Archipelago
Life Insurance Limited

Travel Claim form

Please complete clearly in BLOCK CAPITALS. **Are you submitting this claim as a scanned copy?** ☐ **Yes** ☐ **No**

One form must be completed for each claimant.

Further information about how to complete this form can be found on the reverse.

Failure to complete all sections marked 'must be completed' on this form may result in delays.

Section A: Claimant details - must be completed

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ Male ☐ Female
Member number:	Plan number:
Correspondence address:	
Town:	Postcode: Country:
Email:	
Daytime phone:	Evening phone:

Section B: Main member details (if different from section A)

Family name (surname):	First name(s):
Member number:	Plan number:

Section C: Medical expenses and repatriation – must be completed by the medical practitioner/specialist/therapist

Nature of illness or injury or cause of death:	
If injury, how did it happen?	
If illness, has the patient suffered from the condition before? ☐ Yes ☐ No	
If yes, please give the date of the first occurrence (dd/mm/yyyy):	
Name of medical practitioner who treated the patient while abroad:	
Address of medical practitioner:	
Email:	
Daytime phone:	Fax:
Date(s) of treatment (dd/mm/yyyy):	
Was the patient hospitalised? ☐ Yes ☐ No	
If yes, please give admission date (dd/mm/yyyy):	Discharge date (dd/mm/yyyy):
Name and address of hospital:	

Declaration

I declare that to the best of my knowledge and belief the statements made on this Claim form are full, true and complete.

Medical practitioner's/specialist's/therapist's signature:	Practice stamp:
Date (dd/mm/yyyy):	

Section D: Medical expenses and repatriation – must be completed by the member/claimant

Did you return to your home address on the intended date?	☐ Yes ☐ No
If no, when did you return (dd/mm/yyyy)?	
Who accompanied you?	
Did you call the 24-hour International Helpline?	☐ Yes ☐ No

Section E: Loss of deposits, cancellation and curtailment

Date holiday booked (dd/mm/yyyy):	

Please attach original booking invoice and conditions/cancellation invoice.

Date of scheduled departure (dd/mm/yyyy):	Time of scheduled departure:
Date of cancellation or curtailment (dd/mm/yyyy):	
Reason for cancellation or curtailment:	

Please attach original cancellation notice if applicable. If caused by illness, injury or death, section C needs to be completed or attach relevant medical report/copy of death certificate.

If the sick or injured person is someone other than the claimant, provide the following information:

Name:	Relationship to the claimant:
Address:	

Type of expenses claimed:	Amount (including currency):
	Total:

Section F: Travel delay/hijack

Length of delay/hijack, specify how many hours:	Date(s) (dd/mm/yyyy):
Departure point:	Flight number if relevant:
Public transport carrier:	Cause of delay:

Evidence (Irregularity Report) must be supplied by the provider of the public transport service to confirm the length and cause of the delay.

Section G: Missed departure

Reason for missed departure:
Detail the expenses incurred:

Type of expenses claimed:	Amount (including currency):
	Total:

Attach original receipts and provide evidence to support the reason you missed your departure.

Section H: Loss/damage of money/delayed luggage

Date of loss (dd/mm/yyyy):	Time of loss:
Place of loss:	
Circumstances in which loss or damage occurred:	
Where and to whom was the loss or damage occurred:	

Section H: Loss/damage of money/delayed luggage (continued)

Please attach the original Irregularity Report or Police Report and complete the following information:

Contact name:
Address:
Date loss reported (dd/mm/yyyy):
Name of household contents insurer and policy number:
Address of household contents insurer:

Give details of items lost/replaced. Continue on a separate sheet if needed. You must attach the original receipts with your claim.

Item:	Date of purchase:	Place of purchase:	Method of payment:	Owner's initials:	Amount (including currency):
				Total:	

Give details of money lost or stolen:

Description (e.g. cash, traveller's cheques, etc.):	Value taken on trip:	Amount lost (including currency):
	Total:	

Section I: Loss of passport/travel documents

Give details of and reasons for expenses incurred and attach original receipts.

Type of expenses claimed:	Amount (including currency):
Total:	

Section J: Payment details – must be completed

Have you personally had to pay costs for what you are claiming for? ☐ Yes ☐ No

If 'Yes', and you are personally seeking reimbursement, you must tell us how you wish to be reimbursed by ticking either 1, 'Bank transfer' or 2, 'Foreign draft', and completing the required information.

We will only issue payment to:

- the claimant if they are 18 or over;
- the planholder if the claimant is under 18 and is a dependant under the plan; or
- the parent or legal guardian named as the planholder, if the claimant is the main member and is under 18.

If another person or entity has paid on your behalf please give their name:

Failure to complete all information for the chosen reimbursement method may result in you, the named person or entity:

- experiencing delays in receiving the claim settlement; and
- incurring additional bank charges.

☐ 1. Bank transfer – this is the quickest and safest method of payment

Name of account holder:

If the claimant's name (as given in section A) is different to the account holder name, please provide the following details:

Address of account holder:

Email address of account holder:

Telephone number of account holder:

Bank account details:

Bank name:

Bank address (including town and city):

BIC/SWIFT code:

Currency of bank account:

Account number:

To help us direct your payments efficiently, supply the following as relevant:

IBAN number (mandatory for all payments to bank accounts in countries that have adopted IBAN):

Sort code (mandatory for UK located banks):

Routing Code/Branch Code (as available):

ABA number (mandatory for transfers to US located banks):

☐ 2. Foreign draft

Name to appear on the draft:

Currency of the draft:

Important information

Please remember these important points when completing your Claim form:

- Assessment of your claim may be delayed if you and your medical practitioner, specialist or therapist do not complete all the necessary sections of this form.
- Send your claim to us as soon as possible. We recommend that you do so within a maximum period of six (6) months of the first treatment date.
- Always send us the original invoices with this form. Photocopies, receipts and credit card statements will not be accepted.

