

Please complete all sections to facilitate the processing of your claims.

1. Proof of travel i.e. Copy of Arrival/Departure stamps or boarding pass together with passport copy
2. This form is issued without admission of liability
3. Any documentary proof or report required by Liberty Insurance shall be furnished at the expense of the Policyholder or Claimant

### Information of Policyholder

|                              |                    |
|------------------------------|--------------------|
| <b>Name of Policyholder:</b> | <b>Policy No.:</b> |
| _____                        | _____              |

### Information of Claimant

|   |                                 |                      |
|---|---------------------------------|----------------------|
| <b>Name of Claimant:</b>  |                                 | <b>NRIC/FIN No.:</b> |
| _____   |                                 | _____                |
| <b>Email:</b>   |                                 | <b>Contact No.:</b>  |
| _____   |                                 | _____                |
| <b>Mailing Address:</b>   |                                 |                      |
| _____ Postal Code ( )   |                                 |                      |
| <b>Gender:</b>  | <b>Occupation:</b>              |                      |
| <input type="checkbox"/> Female <input type="checkbox"/> Male   | _____                           |                      |
| <b>Are there any other policies of insurance in-force covering you in respect of this event?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |                      |
| If Yes, please state:   |                                 |                      |
| <b>Name of Insurance Company:</b>   | <b>Policy No.:</b>              |                      |
| _____   | _____                           |                      |
| <b>Type of Policy:</b>  | <b>Amount of Compensation:</b>  |                      |
| _____   | _____                           |                      |
| <b>Have you ever had any previous claims?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  |                                 |                      |
| If Yes, please state:   |                                 |                      |
| <b>Name of Insurance Company:</b>   | <b>Date of Previous Claims:</b> |                      |
| _____   | _____                           |                      |
| <b>Circumstances:</b>   | <b>Amount Claimed:</b>          |                      |
| _____   | _____                           |                      |

### Details of Accident/Loss/Injury/Sickness

|  |   |  |
|--|---|--|
| <b>Date of Accident/Loss/Injury/Sickness:</b>  | <b>Time of Accident/Loss/Injury/Sickness:</b> | <b>Place of Accident/Loss/Injury/Sickness:</b> |
| _____  | _____   | _____  |
| <b>Brief Description of Accident/ Loss/ Injury/Sickness:</b>   |   |  |
| _____  |   |  |
| <b>Have you ever suffered any similar condition/recurrence of a previous illness or injury?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| If Yes, please provide details:  |   |  |
| _____  |   |  |

Amount Claimed in respect of Medical Expenses

| Date of Treatment | Details of Medical Expenses Incurred | Currency & Amount Paid |
|-------------------|--------------------------------------|------------------------|
|                   |                                      |                        |
|                   |                                      |                        |
|                   |                                      |                        |
|                   |                                      |                        |

Please provide original medical bills and/or medical reports/memo from the attending doctor stating the diagnosis or nature of the injury/sickness.

Travel Delay/Flight Misconnection

|                                   |                           |                             |                             |
|-----------------------------------|---------------------------|-----------------------------|-----------------------------|
| <b>Details of Original Flight</b> |                           |                             |                             |
| <b>Flight No.:</b>                | <b>Date of Departure:</b> | <b>Time of Departure:</b>   |                             |
| _____                             | _____                     | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
| <b>Place of Departure:</b>        |                           |                             |                             |
| _____                             |                           |                             |                             |
| <b>Details of Delayed Flight</b>  |                           |                             |                             |
| <b>Flight No.:</b>                | <b>Date of Departure:</b> | <b>Time of Departure:</b>   |                             |
| _____                             | _____                     | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
| <b>Place of Departure:</b>        |                           |                             |                             |
| _____                             |                           |                             |                             |

Please provide the following:

- a. E-ticket or original flight itinerary
- b. Letter from Transport Provider confirming the cause and number of hours of delay

Baggage Delay

|                                   |                                   |                             |                             |
|-----------------------------------|-----------------------------------|-----------------------------|-----------------------------|
| <b>Flight No.:</b>                | <b>Date of Arrival:</b>           | <b>Time of Arrival:</b>     |                             |
| _____                             | _____                             | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
| <b>Date of Baggage Collected:</b> | <b>Time of Baggage Collected:</b> |                             |                             |
| _____                             | <input type="checkbox"/> AM       | PM                          |                             |

