

NOTIFICATION OF CLAIM - TRAVEL INSURANCE

IMPORTANT INSTRUCTIONS:

1. For claims processing, all necessary documents have to be submitted. The company reserves the right to request additional documents as deemed necessary.
2. Submission of required documents does not guarantee approval of your claim. The submitted documents will be reviewed and evaluated, subject to limits, terms and conditions of your existing Travel Policy.
3. This form, together with the required claims documents, must be submitted within 30 days from the day of notification to PRUDENTIAL GUARANTEE AND ASSURANCE, INC. (Please refer to the attached "List of Required Claims Documents").

INSURED'S INFORMATION					
Insured's Name :		Date of Birth :	Sex :		
Address :		Policy Number :			
		Home :	Office no. :		
E-mail Address :		Fax :	Mobile no.:		
CLAIMANT'S INFORMATION					
Claimant's Name :		Age :	Sex :		
Address :		Home :	Office :		
		Mobile :			
Relationship to Insured :		E-mail Address :			
TYPE OF LOSS					
PLEASE CHECK THE PARTICULAR TYPE OF LOSS:					
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> PERSONAL ACCIDENT <input type="checkbox"/> Accidental Death and Disablement <input type="checkbox"/> Permanent Total Disability <input type="checkbox"/> Unprovoked Murder and Assault <input type="checkbox"/> Accident Burial Benefit <input type="checkbox"/> TRIP CANCELLATION LOSSES AND DELAYED DEPARTURE <input type="checkbox"/> Flight Delay <input type="checkbox"/> Baggage Delay <input type="checkbox"/> Loss of Baggage </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> MEDICAL & EMERGENCY EXPENSES <input type="checkbox"/> DAILY HOSPITAL INCOME <input type="checkbox"/> TRIP CURTAILMENT </td> </tr> </table>				PERSONAL ACCIDENT <input type="checkbox"/> Accidental Death and Disablement <input type="checkbox"/> Permanent Total Disability <input type="checkbox"/> Unprovoked Murder and Assault <input type="checkbox"/> Accident Burial Benefit <input type="checkbox"/> TRIP CANCELLATION LOSSES AND DELAYED DEPARTURE <input type="checkbox"/> Flight Delay <input type="checkbox"/> Baggage Delay <input type="checkbox"/> Loss of Baggage	<input type="checkbox"/> MEDICAL & EMERGENCY EXPENSES <input type="checkbox"/> DAILY HOSPITAL INCOME <input type="checkbox"/> TRIP CURTAILMENT
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Place where incident, loss or accident occurred:					
Date of Occurrence:		Time of Occurrence:			
Are there any other policies of insurance in force covering you in respect of this event? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, please specify: _____					
FOR PERSONAL ACCIDENT - Medical and Additional Expenses					
Have you ever suffered this or a similar condition or a recurrence of a previous Injury? <input type="checkbox"/> No <input type="checkbox"/> Yes					
If Yes, please specify Nature of Injury:					
Provide Name and Address of your usual Attending Physician:					
Name and Address of other Physician(s) consulted prior to confinement:					
If hospitalized, give Name and Address of Hospital:					
Hospital Confinement: From _____ 20____ at _____ AM/PM To _____ 20____ at _____ AM/PM					

FOR DISABILITY CLAIM

Describe fully the duties of your occupation (attach additional sheets if necessary):

When did you cease work? From _____ 20__ at _____ AM/PM To _____ 20__ at _____ AM/PM

House confinement: From _____ 20__ at _____ AM/PM To _____ 20__ at _____ AM/PM

When did, or will you resume all or any part of your work?

From _____ 20__ at _____ AM/PM To _____ 20__ at _____ AM/PM

Full time or active performance of your duties:

Starting: _____

ATTENDING PHYSICIAN'S STATEMENT

1. Full Name

2. (a) Age of Death

(b) Place of Death

(c) Date of Death

(d) Occupation at date of Death

3. How long have you known the deceased?

4. Length of hospitalization

5. (a) When were you first consulted for the condition which either directly or indirectly caused death?

(b) Who consulted you? (Specify if deceased, relative or others)

(c) Date of last Visit

(d) What was the cause of death? (Immediate, proximate, underlying)

(e) How long in your opinion did deceased suffer from this disease or impairment?

(f) Since when has the patient been incapable of doing the daily normal chores (working, bathing, dressing up, getting in and out of bed, toileting) of life? Please specify physical limitations.

(g) What were the contributory causes of death? State the duration of each:

Disease or Impairment	Duration

(h) Was there any connection (remote or proximate) between the death and occupation, residence, habits or personal history of the deceased? Yes No If Yes, state which and give particulars.

6. State particulars of each condition for which you treated or advised deceased prior to last illness:

Nature of Condition	Dates	Duration	Result of Treatment

7. State names and addresses of other physicians and practitioners who to your knowledge attended deceased during the past three years:

Name	Address	Disease of Impairment	Date

8. Was death due to suicide? Yes No

9. Was there any official inquiry as to the cause of death or a post mortem examination on the body of the deceased? Yes No
If Yes, by whom and with what result?

Date and Place

Physician's Name

Physician's Signature

License No.: _____

Telephone No.: _____

DOCUMENTS SUBMITTED

Type of Document	Details / Official Receipt Numbers	Amount

AUTHORITY, RELEASE AND DECLARATION STATEMENT

AUTHORITY: I/We hereby authorize any medical practitioner, medically related facility, insurance company, government agency or instrumentality or any other personal information controller and processor who collects, holds, processes or uses any of my/our personal information, to disclose to, provide and/ or furnish Prudential Guarantee and Assurance, Inc., its reinsurers and/or any of their duly authorized representatives with, and for any of the latter to collect, retrieve, use and/or otherwise process, or to disclose, provide or furnish to other insurance company(/ies) and their affiliates or representatives, any personal information, sensitive personal information and privileged information, including copies (original or certified) of documents, relating to my/our health and personal identity necessary in the evaluation of any claims under this policy to be conducted by Prudential Guarantee and Assurance, Inc. or for any legitimate purpose. A photocopy of this authorization will be considered as valid as the original. It is understood that any action which any medical practitioner, medically related facility, insurance company, government agency or instrumentality or any other personal information controller and processor who collects, holds, processes or uses any of my/our personal information may take in connection with this authorization releases said persons or entities, or any and all members of their staff from any responsibility or obligation in connection with the release or processing of such records or information.

I/We hereby certify that I/We have carefully read and clearly understood the above said authorization, and do hereby voluntarily accept and acknowledge the same as informed expressions of my/our own free will.

DECLARATION: I declare that all data/statements found herein and on all pages of this form are complete and true, whether written by me or by anyone else on my behalf, shall be binding on me, and that the amounts being claimed herein are lawfully due to me under the terms and conditions of the policy.

Signature over Printed Name of Patient
or of Principal Insured, if Patient is a Minor

Date

FOR PRUDENTIAL GUARANTEE AND ASSURANCE, INC. USE ONLY

Reference File Number :	CLAIM OUTCOME
Evaluation :	Approved <input type="checkbox"/> Denied <input type="checkbox"/>
	Processed By : _____ Signature over Printed Name
	Approved By : _____ Signature over Printed Name

LIST OF CLAIMS DOCUMENTS REQUIRED (WHEN FILING A TRAVEL INSURANCE CLAIM)

I. COMPULSORY DOCUMENTS FOR ALL CLAIMS

1. Completed Claims Form	4. Original Official Receipts of all payments made
2. Letter of Request / Incident Letter	5. Copy of Flight Itinerary & boarding passes
3. Copy of Insurance policy	

II. OTHER SUPPORTING DOCUMENTS FOR EACH BENEFIT

PERSONAL ACCIDENT / ACCIDENTAL BURIAL BENEFIT

- a. Copy of Death Certificate
- b. Original Police Report
- c. Copy of Medical Report or Medical Certificate
- d. Relevant legal Documents of the Beneficiaries establishing the relationship to the Insured
- e. Any documents deemed necessary by the Insurance Company

MEDICAL & HOSPITALIZATION EXPENSES ABROAD

- a. Original medical report / abstract with Medical History.
- b. Clinical Test / Laboratory Results
- c. Detailed Original Hospital Statement of Account
- d. Copy of Operative and/or Histopathology Reports
- e. Police report (if applicable. Example: accidents)

