tic travel insurance consultants

TRAVEL INSURANCE CLAIM FORM

Please complete ALL fields AND supply ALL required supporting documentation stipulated on :
SUPPORTING DOCUMENTATION CHECK LIST

1. PERSONAL DETAILS

Claimant details

Title : ____________ Contact number : ____________

First name : ____________ Date of birth : ____________

Surname : ____________

Email address : ____________

Physical address: ____________

____

ID/Passport number : ____________ Country of residence : ____________

Dependent children sharing in cover

No.	Name	Date of birth
1.		
2.		
3.		

2. JOURNEY DETAILS

Policy Number : ____________

Name of corporate entity (if applicable) : ____________

Medical aid scheme and plan name : ____________

Medical aid membership number : ____________

Was your ticket purchased with a credit card? YES / NO

If YES, credit card bank and name of card : ____________

If YES, first 8 digits of credit card : ____________

Period of travel and destination you travelled to:

Departed on : ____________ Returned on : ____________

Main destination : ____________

3. BANKING DETAILS (EFT transfers into credit cards not available)

(Corporate policy: Provide banking details of the corporate entity insured)

Account Holder : ____________ Bank : ____________

Account Number : ____________ Branch Name : ____________

Branch Code : ____________ Account Type : ____________

TIC is a division of santam

tic travel insurance consultants

4. CLAIM INFORMATION

Date of Incident/Loss : ____________________ Country where incident occurred : ______________________________

Did you notify the Assistance Company? YES / NO Assistance Company reference, if YES : ____________________

Provide a detailed description of your claim :

____

____

____

____

____

____

____

____

____

____

5. MEDICAL CLAIM INFORMATION

1. Emergency Medical Treatment received as a result of (Please mark with X)

   Injury ☐ Illness ☐ Disease ☐ Pre-Existing Condition ☐ Sporting Injury ☐

2. Diagnosis : ____

3. If you were hospitalised, please provide details of the hospital where you were admitted

   Name of Hospital : ______________________________ Date of Admission : ____________________

   Name of Consulting Dr : ______________________________ Contact Number : ____________________

   Have you been treated for this illness/disease within the last 6 months of purchasing your policy? YES / NO

   If yes, provide further details :

____

____

____

____

6. DECLARATION

I hereby confirm that I have answered all questions truthfully and have not withheld information that is material to the claim. I understand that the information provided will be treated as strictly confidential and will be used in accordance with TIC's Consent to Process Personal Information for assessing my claim.

Signature : ____ Date : ____________________

Please refer to SUPPORTING DOCUMENTATION CHECK LIST below

TIC is a division of santam

tic travel insurance consultants

SCHEDULE A – Break down of items claimed

Notes:

- List the items you are claiming for
- Attach all supporting invoices, receipts and cross reference the supporting documents with the relevant number on the schedule below

No.	Description	Supplier	Settlement to	Date Incurred	Currency	Amount
1.			Claimant / Supplier			
2.			Claimant / Supplier			
3.			Claimant / Supplier			
4.			Claimant / Supplier			
5.			Claimant / Supplier			
6.			Claimant / Supplier			
7.			Claimant / Supplier			
8.			Claimant / Supplier			
9.			Claimant / Supplier			
10.			Claimant / Supplier			
11.			Claimant / Supplier			
12.			Claimant / Supplier			
13.			Claimant / Supplier			
14.			Claimant / Supplier			
15.			Claimant / Supplier			
16.			Claimant / Supplier			
17.			Claimant / Supplier			
18.			Claimant / Supplier			
19.			Claimant / Supplier			

tic travel insurance consultants

SCHEDULE B – DISCLOSURE OF MEDICAL INFORMATION

Authorisation for Disclosure of Medical Information by Policy Holder

Policyholder name (patient) : ______________________________

Travel Booking From : ____________________ To : ____________________

I hereby authorise all information relating to my medical history to be disclosed to Travel Insurance Consultants and/or their representatives. I understand that my information will be treated as strictly confidential and will be used in accordance with TIC's Consent to Process Personal Information for assessing my claim.

Policyholder Signature : ____________________ Date : ____________________

Medical History (To be completed by treating physician)
Your patient purchased travel insurance for their journey departure and return dates indicated above. Please include all relevant information of the patient's medical and physical condition, enabling us to assess their travel insurance claim.

1. Diagnosis of illness

____

____

2. State conditions for which your patient has received medical treatment/advice in the past 6 months: (Date, diagnosis, treatment, medication)

____

____

2. State conditions for which your patient is currently receiving treatment: (Date, diagnosis, treatment, medication)

____

____

3. In your opinion, is your patient's medical, physical and emotional condition stable for them to undertake their journey? Yes/No (If No, **please provide reasons**)

____

____

4. Date of last examination : ______/____________________/________

5. How long have you been treating this patient? Years _______ Months ______

Treating physician details:

Name : ______________________________

Email : ______________________________

Contact Number : ____________________ Practice No : ____________________

I hereby declare that the above information is true and accurate and it is legally binding. I agree that an independent medical practitioner, appointed by Travel Insurance Consultants, may contact me to verify the information provided.

