

# Tenet Insurance Company Ltd

(A member of Sampo Japan Group)  
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Company Registration No. 195700067Z http://www.tenetinsurance.com



## TRAVEL INSURANCE CLAIM FORM - PA / Medical Expenses

**Important Notice:**  
1 The acceptance of this form is NOT an admission of liability on the part of the Company.  
2 Claims should be submitted within thirty (30) days after completion of the journey.  
3 All documents provided to substantiate your claim must be original documents.  
4 All medical reports must be submitted at the claimant's expense.  
5 Please complete ALL questions fully and accurately so as not to delay assessment of your claim.  
6 You may use one form for multiple claimants if within the same family and payment is to the same person.

Agency \_\_\_\_\_ Policy / Certificate No \_\_\_\_\_

Have you notified us of this claim earlier?  No  Yes by email / fax / telephone call to \_\_\_\_\_

Please state any reference number assigned to you earlier: Claim no / Temporary ref no \_\_\_\_\_

**Useful notes:**  
a) Medical and TCM bills must indicate a breakdown of the expenses incurred (consultation and medication prescribed). Do not submit receipts as these will not show enough information for the claim to be assessed.  
b) The medical condition being treated must be clearly stated on the statement or doctor's memo.  
c) Specialist Consultation and Treatment must be referred by a General Practitioner.

### A. GENERAL SECTION

1. Insured/Claimant's Particulars  
a. Name: Dr/Mr/Mrs/Ms \_\_\_\_\_  
b. Address \_\_\_\_\_  
c. NRIC / Passport Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_ Contact Number \_\_\_\_\_  
Email address \_\_\_\_\_

2. Circumstances of Claim  
a. Period of travel for this trip \_\_\_\_\_ to \_\_\_\_\_ Date of return \_\_\_\_\_  
*(Please attach copy of passport / itinerary / documents showing period of travel)*

b. Date / Time of Accident/Illness  
Date: \_\_\_\_\_ Time: \_\_\_\_\_

c. Please state exactly what happened including nature and cause of injury or illness (if insufficient space, please attach statement).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Claim History / Other Insurances  
a. Have you or any Insured person ever previously sustained a loss of this nature or made any previous claim in respect of Travel Insurance? If so, please state details.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. Is there any other insurance in force covering this loss?  Yes  No

If so, please state Insurance Company and Policy Number.

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**B. PERSONAL ACCIDENT / MEDICAL EXPENSES / REPATRIATION EXPENSES**

Please attach as applicable:

- 1) Medical Bills and Certificate reports as applicable. 2) Medical Report 3) Boarding Pass/Air Ticket 4) Police or other reports as applicable.

1a. Please give reasons for additional accommodation or traveling expenses incurred if any.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person who incurred expenses \_\_\_\_\_ Relation to Insured \_\_\_\_\_

1b. Has claimant suffered from this complaint before?  Yes  No

Date of previous treatment: \_\_\_\_\_

1c. Treatment Details Overseas:

Out-patient  In-patient  Day Surgery  Admit on \_\_\_\_\_ Discharged on \_\_\_\_\_ No. of Days \_\_\_\_\_

Amount Claimed \_\_\_\_\_

2. Will there be any more bills to be submitted?  Yes  No

If yes, please elaborate \_\_\_\_\_

**C. PAYMENT DETAILS (if claim falls within terms and conditions of the policy)**

For GIRO payments above \$3,000 we require a Direct Credit Authorisation Form duly acknowledged by your bank.

1. Please confirm payee name if claim is payable \_\_\_\_\_

**Note:** If payee is different from claimant or is not listed in the policy please provide a Letter of Authorisation.

2. Tick the method of payment you prefer  By Cheque  By GIRO

2a. If payment is requested by GIRO, please advise bank details:

Bank / Branch: \_\_\_\_\_ Account Number: \_\_\_\_\_

Account Name: \_\_\_\_\_ I.C./Passport Number: \_\_\_\_\_

Signature of payee \_\_\_\_\_

Note: All payment(s) made to this account is based on information provided by you and the Company shall not be liable in respect of any disputes and/or loss and/or damage that may arise out of this transaction.

**DECLARATION - to be signed by the Claimant**

I declare that the particulars stated above are true and correct and I understand that if I have in this or in any further declaration in respect of this claim, made any false or fraudulent statement or suppress conceal or falsely state any material fact whatsoever my claim may be refused.

I hereby authorize any hospital physician, other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
NRIC Number