DAILY HOSPITAL INCOME (up to 10 days)

- a. Original medical report / abstract with Medical History.
- b. Medical certificate from physician or hospital
- c. Clinical Test / Laboratory Results
- d. Copy of Operative and/or Histopathology Reports
- e. Police report (if applicable. Example: accidents)

TRAVEL CANCELLATION EXPENSES

(Documents may be required as applicable on the coverage)

- a. Original medical report and/or Death Certificate of the Insured Person or the immediate family member. (Documents must reflect the date of occurrence, admission to hospital, death, accident, the diagnosis, the clinical background and treatment prescribed)
- b. Proof of occurrence of covered incident such as police report, fire fighter's report, insurance insurer report, etc (Document must include date of accident, type of damage in case of fire loss)
- c. Proof of relationship between Insured Person and the immediate family member
- d. Certification/Affidavit stating the reason for the trip cancellation
- e. Original copy of invoice and receipts for proof of advance payment made for transportation and accommodation expenses issued by the agency or directly by the wholesaler (Airline & Hotel) and a copy of the travel voucher issued by the agency.
- f. A copy of photocopy copy of the cancellation expenses invoice by the travel wholesalers to the retail agency, and a copy of the general condition of sale of the wholesaler & retailer (Travel) agency
- g. Original cancellation document proving the non-refundable portion specified (e.g. travel agency's certification, letter from the airline to the travel agency or client stating that the carrier can't refund the airfare, and statement from the hotel regarding cancellation policies).
- h. Cancellation expenses invoice or payment slip
- i. Other documents that will be required (depending on reason of the travel cancellation)

TRIP TERMINATION (Documents may be required, as applicable on the coverage)

- a. Original medical report and/or Death Certificate of the Insured Person or the immediate family member
- b. Proof of relationship between Insured Person and the immediate family member
- c. Certification/Affidavit stating the reason for the trip curtailment

- d. Proof of occurrence of covered incident such as police report, fire fighter's report, insurance insurer report, etc..
- e. Original copy of invoice and receipts for proof of advance payment made for transportation and accommodation expenses issued by the agency or directly by the wholesaler (Airline & Hotel) and a copy of the travel voucher issued by the agency.
- f. Copy of the general condition of sale of the wholesaler & retailer (Travel) agency
- g. Original cancellation document proving the non-refundable portion specified (e.g. travel agency's certification, letter from the airline to the travel agency or client stating that the carrier can't refund the airfare, and statement from the hotel regarding cancellation policies).
- h. Original official receipts for the additional fees paid for the return ticket to home country such as no show fee, rebooking fees, penalties, etc.. with a copy of the new travel itinerary
- i. Other documents that will be required (depending on reason of cutting the trip short)

FLIGHT DELAY

- a. Original Certification from Airline
- b. Original official receipts of expenses incurred due to incident.
- c. Copy of the flight itinerary of the actual time and date of departure.

BAGGAGE DELAY

- a. Original Property Irregularity Report (P.I.R.) from airline
- b. Original receipts of articles of basic necessity purchased due to delay of luggage
- c. Original acknowledgement receipt/form stating the exact date and time when the baggage was received by the Assured.

COMPENSATION FOR IN-FLIGHT LOSS OR DESTRUCTION OF CHECKED-IN BAGGAGE

- a. Original formal complaint before the police at the place where then incident occurred, duly listing the contents of the luggage and their economic value.
- b. Written complaint before the carrier company, within the time limits established by each company.
- c. Obtain a certificate of the said complaint. Property Irregularity Report (P.I.R) from airline
- d. List of contents of the luggage with estimated price and date of purchase of each item.
- e. Photograph of the damaged item and the original receipt and/or quotation for the repair.
- f. Original certification of settlement of the compensation payment by the carrier.

INDEMNITY FOR THEFT OF LUGGAGE OR PERSONAL BELONGINGS NOT CHECKED-IN

- a. Original Police report from the place where incident occurred
- b. List of contents of the luggage
- c. Original purchase receipts & warranty cards (if applicable) for the items claimed
- d. Certification from hotel or any other party that the loss was not indemnified, or if settlement was made, certification specifying amount settled.
- e. Picture of locks that were forcibly opened (if applicable).
- f. Notarized affidavit for an official statement on what happened.