GROUP PLUS CLAIM FORM

www.aig.sg

AIG

IMPORTANT NOTES FOR CLAIMANT

- This Group Plus Claim Form is to be completed by the Claimant, except where the Claimant is a minor. In such instances the form should be completed by the minor's legal guardian.
- Part C Authorization and Declaration Section of Claim Form must be duly signed/have thumbprint affixed by the Claimant or the Claimant's legal guardian.
- Your claim will not be processed if Part C of the Claim Form is not duly signed/has thumbprint affixed.
- Claim Form must be completed and the claim lodged with supporting documents within 30 days of the incident.
- The acceptance of this Form is NOT an admission of liability on the part of AIG Asia Pacific Insurance Pte. Ltd, (the "Company"). Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant. The Company reserves the right to request for such further documents as it may deem fit in addition to the required documents listed in each of the sections in this Claim Form.
- Please note that information you provide in this claim form will be used for the purposes of claims administration as outlined in this form and will not be used to update any of your existing records that our organization holds. If you wish for us to update any of your information in our records, please contact our customer service representatives at 6419 3000, Mondays to Fridays, between 9am and 5pm. Alternatively, you may contact us at www.aig.sg/contact-online.

Note: a) Incomplete Claim Form will be returned and not be processed.

PART A POLICY HOLDER INFORMATION

Policy No.	
Policy Holder's Name	○ Mr. ○ Mrs. ○ Ms.
Contact Details	_____ (Office) _____ (Fax)
Nature of Business:	
Preferred Method of Communication	○ Mail ○ Email Email Address: _____

CLAIMANT INFORMATION

Claimant's Full Name	○ Mr. ○ Mrs. ○ Ms.	Identity Card no. / Passport No.	
First Name		Last Name	
Are You a US Citizen?	○ Yes ○ No If 'Yes', Please Provide Your Social Security Number (SSN): _____	Marital Status	○ Single ○ Married
Date of birth	D D M M Y Y Y Y	Sex	○ Male ○ Female
Contact Details	_____ (Residential) _____ (Fax) _____ (Mobile) _____ (Email)		
Designation / Title		Class Type (e.g. category)	
Relation to Policy Holder			

1. Please indicate your case number, if you have contacted Travel Guard before: _____
2. Have you submitted any claims to / through Travel Guard? ○ Yes ○ No
3. If yes, please select the type of claims submitted: ○ Medical Expense ○ Medical Evacuation / Repatriation ○ Others (Please Specify): _____

Cheque made payable to	

PREFERRED MAILING ADDRESS

Preferred Mailing Address	

PART B EVENT INFORMATION, OTHER POLICIES, RELATED HISTORY

Description of the incident			
Place of incident		Date & Time of Incident	D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM
Purpose of Travel (for travel claim only)	○ Leisure ○ Business / Conference ○ Others (please specify): _____ Current Home Leave Period: _____ Total Home Leave Utilised to date including this trip _____ Days		

Was a Credit Card used to purchase some or all of journey arrangement? ○ Yes ○ No

- If yes, please state the first six digits of the credit card used: _____
- If yes, please advise the amount settled by the credit card: _____
- Date & Time of Departure from Singapore D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM
- Date & Time of Return to Singapore D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM

DETAILS OF YOUR OTHER INSURANCE OR COMPENSATION CLAIMS

Details of your claims other than this insurance policy (i.e. other insurance policies, third party and others)

Name of Insurer / Third Party	Policy/ Reference Number	Type of Benefit	Have you filed a claim?	Amount Claimed

Have your other claims been paid by the other policies above? ○ Yes ○ No

NOTE: If the space provided is insufficient for your answer, please continue on a separate sheet.

PLPF100-03/20

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PART C DECLARATION AND AUTHORISATION

I declare to the best of my knowledge and belief that the above particulars are true and accurate. If I made or shall make any false or fraudulent statements, or withhold material facts whatsoever in respect of this claim, the Policy shall be void and I shall forfeit all rights to recover therein. I agree to the conditions set out at the beginning of this claims form.

I authorise any hospital doctor, other person who attended or examined me, to furnish to the Company, and /or it's authorised representatives, any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

I, HEREBY DECLARE that to the best of my knowledge and belief, the above particulars as declared by me above are true and complete in every respect and are made without reservation of any kind.

