

IMPORTANT NOTES FOR CLAIMANT

- This Group Plus Claim Form is to be completed by the Claimant, except where the Claimant is a minor. In such instances the form should be completed by the minor's legal guardian.
- Part C Authorization and Declaration Section of Claim Form must be duly signed/have thumbprint affixed by the Claimant or the Claimant's legal guardian.
- Your claim will not be processed if Part C of the Claim Form is not duly signed/has thumbprint affixed.
- Claim Form must be completed and the claim lodged with supporting documents within 30 days of the incident.
- The acceptance of this Form is NOT an admission of liability on the part of AIG Asia Pacific Insurance Pte. Ltd, (the "Company"). Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant. The Company reserves the right to request for such further documents as it may deem fit in addition to the required documents listed in each of the sections in this Claim Form.
- Please note that information you provide in this claim form will be used for the purposes of claims administration as outlined in this form and will not be used to update any of your existing records that our organization holds. If you wish for us to update any of your information in our records, please contact our Customer Care Consultants at 6419 3000, between Mondays to Fridays, 9am to 5pm. Alternatively, you may send us an email via www.aig.com/sg/contactus.

Note: a) Incomplete Claim Form will be returned and not be processed.

PART A POLICY HOLDER INFORMATION

Policy No.			
Policy Holder's Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		
Contact Details	_____ (Office)		_____ (Fax)
Nature of Business:			
Preferred Method of Communication	<input type="checkbox"/> Mail <input type="checkbox"/> Email Email Address: _____		

CLAIMANT INFORMATION

Claimant's Full Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Identity Card no. / Passport No.										
	First Name	Last Name										
Are You a US Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If 'Yes', Please Provide Your Social Security Number (SSN): _____	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married								
Date of birth	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	
D	D	M	M	Y	Y	Y	Y					
Contact Details	_____ (Residential)		_____ (Fax)	_____ (Mobile)								
	_____ (Email)											
Designation / Title	Class Type (e.g. category)											
Relation to Policy Holder												
1. Please indicate your case number, if you have contacted Travel Guard before: _____												
2. Have you submitted any claims to / through Travel Guard? <input type="checkbox"/> Yes <input type="checkbox"/> No												
3. If yes, please select the type of claims submitted: <input type="checkbox"/> Medical Expense <input type="checkbox"/> Medical Evacuation / Repatriation <input type="checkbox"/> Others (Please Specify): _____												
Cheque made payable to												

PREFERRED MAILING ADDRESS

Preferred Mailing Address				
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PART B EVENT INFORMATION, OTHER POLICIES, RELATED HISTORY

Description of the incident												
Place of incident	Date & Time of Incident	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	Hour	: Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM
D	D	M	M	Y	Y	Y	Y					
Purpose of Travel (for travel claim only)	<input type="checkbox"/> Leisure <input type="checkbox"/> Business / Conference <input type="checkbox"/> Others (please specify): _____											
	Current Home Leave Period: _____		Total Home Leave Utilised to date including this trip _____ Days									
Was a Credit Card used to purchase some or all of journey arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No											
• If yes, please state the first six digits of the credit card used: _____												
• If yes, please advise the amount settled by the credit card: _____												
• Date & Time of Departure from Singapore	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	Hour	: Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM	
D	D	M	M	Y	Y	Y	Y					
• Date & Time of Return to Singapore	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	Hour	: Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM	
D	D	M	M	Y	Y	Y	Y					

DETAILS OF YOUR OTHER INSURANCE OR COMPENSATION CLAIMS

Details of your claims other than this insurance policy (i.e. other insurance policies, third party and others)				
Name of Insurer / Third Party	Policy/ Reference Number	Type of Benefit	Have you filed a claim?	Amount Claimed
Have your other claims been paid by the other policies above? <input type="checkbox"/> Yes <input type="checkbox"/> No				

NOTE: If the space provided is insufficient for your answer, please continue on a separate sheet.

PART C DECLARATION AND AUTHORISATION

I declare to the best of my knowledge and belief that the above particulars are true and accurate. If I made or shall make any false or fraudulent statements, or withhold material facts whatsoever in respect of this claim, the Policy shall be void and I shall forfeit all rights to recover therein. I agree to the conditions set out at the beginning of this claims form.

