



**Liberty Pte Limited**  
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Singapore 048583  
Tel: 1800-LIBERTY (5423 789)  
UEN | GST Reg. No. 201538069C  
libertyinternational.com/sg

### Claim Form: Overseas StudentCare

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](mailto: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.: _____
Email: _____	Contact No.: _____
Mailing Address: _____ Postal Code (       )	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Occupation: _____
<b>Are there any other policies of insurance in-force covering you in respect of this event?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state: Name of Insurance Company: _____ Policy No.: _____ Type of Policy: _____ Amount of Compensation: _____	
<b>Have you ever had any previous claims?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state: Name of Insurance Company: _____ Date of Previous Claims: _____	



## Claim Form - Overseas StudentCare

Circumstances:	Amount Claimed:
_____	_____

### Details of Accident/Loss/Injury/Sickness

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.

### Travel Delay/Flight Misconnection

#### Details of Original Flight:

Flight No.: \_\_\_\_\_ Date of Departure: \_\_\_\_\_ Time of Departure:  AM  PM

Places of Departure: \_\_\_\_\_

#### Details of Delayed Flight:

Flight No.: \_\_\_\_\_ Date of Departure: \_\_\_\_\_ Time of Departure:  AM  PM

Places of Departure: \_\_\_\_\_



## Claim Form - Overseas StudentCare

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.:	Date of Arrival:	Time of Arrival:
_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Date of Baggage Collected:	Time of Baggage Collected:	
_____	<input type="checkbox"/> AM <input type="checkbox"/> PM	

Please provide the following:

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

### Loss/Damage to Baggage & Personal Effects

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?**

Yes       No

If No, please state reasons:

\_\_\_\_\_

**State the amount of compensation from the authorities (if applicable)**

\_\_\_\_\_

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

**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



# Claim Form - Overseas StudentCare

## Others

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

## Bank Account Information for Electronic Transfer

Name of Bank: _____	Bank Code.: _____	Branch Code: _____
Bank Account No.: _____	Name of Bank Account Holder: _____	

I agree to hold Liberty Pte Limited harmless and that it is fully and finally discharged of its obligations once it has made payment to the bank and bank account number given above.

## 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](mailto: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

\_\_\_\_\_  
Authorized Signature &  
Company Stamp of Policyholder

