

Contact us at:

T: +65 6221 2199

F: +65 6725 0853

E: claims@budgetdirect.com.sg

Claim Number (for official use)	
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TRAVEL CLAIM FORM

Please complete this form and submit it together with copies of your passport (showing clearly the departure and return dates), air ticket, boarding pass and travel itinerary, and all other relevant copy or original documents within 30 days from the date of your return to Singapore. We may require you to provide additional documents or information depending on the circumstances of your claim. If we ask for any document or report, you will have to pay the costs of obtaining them. Where applicable, all documents submitted to us must be translated into English by a certified translator. Do note that any failure to provide supporting documents may result in delays in the processing of your claim.

IMPORTANT NOTE: If we accept this form, it does not mean that we are taking legal responsibility for your claim.

Particulars of Policyholder

Name (as shown in NRIC, FIN or Passport):		Policy number:
NRIC, FIN or Passport number:	Sex: Male / Female	Date of birth (dd/mm/yyyy):
Contact numbers:		Email:
(H)	(O)	
Address:		

Particulars of Insured Person/Claimant

(You may skip filling up this section if the Insured Person/Claimant is the Policyholder)

Name (as shown in NRIC, FIN or Passport):		Relationship to Policyholder:
NRIC, FIN or Passport number:	Sex: Male / Female	Date of birth (dd/mm/yyyy):
Contact numbers:		Email:
(H)	(O)	
Address:		

Claim Payment Details

(We will pay by cheque to you/Insured Person/Claimant or their legal representative (for death claim))

Payee name (name of beneficiary as per bank account):	NRIC, FIN or Passport number:
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Travel Period

Start of trip (dd/mm/yyyy):	End of trip (dd/mm/yyyy):
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Details of the Incident

Country or city where the incident of loss, injury or illness occurred:

Date on which the incident of loss, injury or illness occurred (dd/mm/yyyy):

Time at which the incident of loss, injury or illness occurred (am/pm):

Description of how the incident of loss, injury or illness occurred:

Travel Details

***Please tick the type of your claim**

- Accidental Death
- Permanent Total Disablement
- Overseas Medical Expenses
- Medical Expenses in Singapore
- Overseas Hospital Confinement

- Return of Minor Children
- Overseas Quarantine Allowance
- Quarantine Allowance in Singapore
- Treatment by a Chinese Medicine Practitioner or a Chiropractor
- Compassionate Visit

Nature and extent of the injury or sickness:

Diagnosis of the injury or sickness by a medical practitioner/specialist:

Name(s) and address(es) of the attending medical practitioner and specialist (if any):

Did the injury or sickness result in permanent disability?

Yes / No

If yes, please describe which part(s) of the body is/are affected:

Is the injury or sickness due to a pre-existing medical condition or physical disability?

Yes / No

If yes, please provide date on which treatment was first sought for this medical condition or physical disability:

Date of medical consultation or compassionate visit	Details of expenses	Amount you want to claim (S\$)
Number of days of quarantine or confinement (local):		Number of days of quarantine or confinement (overseas):

■ Please tick if applicable		Trip Cancellation/Shortened/Disruption/Postponement	
Intended date of departure (dd/mm/yyyy):		Intended time of departure (am/pm):	
Intended place of departure:	Country or city:		Name of the airport/port/station:
Flight/vessel/coach/train number:			
Date on which the trip was cancelled, shortened, disrupted or postponed (dd/mm/yyyy):		Time at which the trip was cancelled, shortened, disrupted or postponed (am/pm):	
Reason the trip was cancelled, shortened, disrupted or postponed:			
Total amount paid by you (S\$):		Amount you want to claim (S\$):	
Did you receive any refund for the amounts paid by you (S\$)? Yes / No		If yes, please state how much refund you received (S\$) and who paid you the refund:	

■ Please tick if applicable		Travel Delay/Travel Misconnection/Trip Diversion	
Intended date of departure (dd/mm/yyyy):		Intended time of departure (am/pm):	
Intended place of departure:	Country or city:		Name of the airport/port/station:
Original flight/vessel/coach/train number:			
Actual date of departure (dd/mm/yyyy):		Actual time of departure (am/pm):	
Actual place of departure:	Country or city:		Name of the airport/port/station:
Actual flight/vessel/coach/train number:			
Reason for your travel delay, travel misconnection or trip diversion:			
Total amount paid by you (S\$):		Amount you want to claim (S\$):	
Did you receive any refund for the amounts paid by you (S\$)? Yes / No		If yes, please state how much refund you received (S\$) and who paid you the refund:	

