TRAVEL INSURANCE CLAIM FORM

PNR/Certificate/Policy No: ..... Period from: ..... To: .....

Date of Departure: ...../...../..... Flight No: .....From: .....To: .....

Date of Arrival: ...../...../..... Flight No: .....From: .....To: .....

Name, Surname: ..... ID No: ..... Passport No: .....

Residence Address in Turkey: .....

..... E-mail: .....

Date of Birth: ...../...../..... Phone No:Work/Home:..... Mobile Phone No: .....

Please state the name and telephone number of the person whom we can contact in case that we fail to reach you: .....

.....

Once your claim has been approved, please fill in your bank account details in the below section for the indemnity payment

Account Owner: .....Bank name: ..... Branch Name/Code: .....

IBAN: ___

Account Currency: TRY ☐ EURO ☐ USD ☐ SWIFT/BIC: .....

LOSS/DELAY OF CHECKED BAGGAGE AND PERSONEL EFFECTS LOSS

Please describe when & where the loss/delay took place: .....

.....

Please state amount of loss: ..... Please state name of the common carrier: .....

Scheduled date/time/city of arrival: ...../...../..... .....:..... .....

Actual date/time/place baggage delivered: ...../...../..... .....:..... .....

Please state compensation received from Airline/Travel Firm: .....

TRIP CANCELLATION/DELAY/INTERRUPTION AND MISSED DEPARTURE

Please describe how, where & when the loss/delay took place: .....

.....

Do you get visa? : Yes ☐ No ☐ If yes, please provide the valid date of visa : ...../...../..... ----- ...../...../.....

Please state amount of trip which paid to Airline / Travel Firm: .....

Please state compensation received from Airline/Travel firm: .....

MEDICAL REIMBURSEMENT/ ACCIDENTAL PERMANENT DISABILITY

In event accident, please state how, when, where the accident took place: .....

.....

.....

In event of illness, please state when, where symptoms first occurred and which diagnosis treated: .....

.....

.....

Have you ever been treated for this illness before? Yes ☐ No ☐ If yes, provide name and contact information of doctor: .....

.....

Please provide name of any prescription medicine you are taking before travel, regularly: .....

.....

If you have any other health/travel insurance, please provide insurance company' names: .....

Please state total medical expenses amount/paid or not paid, if paid by whom: .....

.....

ACCIDENTAL DEATH / REPATRIATION

Please state how, when, where the incident took place: .....

.....

Please state who paid repatriation expenses and provide amount: .....

LEGAL FEES/ BAIL BOND / ROBBERY

Please describe incident: .....

Please state name of the eye witnesses and their contact information: .....

Lawsuit filed? Yes ☐ No ☐ If you contacted an attorney, please provide name, full address, phone numbers of attorney: .....

- I do declare and certify by my signature that the above information is true and correct. I further declare and agree that payment of indemnification will be made based on the information I provided on this form. If above information be proved false or anything contrary is found , I understand and accept irrevocably that AIG Sigorta is at liberty to exercise of all legal rights. I also agree to submit/ provide all claim related documents to the insurance company.
- I hereby, automatically authorize through the policy, this declaration and the pre-authorization, that all claim related documents, to furnish the insurance company, or its authorized representative, any and all information pertinent to this claim, a copy of this authorization shall be deemed as effective and as valid as the original.

Name, Surname: **Signature** **Date: ...../...../.....**