CHARTIS

TRAVEL GUARD
CHARTIS

Chartis Egypt Insurance Company S.A.E
Cairo - Egypt
Nile City, Northern Tower, 26th Floor
Ramlet Beaulac - Corniche ElNile

TRAVEL CARE INSURANCE CLAIM FORM

IMPORTANT:

Please contact at our 24-hour help line- Assistance Center :

Zone	Assistance Company	Claims Administrator
Europe	**Europe Assistance (Suisse) S.A** Tel.:+ 41 22 341 02 04 / Fax:+ 41 22 939 2245	**Golden Care** 31,bd. Helvetique, 1207, Geneva Tel.:+ 41 22 786 1200 / Fax:+ 41 22 786 1220 e-mail:travelegypt@egoldencare.com
USA & Canada	**Travel Guard Assist** +1-800-626-2427	**Travel Guard Assist** Att: Travel Care 6464 Savoy Dr Suite 200 Houston TX 77036 **United States**
Rest of the world	**Travel Guard Assist** +1- 713-267-2525	

Please note, the first EGP 500 of your expenses is deductible, and must be borne by you.

1. This is a One Call Claim Form, we may ask for more details upon notification.
2. Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract
3. No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format (Attending Doctor's Report - Page 4)
4. Please answer all questions completely. In case of insufficient space, please attach an additional sheet
5. Please attach all bills, receipts, credit card slips pertaining to your claim.

Certificate/ Policy No.______________ Period From _________________ to: _________________

DETAILS OF THE APPLICANT

Name : ____ Phone Nos. ____
Address:____

Relationship with Insured person:

DETAILS OF PATIENT/ INSURED PERSON

Name : ____ Phone Nos. ____
Permanent Address:____
____
Date of Birth: ______/______/_______ Sex: M / F
Assistant Co. Ref. No.: ________________________________ Passport No.: _______________________
Date of Departure: ___/___/___ Flight No. _________ From __________________ to ____________________
Date of Arrival: ___/___/___ Flight No. _________ From __________________ to ____________________

Please indicate whether claim is in respect of :

☐ Accident & Sickness ☐ Hospitalization Benefit ☐ Travel Delay ☐ Baggage Loss
☐ Baggage Delay ☐ Loss of Passport ☐ Personal Liability ☐ Hijack

Please complete the Section relevant to your claim.

LOSS/DELAY OF CHECKED BAGGAGE

Describe when & where the loss/delay took place:
____
____
____
State the extent of Loss: ____
Name the common carrier: ___________________________
1. Flight No. ___________________ From ________________________________ to ________________________________
2. Flight No. ___________________ From ________________________________ to ________________________________
Has the common carrier been notified at the time of loss? Yes ☐ No ☐ Airline Reference No. ____________________
Details of compensation received from carrier: ____
Scheduled date/time of Arrival:__/__/__; __:__hrs. Actual date/time when bags delivered :___/___/____; __:__hrs
No. of Hours delayed :__________

Item Purchased/Lost *	Date of Purchase	Place	Cost
		TOTAL	
Less Compensation received from Airline:			
		Net Amount:	

** In case of Delay, please provide details of purchases made*
** In case of Loss, please provide details of items lost.*

LOSS OF PASSPORT

Please provide details of the incident i.e. when, where and how it happened:____
____
____
Details of Police Report (please attach copy): No:_____________________Date: ___________ Place: ________________

Details of Expense incurred	Date	Place	Amount
		TOTAL	

TRAVEL DELAY

Flight No. ________________ Date____/____/______ From _______________________ to________________________
Scheduled time of Departure:___________ Actual time of Departure: ____________ No. of Hours delayed:____________
Whether accommodation & boarding provided by carrier: Yes☐ No☐

Details of Expense incurred	Date	Place	Amount
		TOTAL	

HIJACKING

Flight Details: No. _____________________ From __________________________________ to ______________________
Scheduled Date & time of Departure: ______________________ Scheduled date & time of arrival:___________________________
Date and time of Hijack: __________________________ Date & time Returned: ____
Please provide details of incident: ____
____

PERSONAL LIABILITY

Please provide details of injury/ property damaged: ____
____
____
Details of Amount Claimed: ____
Any other information you would like us to have: ____
____
____

MEDICAL ACCIDENT & SICKNESS BENEFIT

If accident, details of accident i.e. how, when, where it took place:____

____

Date:___________________________ Place: _______________________________________

If sickness, state nature and diagnosis, and advise when & where symptoms first occurred: _______________________

____

Date:___________________________ Place: _______________________________________

Name & Address of consulting physician: ____

____

____

Have you ever been treated for this illness before: ☐ Yes ☐ No

If yes, provide name & address of consulted physician: ____________________________________

____

____

Provide name & address of your family physician: ____

____

____

Provide name of any prescription medicine you are presently taking: ___________________________

Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer:

____

____

Details of treatment	In/ Out Patient		Charges (Currency)	Egyptian Pounds
	From	To		
		Paid		
		Outstanding		
		TOTAL DUE		

Whether Assistance Co. was contacted: Yes☐ No.☐ If Yes, Reference No. _____________________

If No, give reasons: ____

____

____

AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a Photostat copy of this authorization shall be considered as effective and valid as the original.

Date:_______________________ Place:_______________________________________

____

____

Signature of insured :_______________________________________

Attending Doctor's Report

Patient's Name: ____ Age: _______ Sex: M / F Address:
____
____
____
Date contacted: ___________________________________ Time: ___________________________

For Accidental Injury

Nature of Injury: ____
____
X-Ray Taken: Yes ☐ No ☐ Date taken: ____
Diagnosis and Treatment Given: ____
____
____
____
Describe any other disease or infirmity affecting present condition: ____

For Sickness

Nature of Illness: ____
____
____
Diagnosis and Treatment Given: ____
____
____
____
When did patient's symptoms first appear: ____
Describe any other disease or infirmity affecting present condition: ____
____
Is condition due to Pregnancy: Yes ☐ No ☐ Is illness due to any pre-existing condition: Yes ☐ No ☐

If Hospitalized, please provide the following details:

Name of Hospital/ Clinic: ____
Address: ____
____
____
Attending Doctor's Name: ____

Date: ____________________________

Signature:____
Attending Doctor's Signature