

TRAVEL DELAY			
Flight No. _____ Date ____/____/____ From _____ to _____			
Scheduled time of Departure: _____ Actual time of Departure: _____ No. of Hours delayed: _____			
Whether accomodation & boarding provided by carrier: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Details of Expense incurred	Date	Place	Amount
		TOTAL	

MEDICAL ACCIDENT & SICKNESS BENEFIT
If accident, details of accident i.e. how, when, where it took place: _____ _____
Date: _____ Place: _____
If sickness, state nature and diagnosis, and advise when & where symptoms first occurred: _____ _____
Date: _____ Place: _____
Name & Address of consulting physician: _____ _____
Have you ever been treated for this illness before: <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide name & address of consulted physician: _____ _____
Provide name & address of your family physician: _____ _____
Provide name of any prescription medicine you are presently taking: _____
Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer: _____ _____

DETAILS OF MEDICAL EXPENSES				
Details of treatment	In/ Out Patient		Charges (Currency)	Status of Payment
	From	To	Eg : USD / EURO	Paid/ Outstanding
			Paid	
			Outstanding	
			TOTAL	

Whether Assistance Co. was contacted: Yes No. If Yes, Reference No. _____
 If No, give reasons: _____

AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a photostat copy of this authorization shall be considered as effective and valid as the original.

Date: _____ Place: _____

Signature of insured : _____

Attending Doctor's Report

Patient's Name: _____ Age: _____ Sex: M / F

Address: _____

Date contacted: _____ Time: _____

For Accidental Injury

Nature of Injury: _____

X-Ray Taken: Yes No Date taken: _____

Diagnosis and Treatment Given: _____

Describe any other disease or infirmity affecting present condition: _____

For Sickness

Nature of Illness: _____

Diagnosis and Treatment Given: _____

When did patient's symptoms first appear: _____

Describe any other disease or infirmity affecting present condition: _____

Is condition due to Pregnancy: Yes No Is illness due to any pre-existing condition: Yes No

Signature: _____

Attending Doctor's Signature