Allianz

Global Assistance

7th Floor, City Link Tower, 1091/335 Soi Petchburi 35
New Petchburi Road, Makkasan, Rajthevi, Bangkok 10400, Thailand
Tel. +66 (0) 2 342 3255 Fax +66 (0) 2 305 8523
Email claim@allianz-assistance.co.th

CLAIM FORM

In order for your claim to be dealt with promptly, please ensure **Sections 1, 2 and 3** of this Claim Form are fully completed and returned to us by post together with all the required claims evidence. A separate claim form must be completed for each Insured Person who is claiming under the policy.

Please use block letters. Please retain a copy of all documents sent to us for your records.

Claim No. _____ (office use only)

Please note all expenses incurred in completing this claim form and providing all the necessary evidence to support this claim must be paid by you. Expenses incurred in providing evidence are not covered under this policy.

In case you cannot provide the evidence(s) in, please provide a written justification in order for us to consider your claim. The Company reserve rights to decline your claim in case the provided evidence and/or justification is insufficient.

Section 1 – Customer and travel details (to be completed in all cases)

Policy number:			
Name of insured person:			
Nationality and country of residence:			
Passport number:			
Occupation of insured person:			
Date of birth of insured person:			
Address (to be used for correspondence):			
Telephone numbers:	Work:	Home:	Mobile:

Travel details

Date travel arrangements were booked:	
Date of departure:	Date of return:
Destination(s) – City in Thailand:	

Have you made any previous claims in respect of travel insurance: ☐ yes ☐ no

If yes, please provide exact details of claims (e.g. date, amount, type of claim and insurance company involved):

Please indicate which benefits you are claiming for under your policy: (tick the appropriate box/boxes)

- ☐ Medical expenses
- ☐ Loss of / damage to baggage or personal effects
- ☐ Travel delay/missed connecting travel
- ☐ Trip cancellation/curtailment
- ☐ Baggage delay
- ☐ Other expenses
- ☐ Accidental death

Important documents required to process the claim – Section A

Please attach the evidence to the Claim Form and tick the appropriate box. Failure to provide all necessary evidence will result in delays in handling your claim.

- ☐ Copy of policy schedule including itinerary page
- ☐ Certified copy of passport with Visa stamp (if applicable)
- ☐ Original air ticket, e-ticket, boarding pass or certified copy

Section 2 – Claim information

A. Travel delay/missed connecting travel

In order for your travel delay/missed connecting travel claim to be dealt with promptly, please ensure **Sections 1, 2.A and 3** of this claim form are fully completed and returned to us together with all the necessary claims evidence required at end of this section.

Please confirm the scheduled date and time you arrived at your destination.

Date: Time: Destination:

Please confirm the actual date and time you arrived at your scheduled destination or departed your travel.

Date: Time:

Please confirm the total number of hours and minutes of delay in arriving at your schedule destination or departing from your travel connection.

Hours: Minutes:

What was the reason given for the cause of the travel delay?

If travelling by plane, what was your flight number?

B. Loss/damage to baggage, loss of money, loss of travel documents

In order for your baggage/money/document loss or damage claim to be dealt with promptly, please ensure **Sections 1, 2.B and 3** of this claim form are fully completed and returned to us together with all the necessary claims evidence required at end of this Section.

Please state in full exactly what has happened (If necessary, please continue on a separate piece of paper)

Was this incident reported to the police or other responsible authority? ☐ yes ☐ no

If yes, please indicate the Police or other Authority (e.g. airline) this incident was reported to (name and address of authority):

If no, please provide the reason why this was not reported:

Do you have other insurance covering this incident? ☐ yes ☐ no

Company name: Policy number:

Please itemize all lost, stolen or damaged baggage, money or travel documents (e.g. passport). If necessary, please continue to provide details on a separate piece of paper.

Full description of articles (incl. details of damage where applicable. If money, please state the currency).	**Owner of item**	**Original price** (please state currency)	**Date and place of purchase** (please state if not owned by you)	**Payment method** (e.g. credit card)	**Amount claimed** (please state currency)

C. Baggage delay claim

In order for your baggage delay claim to be dealt with promptly, please ensure **Sections 1, 2.C and 3** of this claim form are fully completed and returned to us by post together with all the necessary claims evidence required at end of this section.

Please state the date and time you arrived at your destination.

Date: Time: Flight number:

What was the reason given for the cause of the baggage delay?

Have you received any payment from your Tour Representative or other source? ☐ yes ☐ no

If yes, please provide full details about the source and the amount involved.

