Sagicor GENERAL

Sagicor General Insurance Inc.
122 St. Vincent Street, Port of Spain, Trinidad and Tobago, W.I.
Tel: 1 (868) 623-4744 • Fax: 1 (868) 628-1639
Website: www.sagicor.com • Email: getcovered@sagicorgeneral.com

TRAVEL – CLAIM FORM

(PLEASE COMPLETE ALL DETAILS ON THIS PAGE / PLEASE WRITE IN BLOCK LETTERS AND TICK CORRECT ANSWER BOXES)

STATEMENT OF AND PARTICULARS OF CLAIM

Policy or Certificate No.: .....

Branch or Agent to whom you paid your premium: .....

Name of Insured: .....
Occupation: .....
Address: .....
Telephone No.: ..... **Business:** .....
E-mail: ..... **Vat/B.I.R.#:** .....

PERSONAL LUGGAGE

Name of Owner: .....
Address: .....
.....
Date of loss or damage: ..... Time: ..... a.m. .....p.m. Place: .....
Circumstances of loss or damage: .....
.....
Date advised to Police: ..... **Address of Police Station:** .....
If luggage or money is insured under any other Policy, name and address of Insurers: .....
.....
.....

Details Of Luggage

No. of Articles	Description	When Bought	Where Bought	Cost Paid ($)	Amount Claimed ($)

PERSONAL ACCIDENT/LOSS OF DEPOSITS

Name of injured person: .....
Occupation: ..... **Date of Birth:** .....
Address: .....
.....
Description of accident/illness: .....
Date of loss or damage: ..... Time: ..... a.m. .....p.m.
Nature of injury: .....
Name and Address of doctor who attended: .....
Has a similar injury been sustained before? .....
If so, when? .....

P.T.O.

Name of usual Doctor: .....

Address of usual Doctor: .....

During what period was the injured totally disabled from attending to any part of his occupation or profession?

From (DD/MM/YYYY): ..... **To (DD/MM/YYYY):** .....

If total disablement continues, a medical certificate will be required from the injured person's usual Doctor

N.B. Declaration overleaf to be completed.

For Claims For 'Loss Of Deposits' Please State

	HOTEL/ACCOM. COSTS ($)	TRANSPORT ($)
1) Amount of Deposit:		
2) Percentage returned by carrier:		
Net Amount Claimed:		

I declare that the particulars given on this form are, to the best of my knowledge, true and complete.

Name of Insured: ..... Signature of Insured: ..... Date: .....

MEDICAL AND OTHER EXPENSES

Name of person concerned: ..... **Date of Birth:** .....

Address: .....

.....

Nature of injury or illness: ..... **Date:** .....

Cause of injury or illness: .....

.....

.....

Name and address if Doctor who attended: .....

.....

.....

If the cause was illness, has the person concerned previously suffered similar illness? .....

If so, when? .....

Details of expenses claimed: .....

.....

.....

Receipts and documents supporting this claim are to be sent with this form

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I declare that the particulars given on this form are, to the best of my knowledge, true and complete.

Name of Insured: ..... Signature of Insured: ..... Date: .....