CLAIM FORM
INTERNATIONAL TRAVEL HEALTH INUSRNACE

General Information
(To be filled in for all types on claims:

Policy Particulars:
Policy number: _____

Insured's Name: _____

Insured's Contact No. _____

Loss Particulars:

Date of Loss: _____

Type of Loss (Please Tick)

☐ Personal Accident (Death & Disability) ☐ Medical Expenses ☐ Transport or Repatriation in case of Illness or Accident ☐ Emergency Dental Care ☐ Loss of Credit ☐ In – Flight Loss of Checked – in Baggage ☐ Delayed Departure ☐ Trip Cancellation ☐ Travel one Immediate Family Member

☐ Loss of Passport ☐ Emergency Return Home following Death of Close Family ☐ Repatriation of Family Member Traveling with the Insured ☐ Repatriation of Mortal Remains ☐ Escort of Dependent Children

Please attached the following documents with all types of claims:

1. Air tickets and any other traveling documents
2. Boarding Pass with "Entry & Exit Stamp
3. CNIC Copy
4. Photo Copy of Passport

Medical Expenses Claim – Dental Care

1. Name of Loss Sustaining Person _____
2. Date of Loss _____
3. Place of Loss _____
4. Circumstances of Loss {attach extra sheet(s), if required}

   _____

   _____
5. Name, Address and Telephone Nos. of Hospital/ Clinic where treatment was given

   _____
6. Name of Attending Doctor _____
7. Nature of Ailment _____

_____

8. Was the Ailment/ Injury aggravated due to a pre-existing condition? Please give details

_____

_____

9. Details of Treatment Received & Expenses Incurred {attach extra sheet(s), if required}

_____

_____

10. Total Amount Claimed _____

Please attach the following documents in Original for claim verification and assessment:

1. Medical Bills/ Invoices/ Receipts.
2. Attending Physician's Prescriptions.
3. Tooth/teeth treated.
4. Treatment performed.