D. Medical expenses or trip curtailment claim

In order for your medical expenses or trip curtailment claim to be dealt with promptly, please ensure **Sections 1, 2.D, 2.G and 3** of this claim form are fully completed and returned to us by post, together with all the necessary claims evidence required at end of this section.

Please tell us the date and place where the injury was sustained or the illness was contracted.

Date: Country:

Please advise us of the cause of the injury or illness contracted.
(If the claim is for trip curtailment, please also provide full details of the reason why the trip was curtailed)

Please provide details of the treatment provided (If necessary, please continue on a separate piece of paper)

Name of hospital/clinic:

Name of doctor:

Date of admission/treatment in hospital:

Has the injury or illness occurred before? ☐ yes ☐ no

Please provide full details of any health insurance you may have:

Please itemise all medical expenses which you wish to have reimbursed (if necessary, please continue on a separate piece of paper).

Nature of expenses (e.g. doctor's fees)	**Name of hospital/doctor**	**Currency and amount paid**
	Total amount being claimed:	

Please state details of your medical treatment and advice which you have received from a doctor in the last 2 years.

Doctor's name	**Date of treatment or advice**	**Type of illness/injury/ treatment/or medicine**

Are you currently on medical treatment /medication? ☐ yes ☐ no

If yes, please give a description of your current treatment/medication:

E. Trip cancellation claim

In order for your medical expenses or trip curtailment claim to be dealt with promptly, please ensure **Sections 1, 2.E and 3** of this claim form are fully completed and returned to us by post, together with all the necessary claims evidence required at end of this section.

Please advise the date on which you either decided or were advised to cancel trip:

Day: Month: Year:

Please advise the date on which you gave your cancellation instruction to your travel company:

Day: Month: Year:

If the dates above differ, please provide an explanation below:

Please describe the exact circumstances which have caused you to cancel your trip:

F. Other claims

Please provide us with all required documentation relating to your claim.

Please tell us in as many details as possible what happened to you in order for your to make this claim.
Be as specific as possible, including dates and amount paid (if necessary, please continue on a separate piece of paper).

Which policy benefit section(s) do you believe to be the most applicable under which you can make this claim?

G. Medical certificate

In order for your medical expenses, trip cancellation or curtailment claim to be dealt with promptly, please ensure this section is fully completed by your doctor.

Patient name:

Age/date of birth:

Date of visit/admission: Date of discharge:

Doctor:

History of present illness:

Pre-existing illness: ☐ yes ☐ no

If there any indication that the condition suffered was due to substance, alcohol or drug abuse: ☐ yes ☐ no

Vital signs: BP: HR: PR: BT: BW:

General appearance:

Neuro:

HEENT: Lungs:

Heart:

Abdomen: Extremities:

Investigation/laboratory findings:

Diagnosis:

Medication/treatment:

Hospital course/progress:

Treating doctor's opinion:					
Follow-up appointment:	☐ yes	Date:	☐ no		
Home medication (if discharged):					
Travel recommendation (fit to fly with or without escort, required assistances):					
Permit to travel:	☐ Fit to fly date:			☐ Unfit to fly	
Need escort:	☐ Yes	☐ Doctor	☐ Nurse	☐ Non-medical escort	☐ No escort
Need wheelchair assistance:	☐ Yes	☐ WCHR	☐ WCHS	☐ WCHC	☐ No
Need oxygen supplement:	☐ Yes	☐ Intermittent	☐ Continuous	☐ LPM	☐ No
Need stretcher:	☐ Yes	☐ No	Others:		

I certify that the statements contained in this Medical Certificate are true and correct.	
Doctor's signature:	Date:

Section 3 – Claim payment method and declaration (to be completed in all cases)

Method of payment

Please tick your preferred method of payment.

☐ **Direct Credit to a Bank Account:**

Name of Bank:

Account Name:

SWIFT/IBAN Code (for overseas account only)

☐ **By Cheque to the correspondence address (detailed in Section A)**

Please read below declaration carefully, sign and date it.

Declaration

I / We declare that all statements and details contained on this claim form are true and correct.

I / We acknowledge that the underwriter or its agent may give to, or obtain from other insurers and/or other authorities, personal information relating to this claim.

Signature of the claimant:	Date:

Additional information

Allianz

Global Assistance

Release of medical information

I, _____ passport number _____, hereby authorise any hospital, physician or other person who has medically examined me to furnish Allianz Global Assistance (Thailand) all information with respect to any illness or injury, medical history, consultation, prescription or treatment that were rendered to me. A Photostat /Faxed copy of this authorization shall be considered as effective and valid as an original.

I understand that this authorization will allow Allianz Global Assistance (Thailand) to use the information obtained to investigate and adjudicate my claims.

Patient's signature:
Witness's signature:
Date of signature and location: