



IAG Insurance (Thailand) Ltd. T 66 2 207 0266 to 85
 24th Fl., Thanapoom Tower, F 66 2 207 0575 to 76
 1550 New Petchburi Rd., www.iag.co.th
 Makkasan, Ratchtevi
 Bangkok 10400

TRAVEL ACCIDENT INSURANCE

IMPORTANT

Please keep a separate note of this claim reference number and quote it whenever you contact us.

Date:

Dear

MEDICAL EXPENSES AND CURTAILMENT FORM

Here is your claim form as requested. Please complete it fully and return it to us. If you have received an identical claim form please return this form indicating the claim reference number previously supplied.

Please check that we have correctly stated your name, initial(s), address and post code and amend if necessary.

Our aim is to give you the fastest possible service but to achieve this, we need you to answer ALL the questions in detail and to submit documents in support of the claim.

The section below details the documents which we need to deal with your claim and some notes which we would ask you to read carefully when completing the form. Thank you.

VERY IMPORTANT

Please ensure you enclose the following ORIGINAL (not photocopied) documents (if not already sent).

- | | |
|--|--|
| <p>a) Proof of insurance, such as a numbered certificate or validation receipt or tour operators invoice showing insurance. <input type="checkbox"/></p> | <p>e) The holiday booking invoice or other Documents issued as evidence of holiday / trip cost. <input type="checkbox"/></p> |
| <p>b) Medical evidence to support details of illness or injury. <input type="checkbox"/></p> | <p>f) Original receipts for any costs incurred. <input type="checkbox"/></p> |
| <p>c) Original travel tickets (ie. flight coupon / ferry / coach tickets) <input type="checkbox"/></p> | <p>g) If the claimant was a hospital in-patient, please attach evidence to show admission and discharge dates. <input type="checkbox"/></p> |
| <p>d) In cases of death, a copy of the death Certificate is required. <input type="checkbox"/></p> | <p>h) If the holiday was curtailed we require any additional Travel tickets (flight coupons / ferry tickets / rail tickets / taxi costs). <input type="checkbox"/></p> |

TELECLAIMS

If you have no objection, in an effort to promote speedier and more customer-friendly claims handling we may find it easier to telephone you during the course of our normal working hours (8am - 6pm) to discuss your claim and/or request further details. Please advise us of any relevant numbers on which you can be reached:

_____ or _____

CLEAR BLOCK CAPITALS MUST BE USED PLEASE

<p>1. Claimant's title: MR / MRS / MISS / MS. Forenames: _____ Surname: _____</p>	<p>6. a. The date of policy issued (this is important): DAY: _____ MONTH: _____ YEAR: _____</p>
<p>2. Address: _____ _____ _____ Post Code: _____</p>	<p>b. The certificate no and prefix: PREFIX: _____ NO: _____</p>
<p>3. Telephone No. Daytime: _____ Evening: _____</p>	<p>7. The name of the travel agent who issued the insurance: _____</p>
<p>4. Occupation: _____ Age: _____</p>	<p>8. The period of your holiday/trip giving total number of days: From: _____ To: _____ Total no. of days: _____</p>
<p>5. The destination and country of this holiday/trip: _____</p>	<p>9. No. of people covered by this policy: _____</p>
<p>12. Please tell us the date and resort in which the injury was sustained or the illness contracted.</p>	<p>Date: _____ Resort: _____ Country: _____</p>
<p>13. Please advise the nature of the injury or illness and the circumstances in which it arose. If the claims is for the curtailment of the holiday please provide full details of the reason for the curtailment and supply documentary evidence. DATE: _____ TIME: _____ PLACE _____ _____ _____ _____</p>	
<p>14. Please advise whether treatment was being given for the illness / injury or any other medical condition prior to the holiday. YES / NO If YES please give details. _____ _____</p>	
<p>15. Was the medical assistance company contacted? If so, what assistance was provided? Name of assistance service: _____ Assistance provided: _____ Reference if know: _____</p>	<p>16. If you were admitted to hospital, please advise: Name of hospital: _____ Date Admitted: _____ Date discharged: _____ Total number of full days as in-patient: _____</p>
<p>17. If the curtailment was due to death or illness, please advise the name of the person and the relationship to the claimant. Name _____ Relationship _____</p>	
<p>18. By what method of transport did you return to the Thailand? Was your trip curtailed or extended? Date Curtailed: _____ No. of days unused: _____ Date extended: _____ No. of days extended: _____ Method of transport: _____ (Please provide original travel tickets) _____</p>	



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CURTAILMENT ONLY

IMPORTANT:

The circumstances leading to the curtailment of your holiday must be supported by independent documentary evidence.

Names of all persons curtailing:		Total holiday cost per person Excluding insurance premium and surcharges
	Date you returned	
	/ /	
	Date you should have returned	
	/ /	
OFFICE USE ONLY		
Curtailment		
Cost per day		
No. of days lost		
Gross		
Excess total		
Nett		

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THE DECLARATION

PRIOR TO RETURNING THE CLAIM FORM PLEASE STUDY THE POLICY WORDING AND READ THE TEAMS AND CONDITIONS AS THEY RELATE TO YOUR CLAIM.

PLEASE NOTE NEITHER WE NOR INSURERS ARE RESPONSIBLE FOR THE COSTS OF OBTAINING DOCUMENTATION IN SUPPORT OF THE CLAIM.

We believe our policyholders are honest. This contract is based upon mutual trust between us, however, fraudulent claims are occasionally made.

Where fraud (which can include exaggerated claims) is detected the claim will not be paid. The policy will be rendered invalid and we may refer the matter to the police or take other legal action.

DECLARATION:

I/We declare that to the best of my knowledge and belief all information as stated herein is correct and that the company is subrogated with all rights I/We may have against a third party. Furthermore, by signing this documentation the patient also consents to Claims International Limited seeking reimbursement of medical expenses paid by them arising out of medical treatment received from the Department of Social Security and any relevant authority related thereto.

I/We have not withheld any information or documentation from insurers within my/our knowledge connected with this claim.

I/We agree to provide any further information or documentation as may be reasonably required.

I subrogate and assign to insurers all rights of recovery/salvage against any person or organisation and will do whatever else is necessary to secure such rights.

SIGNATURE OF CLAIMANT: _____ DATE: _____