In relation to the personal information collected in this claim form, I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority to provide that information to AIG Asia Pacific Insurance Pte. Ltd. ("AIG"), I have informed the individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by AIG, as set out in the contents of the consent clause below and the individual agrees and consents, that AIG may collect, use and process my/his/her personal information as follows:

(a) the personal information collected in this form (or otherwise provided during the course of the claim process, including by way of call recordings) may be collected, used and disclosed by AIG to:
- (i) process and administer this insurance claim;
- (ii) assess, investigate, adjust and make a decision on this claim;
- (iii) administer my insurance policy (including pursuing recovery from reinsurers or other parties);
- (iv) deal with disputes and complaints,
- (v) respond to requests for information from public and governmental/ regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;
- (vi) respond to requests from the policyholder;
- (vii) carry out due diligence or other screening activities (including background check(s)) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by AIG;
- (viii) compliance with legal or regulatory obligations, risk management procedures and AIG internal policies;
- (ix) manage AIG's infrastructure and business operations; and
- (x) for other purposes stated in AIG's Data Privacy Policy.

(b) AIG may transfer the personal information to the following classes of persons (whether located in Singapore or elsewhere) for the purposes identified in (a) above:
- (i) third parties providing services related to the administration of my policy (including reinsurers) and processing of my claim;
- (ii) AIG's agents;
- (iii) brokers, my authorised agents or representatives or next-of-kin;
- (iv) the policyholder;
- (v) legal process participants and their advisors;
- (vi) governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums;
- (vii) other financial institutions for the purpose of administering this claim, obtaining policy payments;
- (viii) loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers, external auditors;
- (ix) another member of the AIG group (for all of the purposes stated in (a)) in any country; or
- (x) other parties referred to in AIG's Data Privacy Policy for the purposes stated therein.

Note: The full version of AIG's Data Privacy Policy can be found at www.aig.sg/privacy.

Signature of Claimant/Guardian			
Signature of Policy Holder & Company Stamp		Dated	D D M M Y Y Y Y

PART D ACCIDENT AND ILLNESS CLAIM

For Accident Related Claim Only

Type of Disablement Claim	☐ Permanent Total Disablement ☐ Permanent Partial Disablement ☐ Weekly Benefit for Temporary Total Disablement ☐ Accident Medical Reimbursement ☐ Others (please specify): _____
(a) Date & Time of Accident	D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM
(b) Where did the accident occur?	
(c) How did the accident occur?	
(d) Injuries Sustained	
(e) If you had a history of similar injury, which you have experienced in the past, please give details as to when, where and from whom you received medical diagnosis, treatment, consultation or prescribed drugs	
(f) Disablement Commencement	D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM (g) Date of Death D D M M Y Y Y Y
(h) Are you still suffering the above stated disability?	○ If yes, please advise the expected date & time of returning to work: D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM ○ If no, please advise the date & time of returning to work: D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM
(i) Have you sustained any fractures from this accident?	○ Yes ○ No If yes, please advise the type of fracture: _____
(j) Have you sustained a burn injury from this accident?	○ Yes ○ No If yes, please provide the following information: ☐ Head ☐ Body Degree of burn: _____
(k) Have you lodged a police report	○ Yes ○ No Date of report D D M M Y Y Y Y Police Station that you lodged report?
(l) Name and address of any witness of the incident	
(m) Was the sum insured or benefits of your policy based on your monthly salary?	○ Yes ○ No If yes, please advise the last drawn salary prior to the accident: _____

(n) Please furnish the details of any hospitalization in connection with this injury

Name of Hospital	Admission Date (DD-MM-YYYY)	Date Discharged (DD-MM-YYYY)	Admission No.	Type of Ward

(o) Please provide information on your first consultation

Doctor Consulted			
Doctor's Address			
Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

(p) Please provide information of your regular doctor.

Family Doctor			
Family Doctor's Address			
Family/ Regular Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

For Illness Related Claim Only

Claim Description (fill in items that apply)

(a) Give a brief description of the illness suffered

i) Are there any symptoms which are or were evident for this condition? If yes, please advise the date of onset of the symptoms. D D M M Y Y Y Y

ii) Have you been recommended to receive or received treatment, advice or diagnosis for this condition? If yes, please advise the date of your 1st consultation. D D M M Y Y Y Y

(iii) Please describe the symptoms you experienced.

(d) Please provide information on your first consultation.

Doctor Consulted			
Doctor's Address			
Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

(e) Please provide information of your regular doctor.

Family Doctor			
Family Doctor's Address			
Family/ Regular Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

(f) Please furnish the details of any hospitalization in connection with this illness

Name of Hospital	Admission Date (DD-MM-YYYY)	Date Discharged (DD-MM-YYYY)	Admission No.	Type of Ward

(h) Have any of your family members experienced this similar or related illness? If yes, please provide details.

Relationship of Family Member	Nature of Illness	Date Diagnosed (DD-MM-YYYY)	If Deceased, Date (DD-MM-YYYY)	Age

(i) Are there any other illness/complaints suffered by you prior to this event? If yes, please provide details.

AIG Asia Pacific Insurance Pte. Ltd.
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SECTION 1 – ACCIDENTAL DEATH

Documents Required:
- Certified true copy of Death Certificate
- Autopsy report (where applicable)
- Police report for road traffic accidents or other accidents (where applicable)
- All relevant medical reports
- Police investigation report
- Corner's inquiry (where applicable)
- Certified True Copy of Pay Slip
- Employment contract
- When claiming for your spouse/child(ren) please furnish copy of you and your spouse/child(ren)'s flight itinerary (Travel Claims only)

SECTION 2 – PERMANENT DISABLEMENT

Documents Required:
- Police report for road traffic accidents or other accidents (where applicable)
- All relevant medical reports
- Police investigation report
- Certified True Copy of Pay Slip
- Employment contract

SECTION 3 – BURN AND FRACTURE

Documents Required:
- Medical report indicating type & location of fracture/degree of burns
- Police report for road traffic accidents (where applicable)

SECTION 4 – MEDICAL EXPENSES

Documents Required:
- Original final medical invoice and receipts (as proof of payment)
- Police report for road traffic accidents or other accidents (where applicable)
- Medical Report / Inpatient Discharge Summary / Doctor's Memo / Attending Physician's Statement (at Claimant/Guardian's expense)

SECTION 5 – TEMPORARY DISABILITY

Documents Required:
- Medical Report / Inpatient Discharge Summary / Doctor's Memo / Attending Physician's Statement (at Claimant/Guardian's expense)
- Medical Certificate

SECTION 6 – HOSPITAL VISITATION

Please provide description of loss			
Period of Hospitalization from	D D M M Y Y Y Y to D D M M Y Y Y Y		
Please state their name and relationship to you	Name:		Relationship:

Details of accomodation expenses and additional travel expenses (continue on a seperate sheet if necessary)

Item	Amount
Total amount	

Documents Required:
- Original invoices & receipts for purchase of economy class air-ticket or first class rail ticket.
- Original invoices & receipts of hotels accommodation expenses incurred.
- Medical report showing details of admission and duration of hospitalization.

SECTION 7 – LOSS OF TRAVEL DOCUMENTS AND MONEY

Please tick the appropriate box:	☐ Loss of Travel Document ☐ Loss of Money		
Cause of Loss	○ Destroyed or Lost due to Natural Disaster: ○ Earthquake ○ Fire ○ Tsunami ○ Volcano Eruption ○ Extreme Weather ○ Others (please specify): _____ ○ Robbery, Burglary, Theft ○ Damage or Lost while held by Airline or Service Provider		
Please provide details on the circumstances surrounding the incident and the precautions taken to protect your property			
Where did the loss occur?			
Date and time of the loss	D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM		
To whom the incident was reported (e.g.: police, airline, cruise company, etc)			
Date and time reported	D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM		
Were your items in the custody of the carrier / service provider?	○ Yes ○ No	Service Provider Contact No.	
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	○ Yes ○ No	If yes, please provide details on the compensation or cash settlement amount received : _____ If no, please provide evidence of denial of compensation from the service provider.	
Where were the items located at the time of the loss?			

Loss/Theft of Money

Amount of Cash & Travelers' cheques taken on trip				Amount of cash & travelers cheques damaged, stolen, destroyed or lost during the trip		
Owner's Name	Traveler's Cheque	Cash	Currency	Traveler's Cheque	Cash	Currency

Loss of Travel Documents Please detail the expenses you incurred in obtaining a replacement passport or travel document (continue on a separate sheet if necessary)

Owner's Name	Description	Date	Amount	Currency
	Additional Travel Expenses			
	Additional Accommodation Costs			
	Travel Documents Replacement Costs			
	Total expense			

Documents Required:
- Police Report/ Hotel Management report for loss due to any reason
- Proof of event for loss due to natural disasters
- Original receipts of expenses incurred to obtain replacement passports or travel tickets
- Original receipts for hotel accommodation expenses incurred
- Original receipts of transportation expenses incurred
- Proof of purchase of travellers cheques

SECTION 8 – LOSS/DAMAGE TO LUGGAGE AND PERSONAL EFFECTS

Please tick the appropriate box:	☐ Baggage Loss ☐ Baggage Damage ☐ Damage/ Loss Personal Effects
Cause of Loss	○ Destroyed or Lost due to Natural Disaster: ○ Earthquake ○ Fire ○ Tsunami ○ Volcano Eruption ○ Extreme Weather ○ Others (please specify): _____ ○ Robbery, Burglary, Theft ○ Damage or Lost while held by Airline or Service Provider
Please provide details on the circumstances surrounding the incident and the precautions taken to protect your property	
Where did the loss occur?	
Date and time the loss was discovered	D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM
To whom the incident was reported (e.g.: police, airline, cruise company, etc)	
Date and time reported	D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM
Were your items in the custody of the carrier / service provider?	○ Yes ○ No — Service Provider Contact No.
Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc)	○ Yes ○ No If yes, please provide details on the compensation or cash settlement amount received : _____ If no, please provide evidence of denial of compensation from the service provider.
Where were the items located at the time of the loss?	
Any actions taken to attempt the recovery of your property?	○ Yes ○ No If yes, please provide details on the actions taken: _____ If no, please provide details for not attempting recovery: _____

Details of damaged, stolen, destroyed or lost personal effects (continue on a separate sheet if necessary). Please provide full details of each item claimed for. (For cameras, include the make and model number, lens details etc. For jewellery include nature and quality of metal content, type of stone etc.). Purchase receipts, valuations or other documentation to substantiate ownership should be provided whenever possible.

Description of item	Owner's Name	Place of Purchase	Date of Purchase	Purchase Method	Purchase Price

Documents Required:
- Certified true copy of Property Irregularity/Hotel Management Report/Police Report (where applicable)
- Original purchase receipts and warranty cards (where applicable) of lost of items. If not available please provide estimated purchase price & year of purchase.
- Original repair bills & photographs for damaged items
- Letter of compensation from airlines/hotel management/any other parties
- Letter of Refund from your service provider (e.g. Airline/Hotel Management/Tour Agency)

SECTION 9 – BAGGAGE DELAY

Planned Arrival Date	D D M M Y Y Y Y	Actual Arrival Date	D D M M Y Y Y Y
Planned Arrival Time	Hour : Minutes ○ AM ○ PM	Actual Arrival Time	Hour : Minutes ○ AM ○ PM
Place of Departure			

Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc) ○ Yes ○ No If yes, please provide details on the compensation or cash settlement amount received : _____
If no, please provide evidence of denial of compensation from the service provider.

Documents Required:
- Property Irregularity Report
- Acknowledgement Receipt on when delayed baggage was recovered

SECTION 10 – TRAVEL DELAY

Location of Incident	
Cause	☐ Earthquake ☐ Fire ☐ Tsunami ☐ Volcano Eruption ☐ Adverse Weather ☐ Strike Riot, Civil Unrest, Civil Commotion ☐ Carrier Defect ☐ Others (please specify): _____
Carrier Type:	○ Aircraft ○ Ship ○ Train ○ Others (please specify): _____
Original Flight Details	Planned Arrival Date & Time: D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM Actual Arrival Date & Time: D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM
Actual Flight Details	Planned Arrival Date & Time: D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM Actual Arrival Date & Time: D D M M Y Y Y Y Hour : Minutes ○ AM ○ PM
Length of Delay	Hour : Minutes

Please state the reason provided by the tour operator, airline, cruise company, rail company etc for the cause of the delay:

Did you receive any compensation from the service provider? (e.g.: airline, cruise company, etc) ○ Yes ○ No If yes, please provide details on the compensation or cash settlement amount received : _____
If no, please provide evidence of denial of compensation from the service provider.

Document Required:
- Letter from the airline stating the cause and duration of the delay

SECTION 11 – TRAVEL CANCELLATION / TRAVEL CURTAILMENT / TRAVEL DISRUPTION / EMPLOYMENT DISRUPTION

Please tick the appropriate box:	☐ Travel Cancellation ☐ Travel Curtailment ☐ Travel Disruption ☐ Employment Disruption		
Travel Booking Date	D D M M Y Y Y Y	Date of event that resulted in the cancellation/ curtailment	D D M M Y Y Y Y
Original Scheduled Departure/ Return Date	D D M M Y Y Y Y	Location of Incident Causing Claim	
Cancellation/ Curtailment Reasons	☐ Earthquake ☐ Fire ☐ Tsunami ☐ Volcano Eruption ☐ Extreme Weather ☐ Airspace/Multiple Airport Closures ☐ Strike Riot, Civil Unrest, Civil Commotion resulting in cancellation of scheduled flights ☐ Epidemic/ Pandemic ☐ Travel Agent Insolvency ☐ Death, Serious Sickness, Injury (please specify illness/sickness/injury): _____ ☐ Others (please specify): _____		
Was a home government warning issued?	○ Yes ○ No	Amount Paid by you	
Has compensation been made by other parties?	○ Yes ○ No	If yes, please state amount compensated by other parties.	

If travel cancellation is due to death, serious sickness of the insured's immediate family member/ Travel companion please state their:

Full Name: _____ Relationship to Policyholder/ Insured: _____

Did you need to cancel / curtail your trip because of a relative who is not travelling with you or because of a travelling companion? ○ Yes ○ No

Please indicate which ○ Relative ○ Travelling Companion Please advise their name: _____ If a Relative, please advise their Relationship to you: _____

Date you became aware of the need to cancel / curtail your trip	D D M M Y Y Y Y	Date you informed your carrier/ travel agent/tour operator	D D M M Y Y Y Y

Name, address and contact number of your usual doctor (if you need to cancel / curtail your trip on medical grounds, including death)

Details of trip costs, refunds due or paid and additional expenses incurred (continue on a separate sheet if necessary)

Item	Amount	Refund Due or Paid	Additional Expenses (for Curtailment)

Documents Required:
- Medical report from the doctor certifying details of diagnosis and reason why claimant is unfit to travel.
- Original invoice from the travel agency and statement showing breakdown of tour package and amount refunded.
- Proof of event for cancellation due to other insured perils.

SECTION 12 – HI-JACK

Date of Incident	D D M M Y Y Y Y	Place of Occurance	
Description of Incident			

Documents Required:
- Proof of event
- Letter from the service providers and report from relevant authorities detailing such event

SECTION 13 – BAIL BOND

Date of Incident	D D M M Y Y Y Y	Place of Occurance			
Description of Incident				Claimed Amount	

Documents Required:
- Police Report
- Certified True Copy of the Letter from the authorities as proof of detention

SECTION 14 – KIDNAP

Date of Incident	D D M M Y Y Y Y	Place of Occurance	
Description of Incident			

Documents Required:
- Police Report
- Proof of event

SECTION 15 – LEGAL SUSPENSE

Date of Incident	D D M M Y Y Y Y	Place of Occurance			
Description of Incident				Claimed Amount	

Documents Required:
- All relevant correspondence/documents

SECTION 16 – PERSONAL LIABILITY

Which of the following are you being held liable for?	☐ Damages	☐ Medical Compensation	
Please provide details of the circumstances			
Please provide details on the extent of damages or injuries sustained by the other party/person (please attach photos):			
Have you instructed solicitors to represent you at this time?	○ Yes ○ No	If yes, please provide the name of solicitors : _____	Solicitors contact number: _____
Was the accident due to carelessness or negligence on your part?	○ Yes ○ No	Have you in any way admitted liability?	○ Yes ○ No
Name and address of any witness to the incident		Name and address(es) of the other party / parties	
If any, which Police Officer and Police Station did you report the occurrence?			
If a claim has been made upon you, was the amount of such claim specified?	○ Yes ○ No	If yes, please state the amount _____	
Please provide any additional information which you consider would help us in dealing with any claim that may be made against you.			

Documents Required:
- All relevant correspondence/documents

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