PNBGen

PAL TRAVEL INSURANCE CLAIM FORM

The acceptance of this Form is NOT an admission of liability on the part of the Company.

POLICY INFORMATION

Where did you avail your travel insurance? Policy Number: Policy Coverage Period:	**Policy Type:** ☐ Domestic ☐ Asia ☐ Rest of the World	**Plan Type:** ☐ Peso ☐ Dollar

PARTICULARS OF INSURED PERSON / CLAIMANT

Name of Insured Person:	Tel. No. (Office):	Tel. No. (Residence):
Name of Family Member/s, if Family Plan:	E-mail Address:	Mobile No.:
	Address:	

PARTICULARS OF LOSS / OCCURRENCE

On a separate sheet of paper, explain exactly how the loss occurred.

Place of loss or occurrence:	Date of loss:	Time of loss:

CLAIMS HISTORY

Have you or any insured person previously made a claim under a travel policy? ☐ Yes ☐ No

If yes, please specify below:

DATE & CIRCUMSTANCES OF SIMILAR CONDITION & RECURRENCE	NAME OF INSURANCE COMPANY(S) INVOLVED
	(Please use supplementary sheet if necessary)

ACCIDENTAL DEATH / DISABILITY AND DISMEMBERMENT

(Please use the Accident and Sickness Proof of Loss Claim Form)

MEDICAL EXPENSE COVERAGE / MEDICAL EVACUATION & REPATRIATION / HOSPITAL CONFINEMENT

(Please use the Accident and Sickness Proof of Loss Claim Form)

TRAVEL DELAY / MISSED CONNECTING FLIGHT / BAGGAGE DELAY

(Please attach letter from Carrier/Airlines and Boarding Pass)

ORIGINAL FLIGHT DETAILS	DELAYED / MISSED FLIGHT DETAILS	COLLECTION OF DELAYED BAGGAGE
Date:	Date:	Date:
Time:	Time:	Time:
Place of Departure:	Place of Departure:	Place of collection:
Flight No.:	Flight No.:	Flight No.:
Name of Airline:	Name of Airline:	Name of Airline:
Expenses incurred by you:	Amount recovered from other sources:	Amount claimed:

LOSS OR DAMAGE OF BAGGAGE AND PERSONAL EFFECTS

(Please furnish relevant Report from relevant authorities or Carrier/Airlines AND original purchase receipts)

Give details of amount claimed

DESCRIPTION OF ITEM	WHEN AND WHERE PURCHASED	ORIGINAL PURCHASE PRICE	AMOUNT RECOVERED FROM OTHER SOURCES	AMOUNT CLAIMED
				(Please use supplementary sheet if necessary)

PERSONAL MONEY / TRAVEL DOCUMENTS

(Please furnish relevant Report from relevant authorities or Carrier/Airlines)

Details of amount claimed

AMOUNT LOST	AMOUNT RECOVERED FROM OTHER SOURCES	AMOUNT CLAIMED
		(Please use supplementary sheet if necessary)

TRIP CANCELLATION / CURTAILMENT

(Please attach documents from Carrier/Travel Agent)

When and where was holiday booked? Intended Departure Date:		Date Cancelled:
AMOUNT PAID BY YOU:	AMOUNT RECOVERED FROM OTHER SOURCES:	AMOUNT CLAIMED:

PERSONAL LIABILITY

(Please attach letter from Third Party, Police or Court)

Was the accident due to carelessness, or negligence on your part?	Have you in any way admitted liability?	
To which Police Officer and Police Station (if any) did you report the occurrence?		
Names & addresses of the other party(s)		
Nature of personal injury sustained by any person	Name/Age	Nature of Injury
Extent of damage to property belonging to other party(s)		
Whether any claim has been made upon you. If so, was the amount of such claim specified?		
Please give any additional information which you consider would help the Insurer in dealing with any claim that may be made against you.		

COMPASSIONATE VISIT / AIRCRAFT HIJACKING

(Please specify details of any claim. Use supplementary sheet if necessary))

Name of Police Station, Carrier/Airline or other authorities where Report lodged (if applicable)

DETAILS OF CLAIM	AMOUNT CLAIMED

*I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail 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 Insured Person/Claimant_____