

Travel Claim Submission Checklist

We are sorry to hear of your accident/loss. In order for us to consider your claim, please complete the Travel Claim Form and submit it with:

- 1) A copy of your passport with departure and return dates/air tickets/boarding pass;
- 2) A copy of your travel itinerary;
- 3) Any written confirmation from any relevant sources stating any compensation paid or payable;

and the relevant documents listed below within thirty (30) days from the date of return from your trip. Thank you.

Please tick the section(s) that you are claiming for	Documents needed
<input type="checkbox"/> Accidental Death	<ul style="list-style-type: none"> - 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)
<input type="checkbox"/> Total & Permanent Disablement	<ul style="list-style-type: none"> - 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)
<input type="checkbox"/> Medical Expenses	<ul style="list-style-type: none"> - Original final medical bills/receipts - Any available medical reports/inpatient discharge summary - Copy of police report/road traffic accident report (if applicable) <p>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.</p>
<input type="checkbox"/> Loss of Personal Possessions	<ul style="list-style-type: none"> - Copy of police report at place of loss and/or airline/other transport operator property irregularity report - Original purchase receipts/invoices of items lost - Photographs of damaged items (damaged items must not be disposed without our consent) - Original repair receipts/invoices and warranty card
<input type="checkbox"/> Delayed Baggage	<ul style="list-style-type: none"> - Airline/other transport operator property irregularity report - Acknowledgement slip or confirmation from airline/other transport operator on date and time baggage was returned
<input type="checkbox"/> Travel Cancellation	<ul style="list-style-type: none"> - Relevant documents to substantiate the reason for trip being cancelled: <ul style="list-style-type: none"> o Certified true copy of death certificate of deceased if due to death o Medical certificate/report of patient if due to serious sickness/ injury o Documents to substantiate insolvency of travel agency/airline - Documentary proof of relationship between policyholder and deceased/injured/sick person - Original 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

Please tick the section(s) that you are claiming for	Documents needed
<input type="checkbox"/> Trip Cut-Short	<ul style="list-style-type: none"> - Relevant documents to substantiate the reason for trip being curtailed: <ul style="list-style-type: none"> o Certified true copy of death certificate of deceased if due to death o Medical certificate/report of patient if due to serious sickness/injury - Documentary proof of relationship between policyholder and deceased/injured/sick person - Original 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
<input type="checkbox"/> Travel Delay	<ul style="list-style-type: none"> - 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
<input type="checkbox"/> Rental Car Excess	<ul style="list-style-type: none"> - Rental car agreement - Copy of police report/road traffic accident report (if applicable) - Original invoice for payment of excess
<input type="checkbox"/> Personal Liability	<ul style="list-style-type: none"> - All correspondence/documents from third parties for our handling - Copy of police report/road traffic accident report (if applicable) - Any photographs where applicable <p>Do not to admit any liability or make any offer, promise or payment without our prior consent.</p>
<input type="checkbox"/> Pet Hotel	<ul style="list-style-type: none"> - Copy of pet license - Original 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: <ul style="list-style-type: none"> o Written confirmation from airline/other transport operator stating period of delay and reason if due to travel delay o Medical certificate/report (if applicable)

We would also like to highlight that:

- Any cost of obtaining documents is not reimbursable under the policy.
- Where applicable, all documents must be translated into English.

You may send your claim documents to our office at:

TRAVEL CLAIMS
Direct Asia Insurance (Singapore) Pte Ltd
88 South Bridge Road
Singapore 058716

If you need any assistance, please call us at **6532 1818** or email us at
Claim@DirectAsia.com

Travel Claim Form

* To delete appropriately

1. Policyholder's Details

Name (as in NRIC/Passport): <i>Mr/Miss/Mrs/Mdm/Dr*</i>	NRIC/Passport number:	Policy number:
Occupation:	Email:	
Contact numbers: (O) _____ (H) _____ (HP) _____		

2. Claimant's Details (If Claimant is different from Policyholder)

Name (as in NRIC/Passport): <i>Mr/Miss/Mrs/Mdm/Dr*</i>	NRIC/Passport number:	Occupation:
Date of birth: (dd/mm/yyyy):	Email:	
Contact numbers: (O) _____ (H) _____ (HP) _____		

3. Incident Details

Date of occurrence (dd/mm/yyyy):	Country/City of occurrence:
Time of occurrence: _____ <i>am/pm*</i>	
Please describe to us the incident in detail from :	

4. Travel Details (You may skip this section if your itinerary is included)

Duration of trip (dd/mm/yyyy)	From:	To:
Departure		
Place of departure:	Name of airport/port/station:	Flight/Vessel number:
Date of departure (dd/mm/yyyy):	Time of departure: <i>am/pm*</i>	
Transit (You may skip this portion if there was no transfer of flight/vessel)		
Place of departure:	Name of airport/port/station:	Flight/Vessel number:
Date of departure (dd/mm/yyyy):	Time of departure: _____ <i>am/pm*</i>	
Arrival		
Place of arrival:	Name of airport/port/station:	Flight/Vessel number:
Date of arrival (dd/mm/yyyy):	Time of arrival: _____ <i>am/pm*</i>	

