



Star Assurance

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TRAVEL INSURANCE CLAIM FORM

POLICY NUMBER:.....INSURED'S NAME:.....

ADDRESS:.....Email Address:.....

BUSINESS/OCCUPATION:..... DATE OF BIRTH:.....

PERIOD OF INSURANCE: START DATE:.....EXPIRE DATE:.....

PASSPORT NO:..... TEL. NO:.....

1. Country Of Residence:.....Country of Visit:.....

2. Purpose of Visit:.....

3. Date of Loss/Incidence:.....

4. Please give the full narration of the incidence:.....
.....
.....

5. How long were you hospitalized:.....
.....

6. (a) Name of Hospital you attended?.....

(b) What is the name and address of the doctor attending to you?.....
(Please attach a Medical Report from the Hospital)

7. Have you required medical or surgical treatment during the past five years?
Is so, please give particulars:
.....
.....
.....

8. For Baggage loss; a) was the incident reported to the Police?:.....

b) Was the incident reported to the Airline?.....

9. List of Missing items:.....
.....
.....

I HEREBY DECLARE THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY/ OUR KNOWLEDGE AND BELIEF

Signature:.....

Date:.....