindly state the reasons for the delayed departure _____

KINDLY ATTACH WRITTEN CONFIRMATION FROM THE CARRIER/HANDLING AGENT

Section 8 - Loss of Passport

Kindly list details of additional travel or accommodation expenses incurred as a result of the loss of your passport _____

How did the additional travel & accommodation expenses be incurred? _____

DECLARATION

I/We hereby declare that the information given above, are full and complete and to the best of my/our knowledge and belief are correct in every respect/ I/We consent to the seeking of information from other Insurers, their Agents and Insurance Associations to check the answers I/We have provided and I/We authorise the giving of such information for such purposes.

Date _____ Signature of Policyholder _____

Date _____ Signature of Claimant _____