



The Issue of this form is not an admission of liability on the part of the Company

**TRAVEL CLAIM FORM**

Name of Insured: \_\_\_\_\_ Policy No: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone No: \_\_\_\_\_

**PLEASE READ CAREFULLY** To enable us to assist you PLEASE  
• Complete all relevant questions fully.  
• Enclose any receipts, invoices, Flight/Baggage delayed report, Medical Bills, Medical Report, proofs or certificates with the claim form.  
• **IN ALL CASES** enclose a copy of your Insurance Policy or Certificate.

**SECTION A: Travel Baggage/Money/Documents/Personal Effects**

Date of Loss/Damage:	_____	Time of Loss/Damage:	_____
Place of Loss/Damage:	_____		
Was the Loss reported to the Local Police? YES <input type="checkbox"/> NO <input type="checkbox"/> (If Yes, please provide a copy of the police report)			
Please explain what happened:			

Is there any other Insurance in force providing cover for this loss? YES  NO  If so, please advise:

Name of Insurer: \_\_\_\_\_ Policy No: \_\_\_\_\_

**SCHEDULE OF LOST OR DAMAGED ITEMS:**

Description	Where Purchased	Date Purchased	Purchase Price	Replacement Cost

**SECTION B: Delayed Baggage**

Flight No: _____	Flight From: _____	Flight To: _____
Schedule Date & Time of Arrival: _____	Date & Time Baggage was delivered to the Destination: _____	
Cost of Emergency Purchase of Essential Clothing & Requisites: _____		

**SECTION C: Travel Delay**

Date & Time of Departure: _____	Departing From: _____
Final Destination: _____	Flight No: _____
Schedule Date & Time of Arrival: _____	Date & Time of Actual Arrival: _____

Date of Cancellation: \_\_\_\_\_

Cost Incurred:

Reason for Claim: \_\_\_\_\_

Name of Sick/Injured Person: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Amount Claim: \_\_\_\_\_

**SECTION E: Overseas Medical Expenses/Personal Accident**

**DETAILS OF ILLNESS OR INJURY**

Name of Claimant:	Occupation:
Give brief details of nature of illness or injury	
In case of injury, state the date and give brief details of the cause:	
Date of symptoms first appeared:	
If treatment is continuing, by what date do you consider that all treatment will be finalized?	

**DECLARATION BY INSURED**

Are all the medical expenses claimed in respect of one injury or illness?
Are all or any part of claims recoverable from any other source? If so, from what source and to what extent?
Have you ever made a claim for compensation in respect of accidental injury/illness from any insurer? If so, state name of Company, amount and date received.
Have you ever suffered from or experienced the symptoms of this or like condition before? If so, please state date and period of treatment and name of medical attendant.
Are you still totally unable to perform any portion of your duties?

\_\_\_\_\_ of \_\_\_\_\_  
Medical Authority to Dr. \_\_\_\_\_

I hereby authorize you, or any physician, surgeon or other person in your employ or associated with you, to provide HSBC Insurance (Asia) Limited with any or all information of a medical or surgical nature that you may have regarding me and/or any member of my family. A photo copy of this authorization shall be considered as effective and valid as the original.

Name/Signature of Claimant: \_\_\_\_\_ Date: \_\_\_\_\_

I/We declare that I/We have not withheld any material information and that all statements made on this form are true to the best of my/our knowledge and belief and that the articles and property described overleaf belong to me/us, and that no other person has any interest thereon whether as Owner, Mortgagee, Trustee and otherwise except as mentioned in the Policy.

Name/Signature of Insured:	Date:
Name and Address of Witness:	
Signature of Witness:	NRIC/Passport No: