

CLAIM FORM
INTERNATIONAL TRAVEL HEALTH INSURANCE

General Information

(To be filled in for all types of 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

Personal Accident (Death or Permanent Disability)

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. Cause of Death (for death claims only)

6. Cause and Extent of Disability (for disability claims only)

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

7. Name of Attending Doctor _____
8. Details of Any Third Party Involved in the Accident

9. Total Amount Claimed _____

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

1. Death Certificate issued by Competent and Authorized Entity stating cause of death (for death claims only).
2. Disability Certificate issued by Competent & Authorized Entity stating cause and extent of disability (for Permanent Disability claims only).
3. Police Report stating cause of loss.
4. Medical Treatment Documents

❖ Please note that submission of above mentioned documents or any other documents shall not mean entitlement to a claim.