UEN: T15FC0029B
GST Reg No: M90370081T
3 Temasek Ave., #16-01 Centennial Tower
Singapore 039190
Tel: +65 6804 6000
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Travel Insurance Claim Form

IMPORTANT NOTICE

The acceptance of this form should NOT be misconstrued as an admission of liability on the part of Great American Insurance Company. Any documentary proof or report required by the Company shall be furnished at the expense of the policyholder or claimant.

Required documents – For annual travel plans, please provide a copy of the passport revealing the duration of the trip. Insurers reserve the rights to request for additional information for the purpose of claim assessment. To avoid delays on the claim assessment, please return the claim form duly completed with the relevant supporting documents to the following address:

Claims Manager
Great American Insurance Company, Singapore Branch
3 Temasek Avenue #16-01
Centennial Tower
Singapore 039190

Applicant

Name of Policy Holder _____ Name of Claimant _____

Insurance Policy No. _____ Occupation _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Gender: ☐ Male ☐ Female

Tel No. (Home) _____ Tel No. (Mobile) _____

Purpose of Trip ☐ Business ☐ Vacation Country which you have travelled to _____

Place at which the incident, loss or illness occurred _____

Date _____ Time _____

Are there any other insurance policies in force that cover you in respect of this event? ☐ Yes ☐ No

If yes, please specify _____

Description of the incident, loss or illness _____

_____

_____

_____

_____

Personal Accident / Illness—Medical and Additional Expenses

Please attach original medical receipts and copy of discharge summary or medical report wherever applicable.

	Yes	No
Have you suffered from this illness or injury previously?	☐	☐
If yes, please specify _____		
Is the illness / injury you have suffered or are suffering from a recurrence of a previous illness or injury	☐	☐
If yes, please specify _____		
State the amount claimed _____		
Name and address of your usual attending doctor _____		
Were you on medication / medical treatment for this sickness during the 180 days preceding this trip?	☐	☐

Baggage and Personal Effects

Please provide police report and original purchase receipts, baggage irregularity report and other supporting documents.

State the location of the police station, name of airline / carrier or other authorities where the report was lodged.

_____

Give detailed of amount claimed (If insufficient space, please provide detail in separate sheets)

Item	Description	Date and Place where item was purchased	Original Purchase Price	Description for wear and tear	Claim Amount

Baggage Delay

Please provide boarding pass, Baggage Irregularity Report, Baggage Acknowledgment Slip and any correspondence from the airline office.

Flight Details	Collection of Delayed Baggage
Arrival Date _____	Date _____
Arrival Time _____	Time _____
Place of Departure _____	Place _____
Flight No. _____	
Name of Airline _____	

Cancellation / Curtailment / Postponement

Please provide documents from carrier / travel agent and any relevant documents to support your claim.

When and where was the trip booked? _____

Intended Departure Date _____ Date of Cancellation _____

Reason for which the trip was cancelled / curtailed _____

Amount paid by you _____ Amount recovered from source(s) _____

Amount claimed _____

Flight Delay / Misconnection

Please attach letter from Airlines/Carrier stating the reason and duration of delay.

Original Flight Details	Delayed Flight Details
Date _____	Date _____
Time _____	Time _____
Place of Departure _____	Place of Departure _____
Flight No. _____	Flight No. _____
Name of Airline _____	Name of Airline _____

Others

Hijack, overbooked flight, personal liability, loss of hotel facilities, home protection, alternate employee expenses and /or terrorism.

In respect of any other claim which does not fall within the sections stated above, please provide details of the claim you are submitting. If the space below is insufficient for such details, please attach additional page(s).

_____

_____

_____

_____

_____

I declare that 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 authorize any hospital doctor, other person who has attended to or examined me, to provide to the Company, and/or its authorized representatives, with any and all information relating to my medical conditions, illness, 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.

_____	_____	_____
Name of Policy Holder	Signature/Company Stamp (if applicable)	Date
_____	_____	_____
Name of Claimant	Signature	Date