I authorise any hospital doctor, other person who attended or examined me, to furnish to the Company, and /or its authorised representatives, any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

I, HEREBY DECLARE that to the best of my knowledge and belief, the above particulars as declared by me above are true and complete in every respect and are made without reservation of any kind.

In relation to the personal information collected in this claim form, I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority to provide that information to AIG Asia Pacific Insurance Pte. Ltd. ("AIG"), I have informed the individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by AIG, as set out in the contents of the consent clause below and the individual agrees and consents, that AIG may collect, use and process my/his/her personal information as follows:

- (a) the personal information collected in this form (or otherwise provided during the course of the claim process, including by way of call recordings) may be collected, used and disclosed by AIG to:
- (i) process and administer this insurance claim;
 - (ii) assess, investigate, adjust and make a decision on this claim;
 - (iii) administer my insurance policy (including pursuing recovery from reinsurers or other parties);
 - (iv) deal with disputes and complaints,
 - (v) respond to requests for information from public and governmental/ regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;
 - (vi) respond to requests from the policyholder;
 - (vii) carry out due diligence or other screening activities (including background check(s)) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by AIG;
 - (viii) compliance with legal or regulatory obligations, risk management procedures and AIG internal policies;
 - (ix) manage AIG's infrastructure and business operations; and
 - (x) for other purposes stated in AIG's Data Privacy Policy.
- (b) AIG may transfer the personal information to the following classes of persons (whether located in Singapore or elsewhere) for the purposes identified in (a) above:
- (i) third parties providing services related to the administration of my policy (including reinsurers) and processing of my claim;
 - (ii) AIG's agents;
 - (iii) brokers, my authorised agents or representatives or next-of-kin;
 - (iv) the policyholder;
 - (v) legal process participants and their advisors;
 - (vi) governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums;
 - (vii) other financial institutions for the purpose of administering this claim, obtaining policy payments;
 - (viii) loss adjusters, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers, external auditors;
 - (ix) another member of the AIG group (for all of the purposes stated in (a)) in any country; or
 - (x) other parties referred to in AIG's Data Privacy Policy for the purposes stated therein.

Note: The full version of AIG's Data Privacy Policy can be found at http://www.aig.com.sg/sq-privacy_1030_237853.html.

Name of Claimant/Guardian											
Signature of Claimant/Guardian		Dated	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				

PART D ACCIDENT AND ILLNESS CLAIM

For Accident Related Claim Only

Type of Disablement Claim	<input type="checkbox"/> Permanent Total Disablement <input type="checkbox"/> Permanent Partial Disablement <input type="checkbox"/> Weekly Benefit for Temporary Total Disablement <input type="checkbox"/> Accident Medical Reimbursement <input type="checkbox"/> Others (please specify): _____																		
(a) Date & Time of Accident	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table> Hour : Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM	D	D	M	M	Y	Y	Y	Y										
D	D	M	M	Y	Y	Y	Y												
(b) Where did the accident occur?																			
(c) How did the accident occur?																			
(d) Injuries Sustained																			
(e) If you had a history of similar injury, which you have experienced in the past, please give details as to when, where and from whom you received medical diagnosis, treatment, consultation or prescribed drugs																			
(f) Disablement Commencement	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table> Hour : Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM	D	D	M	M	Y	Y	Y	Y	(g) Date of Death	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y												
D	D	M	M	Y	Y	Y	Y												
(h) Are you still suffering the above stated disability?	<input type="checkbox"/> If yes, please advise the expected date & time of returning to work: <table border="1" style="display: inline-table; border-collapse: collapse; margin-left: 10px;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table> Hour : Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> If no, please advise the date & time of returning to work: <table border="1" style="display: inline-table; border-collapse: collapse; margin-left: 10px;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table> Hour : Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM			D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y												
D	D	M	M	Y	Y	Y	Y												
(i) Have you sustained any fractures from this accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please advise the type of fracture: _____																		
(j) Have you sustained a burn injury from this accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information: <input type="checkbox"/> Head <input type="checkbox"/> Body Degree of burn: _____																		
(k) Have you lodged a police report	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of report	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">D</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">M</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> <td style="width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	Police Station that you lodged report?							
D	D	M	M	Y	Y	Y	Y												
(l) Name and address of any witness of the incident																			
(m) Was the sum insured or benefits of your policy based on your monthly salary?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please advise the last drawn salary prior to the accident: _____																		