5. Types of claim

ACCIDENTAL DEATH/TOTAL PERMANENT DISABLEMENT/MEDICAL EXPENSES

Diagnosis/Nature of injury or illness: _____

Did these injuries result in permanent disability? Yes No

Date Incurred	Details of Expenses	Amount Claimed (S\$)

You may include a separate list if there is insufficient space provided above.

TRAVEL CANCELLATION

Reason:		
Date of cancellation (dd/mm/yyyy):		Scheduled date of departure (dd/mm/yyyy):
Total amount paid:	Refund received and source:	Amount claimed:

TRAVEL CUT-SHORT

Reason:		
Actual date of departure (dd/mm/yyyy):		Scheduled date of departure (dd/mm/yyyy):
Total amount paid:	Refund received and source:	Amount claimed:

TRAVEL DELAY

Scheduled Flight/Vessel Details	Actual Flight/Vessel Details
Flight/Vessel number:	Flight/Vessel number:
Date and time of departure:	Date and time of departure:
Place of departure & name of airport/port/station:	Place of departure & name of airport/port/station:

DELAYED BAGGAGE

Scheduled flight/vessel number:	Date baggage collected (dd/mm/yyyy):
Date and time of departure:	Time of collection: am/pm*
Place of departure and name of airport/port/station:	Place of collection:

LOSS OF OR DAMAGE TO PERSONAL POSSESSIONS

Description of Item Lost or Damaged	Date of Purchase	Place of Purchase	Original Purchase Price	Amount claimed (S\$)

You may include a separate list if there is insufficient space provided above.

If you are entitled to claim under any other insurance policy, (eg. other travel, personal accident, pet insurances), please provide us the details of those policies:

Insurance Company	Type of Policy	Policy Number	Compensation Amount (S\$)

Have you made any claims against any of the above insurers? Yes No

6. Bank Details

Please provide your bank details below for reimbursement directly into your local bank account.

Bank Account Holder Name	Bank Name	Branch Code	Bank Account No.

7. Declaration

I declare that all the particulars given by me in this form are true and correct.

I agree that my claim may be reduced or denied and the Policy may be cancelled if I have made or were to make any false or fraudulent statements, or have withheld material facts in respect of this claim.

I also consent to DirectAsia.com obtaining information from hospitals, physicians and any other person I have consulted and I hereby authorize the giving of such information. I also agree to execute all necessary authorizations or documents for the release of such information to DirectAsia.com. A photocopy of this authorization shall be considered as effective and valid as the original.

Name

Signature

NRIC/Passport Number

Date

Medical Report

This report is to be completed by the Attending Physician. Dates should be in DD/MM/YYYY format.

Section A	
1) Name of patient (as in NRIC/Passport): <i>Mr/Miss/Mrs/Mdm/Dr*</i>	2) NRIC/Passport number:
3) When did you first attend to the patient for this condition and what was the nature of treatment?	4) When was the approximate date of discovery of the illness/injury?
5) Did the patient have any symptoms prior to consulting you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state the symptoms and when it first started:	6) If this condition existed before symptoms were apparent to the patient, when did this condition first develop?
7) What is the cause of the illness/injury?	8) What is the final diagnosis of illness or extent of injury?
9) Please state the surgical procedures/treatment rendered and the dates. If no surgery was performed, please state treatment/medication given. <u>Admission/Discharge/Surgery Date</u> <u>Surgical Procedure</u> <u>Name of Physician/Surgeon/Anaesthetist</u>	
10) Was the patient referred by any doctor to see you? <input type="checkbox"/> Yes <input type="checkbox"/> No Please state the name and address of the referring doctor:	
11) Has the patient previously consulted other doctors for the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Please state the name and address of all the other doctors: <u>Name</u> <u>First Consultation Date</u> <u>Name of clinic & address</u>	
Section B (To be completed only if the injury has resulted or is likely to result in disablement.)	
12) Is the injury likely to cause loss of use of the part(s) injured? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	
13) What is the percentage of disablement sustained?	14) Does the patient require follow-up treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
15) How long has the patient been disabled from engaging in or attending to usual business as the sole result of the injuries? From _____ to _____	
16) How much longer do you foresee that such disablement will continue? From _____ to _____	
17) Is the patient's disablement associated, contributed, or affected by any past illness, injury or accident? If so, please give details:	
Section C	
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.com.	
Name & Designation:	Signature:
Date:	Clinic/Hospital Stamp & Address: