ايـنـسـورنـس نـاسـيـونـل

National Insurance Company Berhad
(Incorporated in Negara Brunei Darussalam)

Head Office : Units 12 & 13, Block A, Regent Square, Simpang 150, Kampong Kiarong,
Bandar Seri Begawan BE1318 Negara Brunei Darussalam
P.O. Box 1251, Bandar Seri Begawan BS8672, Negara Brunei Darussalam
Tel: 242 6888, 245 0800 , 222 6222 Fax: 242 9888 (Admin/Claim), 245 4277 (Underwriting)
Email: insurance@national.com.bn

Kuala Belait : Unit 20, Block C, Lot 8989, Jalan Pandan Tujuh, Kuala Belait KA1931
Negara Brunei Darussalam
P.O.Box 1336, Kuala Belait, KA1189, Negara Brunei Darussalam
Tel: 333 1222, 333 6468, 333 6469 Fax: 334 2191
Email: kb@national.com.bn

TRAVEL PROTECTOR CLAIM FORM

IMPORTANT NOTES

- Please read the instructions in this claim form carefully and complete the applicable section under which you would like to make a claim.
- When completing the appropriate section please ensure that it is completely filled out. If the space provided is not sufficient, please provide the requested information on a separate sheet and attached it to the claim form.
- Your completed claim form must be submitted to us with original receipts, reports, and proof of ownership for any claims relating to Luggage and Personal Effects or any other supporting documents.
- We reserve the right to request for the original receipts, reports or any other supporting documents as and when required.
- If the document is in a foreign language, you are required to provide an English translation at your own expense.
- As each claim is unique, further information may be requested by us.
- If any part of your claim is dishonest or fraudulent in nature, your claim will be denied and we reserve the rights to refer the matter to the appropriate authorities.
- Should your claim does not account to travel and is restricted within Brunei Darussalam, please disregard the irrelevant sections.
- If you do not wish to pursue this claim after your submission please write in to inform us immediately.

The issue of this form is not an admission of liability. It should be completed as fully and accurately as possible and returned immediately.

CLAIMANT DETAILS (All questions in this section must be answered)

Policy No:	**Period of Insurance: From:** **to**
Name of Policyholder(s):	
Name of claimant (Mr/Mrs/Miss/Ms):	**Marital Status:**
NRIC/Passport No:	**Date of Birth:**
Occupation:	**Relationship to Policyholder:**
Address:	
Mobile No:	**Office Tel No:**
Home Tel No:	**Email Address:**
Date of booking for travel arrangements:	
Date of departure:	**Date of return:**

Please tick the relevant section(s) you are claiming:

- ☐ 1. PERSONAL ACCIDENT
- ☐ 2. MEDICAL, DENTAL AND OTHER EXPENSES
- ☐ 3. COMPASSIONATE VISIT BY RELATIVE/FRIEND
- ☐ 4. CHILD HELP
- ☐ 5. EMERGENCY SERVICES
- ☐ 6. HOSPITAL ALLOWANCE
- ☐ 7. REPATRIATION EXPENSES
- ☐ 8. OTHERS

1. Type of injury / sickness:		
2. Date of accident causing the injury /date of onset of illness:		
3. Please state the nature of the illness/ accident leading to the injury:		
4. Country and place where illness / injury were treated:		
5. Please provide the name and address of any person (s) who had witnessed the accident:		
6. If the insured person was admitted to hospital, please state:		
7. Date of admission:	Time:	am/pm
8. Date of discharge:	Time:	am/pm
9. Have you ever suffered from this illness or a similar condition or a recurrence of a previous illness or injury? Yes ☐ No ☐		
If you have answered "Yes", please specify:		
10. Date of first medical/dental consultation:		
11. Name of Doctor, Dentist and/or Hospital:		
12. Name and address of your usual family attending doctor		

Please provide us with all of the following documents relating to your claim:

- Medical/hospital/dental report detailing treatment sought and diagnosis (at the insured's expense)
- Itemized original medical bills and receipts
- Death certificate and burial/cremation permit (if death occurs)
- Police report
- If hospital benefits is being claimed, please provide a confirmation from hospital on admission and discharge dates
- Original bills incurred for accommodation and transportation (for Compassionate Visit and Child Help claims)
- Written advice by a qualified medical practitioner stating that the person requires assistance, accommodation or to be remain behind with or travel together (for Compassionate Visit and Child Help claims)
- Original air tickets
- Copy of travel itinerary
- Original boarding pass
- Letter of Probate or Letter of Administration (in respect of death claim)

Please tick on the relevant section(s) you are claiming:

☐ 8. BAGGAGE AND PERSONAL EFFECTS

☐ 9. PERSONAL MONEY AND TRAVEL DOCUMENTS

NOTE: If your travel baggage is lost by the Airline/Carrier, the Warsaw Convention imposes a liability upon the Airline/Carrier and you should proceed to claim with your Airline/Carrier first before submitting your claim with us.

1. Please provide full details of how losses/ damage occurred:

2. Date of loss/damage occurred: Time: am/pm Location/Country:

3. Did you report the event to Police/Airline/handling agent or others? ☐ Yes ☐ No

a. If you have answered yes, please state:

b. Date Reported: Time: am/pm Location/Country:

c. Report Reference:

4. Have you lodged a claim against the Carrier/Airline or other Authority or against any individual responsible for the loss or damage to your property? ☐ Yes ☐ No

If you have answered 'Yes', please provide the Carrier/Airline name: Claim No:

If you have answered 'No', you should proceed to claim with your Carrier/Airline before submitting your claim to us.

5. Are any of the items covered by other insurance? ☐ Yes ☐ No

If you have answered "Yes", please stat the Company's Name: Policy Number:

6. Were all the missing articles owned by you? ☐ Yes ☐ No

If you have answered "No", please provide its details:

7. Have you replaced any of the stolen/damaged items? ☐ Yes ☐ No

If your answered "Yes", please provide proof of purchase.

Description of item lost/damaged	Original Purchase Price (state currency)	Date of Original Purchase	Place of Purchase	Amount claimed	Proof of ownership. Yes/No

8. For Personal Money, state amount lost:
9. For travel documents, state cost in obtaining replacement travel documents:

Please provide us with all the following documents relating to your claim:

- A loss report from the authority you reported the loss to: e.g. police report, letter from hotel, or a Property
- Irregularity Report (PIR) from the Carrier.
- Your airline tickets and baggage tags.
- In the case of damaged items-please send us a quotation for repairs and photographs of the damaged items.
- Proof of ownership, which may be in the form of original purchase receipts of lost / damaged items, invoices, statements, credit card statements
- Documents stating the amount of compensation from airlines or other carrier/provider
- Any relevant document that supports your reason for the damage /loss.

☐ 10. DELAYED BAGGAGE

1. Name of Airline/Carrier which has caused the delay of your luggage:		
2. Your arrival date:	Your arrival time:	AM/PM
3. Date that your luggage was returned to you:	Time of return:	AM/PM
4. What kind of compensation was received from the airline/carrier?		

Please complete the below schedule in full. Claims will be converted to Brunei dollars using currency rate applicable at the date and time the expenses were incurred.

Description of Essential items purchased	Date of Purchase	Price Paid	Store where item was Purchase	Receipt Attached Yes/No

Please provide us with all of the following documents relating to your claim:

- A loss report issued by the carrier (usually in the form of a Property Irregularity Report).
- Confirmation of the date and time the delayed luggage was delivered.
- Itemized receipts for the purchase of Essential items claimed by you.
- Letter from Airline/Carrier showing compensation.
- Your airline tickets and baggage tags from the Carrier who caused your luggage to be delayed.

☐ 11. PERSONAL LIABILITY

Important: You must not admit liability or make any offer, promise or payment without our prior written consent. Submit all correspondence/documents from the third party to us immediately for our attention.

