

Claim Form: Travel

Please complete all sections to facilitate the processing of your claims.

1. Proof of travel i.e. Copy of Arrival/Departure stamps or boarding pass together with passport copy
2. This form is issued without admission of liability
3. Any documentary proof or report required by Liberty Insurance shall be furnished at the expense of the Policyholder or Claimant

Information of Policyholder

Name of Policyholder:	Policy No.:
<hr/>	<hr/>

Information of Claimant

Name of Claimant:	NRIC/FIN No.:
<hr/>	<hr/>
Email:	Contact No.:
<hr/>	<hr/>

Mailing Address:	Postal Code ()
<hr/>	<hr/>

Gender:	Occupation:
<input type="checkbox"/> Female <input type="checkbox"/> Male	<hr/>

Please advise Period of Travel for this trip.	From:	To:
<hr/>	<hr/>	<hr/>

Are there any other policies of insurance in-force covering you in respect of this event?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If Yes, please state:

Name of Insurance Company:	Policy No.:
<hr/>	<hr/>

Are you making a claim for the same event from another source/policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If Yes, please state:

Claim Details:	Amount Claimed:
<hr/>	<hr/>

Was there any compensation provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If Yes, please state:

Amount of Compensation:
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Have you ever had any previous claims?

☐ Yes

☐ No

If Yes, please state:

Name of Insurance Company:

Date of Previous Claims:

Circumstances:

Amount Claimed:

Details of Accident/Loss/Injury/Sickness

Date of Travel Period:

Date of Accident/Loss/Injury/Sickness:

Time of Accident/Loss/Injury/Sickness:

Place of Accident/Loss/Injury/Sickness:

Brief Description of Accident/Loss/
Injury/Sickness:

Have you ever suffered any similar condition/recurrence of a previous illness or

☐ Yes

☐ No

injury?

If Yes, please provide details:

Amount Claimed in respect of Medical Expenses

Date of Treatment	Details of Medical Expenses Incurred	Currency & Amount Paid

Please provide original medical bills and/or medical reports/memo from the attending doctor stating the diagnosis or nature of the injury/sickness.

For all hospitalisations overseas, please obtain detailed medical reports from Doctor concerned.

Travel Delay/Flight Misconnection/Travel Diversion

Original Flight No.:	Original Departure Date:	Time of Departure:
		<input type="checkbox"/> AM <input type="checkbox"/> PM
Actual Flight No.:	Actual Departure Date:	Time of Departure:
		<input type="checkbox"/> AM <input type="checkbox"/> PM
Cause of Delay:	Length of Delay:	



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Please provide the following:

- E-ticket or original flight itinerary
- Letter from Transport Provider confirming the cause and number of hours of delay

Baggage Delay

Flight No.: _____	Flight Arrival Date: _____	Time of Arrival: <input type="checkbox"/> AM <input type="checkbox"/> PM
Baggage Collection Date: _____	Place of Baggage Collection: _____	Baggage Collection Time: <input type="checkbox"/> AM <input type="checkbox"/> PM

Please provide the following:

- E-ticket or original flight itinerary
- Property Irregularity Report
- Baggage Acknowledgement Slip

Trip Cancellation/Curtailment

Reason for Cancellation/Curtailment: _____		
Intended Date of Departure: _____	Date of Cancellation of Trip: _____	Amount Paid by You: _____
Amount Refunded: _____	Amount Claimed: _____	
If Trip/Curtailment has caused any medical condition, has the patient suffered from this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please state: Name of Doctor consulted: _____ Date of Consultation: _____		
Mailing Address: _____ Postal Code ()		

Please provide the following:

- Supporting documents for trip cancellation/curtailment
- Tour booking invoice/receipt
- Letter from Travel Agency/airline confirming the non-refundable amount of travel costs paid in advance

Loss/Damage to Baggage & Personal Effects, Loss of Money, Loss of Travel Documents

Date of Loss/Damage: _____	Time of Loss/Damage: _____	Place of Loss/Damage: _____
Please provide full details of circumstances leading to the loss/damage. (please retain damaged articles for inspection if necessary) _____		
Has this Loss/Damage been reported to the relevant authorities and police overseas? <input type="checkbox"/> Yes <input type="checkbox"/> No		



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If No, please state reasons:

State the amount of compensation from the service provider (if applicable)

Otherwise, please provide evidence of denial from service provider (if applicable)

Loss/Damage to Baggage & Personal Effects

Description of Property Lost/Damaged (Brand/Model)	Owner of Property	Date of Purchase	Original Purchase of Price	Original Receipts
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Please state reasons for non-submission of original receipts
(if applicable)

Please provide the following:

- Original purchase receipts/invoices of the lost/damaged items
- Written report(s) lodged with Police, Local Government Authority/Transport Provider/Singapore Embassy (whichever applicable)
- Photographs of damaged items

Others

If you have any other claim, which does not fall within the sections stated above, please provide details here:

Payment Details

Please select the claim payment mode.

☐ For payment by cheque

☐ For payment by direct transfer into Policyholder's bank account.

Please provide a copy of your bank account statement showing the Name of Bank, Name of Account Holder and Account Number for your initial claim submission.

Full name (as shown in the bank account):	Nationality:
<hr/>	<hr/>
Name of Bank:	Bank Account Number:
<hr/>	<hr/>

☐ For payment by PayNow

Please provide us with a copy of NRIC for verification purpose. The claim reimbursement can only be made to the Insured/Claimant and will be paid via transfer to your bank account linked by PayNow NRIC/FIN ID by default. Please ensure that you have signed up for PayNow with your bank by linking it to your NRIC/FIN ID.

NRIC/FIN ID:	UEN:
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INDEMNITY

The Company shall not be liable for any loss incurred by you as a result of you providing the Company with incorrect bank account details for the payment of your claim.

PAYMENT BEFORE COVER WARRANTY (INDIVIDUAL)

Please note that the total premium must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) on or before the inception date of the coverage, failing which the Policy shall be deemed to be automatically canceled and no benefits whatsoever shall be payable by the Company.

PERSONAL DATA PROTECTION

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, other insurers, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished in the past, present & in the future, for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing my policies, communicating with me, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If there is any personal data relating not to myself but to other individuals that I have furnished in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Insurance Pte Ltd and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

DECLARATION

- 1) I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorize the release of any medical information necessary to process this claim.

Date

Signature of Claimant

Date

Signature of Policyholder &
Company Stamp

