

# Travel Insurance

## Claim Form

TO FACILITATE THE PROCESSING OF YOUR CLAIM, YOU ARE REQUIRED TO COMPLETE SECTIONS A, B AND C FOR ALL CLAIM SUBMISSIONS.

The issue and acceptance of this form does NOT constitute an admission of liability by Chubb Arabia Cooperative Insurance Company or waiver of its rights.

The information requested and documents mentioned in this form are a general guide. Further documents or information may be required depending on

the circumstances of your claim. Note that failure to provide supporting documentation may result in delays in the processing of your claim.

Your Policy may not provide cover under every section shown in this Claim Form.

### **Section A: Particulars of Policyholder/Insured Person and Claimant**

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**Name of Policyholder/ Insured Person (as shown in ID/Passport)**

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**Address of Policyholder/ Insured Person**

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**Post code**

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**Policy No**

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**Period of insurance**

**From**

**To**

**Tel No. (Mobile)**

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**Tel No. (Office)**

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**Tel No. (Residence)**

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**Email**

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**Name of Intermediary (if any)**

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**Gender**

Male  Female

**ID/Passport No.**

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**Nationality**

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**Date of birth**

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**Age**

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**Occupation**

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**Date of employment**

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**Name of employer**

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**Name of Claimant (as shown in ID/Passport) - if different from Policyholder/Insured Person**

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**Address of Claimant**

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**Post code**

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**Policy No**

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**Periof of insurance**

**From**

**To**

**Tel No. (Mobile)**

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**Tel No. (Office)**

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**Tel No. (Residence)**

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**Email**

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**Name of Intermediary (if any)**

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**Gender**

Male  Female

**ID/Passport No.**

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**Nationality**

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**Date of birth**

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**Age**

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**Occupation**

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**Date of employment**

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**Name of employer**

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**Section B: Payment Details**

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Please provide details for payment of your claim in the event that the claim is deemed payable by Chubb Arabia Cooperative Insurance.

I hereby authorise and request Chubb to pay benefit due in respect of this claim as follows (Name as per Bank Account):

- Electronic Funds Transfer (for payments in SAR and to bank accounts in KSA)

Payee Name (as per bank account name)

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Name of Bank

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Branch Code No.

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Account No.

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- Cheque Payment

Payee Name (as per bank account name)

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If no name is provided, settlement will be effected to the policyholder as provided for under the terms of the policy.

**Section C: Details of the Accident/Loss/Illness**

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**Chronology and Description of the Accident/Loss/Illness**

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**Date of departure from KSA** \_\_\_\_\_

**Period of travel**                      **From** \_\_\_\_\_ **To** \_\_\_\_\_

**Destination Country(s)** \_\_\_\_\_

**Place of Occurrence** \_\_\_\_\_

**Purpose of trip**       Leisure     Business     Others (Please specify) \_\_\_\_\_

**Date of Accident/Loss/Illness** \_\_\_\_\_

**Time of Accident/Loss/Illness** \_\_\_\_\_

**When and who discovered the Accident/Loss** \_\_\_\_\_

**Relationship of person to the Insured** \_\_\_\_\_

**Were there witnesses to the accident?**                       Yes                       No

If Yes, please provide the following details

	<b>Witness 1</b>	<b>Witness 2</b>
Name	_____	_____
Address	_____	_____
ID/Passport No	_____	_____
Contact Number	_____	_____

**Section D: Personal Accident/Illness – Medical and Additional Expenses**

Please note:

1. Personal Accident - please enclose Police Report (if any), Detailed Medical Report, Medical Certificate.
2. Medical, Dental or Post Journey Medical Expenses – please enclose Original Detailed Pre-Medical/Final Hospitalisation/Post-Medical Bills, Inpatient Discharge Summary, Detailed Medical Report/Memo from Attending Physician on the type of illness or injury sustained.
3. Emergency Travel Expenses – please enclose Certified True Copy of Death Certificate and Proof of Relationship or written advice of attending Physician indicating the need to travel to or remain with the Insured Person, with Original Bills and Receipts of travel and accommodation expenses incurred.
4. Accidental Death – please enclose Police Report, Certified True Copy of Death Certificate, Autopsy Report, Toxicological Report.

1. Was it due to illness?  Yes  No

If Yes, please specify type of illness \_\_\_\_\_

When did first symptoms appear? \_\_\_\_\_

When did you receive medical attention for this condition? Please provide name & address of Attending Physician.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Have you ever had this or similar condition?  Yes  No

If Yes, please provide details: \_\_\_\_\_

Is this a Routine Check-up?  Yes  No

If Yes, please provide details, dates and name and address of the Attending Physician.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Was it due to an Accident?  Yes  No

If yes, please provide the Date of Accident \_\_\_\_\_

Details of the Accident and Injury (Kindly also indicate the location where Accident occurred)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Amount paid by you**

**Amount recovered from other sources (please provide details of settlement)**

**Amount claiming against Chubb**

**Section E: Cancellation/Curtailment**

Please note:

1. Please enclose documentary proof of relevant expenses incurred as a result of this trip cancellation or curtailment, original trip booking and invoice, Death Certificate, Medical Report and/or Written Memo from Attending Physician to cancel trip, Proof of Relationship, Travel Agents' confirmation of the amount of refund.
2. Original Invoice or Receipt of charges incurred in amending or purchasing additional air ticket (for Trip Curtailment).

When, where and with which Provider was the holiday booked?

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Intended Departure Date \_\_\_\_\_

Please state the reason for Cancellation / Curtailment

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Date you became aware of the need to cancel/curtail your trip \_\_\_\_\_

Date Cancelled/Curtailed \_\_\_\_\_

Amount paid by you	Amount recovered from other sources (please provide details of settlement)	Amount claiming against Chubb
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**Section F: Loss of Luggage**

Please note: Losses must be reported to the Police Authority, responsible Hotel Management or responsible officer of any aircraft, conveyance immediately, in any event within 24 hours from the time of occurrence.

Please enclose Police Report or report issued by responsible Hotel Management or carrier evidencing such losses, Property Irregularity Report for losses in carriers' custody, Original Purchases Bills, Photographs of damaged items, original Repairs Bills for damaged items. If the responsible Hotel Management or carrier has made compensation for the damaged or lost items, please request them to issue a note or letter certifying the compensation issued or will be issued to you.

Details of amount claimed (Please use supplementary sheet if necessary)				
Description of item	When and where purchased	Original purchase price	Amount recovered from other sources (Please provide details of settlement)	Amount claiming against Chubb

Any actions taken in attempt to recover your property?  Yes  No

If Yes, please provide details on the actions taken; if No, please provide details for not attempting recovery.

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**Section G: Travel Documents**

Please note: Losses must be reported to the Police Authority, responsible Hotel Management or responsible officer of any aircraft, conveyance immediately, in any event within 24 hours from the time of occurrence.

Please enclose Police Report or report issued by responsible Hotel Management or carrier evidencing such losses, Original Receipts for replacement of travel documents.

**Details of amount claimed (Please use supplementary sheet if necessary)**

Amount lost or stolen	Amount recovered from other sources (Please provide details of settlement)	Amount claiming against Chubb
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**Section H: Flight Delay/Baggage Delay/Flight Overbooking**

Please Note:

1. Flight Delay / Misconnection/ Diversion – enclose the original itinerary, boarding pass showing the actual take off time and date, written confirmation from carrier/airline or their agents specifying reasons for and hours of delay/diversion.
2. Baggage Delay – to enclose original itinerary, written confirmation from carrier/airline or their agents specifying reason and the number of hours of baggage delay, Property Irregularity Report, Acknowledgement Receipt of baggage received.

**Reason for claim**

Flight Delay  Baggage Delay  Flight Overbooking  Hotel Cancellation

**Details of flight itinerary**

Original Travel Details	Actual Travel Details
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**Flight Delay**

Transport/Flight No.:	Transport/Flight No.:
Scheduled Departure Date, Time and Place:	Scheduled Departure Date, Time and Place:
Scheduled Arrival Date, Time and Place:	Scheduled Arrival Date, Time and Place:

Length of delay: \_\_\_\_\_

Reason provided by Carrier for cause of delay (Please provide documentary proof from Carrier):

