

Travel Insurance Secondment Claim Form

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PLEASE COMPLETE ALL SECTIONS TO FACILITATE THE PROCESSING OF YOUR APPLICATION

This form must be completed truthfully and accurately.

The list of documents required is not exhaustive and we reserve our right to request from you any additional information/documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

The completed form should be returned together with all supporting documents as soon as possible to the following address:

Chartis Singapore Insurance Pte. Ltd.
CHARTIS Building, 78 Shenton Way, #07-16, Singapore 079120

The acceptance of this Form is NOT an admission of liability on the part of Chartis Singapore Insurance Pte. Ltd. ("the Company"). Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

Any information collected or held by Us whether contained in the Application / Proposal or Claim Form or otherwise obtained in any other manner, may be used and disclosed to Our associated individuals / companies or any independent third parties (within or outside Singapore) for any matters related to your claim and to communicate with You for any purpose.

Section A - General Information

Name of Insured Person/Claimant (if different from Insured Person)	Policyholder's Name	Insurance Policy No.
Country of Secondment	Date Insured Person Joined the company	Date of Secondment
Plan and/or Category of Employee	Purpose of Trip <input type="checkbox"/> Business <input type="checkbox"/> Home Leave Current Home Period : _____ Total Home Leave utilised to-date including this trip _____ days Other: _____	
Name of Company		
Telephone No	Office	Email address
Home Address		Nationality : Social Security No. (For US Citizen) :
Date of Birth	Occupation	Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female
Place where incident, loss or illness occurred	Time	Date
Description of the incident, loss or illness		
Are there any other policies of insurance in force covering you in respect of this event? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify : _____		

PLEASE FILL IN THE APPLICABLE PORTION

Section B - Personal Accident/Illness – Medical And Additional Expenses

Documents required for Section B.

- Original medical receipts and copy of discharge summary or available medical report

1. Have you ever suffered this condition or a similar condition or a recurrence of a previous illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify : _____
2. State amount claimed \$ _____
3. State name and address of your usual attending Doctor

Section C - Luggage & Personal Effects

Documents required for Section C

- Police Report and original purchase receipts and warranty cards, if applicable.

Location of police station, name of airlines/carrier or other authorities where report is lodged.					
Give details of amount claimed					
Item	Description	When and where purchased	Original purchased price	Depreciation for wear and tear	Amount Claimed

Section F - Others

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 another page.

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 authorise any hospital doctor, other person who has attended or examined me, to furnish to the Company, and/or its authorised representatives, any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of the Claimant

Date

Signature of the Policyholder

Date

Name:	Designation:	Company Stamp:
Particulars of Agent Name :	Mobile :	Email Address :