Section A – Claimant details

- If the claimant is a dependant under the age of 18, the main member must complete the form and sign the declaration for them. If the claimant is a member under the age of 18, the parent or legal guardian named as the planholder must complete the form and sign the declaration for them.

Section H – Loss/damage of money/delayed luggage

- If you have a household contents insurance plan or policy that covers you for lost/damaged goods, we will need to know the details as it may affect the amount we pay in respect of your claim.

Section J – Payment details

If you are not personally seeking reimbursement we will pay the treatment provider directly, as long as the payment instructions are shown clearly on the invoice. If you are personally seeking reimbursement, you need to tell us how you wish to be reimbursed.

i. Ensure that you are able to receive payment in the method and currency you have requested.
ii. We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.
iii. We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details.
iv. If you do not give us the sort code/routing code, BIC/SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.
v. Payment by foreign draft in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
vi. We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the currency of your plan. For the current list of applicable currencies and countries please refer to our website.
vii. We cannot issue foreign drafts to banks based in Qatar.
viii. Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.

Section K

If the declaration has not been read and signed, we will not be able to process your claim.

Excess

The standard excess for each claim will be deducted from any reimbursement.

Checklist

There are two ways to send your claim to us:

1. By post – have you included:

- a fully completed Claim form with signed and dated declarations? ☐
- original itemised invoices? ☐

Photocopies, receipts and credit card statements are not acceptable. We are unable to return original documents, but are happy to provide certified copies on request.

- an original Irregularity Report from the airline and/or Police Report if you are claiming under sections F-I? ☐

2. By email – have you read the scanned claims acceptance criteria? ☐

You will find the criteria for accepting scanned claims in your Claims procedures or in the Members section at www.interglobalpmi.com

Please call us on +603 6201 0899 or email claims@archipelagolife.com if you require any further assistance.

Send your claim to: Claims Team, Archipelago Life Insurance Limited, B-08-07 Gateway Corporate Suites, Gateway Kiaramas, No 1 Jalan Desa Kiara, Mont Kiara, 50480 Kuala Lumpur, Malaysia. W www.archipelagolife.com F +603 62010481

Whenever coverage provided by any insurance policy would be in violation of any US, UN or EU economic or trade sanctions, such coverage shall be null and void. For example, we cannot pay for health care services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Asset Control (OFAC) license. Learn more on the US Treasury's website at: www.treasury.gov/resource-center/sanctions.

All plans are underwritten by Archipelago Life Insurance Limited and administered by Aetna Global Benefits (UK) Limited, registered in England (Company Registration No. 03554885), which is authorised and regulated by the Financial Conduct Authority (Firm Reference No. 312279), Woolmead House East, The Woolmead, Farnham, Surrey, GU9 7TT, United Kingdom. Archipelago Life Insurance Limited is licensed by Labuan FSA, Company No. LL09829, Licence No. IS2013141.
Registered office address: Level 1, Lot 7, Block F, Saguking Commercial Building, Jalan Patau-Patau, 87000 Labuan FT, Malaysia.

Section K: Data Protection and Declaration – the Declaration must be signed by the claimant or the main member if the claimant is a dependant under the age of 18

Data Protection Notice

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with the Personal Data Protection Act 2010.

We will use any personal data we collect about you and where appropriate, your dependants, to process your claims, administer your policy, detect and prevent fraud, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

The policyholder consents to the processing of the personal data provided to the insurer and the transfer of such personal data to other Archipelago Life Insurance Limited entities for the purposes of performance of the contract, such personal data shall be governed by the personal data protection laws of that country. The policyholder is responsible to ensure that all data provided to the insurer are accurate at all times and is obliged to inform the insurer of any changes.

Your information may also be used for the detection and prevention of fraud and for audit purposes. Archipelago Life Insurance Limited works with other insurance providers, regulatory bodies and law enforcement organisations to prevent and detect fraud.

We will not disclose any such information outside of the Company, including any third parties working on our behalf, except for fraud prevention purposes, and/or if required/obliged by law or governmental or judicial bodies or agencies or to our regulators under proper authority.

Your medical information will only be disclosed to those involved with your treatment or care, including your general practitioner/primary health physician, or to their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents.

We will communicate directly with you about your claim if you are aged 18 or over, or with the main member if you are under 18 unless we are advised otherwise. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information; or to another person that you have authorised us to provide such information.

If you want us to disclose your medical information to another individual or next of kin, please complete the section below.

I would like information about this claim to be provided to:

Name:	Relationship:

Declaration

I declare that all the details given on this Claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I may be committing a criminal offence and that this may invalidate the plan and make me liable to prosecution. For this medical claim I authorise any medical practitioner, specialist, therapist or other relevant establishment who has attended me/the claimant in the past, or is attending me/the claimant at present, to give any details that may be asked for by the insurer or any authorised administrator.

I confirm that I give explicit consent (on behalf of myself and any family members specified in this form) for Archipelago Life Insurance Limited to process our personal information with respect to our membership.

I authorise and request any hospital, specialist, physician or other health provider to furnish Archipelago Life Insurance Limited or its duly authorised agent acting on Archipelago Life Insurance Limited's behalf with such information as Archipelago Life Insurance Limited or such agent may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of Archipelago Life Insurance Limited considering this claim.

I do (not)* wish to see a copy of any medical report before it is sent to Archipelago Life Insurance Limited. (*Delete the word NOT if you wish to see a copy of the medical report before it is sent to Archipelago Life Insurance Limited).

Claimant's/member's signature:
Date (dd/mm/yyyy):