FAIRFIRST INSURANCE LIMITED
(Company No. PB 5180)
No. 33, St. Michael's Road, Colombo 03, Sri Lanka.
Tel : 011-2428428 (Customer Service) 011-2428000 (General Line) Fax : 011-2438438
E-mail: info@fairfirst.lk Website: www.fairfirst.lk

NOTIFICATION OF CLAIM - TRAVEL INSURANCE

IMPORTANT INSTRUCTIONS :

1. Please contact the emergency hotline indicated in the policy contract in case you need emergency assistance while traveling.
2. For claims processing, all necessary documents has 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 the limits, terms and conditions of your exiting Travel Policy.
4. This form together with the official receipt(s) must be submitted within a period of not more than 90 days from the date of the assistance. Failure of the claimant to submit necessary documents within the given period shall be deemed an abandonment of the claim.
5. The policy only extends coverage for Emergency Medical expenses incurred while overseas. Pre existing conditions & complications arising out of pre existing conditions are excluded under the Policy.

INSURED'S INFORMATION

Insured's Name :		Age :	Sex :
Policy Number : BAATX/COM/000002	Address :		
Contact Information :	Home :	Office :	Mobile :
E-mail Address :			Fax :

CLAIMANT'S INFORMATION

Claimant's Name :		Age :	Sex :
Address :		Birthday :	
		Relationship to Insured :	
Contact Information :	Home :	Office	Mobile :

TYPE OF LOSS

PLEASE CHOOSE THE PARTICULAR TYPE OF LOSS:

_____ Medical Expenses	_____ Repatriation Expenses	_____ Trip Cancellation
_____ Trip Curtailment	_____ Trip Delay	_____ Baggage Loss
_____ Baggage Delay	_____ Personal Accident	_____ Personal liability
_____ Loss of Passport	Other _____	

CLAIM DETAILS (ACCIDENT / SICKNESS & MEDICAL)

Nature and condition of injury or sickness :	
Place / Address where injury / sickness occurred :	
Hospitalization / consultation dates :	
Name of Hospital / Attending Doctor :	Hospital Address / Contact Number(s) :
Date when patient had any prior treatment of the same illness :	
If injury is fatal Please attach a copy of the death certificate :	

OFFICIAL RECEIPTS SUBMITTED

Official Receipt (O.R.) Number	Details	Amount

TOTAL AMOUNT CLAIMED : _____ (_____)

ATTENDING PHYSICIAN STATEMENT (If Applicable)

Out - Patient ☐ In - Patient ☐	Date of Admission :
Date of Consultation :	Date Discharged :

Complete Diagnosis of Medical Condition :

Do you consider this consultation / hospitalization as a continuous treatment for a chronic disease	☐ YES	☐ NO
Does the patient have any other disease or infirmity that is affecting his / her present condition?	☐ YES	☐ NO

If YES, Please describe :

_____
Attending Physician's
Signature over Printed Name

CLAIM DETAILS (EXCLUDING ACCIDENT / SICKNESS & MEDICAL)

Date of incident : _____

Country & Place : _____

Detailed description of the incident : _____

Was the incident reported to the police: **YES / NO** (If so attach copy of police report)

In respect of baggage losses (Common carrier)

Item/Description	Value	Item / Description	Value
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hours delays (Baggage loss / Trip delay) : _____
(To be supported by airlines / tour operators confirmation)

Name & address of third party (Personal liability) : _____

_____

Additional Information : _____

_____

AUTHORITY, RELEASE AND DECLARATION STATEMENT

AUTHORITY : I hereby authorize my travel insurance and / or Fairfirst Insurance Limited and its authorized representatives to request and receive any information, document or record from any hospital, clinic, laboratory, attending physician and other health service provider, which information or document relates to any examination laboratory test results, medical history and / or treatment in connection with this claim, and such other matters related thereto.

RELEASE & SUBROGATION : Payment received by me in relation to this claim shall constitute as full, final and complete settlement. I further agree that the Company is subrogated to my rights of recovery on all claims and rights of action to the extent of the payments made and/or on account of the losses incurred or which may be incurred by the Company against any person, corporation or entity in connection with this claim and I further agree to authorize the Company to commence all legal actions and proceedings necessary to enforce my claim or recovery thereof with any undertaking to extend my cooperation or assistance whenever necessary.

DECLARATION : I declare that all date / 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 Insured/Claimant or of Principal Insured — Date