



AIG Egypt Insurance Company S.A.E
Giza - Egypt
44 Abdelmonem Riad St. 2 nd. Floor
Mohandeseen

TRAVEL CARE INSURANCE CLAIM FORM

IMPORTANT:

Please contact at our 24-hour help line- Assistance Center :

Table with 3 columns: Zone, Assistance Company, Claims Administrator. Rows include Europe, USA & Canada, and Rest of the world.

- Please note, the first EGP 500 of your expenses is deductible, and must be borne by you.
1. This is a One Call Claim Form, we may ask for more details upon notification.
2. Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract
3. No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format (Attending Doctor's Report - Page 4)
4. Please answer all questions completely. In case of insufficient space, please attach an additional sheet
5. Please attach all bills, receipts, credit card slips pertaining to your claim.

Certificate/ Policy No. Period From to:

DETAILS OF THE APPLICANT

Name : Phone Nos.
Address:
Relationship with Insured person:

DETAILS OF PATIENT/ INSURED PERSON

Name : Phone Nos.
Permanent Address:
Date of Birth: / / Sex: M / F
Assistant Co. Ref. No.: Passport No.:
Date of Departure: / / Flight No. From to
Date of Arrival: / / Flight No. From to
Please indicate whether claim is in respect of :

- Accident & Sickness Hospitalization Benefit Travel Delay Baggage Loss
Baggage Delay Loss of Passport Personal Liability Hijack
Please complete the Section relevant to your claim.

LOSS/DELAY OF CHECKED BAGGAGE

Describe when & where the loss/delay took place:
State the extent of Loss:
Name the common carrier:
1. Flight No. From to
2. Flight No. From to
Has the common carrier been notified at the time of loss? Yes No Airline Reference No.
Details of compensation received from carrier:
Scheduled date/time of Arrival: / / ; : hrs. Actual date/time when bags delivered : / / ; : hrs
No. of Hours delayed :

Table with 4 columns: Item Purchased/Lost \*, Date of Purchase, Place, Cost. Includes a summary row for TOTAL and Net Amount.

**LOSS OF PASSPORT**

Please provide details of the incident i.e. when, where and how it happened: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Details of Police Report (please attach copy): No: \_\_\_\_\_ Date: \_\_\_\_\_ Place: \_\_\_\_\_

Details of Expense incurred	Date	Place	Amount
		<b>TOTAL</b>	

**TRAVEL DELAY**

Flight No. \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_  
 Scheduled time of Departure: \_\_\_\_\_ Actual time of Departure: \_\_\_\_\_ No. of Hours delayed: \_\_\_\_\_  
 Whether accommodation & boarding provided by carrier: Yes  No

Details of Expense incurred	Date	Place	Amount
		<b>TOTAL</b>	

**HIJACKING**

Flight Details: No. \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_  
 Scheduled Date & time of Departure: \_\_\_\_\_ Scheduled date & time of arrival: \_\_\_\_\_  
 Date and time of Hijack: \_\_\_\_\_ Date & time Returned: \_\_\_\_\_  
 Please provide details of incident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PERSONAL LIABILITY**

Please provide details of injury/ property damaged: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Details of Amount Claimed: \_\_\_\_\_  
 Any other information you would like us to have: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### MEDICAL ACCIDENT & SICKNESS BENEFIT

If accident, details of accident i.e. how, when, where it took place: \_\_\_\_\_  
 \_\_\_\_\_

Date: \_\_\_\_\_ Place: \_\_\_\_\_  
 If sickness, state nature and diagnosis, and advise when & where symptoms first occurred: \_\_\_\_\_  
 \_\_\_\_\_

Date: \_\_\_\_\_ Place: \_\_\_\_\_  
 Name & Address of consulting physician: \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been treated for this illness before:  Yes  No  
 If yes, provide name & address of consulted physician: \_\_\_\_\_  
 \_\_\_\_\_

Provide name & address of your family physician: \_\_\_\_\_  
 \_\_\_\_\_

Provide name of any prescription medicine you are presently taking: \_\_\_\_\_

Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer: \_\_\_\_\_  
 \_\_\_\_\_

Details of treatment	In/ Out Patient		Charges (Currency)	Egyptian Pounds
	From	To		
			Paid	
			Outstanding	
			<b>TOTAL DUE</b>	

Whether Assistance Co. was contacted: Yes  No  If Yes, Reference No. \_\_\_\_\_  
 If No, give reasons: \_\_\_\_\_  
 \_\_\_\_\_

#### AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, 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 Photostat copy of this authorization shall be considered as effective and valid as the original.

Date: \_\_\_\_\_ Place: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Signature of insured :** \_\_\_\_\_

**Attending Doctor's Report**

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F Address: \_\_\_\_\_  
\_\_\_\_\_  
Date contacted: \_\_\_\_\_ Time: \_\_\_\_\_

**For Accidental Injury**

Nature of Injury: \_\_\_\_\_  
X-Ray Taken: Yes  No  Date taken: \_\_\_\_\_  
Diagnosis and Treatment Given: \_\_\_\_\_  
\_\_\_\_\_  
Describe any other disease or infirmity affecting present condition: \_\_\_\_\_

**For Sickness**

Nature of Illness: \_\_\_\_\_  
\_\_\_\_\_  
Diagnosis and Treatment Given: \_\_\_\_\_  
\_\_\_\_\_  
When did patient's symptoms first appear: \_\_\_\_\_  
Describe any other disease or infirmity affecting present condition: \_\_\_\_\_  
Is condition due to Pregnancy: Yes  No  Is illness due to any pre-existing condition: Yes  No

***If Hospitalized, please provide the following details:***

Name of Hospital/ Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Attending Doctor's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Attending Doctor's Signature