1. Date and time of incident:	Place of incident:

2. Please provide details about the incident and the extent of property damaged or bodily injury:
3. When did you first receive notice of the claim?
4. Name, address and contact number of person claiming against you:

5. Is the incident subject to investigation by the police?	☐ No	☐ Yes
If you have answered "Yes", please provide location of police station, date reported and name of the attending officer.		
6. Was there any witness at the time of incident?	☐ No	☐ Yes
If you have answered "Yes", please provide name and address of every witness who was present:		

Please provide us with all of the following required documents relating to you claim:

- Copy of third party's claim / incident report at the premises.
- Any relevant documentation that supports your reason for the damage/loss.
- Copy of your tour booking invoice / travel itinerary
- The itemized original receipts, invoices.
- The medical report / hospital records giving full details of the matter for which treatment was sought. In case of damage to property – please send a quotation for repairs and photographs of damaged items.
- Police report
- Original air tickets.
- Original boarding pass.

Please tick on the relevant section(s) you are claiming:

☐ 12. TRAVEL DELAY ☐ 14. HIJACKING

☐ 13. MISSED FLIGHT CONNECTION ☐ 15. OVERBOOKED SCHEDULED PUBLIC CONVEYANCE

Original Flight Details	Delayed/Rescheduled Flight Details
1. Date of scheduled flight:	6. Date of actual flight:
2. Time:	7. Time:
3. Place of departure:	8. Place of departure:
4. Flight No:	9. Flight No:
5. Name of Airline:	10. Name of Airline:
Reason for travel delay and / or missed flight connection:	

Please provide us with all of the following documents relating to your claim:

- Written confirmation from Airline/Carrier/scheduled public conveyance stating the reason and duration of delay
- Letter from the carrier showing compensation
- Copy of tour booking invoice/travel itinerary.
- Original air tickets.
- Original boarding pass
  Original receipts for meals, accommodation or refreshment expenses incurred if not provided or compensated by airline or carrier (for Missed Flight Connection and Overbooked Scheduled Public Conveyance Claim).

Please tick the relevant section(s)

☐ 16. LOSS OF DEPOSIT OR CANCELLATION ☐ 17. CURTAILMENT

1. Date your trip was originally booked:			2. Date of Travel Cancellation:		
3. Date and details of the incident that caused you to cancel or curtail your trip:					
Cost of original booking	Description of Booked item	Name of Carrier/Travel Agency	Amount of Refund Received	Cancellation Charges	Amount Claimed
e.g. BND2,000	e.g. UK flight	e.g. Royal Brunei Airlines	e.g.BND200	e.g.BND50	e.g.BND1750
If your trip cancellation / curtailment was due to a medical reason, please state:					
4. Name of person taken ill or injured and his / her relationship to you:					
5. Nature of illness or injury:					
6. When was the illness first discovered or when did the injury first occur? (Please state date):					

Please provide us with all of the following documents relating to your claim; For loss of deposit or cancellation:

- The travel agent's letter and tour booking invoice detailing all cancellation charges. This MUST show all amounts paid for your travel and amounts refunded.
- If your travel was cancelled / curtailed due to medical reasons, the Medical Certificate and written advice or diagnosis from the Doctor who recommended cancellation (at the insured's expense).
- If your travel was cancelled due to the unfortunate event of Death, injury, illness of next of kin, death certificate or attending doctor's written advice respectively (at insured's expense)
- Document to confirm relationship of next of kin
- Documents to confirm bankruptcy/insolvency of travel agent
- Any relevant document that supports your reason for canceling
- Copy of original itinerary.

For curtailment

- If due to own injury/illness or that of traveling companion, written advice from overseas attending doctor confirming their advice for you or your traveling companion's return to Brunei(at the insured's expense).
- If due to next of kin injury/illness/death, death certificate or attending doctor's written advice respectively is required (at the insured's expense).
- Document confirming relationship of next of kin.
- Please provide all original transport and accommodation receipts / invoices.
- Terms and conditions issued by Travel Agent and/or Transport, Tour or Accommodation Provider.
- Copy of original itinerary.
- Original air tickets
- Original boarding pass.

