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*Day \_\_\_\_\_\_\_\_month \_\_\_\_\_\_\_\_year \_\_\_\_\_\_\_\_*

**TRAVEL INSURANCE**

**CLAIM FORM**

Note: The acceptance of this form is **not** an admission of liability on the part of PVI Insurance.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Policy Number: | | | Period of Insurance: | | | | | | | |
| Name of Policyholder (if group insurance): | | | | | | | | | | |
| **SECTION (A): INFORMATION OF INSURED PERSON AND CLAIMANT** | | | | | | | | | | |
| **Information of Insured Person**:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID/Passport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of issuance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issuing body: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Ticket/Boarding Pass: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Departure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Destination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Information of Claimant**:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship with Insured Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID/Passport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of issuance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issuing body: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| *(\*) Claimant shall include the Policyholder, the Insured Person, the beneficiary or the legal representative of the Insured Person, as the case may be.* | | | | | | | | | | |
| **SECTION (B): PARTICULARS OF LOSS OCCURRENCE** | | | | | | | | | | |
| Explain exactly how the loss occurred:  Place of loss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Time of loss occurrence:\_\_\_\_\_\_\_\_Time: \_\_\_\_\_\_\_\_day:\_\_\_\_\_\_\_\_month: \_\_\_\_\_\_\_\_year: \_\_\_\_\_\_\_\_  Loss discovery/witnesses (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship with Insured Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID/Passport: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of issuance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issuing body: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **SECTION (C): CLAIM INFORMATION** | | | | | | | | | | |
| 1. **PERSONAL ACCIDENT – MEDICAL AND ADDITIONAL EXPENSES**   **(Please attach supporting documents, e.g. original medical receipts, accident report, police report, death certificate and/or relevant documents)** | | | | | | | | | | |
| Claim of:  Personal accident  Emergency medical evacuation  Overseas compassionate visit  Medical expenses  Mortal remains repatriation  Return of children  *Please select claim by double clicking on the appropriate selection box and changing the Default Value to ‘checked’ in the pop-up.* | | | | | | | | | | |
| Further information: *(If Yes, please give the details in the right column)* | | | | | | | | | | |
| Have you ever suffered a similar medical condition or is this medical condition related to a previous injury?  Yes  No  *Please select Yes/No by double clicking on the appropriate selection box and changing the Default Value to ‘checked’ in the pop-up.* | | | | If yes, please specify dates & circumstances of similar medical condition or previous injury and name & address of the doctor concerned: | | | | | | |
| During the 24 hours before the injury, did the Insured drink any alcohol or take any drugs?  Yes  No  *Please select Yes/No by double clicking on the appropriate selection box and changing the Default Value to ‘checked’ in the pop-up.* | | | | If yes, please state type and quantities: | | | | | | |
| Amount paid by you (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VND  Amount recovered from other sources: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VND  *(paid/compensated by others, if any)*  Amount claimed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VND | | | | | | | | | | |
| 1. **CANCELLATION/CURTAILMENT OF TRIP (Please attach documents issued by Carrier/Travel Agent)** | | | | | | | | | | |
| Claim of:  Cancellation  Curtailment  *Please select claim by double clicking on the appropriate selection box and changing the Default Value to ‘checked’ in the pop-up.* | | | | | | | | | | |
| Ticket Information:  Booked date:  Booked place: | | | | | | | Scheduled Departure Date: | | | |
| Carrier/Travel Agent:  Name:  Address:  Phone Number: | | | | | | | Date of Cancellation: | | | |
| Cause of Cancellation/Curtailment: | | | | | | | Number of Curtailed Date: | | | |
| Amount paid by you (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VND  Amount recovered from other sources: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VND  *(paid/compensated by others, if any)*  Amount claimed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VND | | | | | | | | | | |
| 1. **PERSONAL EFFECTS/TRAVEL DOCUMENT LOSS AND DAMAGE (Please furnish relevant reports from relevant authorities or Carriers/Airlines AND original purchase receipts)** | | | | | | | | | | |
| Details of amount claimed: | | | | | | | | | | |
| Description of item: | When and where purchased | | | | Original purchase price | | | Amount recovered from other sources | | Amount claimed |
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| 1. **FLIGHT DELAY/BAGGAGED DELAY (Please attach letter from Carriers/Airlines and Boarding Pass)** | | | | | | | | | | |
| Original flight details | | Replacement flight details | | | | | | | Collection of delayed baggage | |
| Date: | | Date: | | | | | | | Date: | |
| Time: | | Time: | | | | | | | Time: | |
| Place of Departure: | | Place of Departure: | | | | | | | Place of collection: | |
| Place of Arrival: | | Place of Arrival: | | | | | | |
| Flight number: | | Flight number: | | | | | | |
| Amount paid by you (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VND  Amount recovered from other sources: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VND  *(paid/compensated by others, if any)*  Amount claimed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VND | | | | | | | | | | |
| 1. **OTHERS (Please specify details of any claim other than (I) to (IV)** | | | | | | | | | | |
| Name of Police Station, Carrier/Airline or other authorities where report was lodged (if applicable) | | | | | | | | | | |
| Details of claim  (please attach supporting documents, if any) | | | | | | Amount claimed | | | | |
|  | | | | | |  | | | | |
| **SECTION (D): ANY OTHER INSURANCE** | | | | | | | | | | |
| Are there any other insurance policies in force covering you in respect of this event?  Yes  No  *Please select Yes/No by double clicking on the appropriate selection box and changing the Default Value to ‘checked’ in the pop-up.*  If yes, please specify below and attach supporting documents:  Insurer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Claim amount paid (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **SECTION (E): PAYMENT** | | | | | | | | | | |
| Subject to PVI’s approval of this claim, should you wish to have the claim benefits transferred directly into a bank account, please provide the following detail:   * The Beneficiary * Bank Name * Bank * Bank Address * Account Number   Remark: The beneficiary should be the Insured or his/her heir. | | | | | | | | | | |

\*I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every aspect and;

\*I/We agree that if I/ We have made or in any further declaration in respect of the said claim shall make any false or fraudulent statements of suppress conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recover there under in respect of past or future claims shall be forfeited.

\* I/We hereby authorize any hospital physician, other person who has attended or examined me, to furnish to the Company, or its Authorized Representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photo-static copy of this authorization shall be considered as effective and valid as the original.

Date:

|  |  |
| --- | --- |
| Signature of Claimant | Signature of Insured Person |

Note:

* If the Insured is a Company, please affix Company stamp
* If the Insured Person is claiming on his own behalf, only the Insured Person’s signature is required
* If the Insured Person is a child under 18 years of age or in a state of being unable to read, declare and sign this claim form, only the Claimant’s signature is required.