<input type="checkbox"/> Please tick if applicable Travel Agency Insolvency	
Name of travel/tour agency or transport provider:	Date on which the travel/tour agency or transport provider stopped operating for business (dd/mm/yyyy):
Date of booking with the travel/tour agency or transport provider (dd/mm/yyyy):	Intended date of departure (dd/mm/yyyy):
Total amount paid by you (S\$):	Amount you want to claim (S\$):
Did you receive any refund for the amounts paid by you (S\$)? Yes / No	If yes, please state how much refund you received (S\$) and who paid you the refund:

<input type="checkbox"/> Please tick if applicable Overbooked Public Transport	
Name of transport provider or handling agent:	
Intended date of departure (dd/mm/yyyy):	Intended time of departure (am/pm):
Actual date of departure (dd/mm/yyyy):	Actual time of departure (am/pm):
Total amount paid by you (S\$):	Amount you want to claim (S\$):
Did you receive any refund for the amounts paid by you (S\$)? Yes / No	If yes, please state how much refund you received (S\$) and who paid you the refund:

<input type="checkbox"/> Please tick if applicable Baggage Delay	
Flight/vessel/coach/train number:	Place of baggage collection (airport/port):
Flight/vessel/coach/train arrival date (dd/mm/yyyy):	Flight/vessel/coach/train arrival time (am/pm):
Baggage collection date (dd/mm/yyyy):	Baggage collection time (am/pm):

<input type="checkbox"/> Please tick if applicable Loss or Damage of Baggage and Personal Belongings (To attach additional page if required)				
Description of the lost or damaged item	Date the item was purchased (dd/mm/yyyy)	Place the item was purchased	Price the item was purchased for (S\$)	Amount you want to claim (S\$)
Did you receive any compensation or cash settlement from the service provider (for example, the airline) for any of the claim(s) above (S\$)? Yes / No			If yes, please state how much refund(s) you received (S\$) and who paid you the refund(s):	

<input type="checkbox"/> Please tick if applicable Emergency Telephone Charges		
Date on which the telephone call was made	Details of the telephone call (for example, the person you called and the purpose of such call)	Telephone charge incurred which you want to claim (S\$)

<input type="checkbox"/> Please tick if applicable Rental Vehicle Excess	
Rental vehicle number:	Name of rental company:
Name of contact person at the rental company:	Contact number of the rental company:
Date of accident (dd/mm/yyyy):	Time of accident (am/pm):
Place of accident:	
Excess or deductible of the motor insurance policy covering the rental vehicle which you have paid and want to claim (S\$):	

<input type="checkbox"/> Please tick if applicable Other insurance(s) covering you for this claim (To attach additional page if required)					
Name of insurer	Policy number	Insurance period		Type of insurance policy	Amount you can claim from this insurer (S\$)
		Start date	End date		

■ Please tick if applicable

Other Sections

(For any other claim which does not fall within the sections shown above, please provide details of the claim below)

Empty box for providing details of the claim.

(To attach additional page if required)

MEDICAL REPORT

This report is to be completed by the attending medical practitioner and specialist (if any).

1. Name of patient:	2. NRIC, FIN or Passport number:
3. Date of first consultation (dd/mm/yyyy):	4. Date of diagnosis (dd/mm/yyyy):
5. Full description of the injury or sickness (including any permanent disability):	
6. State the cause of the injury or sickness (including any permanent disability):	
7. Any pre-existing medical history relevant to the injury or sickness (including any permanent disability):	
8. Any referral letter: Yes / No If yes, please provide name, address and first consultation date of the referring medical practitioner:	
9. When will the patient be fit to travel again, following the injury or sickness?	
10. Please describe the patient's state of health at the time the holiday was booked:	
Declaration I have examined the patient and/or referred to his/her medical records and declare that the information given is correct and no relevant details have been withheld.	
Name of medical practitioner (and if registered in Singapore, the MCR number):	Clinic or hospital stamp:
Address and contact number:	
Signature:	
Date of signature:	

List of Supporting Documents
(in each case, where applicable)

For Medical Expenses

- Medical bills and receipts (original)
- Medical reports and in-patient discharge summary (original)
- Telephone bills relating to emergency telephone charges to our emergency assistance company (original)
- Medical leaves certificate(s) (copies)
- Police or road traffic accident report (copies)

