



Sagicor General Insurance Trinidad & Tobago Limited.

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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

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: