

TRAVEL MASTER CLAIMS FORM

Policy Number: _____ COC Number: _____ Effectivity Date: _____

NAME OF INSURED
 Surname _____ Given Name _____ Middle Name _____

GENDER Male Female **CIVIL STATUS** Single Married Widowed Separated

AGE _____ **DATE OF BIRTH (DD/MM/YYYY)** _____ **BIRTHPLACE** _____ **CITIZENSHIP** _____

PHILIPPINE ADDRESS
 Floor/Unit _____ Building _____ Number _____

 Street _____ Subdivision/Village _____ Barangay _____
 Municipality/City _____ Province _____ Zip Code _____ Email Address: _____

CONTACT INFORMATION:

 Home Phone Number: _____ Office Phone Number: _____
 Mobile Number: _____ Fax Number: _____

PRESENT OCCUPATION: _____ **TAX IDENTIFICATION NUMBER (TIN):** _____

TYPE OF EMPLOYMENT Government Private Others (pls. specify): _____

NATURE OF WORK

<input type="checkbox"/> Agricultural/Mining	<input type="checkbox"/> Insurance	<input type="checkbox"/> Utilities
<input type="checkbox"/> Business/Service	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Healthcare Profession
<input type="checkbox"/> Commercial/Social Personal Services	<input type="checkbox"/> Real Estate	<input type="checkbox"/> Government Employee
<input type="checkbox"/> Construction	<input type="checkbox"/> Transportation/Communication	<input type="checkbox"/> Others (pls. specify): _____
<input type="checkbox"/> Finance/Banking	<input type="checkbox"/> Wholesale/Retail	

INCOME BRACKET (per month)

<input type="checkbox"/> not over PhP 10,000.00	<input type="checkbox"/> over PhP 140,000.00 but not over PhP 250,000.00
<input type="checkbox"/> over PhP 10,000.00 but not over PhP 30,000.00	<input type="checkbox"/> over PhP 250,000.00 but not over PhP 500,000.00
<input type="checkbox"/> over PhP 30,000.00 but not over PhP 70,000.00	<input type="checkbox"/> over PhP 500,000.00
<input type="checkbox"/> over PhP 70,000.00 but not over PhP 140,000.00	

NAME OF EMPLOYER: _____

EMPLOYMENT ADDRESS
 Floor/Unit _____ Building _____ Number _____

Street _____ Subdivision/Village _____ City/State _____

Country _____ Zip Code _____

CLAIMANT'S INFORMATION
NAME
 Surname _____ Given Name _____ Middle Name _____

GENDER Male Female **RELATIONSHIP TO PRINCIPAL INSURED** _____

CONTACT INFORMATION OF CLAIMANT
 Home Phone Number: _____ Fax Number: _____
 Mobile Number: _____ Email Address: _____

I hereby warrant that all information given by me are true and correct to the best of my knowledge, freely and voluntarily given to Malayan Insurance, Co., Inc ("MICO"). I hereby authorize MICO to keep, record, store, use, process my name, address, contact details and all other information I give to MICO, to transfer and share the same to third parties, and other YGC companies, their affiliates, subsidiaries, contractors, partners, agents, intermediaries, and/or other parties they may choose, for survey, statistical analysis, monitoring, research, or direct marketing, promotional, and sale purposes through telephone, e-mail, correspondence, short messaging service, and any other means of communication. If purchasing, transacting and/or acting in behalf of other person(s), I hereby warrant that I am duly authorized to perform such acts and that I am duly allowed to give their information to MICO. I bind myself to advise all other persons in whose behalf I have acted, transacted with and/or purchased any product from MICO of all the terms and conditions herein. I hereby hold MICO, its officers, directors, and employees free and harmless from any liability, directly or indirectly arising from or in connection with the disclosure, sharing, and use of the information stated above."

CLAIM INFORMATION

KINDLY CHECK TYPE OF CLAIM AND DOCUMENTS (Original or Certified True Copy) SUBMITTED:
General requirements:

<input type="checkbox"/> Policy/Confirmation of Cover	<input type="checkbox"/> Police Report
<input type="checkbox"/> Passport	<input type="checkbox"/> NSO Birth Certificate of the beneficiary (if parent/child/sibling)
<input type="checkbox"/> Valid ID of Beneficiary/Claimant with signature and address	<input type="checkbox"/> NSO Marriage Certificate of the beneficiary (if spouse)
<input type="checkbox"/> Notarized Affidavit of how the incident happened	<input type="checkbox"/> E-ticket - initial ticket purchased

Out-patient - EMT
 Official Receipts
 Medical Report
 Laboratory Results

In-patient - EMT
 Statement of Account (with breakdown)
 Official Receipts
 Medical Report
 Laboratory results
 Operative record and hispathology results

Loss of Baggage
 Baggage irregularity report
 Police Report
 Affidavit of Loss
 List of lost items with brand, model, type, and corresponding amount

Baggage Delay
 Baggage irregularity report
 Document stating exact date and time baggage was retrieved
 Official Receipts of expenses incurred (on toiletries and clothing)

Loss of Travel Documents
 Document issued by the carrier for lost travel tickets/ by the embassy for lost passport
 Copy of the replacement travel ticket/passport
 Irregularity report from airline
 Official reports of travel and communication expenses incurred in getting a replacement travel ticket/passport
 Police Report

Flight Delay
 Document issued by the airline recognizing the reason of delay
 Receipt of expenses (food, lodging, transportation)

Strikes and Highjacking
 Document issued by the airline recognizing that such strike/highjack has occurred

Trip Termination
 Medical report of the insured/relative
 Death Certificate of the insured/relative
 Document that will satisfactorily prove cancellation and which will also indicate the non-refundable portion of the travel and accomodation expenses

When were you/the insured injured or taken ill?/Date of Death/Date of Loss

 Date: _____, 20____ at _____ AM/PM
 Date of Admission in the Hospital: _____, 20____ at _____ A.M./P.M.
 Date of Discharge from the Hospital: _____, 20____ at _____ A.M./P.M.
 Name and Address of Hospital where confined: _____

 For accident, describe fully how and where the incident occurred: _____

For sickness, describe type of sickness: _____

I hereby authorize the Physician and/or the hospital Administrator concerned to release any information acquired in the course of my my examination or treatment to any authorized representative of MICO. Furthermore I, the undersigned, declare that the particulars stated on this form are true in every aspect. I have supplied full information on all particulars relevant to this claim and the amounts claimed are lawfully due to me under the terms, conditions and exceptions of the policy.