Travel Insurance Claim Form

STARR COMPANIES

If the space is not enough or no applicable field available, please supplement information by attachment.

POLICYHOLDER AND INSURED PERSO INFORMATION

Policy number	Name of Policyholder	
Name of Insured Person	Name of claimant (if not Insured Person)	Relationship to Insured Person
Claimant NRIC/FIN number	Contact phone number	E-mail address
Correspondence address		

SETTLEMENT METHOD

Please select one of the following settlement method

☐ FAST/PayNow (Valid for Singapore registered account only)

Full Name of Account Holder _____

Mobile No.(+_____) _____OR NRIC/FIN No. _____

☐ Bank Transfer (Valid for Singapore registered account only)

Name of the Bank_____ Bank SWIFT Code _____

Account No. _____ Full Name of Account Holder _____

☐ Bank account outside Singapore (Our Staff will contact you shortly for details and it may take longer to settle your Claim.)

TYPES OF CLAIMS AND AMOUNT

☐ Accidental Death / Permanent Disablement / Burns ☐ Medical Expenses / Overseas Hospital Cash ☐ Personal Baggage / Personal Money / Document Loss

☐ Travel Delay / Re-Route / Baggage Delay ☐ Trip Cancellation / Trip Curtailment ☐ Personal Liability

Others_____ Claim Amount: _____

DETAILS OF ACCIDENT

Date and place of accident	Nature of injury and affected part of body
Circumstances of accident	
Name of witness(es)	Contact phone number of witness(es)

DETAILS OF SICKNESS

Date of symptom first appeared	Date of first consultation	Diagnosis
Name, address & contact phone number of doctor	Name and address of hospital	

DETAILS OF LOSS OF OR DAMAGE TO BAGGAGE/MONEY/DOCUMENT

Date and place of loss or damage	Was the loss reported to relevant authorities (e.g. Police, Common Carrier Operator, etc.) Yes ☐ No ☐ If yes, please provide copy of Loss Report
Circumstances of loss or damage	

Lost or damaged Items	Date of purchase	Purchase cost	Repair cost

DETAILS OF BAGGAGE/TRAVEL DELAY OR RE-ROUTE

Original departure/arrival time Departure time: Arrival time:	Actual departure/arrival time Departure time: Arrival time:
Reason for delay	Any emergency purchase of essential replacement items of clothing and toiletries? Yes ☐ No ☐ If yes, please provide Invoice / Receipt copy
Original itinerary	Re-routed itinerary

DETAILS OF TRIP CANCELLATION OR CURTAILMENT

Reason for Trip Cancellation or Curtailment	
Original itinerary	Curtailed itinerary

DETAILS OF PERSONAL LIABILITY INCIDENT

Date and place of incident	
Circumstances of incident	
Name and contact details of third party claimant	Name and contact details of witness(es)

Important Note: -

Any claim, demand, lawsuit or legal proceedings relating to the incident which the Insured Person becomes aware of or received from third party claimant should be forwarded to Starr International Insurance (Singapore) Pte. Ltd. ("SIIS") unanswered immediately. No admission of liability, offer to settle or payment of claim with third party claimant is permitted without written consent of SIIS.

OTHER INSURANCE OR COMPENSATION

Do you have other insurance policies covering this loss or expenses incurred? ☐ No ☐ Yes (Please specify below)

Name of Insurer	Policy number	Benefit	Sum insured

Did you receive any compensation or offer from common carrier operator or hotel for this claim?

☐ No ☐ Yes (Please specify) _____

DOCUMENTS REQUIRED FOR CLAIM SETTLEMENT

- Travel proof, such as air-ticket, boarding pass, travel agent or airline's official receipt showing the Itinerary, and confirming the departure and return dates
- Incident report issued by relevant authorities (e.g. police, common carrier operator, activity organizer, etc.)
- Original hospital/medical receipt
- Original medical/examination report
- Copy of death certificate/post mortem report for death cases
- Original purchase receipt of the lost/damaged items or repair quotation
- Original receipts for additional or forfeited hotel accommodation and travel expenses
- Original receipt(s) for emergency purchase of essential items due to baggage loss or delay
- Original documentation indicating trip cancellation and non-refundable/refunded amount
- Demand letter/writ of summons from third party claimant
- Confirmation letter from the Airline/Common Carrier Operator certifying the number of hours of delay & the reason of delay (applicable to travel delay & baggage delay claims)

We reserve the right to ask for any other documents to substantiate the claim

DECLARATION AND AUTHORIZATION

- The undersigned hereby declares that to the best of my/our knowledge and belief, the above statement and particulars are fully and truly made. I/We agree that if any fraudulent means or devices are used in connection with obtaining any benefit under the Policy, the Policy shall be void against me/us. I/We agree that any of my/our personal information collected or held by Starr International Insurance (Singapore) Pte. Ltd. ("SIIS") or its authorized representatives is provided and be held, used and disclosed by SIIS to individuals/organization associated with SIIS or any selected third party for the purpose of processing the claims herein, providing data matching and to communicate with me/us for such purposes. The undersigned understand that SIIS may be able to process the claims herein if I/we fail to provide any information requested in this Claim Form. The undersigned further understand that I/we have the right to obtain access and to request correction of my personal information held by SIIS. Such request can be made to SIIS's Operations Services Manager at 138 Market Street, #16-04, CapitaGreen, Singapore 048946.
- I/We hereby irrevocably authorize SIIS or its authorize representative to obtain my/our medical records from my/our treating physicians, hospitals, clinics, insurance companies, government agencies or other relevant organizations in relation to the accident or claim. This authorization is valid even I/we am/are deceased. My/our next of kin is also bound by this authorization. The original or copy of this authorization has the same effects.

Signature of Insured Person/claimant	Signature of Policyholder (with company chop, applicable to group policy)	Date

MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIANS)

Name of patient	Diagnosis
Date of first consultation	Date of occurrence of injury or first symptom

To the best of your knowledge, has the patient ever had the same or similar condition(s) or symptom(s)? If yes, please state the dates and conditions/symptom.

Was the condition caused by any underlying disease? If yes, please specify.

Will the current condition(s) or symptom(s) result in any permanent disability? If yes, please advise detail.

If the current condition or symptom relates to burn injury, please advise (a) degree of burnt and (b) estimated % of burnt body surface.

Is the diagnosis due to or associated with any of the following?

(a) Congenital anomalies	☐ Yes	☐ No
(b) Refractive error or correction of eyesight	☐ Yes	☐ No
(c) Heredity condition	☐ Yes	☐ No
(d) Cosmetic or plastic surgery	☐ Yes	☐ No
(e) Pregnancy or childbirth	☐ Yes	☐ No
(f) Routine medical check-up	☐ Yes	☐ No
(g) Drugs or alcohol	☐ Yes	☐ No
(h) Mental or nervous disorders	☐ Yes	☐ No

Date and details of operation, if applicable

Discharge summary (including investigation procedures, result, diagnosis, treatments, complications and follow-up plan)

Name of hospital	Date of admission	Date of discharge

Address of hospital/clinic

Phone number of hospital/clinic	Date of medical report

Name of attending physician/specialist	Signature and stamp of attending physician/specialist	Date

STARR COMPANIES

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