\_\_\_\_\_

\_\_\_\_\_

**Hotel Cancellation**

Name & Address of the Hotel: \_\_\_\_\_

Reason for cancellation: \_\_\_\_\_

Date of cancellation: \_\_\_\_\_

Amount of claim: \_\_\_\_\_

Any refund paid back by the hotel on cancellation: \_\_\_\_\_

Length of Delay: \_\_\_\_\_

**Baggage Delay**

Arrival Date, Time and Place: \_\_\_\_\_

Date, Time and Place you received your baggage: \_\_\_\_\_

Length of Delay: \_\_\_\_\_

<b>Expenses incurred by you: (please state date and item(s), this may not be applicable, depending on the coverage under the policy that you have.)</b>	<b>Amount recovered from other sources: (please provide details of settlement)</b>	<b>Amount claiming against Chubb:</b>
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**Section J: Others (Please specify details of any claim other than Section C to H)**

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Name of Police Station, Carrier/Airline or other authorities where Report lodged (if applicable):

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**Details of claim (Please use supplementary sheet if necessary)**

**Amount claimed**

Have you engaged solicitors to represent you?

Yes  No

If Yes, please provide details of solicitors.

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**Section K: Any Other Insurance/Claims**

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(Please use supplementary sheet if necessary)

1. Are there any other policies of insurance in force covering you in respect of this event?

Yes  No

If Yes, please specify below:

**Name and address of insurance company(s)**

**Policy No(s)**

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Are you claiming under any of the policies listed above?

Yes  No

If Yes, please provide Claim Reference No.:

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2. Are you making a claim against any other party in respect of this event?

Yes  No

If Yes, please specify below:

**Name of person(s) claiming against**

**Address and contact details**

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**Section L: Claims History**

1. Have you or the Insured Person previously made claim(s) under a travel, medical or accident policy?  Yes  No
2. Have you or the Insured Person made claims with similar occurrences or involving similar items?  Yes  No

If the answer is Yes to any of these, please provide details below:  
(Please use supplementary sheet if necessary)

Date and circumstances of claim(s)	Name(s) of insurance company(s) involved (please indicate claim reference no. & policy no.)
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**Section M: Declaration**

Did you remember to enclose the following? *(Where applicable)*

Document	Yes	NA
Travel Documents (i.e. Air Tickets and/or Boarding Pass)	<input type="checkbox"/>	<input type="checkbox"/>
Medical Bills (Original copy need to be submitted for Reimbursement claim)	<input type="checkbox"/>	<input type="checkbox"/>
Written notes from Physician on type of injury sustained/Inpatient Discharge Summary or Medical Report	<input type="checkbox"/>	<input type="checkbox"/>
Traffic Police Report (if involved in Road Accident)	<input type="checkbox"/>	<input type="checkbox"/>
Original purchase receipts and photographs (for Loss and/or stolen luggage claim)	<input type="checkbox"/>	<input type="checkbox"/>
Overseas Police or relevant authorities concerned Report (Loss of Travel documents /passport claims)	<input type="checkbox"/>	<input type="checkbox"/>
Documents with relevant authorities concerned (for Damage of personal property claim)	<input type="checkbox"/>	<input type="checkbox"/>
Settlement/Reply Letter from transport service provider, hotel or travel agent (for Curtailment or Cancellation claim)	<input type="checkbox"/>	<input type="checkbox"/>
Written confirmation issued by the transport service provider (for Baggage Delay, Flight Delay or Flight Misconnection claim)	<input type="checkbox"/>	<input type="checkbox"/>
Confirmation of receipt of luggage (for Luggage Delay claim)	<input type="checkbox"/>	<input type="checkbox"/>
Death Certificate, Post Mortem Report, Autopsy Report, Police Reports, Letter of Administration (if involves Fatalities)	<input type="checkbox"/>	<input type="checkbox"/>
Documents to proof occurrences of the incident and amount claimed	<input type="checkbox"/>	<input type="checkbox"/>

**Section M: Declaration (Continued)**

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By signing this form, I/We agree that Chubb Arabia Cooperative Insurance Company will use the information supplied here and during the formation and performance of my policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb Arabia Cooperative Insurance Company may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I/We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined me, to furnish to Chubb Arabia Cooperative Insurance Company or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb Arabia Cooperative Insurance Company in its absolute discretion considers relevant for its assessment of my claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

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

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Signature of Policyholder  
(Please affix company stamp if applicable)

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Signature of Claimant  
(if different from Policyholder)

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Date

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Date

Note: You may email the completed claim form to [Travelclaims@chubb.com](mailto:Travelclaims@chubb.com). Please ensure that the relevant scanned copies of supporting documents are submitted as well. You may be required to submit the relevant original copies of the supporting documents. If you have any further questions please contact our claims team at +966 (0) 13 849 3633