(n) Please furnish the details of any hospitalization in connection with this injury

Name of Hospital	Admission Date (DD-MM-YYYY)	Date Discharged (DD-MM-YYYY)	Admission No.	Type of Ward

(o) Please provide information on your first consultation

Doctor Consulted				
Doctor's Address				
Doctor's Contact No.	<input type="text"/>	Doctor's File Ref No. (if applicable)	<input type="text"/>	

(p) Please provide information of your regular doctor.

Family Doctor				
Family Doctor's Address				
Family/ Regular Doctor's Contact No.	<input type="text"/>	Doctor's File Ref No. (if applicable)	<input type="text"/>	

For Illness Related Claim Only

Claim Description (fill in items that apply)

(a) Give a brief description of the illness suffered

i) Are there any symptoms which are or were evident for this condition? If yes, please advise the date of onset of the symptoms.

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

ii) Have you been recommended to receive or received treatment, advice or diagnosis for this condition? If yes, please advise the date of your 1st consultation.

D	D	M	M	Y	Y	Y	Y
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(iii) Please describe the symptoms you experienced.

(d) Please provide information on your first consultation.

Doctor Consulted				
Doctor's Address				
Doctor's Contact No.	<input type="text"/>	Doctor's File Ref No. (if applicable)	<input type="text"/>	

(e) Please provide information of your regular doctor.

Family Doctor				
Family Doctor's Address				
Family/ Regular Doctor's Contact No.	<input type="text"/>	Doctor's File Ref No. (if applicable)	<input type="text"/>	

(f) Please furnish the details of any hospitalization in connection with this illness

Name of Hospital	Admission Date (DD-MM-YYYY)	Date Discharged (DD-MM-YYYY)	Admission No.	Type of Ward

(h) Have any of your family members experienced this similar or related illness? If yes, please provide details.

Relationship of Family Member	Nature of Illness	Date Diagnosed (DD-MM-YYYY)	If Deceased, Date (DD-MM-YYYY)	Age

(i) Are there any other illness/complaints suffered by you prior to this event? If yes, please provide details.



Bring on tomorrow

AIG Asia Pacific Insurance Pte. Ltd.
 AIG Building
 78, Shenton Way #07-16
 Singapore 079120
 www.AIG.com.sg

SECTION 1 – ACCIDENTAL DEATH

Documents Required:

- Certified true copy of Death Certificate
- Autopsy report (where applicable)
- Police report for road traffic accidents or other accidents (where applicable)
- All relevant medical reports
- Police investigation report
- Coroner's inquiry (where applicable)
- Certified True Copy of Pay Slip
- Employment contract
- When claiming for your spouse/child(ren) please furnish copy of you and your spouse/child(ren)'s flight itinerary (Travel Claims only)

SECTION 2 – PERMANENT DISABLEMENT

Documents Required:

- Police report for road traffic accidents or other accidents (where applicable)
- All relevant medical reports
- Police investigation report
- Certified True Copy of Pay Slip
- Employment contract

SECTION 3 – BURN AND FRACTURE

Documents Required:

- Medical report indicating type & location of fracture/degree of burns
- Police report for road traffic accidents (where applicable)

SECTION 4 – MEDICAL EXPENSES

Documents Required:

- Original final medical invoice and receipts (as proof of payment)
- Police report for road traffic accidents or other accidents (where applicable)
- Medical Report / Inpatient Discharge Summary / Doctor's Memo / Attending Physician's Statement (at Claimant/Guardian's expense)

SECTION 5 – TEMPORARY DISABILITY

Documents Required:

- Medical Report / Inpatient Discharge Summary / Doctor's Memo / Attending Physician's Statement (at Claimant/Guardian's expense)
- Medical Certificate

