

Claim Ref

Date

Title	<input type="text"/>	Address	<input type="text"/>		
First Name	<input type="text"/>		<input type="text"/>		
Surname	<input type="text"/>		<input type="text"/>		
Date of Birth	<input type="text"/>		<input type="text"/>		
Occupation	<input type="text"/>	Post Code	<input type="text"/>	Mob.	<input type="text"/>
Nationality	<input type="text"/>	Telephone	<input type="text"/>	Work.	<input type="text"/>
ID Number	<input type="text"/>	Email	<input type="text"/>		

Policy Information

Policy Number	<input type="text"/>				
Name of policy	<input type="text"/>				
Date issued	<input type="text"/>				
Policy start date	<input type="text"/>	Policy end date	<input type="text"/>		
Date the loss occurred	<input type="text"/>	Number of insured travellers	<input type="text"/>		

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

Total amount claimed

Travel details

Booking reference	<input type="text"/>				
Tour operator	<input type="text"/>				
Booking Date	<input type="text"/>				
Departure date	<input type="text"/>	Return date	<input type="text"/>		
Total days	<input type="text"/>	No. in party	<input type="text"/>		
Destination country	<input type="text"/>				
Destination city	<input type="text"/>				

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	<input type="text"/>				
Name of the bank	<input type="text"/>				
Address of the bank:	<input type="text"/>				
Branch Code:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
					Currency of the account:
IBAN Account Number:	<input type="text"/>				
SWIFT / BIC Code:	<input type="text"/>				

Curtailment (cutting short your trip).

Claim Ref:

Reason for curtailment - please tick ONE box only

<input type="checkbox"/>	<input type="checkbox"/>	Injury <input type="checkbox"/>	Non medical <input type="checkbox"/>
--------------------------	--------------------------	--	---

Scheduled return date:

Number of nights booked:

Actual return date:

Number of nights unused:

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

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

Name: Relationship:

Please explain what attempts you made to revalidate or use your original tickets

Details of holiday costs, additional expenses and refunds obtained or due (continue on a separate sheet if necessary).

	Original cost of trip	Additional expenses	Refunds
Ticket costs	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
Accommodation costs	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
Pre-paid excursions / Hire car / parking	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
Total	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>

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

Name	Relationship	Date of birth	Insured on this policy?
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	/ /	YES / NO
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	/ /	YES / NO
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	/ /	YES / NO
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	/ /	YES / NO
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	/ /	YES / NO

24 hour emergency service

(a) Was the assistance company contacted? YES NO

(b) Date and time contacted:

(c) Assistance case reference number:

if NO, please explain the reason for not contacting the assistance company

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

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** _____