

PNB GENERAL INSURERS CO., INC.

2nd Floor, PNB Financial Center, Pres. Diosdado Macapagal Blvd. Pasay City
Tel. No.: DL: 832-0311; Trunkline: 891-6040 to 70 Locals: 2109; 2114; 2101; 2103 & 2104

CLAIM INFORMATION SHEET

NOTIFICATION OF CLAIM - TRAVEL INSURANCE

IMPORTANT INSTRUCTIONS:

1. The Claimant must FULLY accomplish the Travel Accident Claim Report Form.
2. For claims processing, all necessary documents have to be submitted. The company reserves the right to request additional documents as deemed necessary.
3. Submission of required documents does not guarantee approval of your claim. The submitted documents will be reviewed and evaluated, subject to the limits, terms and conditions of your existing Travel Policy.
4. This form together with the official receipt(s) must be submitted within a period of not more than 60 days from the date of such claim/loss. Failure of the claimant to submit necessary documents within the given period shall be deemed an abandonment of the claim.

INSURED'S INFORMATION

Insured's Name:		Age:	Sex:
Policy Number:		Address:	
Contact Information:	Home:	Office:	Mobile:
Email Address:			Fax:

CLAIMANT'S INFORMATION

Claimant's Name:		Age:	Sex:
Address:		Birthday:	
		Relationship to Insured:	
Contact Information	Home:	Office	Mobile:

TYPE OF LOSS

PLEASE CHOOSE THE PARTICULAR TYPE OF LOSS:

- | | | |
|---|---|---|
| ☐ Personal Accident | ☐ Baggage Delay | ☐ Trip Curtailment |
| ☐ Medical Expenses | ☐ Flight Delay | ☐ Loss of Travel Documents |
| ☐ Loss/Damage to Baggage | ☐ Trip Cancellations | ☐ Others |

DETAILS OF INJURY OR SICKNESS

Nature and condition of injury or sickness :	
Place / Address where injury / sickness occurred :	
Hospitalization / consultation dates :	
Name of Hospital / Attending Doctor :	Hospital Address / Contact Number(s) :
Date when patient had any prior treatment of the same illness :	

OFFICIAL RECEIPTS SUBMITTED		
Official Receipt (O.R. Number)	Details	Amount

Name of Payee as it should appear on the check : _____

If payee is not the insured, indicate relationship to the insured : _____

TOTAL AMOUNT CLAIMED : _____ (_____)

For processing of payment on approved claims, please indicate bank details for a Direct Credit to your Nominated Bank Account

Bank Account Name :	
Bank Complete Address :	
Bank Account Number :	Bank Account Type :
Relationship to the Patient (if bank account is other than the Patient's) :	
Notes: 1. Applicable only for claim amounts of up to _____. 2. Check shall be the default mode of payment for approved amount beyond _____. 3. Whenever applicable, cost of inter-branch crediting will be deducted from the approved claim account. 4. A processing fee of _____ will be deducted from your claim resulting from the incorrect information provided by the claimant	

ATTENDING PHYSICIAN STATEMENT (If Applicable)		
☐ Out - Patient	☐ In - Patient	Date of Admission :
Date of Consultation :		Date of Discharge :
Complete Diagnosis of Medical Condition :		
Do you consider this consultation / hospitalization as a continuous treatment for a chronic disease?		☐ Yes ☐ No
Does the patient have any other disease or infirmity that is affecting his/her present condition?		☐ Yes ☐ No
If YES, please describe :		_____ Attending Physician's Signature over Printed Name

AUTHORITY, RELEASE AND DECLARATION STATEMENT	
AUTHORITY : I hereby authorize my travel insurance and / or PNB General Insurers Co. Inc. and its authorized representatives to request and receive any information, document or record from any hospital clinic, laboratory, attending physician and other health service provider, which information or documents relates to any examination laboratory test results, medical history and/or treatment in connection with this claim, and such other matters related thereto. RELEASE & SUBROGATION : Payment received by me in relation to this claim shall constitute as full, final and complete settlement. I further agree that the Company is subrogated to my rights of recovery on all claims and rights of action to the extent of the payments made and/or on account of the losses incurred or which may be incurred by the Company against any person, corporation or entity in connection with this claim and I further agree to authorize the Company to commence all legal actions and proceedings necessary to enforce my claim or recovery thereof with any undertaking to extend my cooperation or assistance whenever necessary. DECLARATION : I declare that all data/statements found herein and on all pages of this form are complete and true, whether written by me or by anyone else on my behalf, shall be binding on me, and that the amounts being claimed herein are lawfully due to me under the terms and conditions of the policy.	
_____ Signature over Printed Name of Insured / Claimant or of Principal Insured	_____ Date

CLAIMS REIMBURSEMENT CHECKLIST

NOTE : PLEASE BE INFORMED THAT WE RESERVE TO ASK FOR ADDITIONAL DOCUMENTS ON A CASE TO CASE BASIS

Basic Requirements :