SECTION 6 – HOSPITAL VISITATION

Please provide description of loss																	
Period of Hospitalization from	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> to <table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y										
D	D	M	M	Y	Y	Y	Y										
Please state their name and relationship to you	Name: _____ Relationship: _____																
Details of accomodation expenses and additional travel expenses (continue on a seperate sheet if necessary)																	
<table border="1"> <thead> <tr> <th>Item</th> <th>Amount</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td style="text-align: right;">Total amount</td> <td> </td> </tr> </tbody> </table>		Item	Amount									Total amount					
Item	Amount																
Total amount																	
<p>Documents Required:</p> <ul style="list-style-type: none"> • Original invoices & receipts for purchase of economy class air-ticket or first class rail ticket. • Original invoices & receipts of hotels accomodation expenses incurred. • Medical report showing details of admission and duration of hospitalization. 																	

SECTION 7 – LOSS OF TRAVEL DOCUMENTS AND MONEY

Please tick the appropriate box:	<input type="checkbox"/> Loss of Travel Document <input type="checkbox"/> Loss of Money								
Cause of Loss	<input type="checkbox"/> Destroyed or Lost due to Natural Disaster: <input type="checkbox"/> Earthquake <input type="checkbox"/> Fire <input type="checkbox"/> Tsunami <input type="checkbox"/> Volcano Eruption <input type="checkbox"/> Extreme Weather <input type="checkbox"/> Others (please specify): _____ <input type="checkbox"/> Robbery, Burglary, Theft <input type="checkbox"/> Damage or Lost while held by Airline or Service Provider								
Please provide details on the circumstances surrounding the incident and the precautions taken to protect your property									
Where did the loss occur?									
Date and time of the loss	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> Hour : Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
To whom the incident was reported (e.g.: police, airline, cruise company, etc)									
Date and time reported	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> Hour : Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
Were your items in the custody of the carrier / service provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No Service Provider Contact No. _____								
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details on the compensation or cash settlement amount received : _____ If no, please provide evidence of denial of compensation from the service provider.								
Where were the items located at the time of the loss?									

Loss/Theft of Money

Amount of Cash & Travelers' cheques taken on trip				Amount of cash & travelers cheques damaged, stolen, destroyed or lost during the trip		
Owner's Name	Traveler's Cheque	Cash	Currency	Traveler's Cheque	Cash	Currency

Loss of Travel Documents Please detail the expenses you incurred in obtaining a replacement passport or travel document (continue on a separate sheet if necessary)

Owner's Name	Description	Date	Amount	Currency
	Additional Travel Expenses			
	Additional Accommodation Costs			
	Travel Documents Replacement Costs			
Total expense				

Documents Required:

- Police Report/ Hotel Management report for loss due to any reason
- Proof of event for loss due to natural disasters
- Original receipts of expenses incurred to obtain replacement passports or travel tickets
- Original receipts for hotel accommodation expenses incurred
- Original receipts of transportation expenses incurred
- Proof of purchase of travellers cheques

SECTION 8 – LOSS/DAMAGE TO LUGGAGE AND PERSONAL EFFECTS

Please tick the appropriate box:	<input type="checkbox"/> Baggage Loss <input type="checkbox"/> Baggage Damage <input type="checkbox"/> Damage/ Loss Personal Effects	
Cause of Loss	<input type="checkbox"/> Destroyed or Lost due to Natural Disaster: <input type="checkbox"/> Earthquake <input type="checkbox"/> Fire <input type="checkbox"/> Tsunami <input type="checkbox"/> Volcano Eruption <input type="checkbox"/> Extreme Weather <input type="checkbox"/> Others (please specify): _____ <input type="checkbox"/> Robbery, Burglary, Theft <input type="checkbox"/> Damage or Lost while held by Airline or Service Provider	
Please provide details on the circumstances surrounding the incident and the precautions taken to protect your property		
Where did the loss occur?		
Date and time the loss was discovered	[D][D][M][M][Y][Y][Y][Y] Hour : Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM	
To whom the incident was reported (e.g.: police, airline, cruise company, etc)		
Date and time reported	[D][D][M][M][Y][Y][Y][Y] Hour : Minutes <input type="checkbox"/> AM <input type="checkbox"/> PM	
Were your items in the custody of the carrier / service provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Service Provider Contact No. _____
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details on the compensation or cash settlement amount received : _____ If no, please provide evidence of denial of compensation from the service provider.	
Where were the items located at the time of the loss?		
Any actions taken to attempt the recovery of your property?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details on the actions taken: _____ If no, please provide details for not attempting recovery: _____	