Signature : ______________________________ Date : ____________________

TIC is a division of santam

SCHEDULE C – DISCLOSURE OF MEDICAL INFORMATION

Authorisation for Disclosure of Medical Information by Related Individual to Policy Holder

Policyholder name : ____________________

Policy/claim number : ____________________

I hereby authorise all information relating to my medical history to be disclosed to Travel Insurance Consultants and/or their representatives. I understand that my information will be treated as strictly confidential and will be used in accordance with TIC's Consent to Process Personal Information for assessing listed policyholder's claim.

Your relationship to policy holder (please circle applicable) : Travel Companion / Immediate Family member / Business Associate / Other

Your name (patient) : ____________________

Your Signature : ____________________ Date : ____________________

Medical History (To be completed by treating physician)
Your patient is related to the policy holder as indicated. Please include all relevant information of the patient's medical and physical condition, enabling us to assess the policyholder's travel insurance claim.

1. Diagnosis of illness

____

____

2. State conditions for which your patient has received medical treatment/advice in the past 6 months: (Date, diagnosis, treatment, medication)

____

____

____

2. State conditions for which your patient is currently receiving treatment: (Date, diagnosis, treatment, medication)

____

____

____

6. Date of last examination : ______/____________________/________
7. How long have you been treating this patient? Years _______ Months ______

Treating physician details:

Name : ____________________

Email : ____________________

Contact Number : ____________________ Practice No : ____________________

I hereby declare that the above information is true and accurate and it is legally binding. I agree that an independent medical practitioner, appointed by Travel Insurance Consultants, may contact me to verify the information provided.

Signature : ____________________ Date : ____________________

TIC is a division of santam

tic travel insurance consultants

SUPPORTING DOCUMENTATION CHECK LIST

The following must be submitted as supporting documentation with the submission of your claim:

(This list is not exhaustive, as we may request further supporting documentation)

The following is required on each claim submission:

Document		Document	
Copy of Flight Tickets		Copy of Passport (Exit and Entry Stamps, if applicable)	
Copy of Accommodation Bookings		Proof of Bank Account	
Copy of Cruise Bookings(if applicable)		Completed Claim Form	

Documents required per Risk category

MEDICAL			
Schedule B – Disclosure of medical information		All Medical Accounts/Invoices	
Medical Reports from treating doctors		All Receipts for accounts paid	
CANCELLATION/CURTAILMENT/EXTENSION (submit what is applicable relating to reason of claim)			
Medical Report giving reason for not travelling		Schedule C – Disclosure of medical information of the person giving rise to your claim	
Notification of Death (stating cause of death)		If due to loss of Travel Documents – Police Report	
Proof of Travel & Accommodation Bookings		If due to Retrenchment or Redundancy – Letter from Company	
If due to Hijack, Strike, Riot or Civil Commotion – confirmation from Transport Carrier		Proof of Non-refundable costs (Paid less refund received)	
If due to Accidental Damage to Residence – Letter from Insurance Company		Confirmation of Non-refundable Travel & Accommodation costs	
If due to an Unspecified Event – proof that Policy was purchased within 48hrs of making your travel bookings		If due to a Terrorist Incident – copy of Prepaid Itinerary	
MISSED CONNECTION			
Report from Transport Carrier		Original Flight Itinerary, showing departure/arrival times of all flights	
Proof of additional costs/expenses incurred			
LUGGAGE / CASH & DOCUMENTS			
Police Report (from authorities where loss occurred)		Proof of black-listing of stolen/lost cell phone	
Valuation Certificate for jewellery		Proof of foreign currency	
Non-refundable entertainment tickets		Receipts for replacement of passport, visas & credit cards	
Confirmation of contribution from Airline			
LUGGAGE DELAY & TRAVEL DELAY			
Written proof of delay from Transport Carrier		Receipts of items purchased	
ACCIDENTAL DEATH OR PERMANENT TOTAL DISABLEMENT			
Death Certificate		Post Morten/Autopsy Report	
Medical Report detailing disablement		Police Report	

TIC is a division of santam

WEATHER CONDITIONS & NATURAL DISASTER			
Written proof from Transport Carrier		Proof of non-refundable portions of Travel & Accommodation costs	
Written proof from the Accommodation provider		All Receipts of additional expenses incurred	
DENIED VISA			
Proof of non-refundable portions of Travel & Accommodation costs		Letter from Embassy	
PERSONAL LIABILITY			
Summons or Letter of Demand from third party			
LEGAL EXPENSES			
Proof of imprisonment			
CAR RENTAL EXCESS WAIVER			
Copy of Rental Agreement		Police Report of accident/theft	
Receipt of paid excess to Rental Company			
POLITICAL EVACUATION			
Proof that Government Advisory was issued declaring a State of Emergency		Proof of expenses incurred for Transportation & Accommodation	
HIJACK AND HOSTAGE OR WRONGFUL DETENTION			
Proof of incident from Transport Carrier		Police Report	
REPLACEMENT AIRFARE			
Proof of Hospitalisation & Medical Reports			

Please return completed claim form and supporting documents to:

1) Email: claims@tic.co.za, or
2) Postal: The Claims Department, P O Box 3337, Cramerview, 2060