



中國交銀保險有限公司
CHINA BOCOM INSURANCE CO., LTD.

香港灣仔告士打道 231-235 號交通銀行大廈 16 樓 電話 Tel (852) 2591 2938 傳真 Fax : (852) 2831 9192
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ISO 9001 : 2000
Certificate No. 202608

TRAVEL INSURANCE CLAIM FORM

P.S. PLEASE ATTACH COPY OF AIR TICKET OR PASSPORT SHOWING THE PERIOD OF JOURNEY FOR FASTER CLAIMS PROCESS

Name of Insured : _____ Policy/Certificate No. _____
 Name of Claimant : _____ Tel : _____
 Address : _____
 Period of Journey : From _____ MM _____ DD _____ YY to _____ MM _____ DD _____ YY

*Type of Claims:

1. <input type="checkbox"/> Medical Expenses	4. <input type="checkbox"/> Repatriation of Remains	7. <input type="checkbox"/> Trip Cancellation/ Curtailment
2. <input type="checkbox"/> Personal Accident	5. <input type="checkbox"/> Baggage & Personal Effect	8. <input type="checkbox"/> Personal Money & Document
3. <input type="checkbox"/> Emergency Medical Evacuation	6. <input type="checkbox"/> Baggage Delay	9. <input type="checkbox"/> Flight Delay
10. <input type="checkbox"/> Personal Liability		

Date, Time, and Place of Loss / Treatment : _____

*To be completed for claim under all Sections

A) For Accident Claims – Describe how the accident occurred :

 B) For Sickness Claims – Describe the diagnosis of sickness :

 Attach all original receipt from medical providers, if any, and submit relevant documents in support thereof.

*To be completed for claim under Section 5 – Baggage / Personal Effects

Describe how the loss occurred : _____

Items Lost / Damaged	Date of Purchase	Purchase Value
_____	_____	_____
_____	_____	_____
_____	_____	_____

* Please also submit relevant Loss Report from Hotel Management, Common Carrier or Police
 * Please confirm whether the lost property are the property of your goodself
 * Please confirm whether there is any other insurance which provide cover for the same loss? If yes, please give us the name of the insurance company and the policy no.

Declaration and Authorization

I declare that information given by me in this from is true and correct to the best of my knowledge. I hereby authorize any physician, medical practitioner, hospital or clinic by whom or where I have been observed or treated to give full particulars about my health including my whole medical history to CHINA BOCOM INSURANCE CO., LTD. A Photostat copy of this authorization shall have the full effect of the original authorization.

Date : _____ Signature of Claimant _____