**Direct Asia Insurance (Singapore) Pte Ltd**
88 South Bridge Road, Singapore 058716

**Claims Hotline:** 6532 1818
**Email:** claim@directasia.com
Company registration: 200822611G

# TRAVEL CLAIM FORM

| **Policy Number:** | |
|---|---|

**Important Notice:**

- Please complete this form and submit it with the supporting documents within 30 days from the date of the event to avoid delay in processing your claim.
- If we ask for any documents or report, you will have to pay the costs of obtaining them.
- Where applicable, all documents must be translated into English by a certified translator.
- If we accept this form, it does not mean we are taking legal responsibility for your claim.

| **Personal Details of Policyholder** | | | |
|---|---|---|---|
| Name (as shown in NRIC, FIN or Passport): | NRIC, FIN or Passport Number | Gender ☐ Male ☐ Female | Date of Birth (dd/mm/yyyy) |
| Home Address | | Occupation | |
| Contact Number (Mobile) (Home) (Office) | | Email | |

| **Personal Details of Insured/Claimant** (You may skip this section if the insured/claimant is the policyholder) | | | |
|---|---|---|---|
| Name (as shown in NRIC, FIN or Passport) | NRIC, FIN or Passport Number | Gender ☐ Male ☐ Female | Date of Birth (dd/mm/yyyy) |
| Home Address | | Occupation | |
| Contact Number (Mobile) (Home) (Office) | | Email | |

| **Claim Payment Details** (We will pay by cheque to you/insured/claimant or their legal representative (for death claim)) | |
|---|---|
| Full Name (as shown in bank account) | NRIC, FIN or Passport Number |

| **Incident Details** | | |
|---|---|---|
| Date of Occurrence (dd/mm/yyyy) | Time of Occurrence ☐ AM ☐ PM | Country or City of Occurrence |
| Description of incident, injury or illness | | |

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| **Types of Claims** |
|---|
| **Accidental Death/Total Permanent Disablement/Medical Expenses**<br>(To attached additional page if required) |
| Diagnosis/Nature of injury or illness |
| Did the injuries result in permanent disability? ☐ Yes ☐ No<br>If yes, please describe which part(s) of the body is/are affected |

| Date Incurred | Details of Expenses | Amount Claimed (S$) |
|---|---|---|
| | | |
| | | |
| | | |

| **Trip Cancellation / Disruption** | | |
|---|---|---|
| Reason of Trip Cancellation/Disruption | | |
| Date of Cancellation/Actual Date of Departure (dd/mm/yyyy) | Scheduled Date of Departure (dd/mm/yyyy) | |
| Total Amount Paid (S$) | Refund Received and Source | Amount Claimed (S$) |

| **Travel Delay** | | |
|---|---|---|
| Scheduled Flight/Vessel/Coach/Train Number | Scheduled Date of Departure (dd/mm/yyyy) | Scheduled Time of Departure (am/pm) |
| Scheduled Place of Departure | Name of airport / port / station | |
| Actual Flight/Vessel/Coach/Train Number | Actual Date of Departure (dd/mm/yyyy) | Actual Time of Departure (am/pm) |
| Actual Place of Departure | Name of Airport/Port/Station | |
| **Delayed Baggage** | | |
| Flight/Vessel/Coach/Train Number | Date of Departure (dd/mm/yyyy) | Time of Departure (am/pm) |
| Place of Departure | Name of Airport/Port/Station | |
| Date of Baggage Collection (dd/mm/yyyy) | Time of Baggage Collection (am/pm) | Place of Baggage Collection |

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| **Loss or Damage to Personal Possessions**<br>(To attached additional page if required) | | | | |
|---|---|---|---|---|
| Description of The Lost or Damaged Item | Date of Purchase (dd/mm/yyyy) | Place of Purchase | Original Price (S$) | Amount Claimed (S$) |
| | | | | |
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| | | | | |
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| **Rental Car Excess** | | |
|---|---|---|
| Date of Accident (dd/mm/yyyy) | Time of Accident<br>(am/pm) | Location of Accident |
| Total Amount Paid (S$) | | Amount Claimed (S$) |

| **Other Insurance(s) Covering You for This Claim**<br>(To attached additional page if required) | | | |
|---|---|---|---|
| Insurance Company | Type of Policy | Policy Number | Compensation Amount (S$) |
| | | | |
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# MEDICAL REPORT

This report to be completed by the attending medical practitioner and specialist (if any).

**Section A**

| 1. Name of patient (as shown in NRIC, FIN or Passport): | 2. NRIC, FIN or Passport Number | 3. Gender ☐ Male ☐ Female |
|---|---|---|

| 4. Date of first attend to condition and nature of treatment | 5. Approximate date of discovery of the illness/injury |
|---|---|

6. Did the patient have any symptoms prior to consulting you? ☐ Yes ☐ No

If yes, please state the symptoms and when it first started

7. If this condition existed before symptoms were apparent to the patient, when did this condition first develop?

| 8. Cause of the illness/injury | 9. Final diagnosis of illness or extent of injury |
|---|---|

10. Please state the surgical procedures/treatment rendered and the dates. If no surgery was performed, please state treatment/medication given

| Admission/Discharge/Surgery Date | Surgical Procedure | Name of Physician/Surgeon/Anesthetist |
|---|---|---|
| | | |

11. Was the patient referred by any doctor to see you? ☐ Yes ☐ No

If yes, please state the name and address of the referring doctor

12. Has the patient previously consulted other doctors for the same or similar condition? ☐ Yes ☐ No

If yes, please state the name and address of all the other doctor

**Section B** (To be completed only if injury has resulted or is likely to result in disablement)

13. Is the injury likely to cause loss of use of the part(s) injured? ☐ Yes ☐ No

If yes, please specify
a) The affected part

b) If the loss is related to finger/toe injuries, please state the affected phalanx and on which finger/toe

| 14. What is the percentage of disablement sustained? | 15. Does the patient require follow-up treatment? ☐ Yes ☐ No |
|---|---|

| 16. How long has the patient been disabled from engaging in or attending to usual business as the sole result of the injuries? From _____ To _____ | 17. How much longer do you foresee that such disablement will continue? From _____ To _____ |
|---|---|

18. Is the patient's disablement associated, contributed, or affected by any past illness, injury or accident? If so, please give details:

**Declaration**

I certify that I have personally examined and treated this patient and that the answers are true to the best of my knowledge and belief, and no material fact has been concealed from DirectAsia.

| Name of medical practitioner | Clinic/Hospital Stamp & Address |
|---|---|
| Signature & Date | |

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## List of Supporting Documents

**Accidental Death**

- Copy of your travel itinerary/air ticket
- Proof of relationship between deceased and claimant
- Certified true copy of death certificate
- Certified true copy of letters of administration/grant of probate (if any)
- Copy of police report/road traffic accident report (if applicable)
- Certified true copy of coroner's/post-mortem/autopsy report (if applicable)

**Total & Permanent Disablement**

- Copy of your travel itinerary/air ticket
- Medical report (to be completed by attending physician)
- Any other available medical reports
- Copies of medical leave certificates
- Copy of police report/road traffic accident report (if applicable)

**Medical Expenses**

- Copy of your travel itinerary/air ticket
- Copy of medical bills/receipts
- Any available medical reports/inpatient discharge summary
- Copy of police report/road traffic accident report (if applicable)

Note: All medical bills must indicate the breakdown of the expenses incurred and the doctor's diagnosis must be clearly stated. We reserve the right to request for additional medical information.

**Loss of Personal Possessions**

- Copy of your travel itinerary/air ticket
- Copy of police report at place of loss and/or airline/other transport operator property irregularity report
- Copy of purchase receipts/invoices of items lost/repair receipts and warranty card
- Photographs of damaged items (damaged items must not be disposed without our consent)

**Delayed Baggage**

- Copy of your travel itinerary/air ticket
- Acknowledgement slip or confirmation from airline/other transport operator on date and time baggage was returned

**Trip Cancellation/Disruption**

- Copy of your travel itinerary/air ticket
- Relevant documents to substantiate the reason for trip being cancelled:
  - Certified true copy of death certificate of deceased if due to death
  - Medical certificate/report of patient if due to serious sickness/ injury
  - Documents to substantiate insolvency of travel agency/airline (For trip disruption claim)
- Documentary proof of relationship between policyholder and deceased/injured/sick person
- Copy of receipts/invoices of advance payments and additional expenses incurred
- Confirmation from the travel agency/airline/other transport operator/hotel and/or any other relevant sources on the cost of non-refundable prepaid travelling expenses

**Travel Delay**

- Copy of your travel itinerary/air ticket
- Written confirmation from airline/other transport operator stating period of delay, reason and any remedial actions taken
- Written confirmation from airline/other transport operator stating reason and amount of refund if scheduled departure is cancelled

**Rental Car Excess**

- Copy of your travel itinerary/air ticket
- Rental car agreement
- Copy of invoice for payment of excess
- Copy of police report/road traffic accident report (if applicable)

**Personal Liability**

- Copy of your travel itinerary/air ticket
- All correspondence/documents from third parties for our handling
- Copy of police report/road traffic accident report (if applicable)
- Any photographs where applicable

**Do not to admit any liability or make any offer, promise or payment without our prior consent.**

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**Pet Hotel**

- Copy of your travel itinerary/air ticket
- Copy of pet license
- Copy of invoices for pet lodging/hotel
- Written confirmation from pet lodging/hotel stating scheduled original and actual collection time
- Relevant documents to substantiate the reason for delay in collecting pet:
  - Written confirmation from airline/other transport operator stating period of delay and reason if due to travel delay
  - Medical certificate/report (if applicable)

**Declaration**

1. I declare that the information given on this form is to the best of my knowledge and belief, true, correct and complete.

2. I understand that my claim may be rejected or my policy may be treated as void, if I have made any false or fraudulent statement or deliberately left out any relevant information, relating to the incident(s) on this form or in any document provided.

3. In connection with the claim(s) submitted in this form, I give consent for DirectAsia and this respective representatives to collect, use, store, transfer and/or disclose my personal data and other information on this form and in any document provided (including that provided by sources other than myself) concerning me, to or with such persons (including any member of DirectAsia or any third party service providers, intermediaries and/or business partners of DirectAsia, and whether in or outside Singapore) for purposes which includes enabling DirectAsia to provide me with the services required of an insurance provider, including the evaluating, processing, administering and/or managing of my/our policy/policies, account(s), and/or claim(s) with DirectAsia (as the case may be), and for other purposes and uses set out in DirectAsia's Privacy Policy which can be found at www.directasia.com/security-privacy, which I have read and accepted the terms thereof.

4. I hereby authorize any medical practitioner, specialist, clinic hospital or any other party who has attended or examined me, to furnish to DirectAsia and their respective representatives any and all information on my injury, sickness, medical history, prescription(s) or treatment, with copies of all clinic/hospital admission and/or medical records. A copy of this authorization shall be considered as effective and valid as the original.

| | |
|---|---|
| Signature of Policyholder<br>Company's stamp (if applicable) | Signature of Insured/Claimant<br>(If the Insured/Claimant is not the Policyholder) |
| Date | Date |