



Liberty Pte Limited
One Raffles Quay #40-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY (5423 789)
UEN | GST Reg. No. 201538069C
libertyinsurance.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.: _____
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Information of Claimant

Name of Claimant: _____	NRIC/FIN No.: _____
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Email: _____	Contact No.: _____
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Mailing Address: _____	Postal Code () _____
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Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Occupation: _____
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Please advise Period of Travel for this trip.	From:	To:
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Are there any other policies of insurance in-force covering you in respect of this event?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If Yes, please state:

Name of Insurance Company: _____	Policy No.: _____
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Are you making a claim for the same event from another source/policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If Yes, please state:

Claim Details: _____	Amount Claimed: _____
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Was there any compensation provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If Yes, please state:

Amount of Compensation: _____



Claim Form - Travel

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:
_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Actual Flight No.:	Actual Departure Date:	Time of Departure:
_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Cause of Delay:	Length of Delay:	
_____	_____	



Claim Form - Travel

Please provide the following:

- E-ticket or original flight itinerary
- Letter from Transport Provider confirming the cause and number of hours of delay

Baggage Delay

Flight No.:	Flight Arrival Date:	Time of Arrival: <input type="checkbox"/> AM <input type="checkbox"/> PM
Baggage Collection Date:	Place of Baggage Collection:	Baggage Collection Time: <input type="checkbox"/> AM <input type="checkbox"/> PM

Please provide the following:

- E-ticket or original flight itinerary
- Property Irregularity Report
- Baggage Acknowledgement Slip

Trip Cancellation/Curtailment

Reason for Cancellation/Curtailment: _____		
Intended Date of Departure:	Date of Cancellation 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please state:		
Name of Doctor consulted:	Date of Consultation:	
Mailing Address:	Postal Code ()	

Please provide the following:

- Supporting documents for trip cancellation/curtailment
- Tour booking invoice/receipt
- 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		



Claim Form - Travel

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
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Please provide the following:

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

Please provide a copy of your bank account statement showing the Name of Bank, Name of Account Holder and Account Number for your initial claim submission.

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

- 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: _____
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Claim Form - Travel

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 Data Protection Policy at <https://www.libertyinternational.com/sg/footer/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@libertyglobalgroup.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

