NOTIFICATION OF CLAIM - TRAVEL INSURANCE

IMPORTANT INSTRUCTIONS:

1. Please contact the PRUDENTIAL GUARANTEE AND ASSURANCE, INC. 24/7 assistance hotline immediately **(+632 8459-4734**) in case you need emergency assistance while travelling.
2. For claims processing, all necessary documents have to be submitted. The company reserves the right to request additional documents as deemed necessary.
3. Submission of required documents does not guarantee approval of your claim. The submitted documents will be reviewed and evaluated, subject to limits, terms and conditions of your existing Travel Policy.
4. This form, together with the required claims documents, must be submitted within 90 days from the day of notification to PRUDENTIAL GUARANTEE AND ASSURANCE, INC. 24/7 assistance hotline. (Please refer to the attached "List of Required Claims Documents").
5. Failure to call the hotline immediately following a claim, and failure to submit the required claim documents within the prescribed period may be grounds for denial of the claim.

INSURED'S INFORMATION

Insured's Name :		Date of Birth :		Sex :	
Address :		Policy Number :			
		Home :		Office no. :	
E-mail Address :		Fax :		Mobile no.:	

CLAIMANT'S INFORMATION

Claimant's Name :		Age :		Sex :	
Address :		Home :		Office :	
		Mobile :			
Relationship to Insured :		E-mail Address :			

TYPE OF LOSS

PLEASE CHECK THE PARTICULAR TYPE OF LOSS:

MEDICAL & EMERGENCY EXPENSES
- ☐ Medical Treatment including Follow Up Treatment
- ☐ Emergency and Accidental Dental Expenses
- ☐ Medical Evacuation and Repatriation
- ☐ Repatriation of Mortal Remains
- ☐ Daily Hospital Confinement
- ☐ Compassionate Visit
- ☐ Return of Minor Children

PERSONAL ACCIDENT
- ☐ Accidental Death and Disablement
- ☐ / Accidental Burial

PERSONAL LIABILITY

TRIP CANCELLATION

TRIP CURTAILMENT

- ☐ Loss of Personal Money
- ☐ Loss of Travel Documents

LOSSES AND DELAYED DEPARTURE
- ☐ Flight Delay
- ☐ Aircraft Skyjacking
- ☐ Flight Misconnection
- ☐ Loss or Damage of Baggage and Personal Effects
- ☐ Baggage Delay

Please state if it does not fall in any of the above

Place where incident, loss or illness occurred:			
Date of Occurrence:		Time of Occurrence:	

Are there any other policies of insurance in force covering you in respect of this event? ☐ Yes ☐ No

If Yes, please specify:

FOR PERSONAL ACCIDENT/SICKNESS - Medical and Additional Expenses

Have you ever suffered this or a similar condition or a recurrence of a previous Illness or Injury? ☐ No ☐ Yes

If Yes, please specify Nature of Illness or Injury:	
Provide Name and Address of your usual Attending Physician:	

Prudential Guarantee
PGA Insurance

Name and Address of other Physician(s) consulted prior to confinement:	
If hospitalized, give Name and Address of Hospital:	
Hospital Confinement: From _____ 20__ at _____ AM/PM To _____ 20__ at _____ AM/PM	

FOR DISABILITY CLAIM

Describe fully the duties of your occupation (attach additional sheets if necessary):

When did you cease work? From _____ 20__ at _____ AM/PM To _____ 20__ at _____ AM/PM

House confinement: From _____ 20__ at _____ AM/PM To _____ 20__ at _____ AM/PM

When did, or will you resume all or any part of your work?

From _____ 20__ at _____ AM/PM To _____ 20__ at _____ AM/PM

Full time or active performance of your duties:

Starting: _____

ATTENDING PHYSICIAN'S STATEMENT

1. Full Name			
2. (a) Age of Death		(b) Place of Death	
(c) Date of Death		(d) Occupation at date of Death	
3. How long have you known the deceased?			
4. Length of hospitalization			
5. (a) When were you first consulted for the condition which either directly or indirectly caused death?			
(b) Who consulted you? (Specify if deceased, relative or others)		(c) Date of last Visit	
(d) What was the cause of death? (Immediate, proximate, underlying)			
(e) How long in your opinion did deceased suffer from this disease or impairment?			
(f) Since when has the patient been incapable of doing the daily normal chores (working, bathing, dressing up, getting in and out of bed, toileting) of life? Please specify physical limitations.			

(g) What were the contributory causes of death? State the duration of each:

Disease or Impairment	Duration

(h) Was there any connection (remote or proximate) between the death and occupation, residence, habits or personal history of the deceased? ☐ Yes ☐ No If Yes, state which and give particulars.

6. State particulars of each condition for which you treated or advised deceased prior to last illness:

Nature of Condition	Dates	Duration	Result of Treatment

7. State names and addresses of other physicians and practitioners who to your knowledge attended deceased during the past three years:

Name	Address	Disease of Impairment	Date

8. Was death due to suicide? ☐ Yes ☐ No

9. Was there any official inquiry as to the cause of death or a post mortem examination on the body of the deceased? ☐ Yes ☐ No
If Yes, by whom and with what result?

Date and Place	Physician's Name	Physician's Signature

License No.: Telephone No.:

DOCUMENTS SUBMITTED

Type of Document	Details / Official Receipt Numbers	Amount

AUTHORITY, RELEASE AND DECLARATION STATEMENT

AUTHORITY: I/We hereby authorize any medical practitioner, medically related facility, insurance company, government agency or instrumentality or any other personal information controller and processor who collects, holds, processes or uses any of my/our personal information, to disclose to, provide and/ or furnish Prudential Guarantee and Assurance, Inc. and/or MAPFRE Asistencia, its reinsurers and/or any of their duly authorized representatives with, and for any of the latter to collect, retrieve, use and/or otherwise process, or to disclose, provide or furnish to other insurance company(/ies) and their affiliates or representatives, any personal information, sensitive personal information and privileged information, including copies (original or certified) of documents, relating to my/our health and personal identity necessary in the evaluation of any claims under this policy to be conducted by Prudential Guarantee and Assurance, Inc. and/or MAPFRE Asistencia or for any legitimate purpose. A photocopy of this authorization will be considered as valid as the original. It is understood that any action which any medical practitioner, medically related facility, insurance company, government agency or instrumentality or any other personal information controller and processor who collects, holds, processes or uses any of my/our personal information may take in connection with this authorization releases said persons or entities, or any and all members of their staff from any responsibility or obligation in connection with the release or processing of such records or information.

I/We hereby certify that I/We have carefully read and clearly understood the above said authorization, and do hereby voluntarily accept and acknowledge the same as informed expressions of my/our own free will.

DECLARATION: I declare that all data/statements found herein and on all pages of this form are complete and true, whether written by me of by anyone else on my behalf, shall be binding on me, and that the amounts being claimed herein are lawfully due to me under the terms and conditions of the policy.

Signature over Printed Name of Patient
or of Principal Insured, if Patient is a Minor

Date

FOR PRUDENTIAL GUARANTEE AND ASSURANCE, INC. USE ONLY

Reference File Number :	CLAIM OUTCOME
Evaluation :	Approved ☐ Denied ☐
	Processed By : Signature over Printed Name
	Approved By : Signature over Printed Name