Details of damaged, stolen, destroyed or lost personal effects (continue on a separate sheet if necessary). Please provide full details of each item claimed for. (For cameras, include the make and model number, lens details etc. For jewellery include nature and quality of metal content, type of stone etc.). Purchase receipts, valuations or other documentation to substantiate ownership should be provided whenever possible.

Description of item	Owner's Name	Place of Purchase	Date of Purchase	Purchase Method	Purchase Price

Documents Required:

- Certified true copy of Property Irregularity/Hotel Management Report/Police Report (where applicable)
- Original purchase receipts and warranty cards (where applicable) of lost of items. If not available please provide estimated purchase price & year of purchase.
- Original repair bills & photographs for damaged items
- Letter of compensation from airlines/hotel management/any other parties
- Letter of Refund from your service provider (e.g. Airline/Hotel Management/Tour Agency)

SECTION 9 – BAGGAGE DELAY

Planned Arrival Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Actual Arrival Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Planned Arrival Time	<input type="text" value="Hour"/> : <input type="text" value="Minutes"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	Actual Arrival Time	<input type="text" value="Hour"/> : <input type="text" value="Minutes"/> <input type="checkbox"/> AM <input type="checkbox"/> PM
Place of Departure			
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes, please provide details on the compensation or cash settlement amount received : _____ If no, please provide evidence of denial of compensation from the service provider.</small>		
Documents Required: • Property Irregularity Report • Acknowledgement Receipt on when delayed baggage was recovered			

SECTION 10 – TRAVEL DELAY

Location of Incident			
Cause	<input type="checkbox"/> Earthquake <input type="checkbox"/> Fire <input type="checkbox"/> Tsunami <input type="checkbox"/> Volcano Eruption <input type="checkbox"/> Adverse Weather <input type="checkbox"/> Strike Riot, Civil Unrest, Civil Commotion <input type="checkbox"/> Carrier Defect <input type="checkbox"/> Others (please specify): _____		
Carrier Type:	<input type="checkbox"/> Aircraft <input type="checkbox"/> Ship <input type="checkbox"/> Train <input type="checkbox"/> Others (please specify): _____		
Original Flight Details	Planned Arrival Date & Time:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="Hour"/> : <input type="text" value="Minutes"/> <input type="checkbox"/> AM <input type="checkbox"/> PM
	Actual Arrival Date & Time:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="Hour"/> : <input type="text" value="Minutes"/> <input type="checkbox"/> AM <input type="checkbox"/> PM
Actual Flight Details	Planned Arrival Date & Time:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="Hour"/> : <input type="text" value="Minutes"/> <input type="checkbox"/> AM <input type="checkbox"/> PM
	Actual Arrival Date & Time:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="Hour"/> : <input type="text" value="Minutes"/> <input type="checkbox"/> AM <input type="checkbox"/> PM
Length of Delay	<input type="text" value="Hour"/> : <input type="text" value="Minutes"/>		
Please state the reason provided by the tour operator, airline, cruise company, rail company etc for the cause of the delay:			
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes, please provide details on the compensation or cash settlement amount received : _____ If no, please provide evidence of denial of compensation from the service provider.</small>		
Document Required: • Letter from the airline stating the cause and duration of the delay			

