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