AIG Travel ClaimsDepartment
Email: Kenyatravelclaims@AIG.com
Eden Square Complex, Chiromo Road
P.O. Box 49460 - 00100. Nairobi, Kenya

Claim Ref

Date

Title		Address			
First Name					
Surname					
Date of Birth					
Occupation		Post Code		Mob.	
Nationality		Telephone		Work.	
ID Number		Email			

Policy Information

Policy Number			
Name of policy			
Date issued			
Policy start date		Policy end date	
Date the loss occurred		Number of insured travellers	

Please advise the section(s) of the policy you are making the claim under:

Total amount claimed

Travel details

Booking reference			
Tour operator			
Booking Date			
Departure date		Return date	
Total days		No. in party	
Destination country			
Destination city			

Electronic Funds Transfer details

You should ensure that your payment details are correct on this form. We shall not be responsible for any incorrect payments or delays arising as a result of the provision of incorrect information. We cannot accept responsibility for the security of the information on this form until it is received by us. We recommend you provide a cancelled cheque.

Name of the account holder

Name of the bank

Address of the bank:

Branch Code:

Currency of the account:

IBAN / Account Number:

SWIFT / BIC Code:

Cancellation

Claim Ref:

Reason for cancellation - please tick ONE box only

Death ☐	Illness ☐	Injury ☐

Date and time you became aware of the need to cancel your trip: / /

Date and time you informed your travel agent or tour operator: / /

Did you need to cancel as a result of a person NOT booked to travel with you? YES NO

If YES, please state their name and relationship to you.

Name: Relationship:

Details of trip costs and refunds due or paid (continue on a separate sheet if necessary).

	Amount Paid		Refund due or paid		Total amount claimed
Ticket costs					
Accommodation costs					
Pre-paid excursions / hire car / parking					
Total		-		=	

Details of all those cancelling (continue on a separate sheet if necessary).

Name	Relationship	Date of birth	Insured on this policy?
		/ /	YES / NO
		/ /	YES / NO
		/ /	YES / NO
		/ /	YES / NO
		/ /	YES / NO

Please detail the reasons for cancellation below (continue on a separate sheet if necessary).

Was a 3rd party involved? YES NO

If YES, please provide their name, address and their insurance/solicitors details:

Medical Certificate

Claim Ref:

This form is to be completed by the registered General Practitioner (GP) of the person whose illness/injury/death has caused the claim.

Note - Any charge made for its completion is the responsibility of the patient or claimant.

- Please answer all questions. Ticks, dashes, "N/A" are not acceptable. Please complete in CAPITALS.

- All information is treated as private and confidential.

DATE TRIP WAS BOOKED:

Name of the patient:

Date of birth:

How long have you been the patients GP?

Give full description of illness or injury that caused the cancellation:

Onset date of symptoms:

Date first consulted:

Date of diagnosis:

In date order, please advise any previous medical history relevant to the above condition.

At the time that the trip was booked, was the person receiving, or on a waiting list for, or recovering from in-patient treatment in a hospital/nursing home? YES NO

If YES, Please provide details:

At the time the journey was booked was the patient:

On a hospital waiting list?	YES NO	
Taking any medication relevant to the above condition?	YES NO	
Undergoing any tests or waiting for results of any tests?	YES NO	
Aware of the condition?	YES NO	
Given a terminal diagnosis?	YES NO	

If cancellation has occurred due to a pregnancy related condition, please describe the condition and why the pregnancy necessitates cancellation:

What date did it became apparent that the travel arrangements should be cancelled?

What date did you advise there was a need to cancel the travel arrangements?

When would they be fit to travel again?

(ii) Has the patient been signed off work? YES NO From To

Please provide the patient's state of health at the time the holiday was purchased:

Was the patient's medical condition stable and under control at the time of booking? YES NO

GP DECLARATION

I have examined the patient and/or referred to their medical records and declare that the information given is correct and no relevant details have been withheld.

GP Name:

Contact number:

GP Signature:

Date Signed:

Surgery Stamp

Declaration and Authority.

Claim Ref:

HOW WE USE YOUR PERSONAL INFORMATION
We are committed to protecting the privacy of customers, claimants and other business contacts.

"Personal Information" identifies and relates to you or other individuals (e.g. your dependants). By providing Personal Information you give permission for its use as described below. If you provide Personal Information about another individual, you confirm that you are authorised to provide it for use as described below.

The types of Personal Information we may collect and why - Depending on our relationship with you, Personal Information collected may include: identification and contact information, payment card and bank account, credit reference and scoring information, sensitive information about health or medical condition or criminal conviction, and other Personal Information provided by you. Personal Information may be used for the following purposes:

- Insurance administration, e.g. communications, claims processing and payment
- Assistance and advice on medical and travel matters
- Management and audit of our business operations
- Prevention, detection and investigation of crime, e.g. fraud and money laundering
- Establishment and defence of legal rights
- Legal and regulatory compliance, including compliance with laws outside your country of residence
- Monitoring and recording of telephone calls for quality, training and security purposes
- Marketing, market research and analysis

Sharing of Personal Information - For the above purposes Personal Information may be shared with our group companies, brokers and other distribution parties, insurers and reinsurers, credit reference agencies, healthcare professionals and other service providers. Personal Information will be shared with other third parties (including government authorities) if required by law. Personal information (including details of injuries) may be recorded on claims registers shared with other insurers. We are required to register all third party claims for compensation relating to bodily injury to workers' compensation boards. We may search these registers to detect and prevent fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim. Personal Information may be shared with prospective purchasers and purchasers, and transferred upon a sale of our company or transfer of business assets.

International transfer - Due to the global nature of our business Personal Information may be transferred to parties located in other countries, including the United States and other countries with different data protection laws than in your country of residence. You therefore specifically consent that we may disclose this information to any other party who has direct interest in it.

Security and retention of Personal Information – Appropriate legal and security measures are used to protect Personal Information. Our service providers are also selected carefully and required to use appropriate protective measures. Personal information will be retained for the period necessary to fulfil the purposes described above.

We are committed to safeguarding your privacy and the confidentiality of your personal information. You can find the details of our Privacy Policy on our website (http://www.aig.co.ke/za-Privacy_916_216924.html).

CLAIMS DECLARATION
I / we give permission for my / our personal information to be used and shared in the ways described above.
I / we confirm that I / we will not provide any personal information about another person without that person's permission, and that where a claim is made on behalf of that person, I / we have their explicit authority to act and receive any payment on their behalf.
I / we declare that all the information given in respect of the claim(s) is to the best of my / our knowledge and belief, full, true and correct, and that no material information has been omitted which would affect the assessment of the claim(s) by the insurer(s).
I / we understand that if I / we give information that is incorrect or incomplete you and / or the insurer(s) may take action against me / us, including court action.
I / we know it is a CRIMINAL offence to defraud, or attempt to defraud an insurer and that by doing so I / we may be prosecuted.
I / we give my / our authority to you to contact my / our household insurers, medical insurers, Government or other insurers / third parties regarding a contribution.
In the event of a medical related claim I/we give my/our authority to contact and obtain information from my/our GP, Doctor, Hospital or other medical facility or practitioner.
I / we have read and fully understand the declarations above (ALL persons claiming must sign below).

Signature: _____ **Name:** _____ **Date** _____