Claim Form

Travel

By Furnishing this form the company makes no admission of liability or waiver of its rights	Policy Number	Claim Number

INSURED PERSONS FULL NAME | HOME ADDRESS | CITY | STATE

DATE OF BIRTH | OCCUPATION | SEX | TELEPHONE NO.

Are there any other policies of insurance in force covering you in respect of this mishap? If so, please give details……

Exact place where accident occurred……

Date of incident……Time……a.m./p.m……..

Give brief description of the incident……

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Name and address of any witness……

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SECTION 1 – PERSONAL ACCIDENT – MEDICAL AND ADDITIONAL EXPENSES

State nature of illness/injury……..	
Have you ever suffered this or a similar condition or a recurrence of a previous illness or injury? If yes, give full details……	
What amount are you entitled to claim under any other policy of insurance of Medical Benefit Fund? Give details……..	

State amount claimed (Attached account/medical certificates or other documents in support of your claim.) …….	**K**

Give name of all attending Physicians ……..		

If claiming weekly benefits attach proof of average weekly earnings from your employer……	**K**

SECTION 2 – CANCELLATION/LOSS OF DEPOSIT

1. When was holiday booked?.....		Through Whom
2. Intended departure date…….. 3. Date cancelled……...		
4. Reason for cancellation (If due to illness attach medical certificate)…… ……..		
5. Amount claimed (Attach supporting documents)……		**K**

SECTION 4 – LUGGAGE & PERSONAL EFFECTS
SECTION 5 – PERSONAL MONEY **Date Notifies**

1. Which police were advised? State police station and attach copy report hereto ……		To whom
2. Have you lodged any claim or complaint against any carrier/Airline or other authority or against any individual responsible for any loss or damage to your property? If so, give details and attach copies of correspondence.	Airlines:_____ _____ _____	Claim No._____ _____ _____

Give details of amount claimed

Item	Description	When and Where Purchased	Original Cost Price	Depreciation for wear and tear	Amount Claimed

SECTION 6 – PERSONAL LIABILITY

1. Name and address of person claiming against you……	
2. Are you related in any way or did you know them prior to the incident? If so, give details……..	
3. Name of injuries/damage sustained by other parties……	
4. Was the incident reported to the police or other authority? If so, give Details……..	

Please attach any claim/writ or summons issued against you . Do not make any admission, offer, promise or payment without written **consent of the company.**

With regard to personal Accident/Medical Expenses/Additional Expenditure claim, I hereby authorise any hospital physician or other person who has attended me, or any employer, to furnish Alpha Insurance Limited or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment copies of all hospital or medical records and copies of all employers, I agree that a photostat copy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said claim shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the policy shall be void and all rights to recover in respect of past or future claims shall be forfeited.

Date……..Signed……