QBE Insurance (Malaysia) Berhad Reg. No. 161086-D
No. 638, Level 6, Block B1, Leisure Commerce Square, No. 9, Jalan PJS 8/9, 46150 Petaling Jaya,
Postal Address P.O. Box 10637, 50720 Kuala Lumpur, MALAYSIA.
Phone: 03-7861 8400 Fax: 03-7873 7430
www.qbe.com.my Email: info.mal@qbe.com

QBE TRAVELON COVER
Claim Form

IMPORTANT NOTICE
The acceptance of this Form is NOT an admission of liability on the part of the Company. Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

Required documents – For annual plans, please provide a copy of the passport showing duration of trip. We reserve the right to request for additional information. To ensure that there is no delay of your claim, please return the claim form duly completed with supporting documents.

Please tick ☐ the relevant boxes below

GENERAL [Please complete the General section followed by the relevant section(s) to which your claim(s) relate(s)]					
Name(s) in full					
Name of Claimant: (if different from Policyholder)					
Occupation			Policy No		
Date of Birth			Sex	Female ☐	Male ☐
Address					
Tel. No. (House)			HP No		
Tel. No. (Office)			Email Address		
Purpose of Trip	Business ☐	Vacation ☐			
Travel agent					
Country(ies) which you travelled to					
Date of booking					
Booked holiday dates	From / /	To	/ /	(dd/mm/yy)	
Do you have other insurance covering this loss?	Yes ☐	No ☐			

A. PERSONAL ACCIDENT / ILLNESS – MEDICAL AND ADDITIONAL EXPENSES ☐		
Note: Please attach Original Medical Bill & Receipts and Copy Of Discharge Summary Or available Medical Report, Death Certificate, Post Mortem Report, Police Report		
1. (i) Have you suffered from this illness or injury previously? If yes please specify	Yes ☐	No ☐
(ii) Is the illness or injury you have suffered or are suffering from a recurrence of a previous illness or injury? If yes please specify	Yes ☐	No ☐

PERSONAL ACCIDENT / ILLNESS – MEDICAL AND ADDITIONAL EXPENSES (continuation)		
2.	Date of accident or onset of illness	
3.	Place of accident or onset of illness	
4.	How did it happen?	
5.	Nature of injury (or official cause of death)	
6.	Period in hospital	
7.	Name and address of your usual attending doctor	
8.	State amount claimed :	RM:
9.	Were you on medication/medical treatment for this sickness during the 180 days preceding the trip?	Yes ☐ No ☐

B. BAGGAGE AND PERSONAL EFFECTS/TRAVEL DOCUMENTS INCLUDING UNAUTHORIZED USE OF CREDIT CARDS ☐

Note: Please furnish Police Report/Original Purchase Receipts/Replacement Receipts/Copies Of Bank Statement indicating usage of credit card/Photographs depicting the extent of damage

Location of police station, name of airline/carrier or other authorities where report lodged:

Give details of amount claimed (if insufficient space, please provide details in separate sheets)

item	Description	When and Where purchased	Original Purchase price(RM)	Depreciation for wear and tear	Amount Claimed (RM)

Did loss/damage occur in the custody of a carrier? Yes ☐ No ☐

Have you received any payment from carrier or other parties responsible for the loss? (If yes, please give amount and details) Yes ☐ No ☐

C. BAGGAGE DELAY ☐

Note: Please attach Boarding Pass, Baggage Irregularity Report, Baggage Acknowledgement Slip and any other relevant correspondence from the Carrier

Flight details		Collection of Delayed Baggage	
Arrival Date		Date	
Arrival Time		Time	
Place of Departure		Place	
Flight No.		Name of Airline	

BAGGAGE DELAY (continuation)

Have you received any payment from carrier or other parties responsible for the delay? (If yes, please give amount) Yes ☐ No ☐

D. LOSS OF DEPOSITS AND CANCELLATION CHARGES INCLUDING CURTAILMENT EXPENSES

- Please provide original tour fare receipt and/or air ticket fare receipt and/or accommodation receipt/original letter from travel agent and or Airline Company confirming your trip had been cancelled and the amount had been refunded by them.
- If cancellation or early return is due to insured/relative/travelling companion's death or sickness or injury or illness please provide us with copies of death certificate or medical advice or certificate with diagnosis and supporting documents proving the relationship.
- If Loss of Deposit of Full Payment Due to Insolvency of Travel Agent- Original receipt for payment for the Airlines ticket, Booking invoice together with the booking terms and conditions, and trip itinerary, Police report detailing the alleged Insolvency of the Travel Agent, written confirmation from Jabatan Insolvensi Malaysia on the insolvent status of the Travel Agent.

When and where was the trip booked?	

Intended departure date		Scheduled return date	
Date of Cancellation		Actual return date	
Why was the trip cancelled?		Reason for your early return?	
Intended departure date		Scheduled return date	
Name of sick or injured person and relationship to insured			

Amount paid by you	Amount recovered by you	Amount claimed
RM	RM	RM

E. FLIGHT DELAY/MISCONNECTION /OVERBOOKED FLIGHT

Note: Please attach letter from Airlines/Carrier stating the reason and duration of delay

Original Flight Details				Delayed Flight Details			
Date		Time		Date		Time	
Place of departure				Place of departure			
Flight No				Flight No			
Name of Airline				Name of Airline			

F. OTHERS (Hijack, Personal Liability, Loss of Hotel Facilities, Home Protection, Alternative Employees Expenses, Terrorism)

In respect of any other claim which does not fall within the sections stated above, please provide details of the claim you are submitting with supporting documents. If the space below is insufficient for such details, please attach another page
Personal Liability Cover - No admission, offer, promise or indemnity shall be made or given by or on behalf of the Insured without written consent of the Company and to submit photos showing the extent of the third party damage and/or bodily injury and the scene of accident, if possible; Particulars of witnesses; any third party correspondence, summons or writs.

DECLARATION / MEDICAL AUTHORISATION

I declare to the best of my knowledge that the above particular are true and correct. 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 authorize any hospital doctor, other person who has attended or examined me, to furnish to the Company, and/or its authorized representatives, with any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

Name of Policyholder		Name of Claimant	
Signature/Company Stamp (if applicable)		Signature	
NRIC No		NRIC No	
Date		Date	