

AIG Egypt Insurance Company S.A.E

Cairo - Egypt

Nile City, Northern Tower, 26th Floor

Ramlet Beaulac - Corniche ElNile



TRAVEL CARE INSURANCE CLAIM FORM

IMPORTANT:

Please contact at our 24-hour helpline- Assistance Center :

Zone	Assistance Company	Claims Administrator
Europe	Europ Assistance (Suisse) S.A Tel.:+ 41 22 341 02 04 / Fax:+ 41 22 939 2245	Golden Care 31,bd. Helvetique, 1207, Geneva Tel.:+ 41 22 786 1200 / Fax:+ 41 22 786 1220 e-mail:travelegypt@egoldencare.com
USA & Canada	AIG Assist +1-800-626-2427	AIG Assist Att: Travel Care 6464 Savoy Dr Suite 200 Houston TX 77036
Rest of the world	AIG Assist +1- 713-267-2525	United States

Please note, the first EGP 500 of your expenses is deductible, and must be borne by you.

1. This is a One Call Claim Form, we may ask for more details upon notification.
2. Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract
3. No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format (Attending Doctor's Report - Page 4)
4. Please answer all questions completely. In case of insufficient space, please attach an additional sheet
5. Please attach all bills, receipts, credit card slips pertaining to your claim.

Certificate/ Policy No. _____ **Period From** _____ **to:** _____

DETAILS OF THE APPLICANT

Name : _____ Phone Nos. _____
 Address: _____
 Relationship with Insured person: _____

DETAILS OF PATIENT/ INSURED PERSON

Name : _____ Phone Nos. _____
 Permenant Address: _____
 Date of Birth: ____/____/____ Sex: M / F
 Assistant Co. Ref. No.: _____ Passport No.: _____
 Date of Departure: ____/____/____ Flight No. _____ From _____ to _____
 Date of Arrival: ____/____/____ Flight No. _____ From _____ to _____

Please indicate whether claim is in respect of :

- | | | | |
|----------------------------------------------|--------------------------------------------------|---------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Accident & Sickness | <input type="checkbox"/> Hospitalisation Benefit | <input type="checkbox"/> Travel Delay | <input type="checkbox"/> Baggage Loss |
| <input type="checkbox"/> Baggage Delay | <input type="checkbox"/> Loss of Passport | <input type="checkbox"/> Personal Liability | <input type="checkbox"/> Hijack |

Please complete the Section relevant to your claim.

LOSS/DELAY OF CHECKED BAGGAGE

Describe when & where the loss/delay took place: _____

State the extent of Loss: _____

Name the common carrier: _____

1. Flight No. _____ From _____ to _____
2. Flight No. _____ From _____ to _____

Has the common carrier been notified at the time of loss? Yes No Airline Reference No. _____

Details of compensation received from carrier: _____

Scheduled date/time of Arrival: ____/____/____; ____:____ hrs. Actual date/time when bags delivered : ____/____/____; ____:____ hrs

No. of Hours delayed : _____

Item Purchased/Lost *	Date of Purchase	Place	Cost
TOTAL			
Less Compensation received from Airline:			

Net Amount:

* In case of Delay, please provide details of purchases made

* In case of Loss, please provide details of items lost.

Attending Doctor's Report

Patient's Name: _____ Age: _____ Sex: M / F

Address: _____

Date contacted: _____ Time: _____

For Accidental Injury

Nature of Injury: _____

X-Ray Taken: Yes No Date taken: _____

Diagnosis and Treatment Given: _____

Describe any other disease or infirmity affecting present condition: _____

For Sickness

Nature of Illness: _____

Diagnosis and Treatment Given: _____

When did patient's symptoms first appear: _____

Describe any other disease or infirmity affecting present condition: _____

Is condition due to Pregnancy: Yes No Is illness due to any pre-existing condition: Yes No

If Hospitalised, please provide the following details:

Name of Hospital/ Clinic: _____

Address: _____

Attending Doctor's Name: _____

Date: _____

Signature: _____

Attending Doctor's Signature