SECTION 11 – TRAVEL CANCELLATION / TRAVEL CURTAILMENT / TRAVEL DISRUPTION / EMPLOYMENT DISRUPTION

Please tick the appropriate box:	<input type="checkbox"/> Travel Cancellation <input type="checkbox"/> Travel Curtailment <input type="checkbox"/> Travel Disruption <input type="checkbox"/> Employment Disruption		
Travel Booking Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Date of event that resulted in the cancellation/ curtailment	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Original Scheduled Departure/ Return Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Location of Incident Causing Claim	
Cancellation/ Curtailment Reasons	<input type="checkbox"/> Earthquake <input type="checkbox"/> Fire <input type="checkbox"/> Tsunami <input type="checkbox"/> Volcano Eruption <input type="checkbox"/> Extreme Weather <input type="checkbox"/> Airspace/Multiple Airport Closures <input type="checkbox"/> Strike Riot, Civil Unrest, Civil Commotion resulting in cancellation of scheduled flights <input type="checkbox"/> Epidemic/ Pandemic <input type="checkbox"/> Travel Agent Insolvency <input type="checkbox"/> Death, Serious Sickness, Injury (please specify illness/sickness/injury): _____ <input type="checkbox"/> Others (please specify): _____		
Was a home government warning issued?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount Paid by you	
Has compensation been made by other parties?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state amount compensated by other parties.	
If travel cancellation is due to death, serious sickness of the insured's immediate family member/ Travel companion please state their:			
Full Name: _____		Relationship to Policyholder/ Insured: _____	
Did you need to cancel / curtail your trip because of a relative who is not travelling with you or because of a travelling companion?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate which	<input type="checkbox"/> Relative <input type="checkbox"/> Travelling Companion <small>Please advise their name: _____ If a Relative, please advise their Relationship to you: _____</small>		
Date you became aware of the need to cancel / curtail your trip	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Date you informed your carrier/ travel agent/tour operator	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Name, address and contact number of your usual doctor (if you need to cancel / curtail your trip on medical grounds, including death)			

Details of trip costs, refunds due or paid and additional expenses incurred (continue on a separate sheet if necessary)

Item	Amount	Refund Due or Paid	Additional Expenses (for Curtailment)

Documents Required:

- Medical report from the doctor certifying details of diagnosis and reason why claimant is unfit to travel.
- Original invoice from the travel agency and statement showing breakdown of tour package and amount refunded.
- Proof of event for cancellation due to other insured perils.

SECTION 12 – HI-JACK

Date of Incident	D D M M Y Y Y Y	Place of Occurrence	
Description of Incident			
Documents Required:			
<ul style="list-style-type: none"> • Proof of event • Letter from the service providers and report from relevant authorities detailing such event 			

SECTION 13 – BAIL BOND

Date of Incident	D D M M Y Y Y Y	Place of Occurrence	
Description of Incident		Claimed Amount	
Documents Required:			
<ul style="list-style-type: none"> • Police Report • Certified True Copy of the Letter from the authorities as proof of detention 			

SECTION 14 – KIDNAP

Date of Incident	D D M M Y Y Y Y	Place of Occurrence	
Description of Incident			
Documents Required:			
<ul style="list-style-type: none"> • Police Report • Proof of event 			

SECTION 15 – LEGAL SUSPENSE

Date of Incident	D D M M Y Y Y Y	Place of Occurrence	
Description of Incident		Claimed Amount	
Documents Required:			
<ul style="list-style-type: none"> • All relevant correspondence/documents 			

SECTION 16 – PERSONAL LIABILITY

Which of the following are you being held liable for?		<input type="checkbox"/> Damages		<input type="checkbox"/> Medical Compensation	
Please provide details of the circumstances					
Please provide details on the extent of damages or injuries sustained by the other party/person (please attach photos):					
Have you instructed solicitors to represent you at this time?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide the name of solicitors : _____ Solicitors contact number: _____	
Was the accident due to carelessness or negligence on your part?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Have you in any way admitted liability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name and address of any witness to the incident				Name and address(es) of the other party / parties	
If any, which Police Officer and Police Station did you report the occurrence?					
If a claim has been made upon you, was the amount of such claim specified?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please state the amount _____	
Please provide any additional information which you consider would help us in dealing with any claim that may be made against you.					
Documents Required:					
<ul style="list-style-type: none"> • All relevant correspondence/documents 					



Bring on tomorrow

AIG Asia Pacific Insurance Pte. Ltd.
AIG Building
78, Shenton Way #07-16
Singapore 079120
www.AIG.com.sg