Please tick the relevant section(s)

☐ 18. HOMESURE

1. Date of fire:
2. Location of fire:
3. Are you the sole owner of the damaged/lost property?
4. Amount claimed:

Documents required

- Copy of police report
- Photographs of damaged items
- Original purchase receipts of lost/damaged items
- Quotation for repair/replacement

Please tick the relevant section(s)

☐ 19. RENTAL VEHICLE EXCESS

1. Date and time of incident:
2. Period of Hire:
3. Location of accident:
4. Country where the vehicle was rented:
5. Rental car company name:
6. Excess you were liable to pay:
7. Please state in full, exactly what happened for the claim to arise:

Please provide us with all the following required documents relating to your claim;

- Copy of your rental vehicle agreement
- Copy of your certificate of insurance.
- Copy of police report in the country where the accident occurred.
- Copy of repair invoice. A copy of the rental company incident report.
- Copy of the receipt for payment of the damage/excess

DECLARATION

Are there any insurance covering you for the event that is the subject of your claim? ☐ Yes ☐ No

If you have answered "Yes", please provide your policy number and name of the insurance company:

Did you purchase your travel accident insurance coverage by credit card? ☐ Yes ☐ No

If you have answered "Yes", have you made any claim against the card? ☐ Yes ☐ No

Which bank has issued your credit card?

_____

I/We declare that the answers given by me/us in this form are in every respect true and correct and that no material information that is likely to affect this claim has been withheld nor any relevant circumstances omitted. I/we agree to the Company seeking information in connection with this claim from any source and I/we authorize the giving of such information in order to handle my/our claim.

Declared on

_____ _____

Authorized signature and Company's stamp Signature of Claimant

PAYMENT DETAILS

Please note that payment will be made to you by cheque. Kindly provide us with your details as follows:

Payee / Beneficiary's Name: _____

Payee / Beneficiary's Address: _____

_____

_____

Payee / Beneficiary's Identity No.:_____

MEDICAL CLAIM FORM

To be completed by the patient's Doctor/Dentist (at insured's expense) in all claims resulting from accident, sickness or injury.
Please complete this form in BLOCK LETTERS and provide as much information as possible.

PATIENT'S DETAILS

Name	Date of birth
NRIC/Passport No	Gender
In what country did the treatment take place?	
What is the cause of the illness/injury/death?	
Please provide full details of the symptoms/medical condition requiring treatment	

1) On what date did the patient first present these symptoms to you?

2) On what date would the first onset of symptoms have been apparent to the patient?

3) Has the patient suffered from this condition previously?

☐ Yes ☐ No If yes, when? DD MM YY:

4) Are you aware of any treatment given for this or any related illness in the past? ☐ Yes ☐ No
If you have answered yes, please provide details

5) Is it likely to re-occur? ☐ Yes ☐ No
6) Does it need rehabilitation? ☐ Yes ☐ No
7) Is it permanent? ☐ Yes ☐ No
8) Does it need long term monitoring, consultations, checkups, examinations or tests? ☐ Yes ☐ No
If you have answered yes, please provide details:

Please provide name and address of the doctor(s) who had treated the patient previously or referred patient to you:
State how long in your opinion the patient will be disabled to perform his/her normal duty/occupation/business
1) Totally from to
2) Partially from to
Should it be a permanent disablement as per medical report, please state in between 0 - 100 percent pertaining to the affected area suffered by patient at this point in time.

Was the condition of the patient due to the following? (Please tick)

		Yes	No
1	Congenital anomaly or genetic defects present at birth		
2	Study and treatment of sleeping disorder		
3	Dental treatment		
4	Sexually transmitted disease, HIV infection or AIDS		
5	Routine health screening, vaccination or immunization purpose		
6	Functional disorder , depression or mental disorder		
7	Alcoholism		
8	Drug addiction		
9	Cosmetic or plastic surgery		
10	Pregnancy, child birth, infertility , miscarriage, abortion		
11	Self- inflicted injuries		

If you have answered 'Yes' to any of the above, please provide further details:-

Applicable to dental treatment only

Was the patient suffering from sudden dental pain at the time he/she visited you for treatment? ☐ Yes ☐ No

Please provide any other additional information for the Company to assess the claim:

Please provide us with all the following required documents relating to your claim;

- Original medical bills and receipts
- Original medical report
- Discharge Ticket

I hereby certify that the foregoing statements are correct

Signature and stamp of Doctor

Name and address of practicing clinic/hospital

Name of Doctor

Telephone No

Date