

SCB TRAVEL INSURANCE CLAIM FORM

Postal Address:
 Suites 304-306, 3/F, 12 Taikoo Wan Road, Taikoo Shing, Island
 East, HongKong

Claims Hotline: +852 8100 2402
 Email: SCBtravelclaims@allianz.com

In order for your claim to be dealt with promptly, please ensure ALL RELEVANT SECTIONS of this Claim Form are fully completed and returned to us by post together with all the required claims evidence. A separate claim form must be completed for each Insured Person who is claiming under the policy.

Please use BLOCK letters. Please retain a copy of all documents sent to us for your records.

Please note all expenses incurred in completing this claim form and providing all the necessary evidence to support this claim must be paid by you. Expenses incurred in providing evidence or translations are not covered under this policy.

SECTION 1 – INSURED DETAILS

Claim No. _____ (AWP Use Only)

1. Policy Number: _____
2. Name of insured person: _____
3. Date of birth: ____/____/____ Occupation: _____
4. Address of claimant to be used for correspondence: _____
5. Tel (Home/ Work): _____ Tel (Mobile): _____ Email: _____
6. Have you made any previous claims in respect to this loss/accident? YES NO
 If yes, please provide exact details of claim/s (date/amount/type of claim/insurance company involved): _____
7. Have you made any claims with other insurance in respect to this loss/ accident? YES NO If yes, please provide information: _____

SECTION 2 – MEDICAL EXPENSE CLAIM

1. Date of Incident: ____/____/____ Time (am / pm): _____ Location (City / Country): _____
2. Please advise (in detail) the nature of the illness contracted or injury sustained for which this claim is related: _____

3. Have you ever been hospitalized or advised to be hospitalized? YES NO If yes, please fill in the table below:

Hospitals Name	Admission Date	Discharge Date	NO. of Hospitalization	Diagnosis	Treatment/Medication

4. Have you ever suffered from any disorder which required that a) received more than 7 days treatment b) were off work/study for more than one week c) had specialized treatment (i.e. chem/radiotherapy and dialyse, etc.)? YES NO If yes, please describe the details: _____

5. Are you currently on treatment/medication or advised to have follow up treatment? YES NO
 If yes, please describe the treatment/medication. _____

6. Please provide details of the treatment provided:
 Name of hospital/clinic: _____ Address: _____
 Name of treating doctor: _____ Specifics of the treatment: _____

7. Has the illness or injury mentioned above occurred previously (prior to this specific incident)? YES NO
 If yes, please provide details (date/location/previous treatment) _____

8. Please itemize all medical expenses that you are seeking reimbursement for:

Explanation of the Expense	Name of Hospital/Doctor	Currency	Amount Claimed
TOTAL			

SECTION 3 – DAILY INPATIENT CASH SUBSIDY CLAIM

- Diagnosis: _____
 Admission Date: ____/____/____ Discharge Date: ____/____/____ Duration: _____

SECTION 4 – BAGGAGE DELAY, TRAVEL DELAY AND/OR MISSED CONNECTION CLAIM

1. Please indicate the claim type: Baggage Delay Travel Delay/Missed Connecting Flight
 Scheduled Time of Arrival: _____ Actual Time of Arrival: _____
2. Flight/train number: _____ Reason for the delay: _____
3. Have you received any compensation for the delay from another source? YES NO
 If yes, please advise from whom and the amount: _____

SCB TRAVEL INSURANCE CLAIM FORM

4. If you missed your connection, did you have to stay in transfer place more than consecutive 12 hours : YES NO
 If yes, provide details _____

SECTION 5 – PERSONAL EFFECTS (LOSS/DAMAGE) CLAIM

1. Date of Incident: ____/____/____ Time (am / pm): _____ Location (City / Country): _____

2. Please advise (in detail) exactly what happened (attach a letter if insufficient space) _____

3. Please advise what action was taken to recover lost articles (if any): _____

4. Were the police or a responsible authority notified within 24 hours of the incident? YES NO

If yes, state who: _____ Location: _____

If no, please provide the reason why: _____

5. Have you received payment from your travel/tour representative for the lost or damaged articles? YES NO

If yes, please advise from whom and the amount paid: _____

6. Please itemize all lost/damaged items that you are claiming for (please note which currency)

Full description of articles/money lost or damaged	Original price	Date & place of purchase	Amount claimed
TOTAL			

SECTION 6 – TRIP CURTAILMENT/CANCELLATION CLAIM

1. Please indicate the claim type: Trip curtailment Trip Cancellation

2. Trip curtailment/cancellation time: _____ Reason: _____

3. Item claimed:

Description	Original Price	Time of Payment	Claimed Amount
TOTAL			

SECTION 7 – ADDITIONAL INFORMATION OR COMMENTS TO SUPPORT YOUR CLAIM

If you are claiming under a section of the policy not provided on this claim form, please provide details below:

We recommend that you contact us for advice on the documents required to support your claim.

Claims Payment

Please indicate your bank information below to receive claims payment by bank transfer. Note that the account name should be that of claimant. No claim will be settled in cash.

Name of Bank: _____

Bank Code: _____ Branch Code: _____ Account Number: _____

Account Holder Name: _____

*If you have any enquiries related to the method of claims payment, please contact us.

Please read the following declaration carefully and sign & date below:

I (the Claimant) declare that all statements and particulars contained on this claim form are true and correct.

I (the Claimant) acknowledge and authorize that the underwriter or its agent may give to and obtain from other insurers and / or other authorities, personal information relating to this claim.

I (the Claimant) authorize the insurer or its agent to get related information and documents in respect to this claim from any other persons, police offices, hospitals, etc.

I (the Claimant) have read the statements on Direct Marketing and agree to the use of my personal information for direct marketing purposes.

Signature of Claimant: _____

Date: ____ / ____ / ____

Full Name: _____

SCB TRAVEL INSURANCE CLAIM FORM

PERSONAL INFORMATION COLLECTION STATEMENT

Allianz Global Corporate & Specialty SE (incorporated in the Federal Republic of Germany with limited liabilities) Hong Kong Branch (“we” or “us”) may use the personal data we collect about you for the following purposes:

- (i) processing and evaluating your insurance application and any future insurance application you may make;
- (ii) administering your insurance policy and providing services in relation to your insurance policy;
- (iii) investigating, processing and paying claims made under your insurance policy;
- (iv) invoicing and collecting premiums and outstanding amounts from you;
- (v) reinsurance purposes;
- (vi) statistical research, data matching and/or verification purposes;
- (vii) contacting you for any of the above purposes;
- (viii) other ancillary purposes which are directly related to the above purposes; and
- (ix) complying with applicable laws, regulations or any industry codes or guidelines or requests.

Such personal data may be disclosed, shared, divulged, supplied or otherwise transferred, within or outside Hong Kong, to:

- (a) any of our related or associated companies, third party service providers, intermediaries, professional advisers and/or vendors in relation to any of the aforesaid purposes; and
- (b) any association, federation or similar organization of insurance companies and/or other business participants in the insurance industry (“Federation”) that exists or is formed from time to time for the benefit and interest of the insurance industry or any members thereof or for regulating the insurance companies or other business participants or any other individual/organization/third party as we may consider necessary or desirable in our discretion; and
- (c) any regulator or government body or authority.

If you do not agree to the provision of the personal data requested on the form or the use of such data for the above purposes, we may not be able to process your application.

Direct Marketing

With your consent, we may

- 1) use your personal information, including your name, contact details, products and services portfolio information, demographics data and/ or policy details, held by us from time to time for direct marketing;
- 2) conduct direct marketing in related to insurance, financial services or other related products and services provided by us, our affiliates, our co-branding partners, our business partners and/or our intermediaries; and/or
- 3) provide the data described in 1 above to all or any of the persons described in 2 above for use by them in marketing those products and services.

Before using your personal information as set out in Direct Marketing statement above, we must obtain your consent.

You may in future withdraw your consent to the use and provision of your personal data for Direct Marketing or your consent to the Personal Information Collection Statement by contacting our Data Privacy Officer.

You may seek access to and request correction of any personal data we hold about you by contacting our Data Privacy Officer at Suites 403 -11, 4/F, 12 Taikoo Wan Road, Taikoo Shing, Island East, Hong Kong

CLAIM Guide

Application Document: All the claims should be applied with 1. a claim form; 2. and the supporting documents listed below ,depending on which benefit(s) the insured applies for.

The insurer reserves the rights to request additional documents shall it deem it's necessary and appropriate to do so for the purpose of reviewing the claim application.

Note: '√' means the document should be original.

Benefit Required Documents	Accidental Death	Disablement	Medical Expenses	Baggage Delay	Personal Effects	Travel Delay	Trip Curtailment /Cancellation
Trip booking certificate (or Purchase certificate)	√	√	√	√	√	√	√
Boarding Pass /Air Ticket	√	√	√	√	√	√	√
Copy of Passport / HKID	√	√	√	√	√	√	√
Medical Report*	√	√	√				
Prescription/Medical expense receipt*			√				
Death Certificate*	√						√
Certificate of Degree of burns/disablement*		√					
Notarial Deed	√						
Police Report or Bank Report*	√	√			√		
Proof of Carrier *				√	√	√	√
Certificate of Hotel*					√		√
Quotation of Reparation					√		
Photo*		√			√		
Invoice of Effects/Accommodation /Travel expenses*				√	√	√	√
Certificate of Travel agency*							√
Certificate for Accompanying*			√				

Accident Notification/Application: Please notify us within 24 hours after accidental death, burns or disablement, and contact us immediately if any medical expense of outpatient is \geq HKD10,000, or you need to be hospitalized, or medical repatriation/evacuation would happen to you. For other claims, you should contact us within 15 days and submit a claim application within 30 days after the incident. If you are unable to provide sufficient evidence to prove the incident giving rise to the claim occurred, then we will not be liable to pay the claim. **Claim form:** You should complete 'Section 1-Insured Details' and 'Declaration' with your signature. You may fill in the other parts according to the type of your claim.