- ☐ Duly-accomplished Notification Of Claim (NOC)
- ☐ Letter of Request or Incident Letter
- ☐ Original Official Receipt(s) or tax invoices for the cost incurred
- ☐ Copy of Flight Itinerary & Boarding Passes
- ☐ Copy of Passport (Pages with biographical date and entry-exit stamps)

For Medical / Hospitalization Expenses : _____ (additional)

- ☐ Original Medical and/or Medical Abstract
- ☐ Laboratory and Test Results
- ☐ Operative and/or Histopathology Reports
- ☐ Hospital Statement of Account and/or Receipts
- ☐ Police Report (if due to accident)

For Baggage Delay

- ☐ Original Property Irregularity Report (P.I.R.) from airline
- ☐ Written confirmation from the airline regarding the length of delay
- ☐ Original Receipts of essential items purchased due to delay of luggage

For Loss of/Damage to Checked-in Baggage

- ☐ Original Property Irregularity Report (P.I.R.) from airline
- ☐ Written confirmation from the airline company about the loss or damage of the checked-in baggage
- ☐ List of contents of the luggage with estimated price and date of purchase of each item
- ☐ Photograph of the damaged item and the original receipt and/or quotation for the repair
- ☐ Original certification of settlement of the compensation payment by the carrier

For Loss of Travel Documents

- ☐ Original Police report from the place where incident occurred
- ☐ Essential costs to replace the passport
- ☐ Travel cost to embassy (Original receipts)
- ☐ Accommodation if required to wait (Original receipts)
- ☐ Original receipts for costs or fees to obtain new travel document

For Accidental Death and Dismemberment

- ☐ Written notice of claim must be submitted to the Company within 7 days from the date of accidental death. The Company reserves the right to deny any claim where notices are filed beyond 7 days.
- ☐ Hospital and physician's report indicating the nature of the loss and extent and period of disability
- ☐ Police reports when relevant
- ☐ In case of death, a copy of the Coroner's report on post-mortem examination
- ☐ Proof of Relationship of claimant with the insured
- ☐ NSO Authenticated Death and Birth Certificate

For Loss of Baggage or Personal Belongings not Checked-in

- ☐ Original Police report from the place where incident occurred duly listing the contents of the luggage and their value
- ☐ Original purchase receipts & warranty cards (if applicable) for the items claimed (Proof of ownership)
- ☐ Certification from hotel or any other party that the loss was not indemnified, or if settlement was made, certification specifying amount settled
- ☐ Picture of locks that were forcibly opened (if applicable)
- ☐ Notarized affidavit for an official statement on what happened

For Travel Cancellation Expenses and Trip Curtailment

- ☐ Reason Unable to Travel (Affidavit stating the Reason of cancelling the trip)
- ☐ Medical (Medical Report and/or Medical Abstract)
- ☐ Death (Death Certificate)
- ☐ Accident (Police Report)
- ☐ Jury (copy of Court Order or Jury Notice)
- ☐ Proof of relationship between Insured Person and the Immediate family member (if needed)
- ☐ Original Receipts or Tax invoice for proof of advance payment made for transportation and accommodation expenses issued by the agency or directly by the wholesaler (airline or hotel) and a copy of the travel voucher
- ☐ Original cancellation document proving the non-refundable portion specified (e.g. travel agency's certification, letter from the airline to the travel agency or client stating that the carrier can't refund the airfare, & statement from the hotel regarding cancellation policies) Original Receipts or Tax invoice for the additional feed paid for the return ticket to home country such as no show fee, rebooking fees, penalties, etc. with a copy of the new travel itinerary

For Flight Delay

- ☐ Original Certification from the Airline Company with cause
- ☐ Original Receipts of expenses incurred due to incident
- ☐ Copy of the flight itinerary of the actual time and date of departure

- ☐ 2 Valid/Government issue ID cards of the insured and beneficiary
In case of permanent disability, original medical report on the sustained injury and/or permanent disability
- ☐ Certification to the legal personality of the beneficiaries. Should these be the legal heirs, order of declaration of heirs made by the competent court will be necessary
- ☐ Certificate of from the Register of Last will procedure, if the designation of beneficiaries were made by will (if applicable)
- ☐ Letter of payment of or exemption from General Inheritance Tax, duly filled out by the relevant Tax office
Other legal documents required

IMPORTANT NOTICE:

< Advice of Loss should be made at least 30 days from the date of the incident

< Submission of all relevant documents must be submitted within 60 days after the date of such loss

FOR EVALUATION PURPOSES - DO NOT FILL UP

Reference File Number:	CLAIM OUTCOME
EVALUATION :	Approved Denied
	Processed By: SIGNATURE OVER PRINTED NAME
	Approved By: SIGNATURE OVER PRINTED NAME