Please provide the following:

- a. E-ticket or original flight itinerary
- b. Property Irregularity Report
- c. Baggage Acknowledgement Slip

Trip Cancellation/Curtailment

|   |                                      |                            |
|---|--------------------------------------|----------------------------|
| <b>Reason for Cancellation/Curtailment:</b> |                                      |                            |
| _____                                       |                                      |                            |
| <b>Intended Date of Departure:</b>          | <b>Date of Cancellation of Trip:</b> | <b>Amount Paid by You:</b> |
| _____                                       | _____                                | _____                      |
| <b>Amount Refunded:</b>                     | <b>Amount Claimed:</b>               |                            |
| _____                                       | _____                                |                            |

Trip Cancellation/Curtailment

|   |                              |                             |
|---|------------------------------|-----------------------------|
| <b>If Trip/Curtailment has caused any medical condition, has the patient suffered from this condition before?</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If Yes, please state:   |                              |                             |
| <b>Name of Doctor consulted:</b>  | <b>Date of Consultation:</b> |                             |
|   |                              |                             |
| <b>Mailing Address:</b>   |                              |                             |
|   |                              |                             |
|   | Postal Code                  | (            )              |

- Please provide the following:
- a. Supporting documents for trip cancellation/curtailment
  - b. Tour booking invoice/receipt
  - c. Letter from Travel Agency/airline confirming the non-refundable amount of travel costs paid in advance

Loss/Damage to Baggage & Personal Effects

| <b>Date of Loss/Damage:</b>   | <b>Time of Loss/Damage:</b> | <b>Place of Loss/Damage:</b>                             |                            |  |
|---|-----------------------------|--|----------------------------|--|
|   |                             |  |                            |  |
| <b>Please provide full details of circumstances leading to the loss/damage.</b><br>(please retain damaged articles for inspection if necessary) |                             |  |                            |  |
|   |                             |  |                            |  |
| <b>Has this Loss/Damage been reported to the relevant authorities?</b>  |                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                            |  |
| If No, please state reasons:  |                             |  |                            |  |
|   |                             |  |                            |  |
| <b>State the amount of compensation from the authorities (e.g. airline)</b>   |                             |  |                            |  |
|   |                             |  |                            |  |
| Description of Property Lost/Damaged (Brand/Model)  | Owner of Property           | Date of Purchase   | Original Purchase of Price | Original Receipts  |
|   |                             |  |                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |                             |  |                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |                             |  |                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |                             |  |                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |                             |  |                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Please state reasons for non-submission of original receipts (if applicable)</b>   |                             |  |                            |  |
|   |                             |  |                            |  |

- Please provide the following:
- a. Original purchase receipts/invoices of the lost/damaged items
  - b. Written report(s) lodged with Police, Local Government Authority/Transport Provider/Singapore Embassy (whichever applicable)
  - c. Photographs of damaged items

Others

**If you have any other claim, which does not fall within the sections stated above, please provide details here:** \_\_\_\_\_

Bank Account Information for Electronic Transfer

|                          |                                     |                     |
|--------------------------|-------------------------------------|---------------------|
| <b>Name of Bank:</b>     | <b>Bank Code:</b>                   | <b>Branch Code:</b> |
| _____                    | _____                               | _____               |
| <b>Bank Account No.:</b> | <b>Name of Bank Account Holder:</b> |                     |
| _____                    | _____                               |                     |

I agree to hold Liberty Insurance Pte Ltd harmless and that it is fully and finally discharged of its obligations once it has made payment to the bank and bank account number given above.

**PAYMENT BEFORE COVER WARRANTY (INDIVIDUAL)**

Please note that the total premium must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) on or before the inception date of the coverage, failing which the Policy shall be deemed to be automatically canceled and no benefits whatsoever shall be payable by the Company.

**PERSONAL DATA PROTECTION**

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, other insurers, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished in the past, present & in the future, for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing my policies, communicating with me, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at [www.libertyinsurance.com.sg/data-protection-policy/](http://www.libertyinsurance.com.sg/data-protection-policy/). If there is any personal data relating not to myself but to other individuals that I have furnished in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Insurance Pte Ltd and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

**DECLARATION**

- 1) I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorize the release of any medical information necessary to process this claim.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Claimant

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Policyholder & Company Stamp