Liberty Pte. Limited
One Raffles Quay #40-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY (5423 789)
UEN | GST Reg. No. 201538069C
libertyinternational.com/sg

Claim Form: Travel

Please complete all sections to facilitate the processing of your claims.

1. Proof of travel i.e. Copy of Arrival/Departure stamps or boarding pass together with passport copy
2. This form is issued without admission of liability
3. Any documentary proof or report required by Liberty shall be furnished at the expense of the Policyholder or Claimant
4. Please submit the completed and signed claim form together with supporting documents to: Claims_admin.sg@libertymutual.com.

Information of Policyholder

Name of Policyholder:	Policy No.:
_____	_____

Information of Claimant

Name of Claimant:	NRIC/FIN No.:
_____	_____
Email:	Contact No.:
_____	_____
Mailing Address:	
_____	Postal Code ( )
Gender: ☐ Female ☐ Male	Occupation: _____
Please advise Period of Travel for this trip.	From: To:

Are there any other policies of insurance in-force covering you in respect of this event? ☐ Yes ☐ No

If Yes, please state:

Name of Insurance Company: Policy No.:

_____ _____

Are you making a claim for the same event from another source/policy? ☐ Yes ☐ No

If Yes, please state:

Claim Details: Amount Claimed:

_____ _____

Was there any compensation provided? ☐ Yes ☐ No

If Yes, please state:

Amount of Compensation:

_____

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Have you ever had any previous claims? ☐ Yes ☐ No
If Yes, please state:

Name of Insurance Company: _____

Date of Previous Claims: _____

Circumstances: _____

Amount Claimed: _____

Details of Accident/Loss/Injury/Sickness

Date of Travel Period:

Date of Accident/Loss/Injury/Sickness:	Time of Accident/Loss/Injury/Sickness:	Place of Accident/Loss/Injury/Sickness:
_____	_____	_____

Brief Description of Accident/Loss/ Injury/Sickness: _____

Have you ever suffered any similar condition/recurrence of a previous illness or injury? ☐ Yes ☐ No
If Yes, please provide details:

_____

Amount Claimed in respect of Medical Expenses

Date of Treatment	Details of Medical Expenses Incurred	Currency & Amount Paid

Please provide original medical bills and/or medical reports/memo from the attending doctor stating the diagnosis or nature of the injury/sickness.
For all hospitalisations overseas, please obtain detailed medical reports from Doctor concerned.

Travel Delay/Flight Misconnection/Travel Diversion

Original Flight No.:	Original Departure Date:	Time of Departure: ☐ AM ☐ PM
_____	_____	
Actual Flight No.:	Actual Departure Date:	Time of Departure: ☐ AM ☐ PM
_____	_____	

Cause of Delay:	Length of Delay:
_____	_____

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Please provide the following:
a. E-ticket or original flight itinerary
b. Letter from Transport Provider confirming the cause and number of hours of delay

Baggage Delay

Flight No.:	Flight Arrival Date:	Time of Arrival:
_____	_____	☐ AM ☐ PM
Baggage Collection Date:	Place of Baggage Collection:	Baggage Collection Time:
_____	_____	☐ AM ☐ PM

Please provide the following:

a. E-ticket or original flight itinerary b. Property Irregularity Report c. Baggage Acknowledgement Slip

Trip Cancelation/Curtailment

Reason for Cancelation/Curtailment: _____		
Intended Date of Departure:	Date of Cancelation of Trip:	Amount Paid by You:
_____	_____	_____
Amount Refunded:	Amount Claimed:	
_____	_____	

If Trip/Curtailment has caused any medical condition, has the patient suffered from this condition before? ☐ Yes ☐ No

If Yes, please state:

Name of Doctor consulted: _____ Date of Consultation: _____

Mailing Address: _____ Postal Code ( )

Please provide the following:
a. Supporting documents for trip cancelation/curtailment
b. Tour booking invoice/receipt
c. Letter from Travel Agency/airline confirming the non-refundable amount of travel costs paid in advance

Loss/Damage to Baggage & Personal Effects, Loss of Money, Loss of Travel Documents

Date of Loss/Damage:	Time of Loss/Damage:	Place of Loss/Damage:
_____	_____	_____

Please provide full details of circumstances leading to the loss/damage.
(please retain damaged articles for inspection if necessary) _____

Has this Loss/Damage been reported to the relevant authorities and police overseas? ☐ Yes ☐ No

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If No, please state reasons:

_____

State the amount of compensation from the service provider (if applicable)
Otherwise, please provide evidence of denial from service provider (if applicable) _____

Loss/Damage to Baggage & Personal Effects

Description of Property Lost/Damaged (Brand/Model)	Owner of Property	Date of Purchase	Original Purchase of Price	Original Receipts
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Please state reasons for non-submission of original receipts (if applicable) _____

Please provide the following:

a. Original purchase receipts/invoices of the lost/damaged items
b. Written report(s) lodged with Police, Local Government Authority/Transport Provider/Singapore Embassy (whichever applicable)
c. Photographs of damaged items

Others

If you have any other claim, which does not fall within the sections stated above, please provide details here:

_____

Payment Details

Please select the claim payment mode.

☐ For payment by direct transfer into Policyholder's bank account.
☐ For payment by direct transfer into bank account under someone other than Policyholder.
A Letter of Authorization and/or proof of relationship is required, together with a copy of the payee's identification document (NRIC or passport) and bank statement.

Full name (as shown in the bank account):	Nationality:
_____	_____
Name of Bank:	Bank Account Number:
_____	_____

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☐ For payment by PayNow
Please provide us with a copy of NRIC for verification purpose. The claim reimbursement can only be made to the Insured/Claimant and will be paid via transfer to your bank account linked by PayNow NRIC/FIN ID by default. Please ensure that you have signed up for PayNow with your bank by linking it to your NRIC/FIN ID.

NRIC/FIN ID:	UEN:
_____	_____

INDEMNITY
The Company shall not be liable for any loss incurred by you as a result of you providing the Company with incorrect bank account details for the payment of your claim.

PAYMENT BEFORE COVER WARRANTY (INDIVIDUAL)

Please note that the total premium must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) on or before the inception date of the coverage, failing which the Policy shall be deemed to be automatically canceled and no benefits whatsoever shall be payable by the Company.

PERSONAL DATA PROTECTION
By signing this form, I/we consent to Liberty Pte. Limited ("Liberty") and its authorised service providers, related entities, and partners (collectively, "Appointees") collecting, using, and disclosing my/our personal data, and any personal data of other individuals provided by me/us, for purposes including: assessing and providing insurance products and services; policy administration, renewals, claims, and payments; compliance, audit, and regulatory reporting; research, analytics, and service improvement; and communication and customer support. I/we confirm that I/we have read and agree to Liberty's Privacy Policy, which explains how Liberty manages personal data, including cross-border transfers. If I/we provide personal data of other individuals, I/we warrant that I/we have obtained their consent (or consent from their legal representatives, where applicable) for these purposes. I/we understand that I/we may access, correct, or withdraw consent for my/our personal data at any time by contacting Liberty's Data Protection Officer at privacy.officer.ap@libertymutual.com, subject to legal and contractual obligations.

DECLARATION

1) I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

   I authorize the release of any medical information necessary to process this claim.

_____	_____
Date	Signature of Claimant
_____	_____
Date	Signature of Policyholder & Company Stamp