INBOUND TRAVEL ACCIDENT INSURANCE CLAIM FORM

The purpose of this document is to help you to complete your Inbound Travel Accident Insurance Claim.

Please read the instructions below and carefully follow them, this will enable us to complete the assessment of your claim efficiently.

This first page is for your information only. You do not need to submit this page with your claim.

To enable us to assess your claim as quick as possible, it is important to complete this form in BLOCK letters accurately and provide us:

- ✓ The claimant's details including the policy number, full name, contact number and email address.
- ✓ The claimant's copy of passport or National Registration Identity Card (NRIC)
- ✓ The bank account details for payment purposes.
- ✓ The total amount of the claim.
- ✓ Specific documents as listed under the section heading.

For your record, please keep a copy of every document that you submit.

If you are claiming more than one policy benefit, please complete each section as required.

If you do not have enough space to write and require more, please attach a letter with the additional information.

In addition, if you are unable to supply one of the required documents, please explain why so that we may consider how to progress with your claim.

Once all of the above is completed, please sign the claim form, attached your required supporting documents and submit all to us together. Please avoid sending the documents separately as they may lost in transition, resulting in a delay assessing your claims.

Please send the completed claims form and/or any additional documents to support claim to:

Myanma Insurance

627/635, Merchant Street

Yangon, Myanmar

If you have any questions or you are unsure of anything, please contact our staff Myanma Insurance (MI) in Myanmar:

Phone: +951386919

Email: lifere1-mi@mminsurance.gov.mm

SECTION A: GENERAL INFORMATION (To be completed for ALL claims)

Please submit:

- Completed claim form
- Travel itinerary
- Copies of front page of passport and the page indicating entry and exit stamp to the country of destination
- VISA
- Boarding passes/ Air tickets

CLAIMANT'S DETAILS

Insured's Name			
NRIC		Passport Number	
Claimant's Name			
NRIC		Passport Number	
Date of Birth		Gender	
Claimant's Address			
Occupation			
Email		Contact Number	

POLICY DETAILS

Policy Number		Effective Date of Policy	
Period of Travel	to	Destination	
Is there any other insurance in force covering this loss? If yes, please furnish the details: Insurance Company Type of Policy Policy Number Compensation Amount			Yes / No _
Have you ever had previous claims in respect of travel insurance during the last 3 years? If yes, please furnish the details: Insurance Company Type of Policy Policy Number Compensation Amount			Yes / No _ _ _ _ _ _

- In the case that the benefit of this policy is claimed by the authorized Hospital or Medical Center on behalf of the Insured
- I hereby agree and confirm that all right of the benefit of this policy is transferred to _____ Hospital/Medical Center which renders or gives the medical treatment to me.

Signature _____

Insured's Name_____

Passport No. _____

SECTION B: MEDICAL, HOSPITAL AND DENTAL EXPENSES

Please submit:

- Original medical invoices
- Original Medical Report and Discharge Summary or duly completed Appendix A
- Original Police Report or Accident Report (if due to road traffic accident)

Date and Place of Injury or Covid-19 infection	
Please describe the cause of injury or Covid-19 infection	
Have you ever suffered from similar condition before? If yes, please furnish the details: Date of Consultation Name of Treating Doctor consulted Address of Doctor consulted	Yes / No _
Total amount you are claiming for this claim	

SECTION C: OTHER LOSSES

Date, Time, and Place of Loss or Damage	
Type of Loss/ Damage • Personal Accident • Permanent Disablement • Others, please describe (_____)	
Description of Loss/ Damage/ Accident **If space is insufficient, please provide the details in a separate paper and submit together with this form.*	
Total amount you are claiming for this claim	
Is there any other insurance in force covering this loss? If yes, please furnish the details: Insurance Company Type of Policy Policy Number Compensation Amount	Yes / No _

SECTION D: BANK ACCOUNT DETAILS

Please provide the claimant's bank details for us to accelerate the claims payment process by directly transfer to the claimant's bank account.

Name (as per bank account)		Bank Name	
Bank Account Number		Bank Branch	

SECTION E: DECLARATION

Please read the declaration carefully before signing.

I confirm that this claim form has been completed in full and all available required information is attached. The information given is true and correct and that no information has been withheld.

I acknowledge that this claim will be decline if any part is false, intentionally inaccurate or withheld, and if this claim is fraudulent, it will be reported to the relevant authorities.

I consent to the collection, use and disclosure of personal information for the purpose of completing this claim.

Signature of Claimant

APPENDIX A - MEDICAL CERTIFICATE

*To be completed by attending Medical Officer/ Doctor

1	Patient's Name	
2	Are you the patient's usual medical attendant? If yes, for how long?	Yes / No
3	Please provide details of the nature of the Covid-19 infection or injury that gave rise to this claim.	
4	Date you first investigated or were consulted by the patient for this condition.	
5	Has patient been investigated, diagnosed or treated previously in respect of the same, similar or related Covid-19 infection/ injury as described in question 3 and is there any indication that the condition was pre-existing?	Yes / No
6	If yes, when was the last time, prior to the occurrence of this claim, treatment was being rendered and what medication was prescribed?	
7	Is there any indication that the condition suffered was due to alcohol or drug abuse?	Yes / No
8	Was the patient advised to continue with the treatment/ medication during the trip?	Yes / No
9	Can you confirm that patient was compelled to cancel the travel arrangement solely due to the condition described in question 3?	Yes / No

I certify that the statement contained in this Medical Certificate are true and correct.

Doctor's Name	
Address	
Contact Number	
Fax Number	
Date	

Doctor's Signature/ Clinic Stamp