

TRAVEL CLAIM FORM

Chartis South Africa Limited
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Braamfontein 2017
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Email: SATravelClaims@chartisinsurance.com

NOTES	TYPE OF CLAIM
<ol style="list-style-type: none"> For all claims, please complete SECTION 1 and SECTION 8. All supporting documentation MUST be submitted together with this form in order to avoid unnecessary delays. For all claims relating to LOSS or THEFT, please provide a carrier and/or police report. Please supply a copy of your POLICY RECEIPT. Please supply a copy of your AIR TICKET. 	<input type="checkbox"/> Death/Personal Accident <input type="checkbox"/> Medical <input type="checkbox"/> Travel Delay <input type="checkbox"/> Baggage/Cash/Documents <input type="checkbox"/> Cancellation & Curtailment <input type="checkbox"/> Personal Liability

SECTION 1 – INSURED PERSON	
Card No / Policy Receipt No	
Surname:	
First Names:	Age:
Postal Address:	
Code:	
E-mail Address:	
Tel. No. Business: ()	Tel. No. Residence: ()
ID No:	Travel Date: / /20 to / /20
1. Date of Accidental Death/Illness/Injury/Loss/Theft	
2. Place of Accidental Death/Illness/Injury/Loss/Theft	
3. How did you pay for your Air Ticket? CASH <input type="checkbox"/> CREDIT CARD <input type="checkbox"/> Please supply a copy of your air ticket	
Bank:	Card No:

SECTION 2 – DEATH/PERSONAL ACCIDENT
Description of Accident:
The following documentation is required in order to substantiate your claim:
1. Certified copies of the abridged and final death certificate
2. A certified copy of the Post Mortem Report
3. A certified copy of the FULL Inquest Report including all witness statements pertaining thereto
4. The police accident report if death was due to a motor accident
5. The police station and reference number if death is the subject of a criminal investigation
6. Copies of any newspaper clippings, eye-witness statements or incident reports that may be available

SECTION 3 – MEDICAL CLAIMS	
1. Did you consult a Medical Practitioner?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Name of Practitioner:	
Tel. No.: ()	
Were you hospitalised as an inpatient?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Detailed Diagnosis:	
2. Have you ever received treatment for this or a related illness?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES, please supply Medical Practitioner's report stating what treatment received prior to the commencement of your journey.	
Please supply name and telephone number of your normal Medical Practitioner.	
3. Have you notified Chartis Travel Assist of your claim?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES, when and where?	
If NO, give reasons why not:	

SECTION 4 – BAGGAGE, CASH AND TRAVEL DOCUMENTS	
1. Describe how the Delay/Loss/Theft/Damage occurred:	
2. Carrier/Police to whom Loss/Theft/Damage reported:	
When and where:	
If NOT reported, give reason why not:	
3. Are you the sole owner of the goods Lost/Stolen/Damaged?	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. In respect of Baggage that is Lost/Stolen/Damaged by an Air Carrier, have you lodged a claim with the respective Air Carrier?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES, please state where and at which office:	
Have you received compensation from the Air Carrier?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES, please state the amount compensated: R	
5. Name of Short Term All Risks Insurers:	
Policy Number:	
Are you claiming from the above named?	YES <input type="checkbox"/> NO <input type="checkbox"/>

SECTION 6 – TRAVEL DELAY	
1. Nature of delay:	
2. Date and time of delay:	
3. Duration of delay:	
4. In the event of Strike/Derangement of the aircraft or sea vessel:	
	Where did the Strike/Derangement take place?
	Duration of Strike/Derangement:
	(Letter from Carrier confirming Strike/Derangement is required)
5. Did you receive any form of Compensation or Alternative Travel Arrangements from the Carrier?	
	Please give details:

SECTION 7 – PERSONAL LIABILITY	
1. Nature of claim, please give full details:	
2. Please supply copies of all correspondence, summons, notice of intent to take legal action, etc	

SECTION 8 – ELECTRONIC FUNDS TRANSFER, DECLARATION AND AUTHORITY	
Account Number:	
Account Holder's Name:	
Name of Bank:	
Type of Account:	
Branch Name:	
Branch Code:	

Attach confirmation of banking details (Copy of cancelled cheque or bank statement)

DECLARATION AND AUTHORITY

I/We declare that the above information is true and correct in every respect and that the signing of this claim form also constitutes written authority for the Company to inspect or investigate any Medical Records or Details relevant to this claim. I/We further declare that I am/we are aware that any misrepresentation and/or non-disclosure in respect of information provided herein shall render my/our claim null and void.

Signed: _____ Date _____ 20 _____

