AIG

TRAVEL GUARD

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 :

Zone	Assistance Company	Claims Administrator
Europe	**Europe Assistance (Suisse) S.A** Tel.:+ 00 41 22 341 02 04/ Fax:+ 00 41 22 939 22 45	**Golden Care** 31,bd. Helvetique, 1207, Geneva Tel.:+ 41 22 786 1200 / Fax:+ 41 22 786 1220 e-mail:travelegypt@egoldencare.com
USA & Canada	**Travel Guard Assist** +1-877-897-1934	Travel Guard Assistance Claims Services 2727 Allen Parkway Suite 200 Houston TX 77019 houclaims@travelguard.com
Rest of the world	**Travel Guard Assist** +1- 817-826-7234	

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 :_____

Item Purchased/Lost *	Date of Purchase	Place	Cost
Less Compensation received from Airline:		**TOTAL**	
**** In case of Delay, please provide details of purchases made***			
**** In case of Loss, please provide details of items lost.***		**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
		TOTAL	

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
		TOTAL	

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	
			TOTAL DUE	

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