# TRAVEL INSURANCE CLAIM FORM

Postal Address:
5th floor, Zone A, Building No.7, Huitong Office Park, No.1 Yaojiayuan
South Road, Chaoyang District, 100025 Beijing, China
Email: Claims.service@allianz.com

In order for your claim to be dealt with promptly, please ensure ALL RELEVANT SECTIONS of this Claim Form are fully completed and returned to us by post together with all the required claims evidence. A separate claim form must be completed for each Insured Person who is claiming under the policy.

Please use BLOCK letters. Please retain a copy of all documents sent to us for your records.

Please note all expenses incurred in completing this claim form and providing all the necessary evidence to support this claim must be paid by you. Expenses incurred in providing evidence or translations are not covered under this policy.

## SECTION 1 – INSURED DETAILS

Claim NO: .....
(AP Use Only)

1. Policy Number: .....
2. Name of insured person: .....Passport/ID number:.....
3. Date of birth: ...../...../..... Occupation: .....
4. Address of claimant to be used for correspondence: .....Code: .....
5. Tel (Home/ Work): .....Tel (Mobile): .....Email:.....
6. Date travel arrangements booked: ...../...../.....Date of departure: ...../...../.....Date of return: .../.../.....
7. Have you made any previous claims in respect to travel insurance? YES☐ NO☐
If yes, please provide exact details of claims (date/amount/type of claim/insurance company involved): .....
.....
8. Are you able to claim through any other source? YES☐ NO☐
If yes, please provide information:.....

## SECTION 2 – MEDICAL EXPENSE CLAIM

1. Date of Incident: ...../...../..... Time (am / pm): .....Location (City / Country): .....
2. Please advise (in detail) the nature of the illness contracted or injury sustained for which this claim is related:
.....
.....
3. Have you ever been hospitalized or advised to be hospitalized? YES☐NO☐If yes, please fill in the table below:

| Hospitals Name | Admission Date | Discharge Date | NO. of Hospitalization | Diagnosis | Treatment/Medication |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

4. Have you ever suffered from any disorder which required that a) received more than 7 days treatment b) were off work/study for more than one week c) had specialized treatment (i.e. chem/radiotherapy and dialyse, etc.)?
YES ☐ NO ☐ If yes, please describe the details: .....
5. Are you currently on treatment/medication or advised to have treatment? YES ☐ NO ☐
If yes, please describe the treatment/medication.....
6. Please provide details of the treatment provided overseas:
Name of hospital/clinic:.....Address: .....
Name of treating doctor:.....Specifics of the treatment:.....
7. Has the illness or injury mentioned above occurred previously (prior to this specific incident)? YES ☐NO ☐
If yes, please provide details (date/location/previous treatment) .....
8. Please itemize all medical expenses that you are seeking reimbursement for:

| Explanation of the Expense | Name of Hospital/Doctor | Currency | Amount Claimed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| **TOTAL OF MEDICAL EXPENSES BEING CLAIMED:** | | | |

## SECTION3 – DAILY INPATIENT CASH SUBSIDY CLAIM

1. Admission Date: ...../...../.....
2. Discharge Date: ...../...../.....
3. Duration of Hospitalization: .....

## SECTION 4 – ACCOMPANYING ON THE INPATIENT OF DEPENDENT CHILDREN CLAIM

1. Information of the inpatient of dependent children:

| Country | Name of Hospital | Admission Date | Discharge Date | Diagnosis |
|---|---|---|---|---|
| | | | | |
| | | | | |

2. Is it recommended by qualified doctors? YES ☐ NO ☐
3. Your accompanying expenses (Up to 5 Days). Currency:_____

| 1st day | 2nd day | 3rd day | 4th day | 5th day | Total |
|---|---|---|---|---|---|
| | | | | | |

## SECTION 5 – ADDITIONAL INFORMATION OR COMMENTS TO SUPPORT YOUR CLAIM

If you are claiming under a section of the policy not provided on this claim form, please provide details below:
We recommend that you contact us for advice on the documents required to support your claim.

.....

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## SECTION 6 – PAYMENT DETAILS AND CLAIM PAYMENT DECLARATION

**Please indicate your information of bank transfer（China Post is not supported）.**
**Note that the account name should be claimant. No claim will be settled in cash.**
Name of Bank and Branch:.....
Account Name: ..... Account No: .....

*Please read the following declaration carefully and sign & date below:*

I (the Claimant) declare that all statements and particulars contained on this claim form are true and correct.
I (the Claimant) acknowledge and authorize that the underwriter or its agent may give to and obtain from other insurers and / or other authorities, personal information relating to this claim.
I (the Claimant) authorize the insurer or its agent to get related information and documents in respect to this claim from any other persons, police offices, hospitals, etc.

Signature of Claimant:..... Date:..../..../.....