For Personal Accident

- Death certificate (certified true copy)
- Proof of relationship between deceased and claimant
- Coroner's/post-mortem/autopsy and toxicology report (copies)
- Police report or road traffic accident report (copies)
- Grant of probate or letter of administration (copies)
- Photographs of the claimant's injury (in amputation cases)

For Travel Inconveniences

- Death certificate (certified true copy)
- Booking invoice and receipts (originals)
- Proof of deposit and documents showing proof of insolvency of travel/tour agency in Singapore
- Proof of relationship between claimant and injured, sick or deceased person
- Written confirmation from travel/tour agency, airline or other transport operator, hotel and/or any other relevant party whom you paid the non-refundable prepaid travelling expenses to (original)
- Written confirmation from travel/tour agency, airline or other transport operator and/or any other relevant party stating the period of delay you had experienced, the reasons for the delay and any remedial actions taken (original)
- Written confirmation from travel/tour agency, airline or other transport operator and/or any other relevant party stating the reason and the amount of refund (if any) (original)

For Personal Belongings

- Report issued by the police at or around the place of the loss or damage within 24 hours of occurrence (original)
- Report issued by the airline or other transport operator, hotel and/or any other relevant party on any property irregularity (original)
- Acknowledgement slip or confirmation from the airline or other transport operator stating the date and time the baggage was collected (original)
- Proof of ownership of the lost or damaged item (for example, the purchase receipts or invoices) (original). In the absence of the above, instruction manual, original packaging, bank statement and photographs may be considered.
- Photographs of the damaged items
- Written confirmation from manufacturer or authorised repairer of the damaged item, stating that the item is beyond economical repair (original)
- Receipts or invoices for repair and/or parts of the damaged item (original)

Other Benefits

- Rental vehicle agreement (copy)
- Police or road traffic accident report (copy)
- Invoice for payment of the excess or deductible under the motor insurance policy covering the rental vehicle during the rental period, and the official receipt showing payment thereof (original)
- Witness' accounts or other relevant details from third parties
- Photographs in relation to the incident
- Details of any solicitor that you have instructed
- Any correspondence from third party and their legal representative (original/copy)
- Fire incident report for home contents (copy)

We may require you to provide additional documents or information depending on the circumstances of your claim. You must not dispose of any damaged item(s) without our prior consent.

Declaration

1. I/We hereby declare that the information given on this form is to the best of my/our knowledge and belief, true, correct and complete.
2. I/We understand that my/our claim may be rejected or my/our policy may be treated as void, if I/we have made any false or fraudulent statement or deliberately left out any relevant information, relating to the incident(s) on this form or in any document provided. In all such cases, Auto & General Insurance (Singapore) Pte. Limited (trading as Budget Direct Insurance) ("Budget Direct Insurance") reserves the right to report me/us to the relevant authorities and recover from me/us all claims that have been paid out under my/our policy and any costs incurred by Budget Direct Insurance in relation to my/our policy.
3. In connection with the claim(s) submitted in this form, I/we give consent for Budget Direct Insurance and their respective representatives or agents to collect, use, store, transfer and/or disclose my/our personal data and other information on this form and in any document provided (including that provided by sources other than myself/ourselves) concerning me/us, to or with all such persons (including any member of the Auto & General Group or any third party service providers, intermediaries and/or business partners of Budget Direct Insurance, and whether in or outside Singapore) for purposes which includes enabling Budget Direct Insurance to provide me/us with the services required of an insurance provider, including the evaluating, processing, administering and/or managing of my/our policy/policies, account(s) and/or claim(s) with Budget Direct Insurance (as the case may be), and for the other purposes and uses set out in Budget Direct Insurance's Privacy Policy which can be found at www.budgetdirect.com.sg, which I/we have read and accepted the terms thereof.
4. I/We hereby authorise any medical practitioner, specialist, clinic, hospital or any other party who has attended or examined me/us, to furnish to Budget Direct Insurance and their respective representatives or agents any and all information on my injury, sickness, medical history, prescription(s) or treatment, with copies of all clinic/hospital admission and/or medical records. A copy of this authorisation shall be deemed as effective and valid as the original.

Signature of Policyholder
Company's stamp (if applicable)

Signature of Insured Person/Claimant
(If the Insured Person/Claimant is not the Policyholder)

Date

Date