FORTUNE GENERAL INSURANCE CORPORATION
4/F Citystate Centre, 709 Shaw Blvd., Pasig City Philippines
Trunk Line: (632) 8706 – 3959 I customercare@fgic.com.ph I www.fgeninsurance.com

Notification of Claim - Travel Insurance

IMPORTANT INSTRUCTIONS:

1. Please contact the emergency hotline indicated in the policy contract in case you need emergency assistance while traveling.
2. For claims processing, all necessary documents have to be submitted. The company reserves the right to request additional documents as deemed necessary.
3. Submission of required documents does not guarantee approval of your claim. The submitted documents will be reviewed and evaluated, subject to the limits, terms, and conditions of your existing Travel Policy.
4. This form together with the official receipt(s) must be submitted within a period of not more than 90 days from the date of the assistance. Failure of the claimant to submit necessary documents within the given period shall be deemed an abandonment of the claim.

INSURED'S INFORMATION

Insured's Name :		Age :	Sex :
Policy Number :		Complete Address :	
Contacts Information	Home :	Office :	Mobile :
E-mail Address :			Fax :

CLAIMANT'S INFORMATION

Insured's Name :		Age :	Sex :
Complete Address :		Birthday : Relationship to Insured :	
Contacts Information	Home :	Office :	Mobile :

TYPE OF LOSS

☐ Medical Expenses ☐ Repatriation Expenses ☐ Trip Cancellation ☐ Trip Curtailment
☐ Flight Delay ☐ Luggage and Personal Effects ☐ Luggage Delay ☐ Personal Accident
☐ Others: (Please Specify) _____

DETAILS OF INJURY OR SICKNESS

Nature and Condition of Injury or Sickness :	
Place / Address where injury or sickness occurred :	
Hospitalization / Consultation Dates :	
Name of Hospital :	Attending Physician :
Hospital Address :	Telephone Number : Fax Number :
Date/s when patient had any prior treatment of the same illness :	

ATTENDING PHYSICIAN STATEMENT (If Applicable)

☐ Out-Patient ☐ In-Patient	Complete Diagnosis of Medical Condition:
Admission Date :	
Discharged Date :	
Date of Consultation :	

Do you consider this consultation / hospitalization as a continuous treatment for a chronic disease?	☐ YES	☐ NO
Does the patient have any other diseases or infirmity that is affecting his / her present condition?	☐ YES	☐ NO

If YES, please describe :	_____ Attending Physician's Signature over Printed Name

OFFICIAL RECEIPTS SUBMITTED

Official Receipt (O.R.) Number	Description	Amount

Name of Payee as it should appear on the check : _____
If Payee is not the insured, indicate relationship to the insured : _____
TOTAL AMOUNT CLAIMED : _____ (_____)
For processing of payment on approved claims, please indicate bank details for a Direct Credit to your nominated Bank Account.
Bank Account Name : _____
Bank Complete Address : _____
Bank Account Number : _____ Account Type : _____
Relationship to the Patient (*if bank account is other than the Patient's) :* _____
Notes : Applicable only for claim amounts of up to _____.
: Check shall be the default mode of payment for approved amount beyond _____.
: Whenever applicable, cost of inter-branch crediting will be deducted from the approved claim amount.
: A processing fee of _____ will be deducted from your claim resulting from the incorrect information provided by the claimant.

AUTHORITY, RELEASE AND DECLARATION STATEMENT

AUTHORITY: I hereby authorize my travel insurance and/or AME Global and its authorized representatives to request and receive information, document or record from any hospital, clinic, laboratory, attending physician and other health service provider, which information or document relates to any examination, laboratory test results, medical history and/or treatment in connection with this claim, and such other matters related thereto.

RELEASE AND SUBROGATION: Payment received by me in relation to this claim shall constitute as full, final and complete settlement. I further agree that the Company is subrogated to my rights of recovery on all claims and rights of action to the extent of the payments made and / or on account of the losses incurred or which may be incurred by the Company against any person, corporation or entity in connection with this claim and I further agree to authorize the Company to commence all legal actions and proceedings necessary to enforce my claim or recovery thereof with any undertaking to extend my cooperation or assistance whenever necessary.

DECLARATION: I declare that all data/statements found herein and on all pages of this form are complete and true, whether written by me of by anyone else on my behalf, shall be binding on me, and that the amounts being claimed herein are lawfully due to me under the terms and conditions of the policy.

_____ _____
Signature over Printed Name of Insured / Claimant or of Principal Insured — Date

CLAIMS REIMBURSEMENT CHECKLIST

Compulsory Documents for All Claims :
- ☐ Duly accomplished Notification of Claim (NOC)
- ☐ Copy of Insurance Policy
- ☐ Request Letter for Reimbursement
- ☐ Original Official Receipt/s (O.R.) of all payments made
- ☐ Copy of Passport with Exit/Entry Dates

For Medical / Hospitalization (additional) :
- ☐ Medical Report with Admitting Medical History
- ☐ Clinical / Laboratory Results
- ☐ Detailed Statement of Account (itemized)
- ☐ Copy of Operative Report or
- ☐ Histopathology Report
- ☐ Copy of Registered Death Certificate (if applicable)
- ☐ Dental Report (for Emergency Dental Care)

Other Documents Submitted :

_____

For Delay or Lost Luggage
- ☐ Property Irregularity Report (PIR) or Baggage Damage Report
- ☐ Incident Report from Client
- ☐ Original Receipts of Basic Necessity Purchased

For Trip Cancellation / Curtailment
- ☐ Airline Itinerary / Booking
- ☐ Certification of Trip Cancellation
- ☐ Copy of Airline Ticket
- ☐ Incident Report from Client

For Flight Delay
- ☐ Certificate from the Airline
- ☐ Incident Report from Client

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FOR EVALUATION PURPOSES (DO NOT FILL-UP)	
Reference File Number :	Claim Outcome : ☐ Approved ☐ Denied
Evaluation:	Processed By: _____ Signature over Printed Name
	Checked By: _____ Signature over Printed Name
	Approved By: _____ Signature over Printed Name