Starr International Insurance Philippines Branch

TRAVEL INSURANCE CLAIM FORM (DOMESTIC)

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STARR INTERNATIONAL INSURANCE PHILIPPINES BRANCH is committed in protecting your personal data privacy. Presented below is an overview of our practices in careful handling of your personal information.

GATHERING
Starr gathers your personal information (which may include sensitive information) in order to establish all necessary details that will assist us in the proper handling and evaluation of your claim. Personal information may be obtained by us directly from you or via a third party such as your insurance intermediary (i.e. agent or broker) or employer (in case of group insurance policy).

When the information is provided to us via third party, we use that information on the basis that you have consented or would reasonably expect us to collect your personal information in this way and ensure that you will be made aware on our practices in handling your personal information.

USE
The main purpose for our collection and use of your personal information is to make sure that appropriate and fair evaluation of claim will be delivered to you in accordance with the terms, conditions and provisions of your insurance policy. All reasonable precautions are carefully taken to protect this personal information and being treated with utmost confidentiality.

DISCLOSURE
We may disclose the information we collect to third parties, including service providers engaged by us to undertake certain claims procedures such as investigation and verification on our behalf. In some circumstances, we may need to transfer personal information to other entities within the STARR Group of Companies (such as our regional office at Hongkong, USA and other countries) or third parties with whom we, or those other STARR Group entities, have sub-contracted to provide specific services for us which may be outside of the Philippines.

In all instances where personal information may be disclosed overseas are for claims related only, in addition to any local data privacy laws, all reasonable precautions are carefully taken and strict measures are in place to ensure that those parties hold and use that information in accordance with the consent you have provided and in accordance with our responsibilities to you under the DATA PRIVACY ACT OF 2012.

Please be informed that you have an option to withdraw your consent by providing us your written notice. However, it is important for you to understand that this may mean that we may not be able to respond favorably to any claim. For data privacy concerns, please reach us at dpo.ph@starrcompanies.com

FRAUD WARNING
Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim (IC Circular No. 2016-50).

IMPORTANT INFORMATION:
a. Please complete the claim form in BLOCK CAPITALS and fill-up all the required information in this form truthfully and accurately. If the space is not enough or no applicable field is available, please supplement information by attaching a separate sheet;
b. Acceptance of this form must not be construed as an admission of liability on the part of Starr International Insurance Philippines Branch;
c. We may require submission of additional document/s, as needed.

SECTION A : POLICYHOLDER AND INSURED PERSON INFORMATION

Policy No.:	Name of Policyholder / Insured:	
Policy Period:	Insured's Address:	
Date of Birth:	Sex: ☐ Male ☐ Female	e-mail Address:
Employer:	Occupation:	Date of Employment:
Insured's Contact Nos.:	*If different from Policyholder/Insured:* Name of Claimant and Relationship to Insured	Contact Nos.:

SECTION B : TYPES OF CLAIMS AND AMOUNT

☐ Accidental Death/Disablement/Burial	☐ Baggage Delay	☐ Personal Liability	Total Claim Amount (please specify currency):
☐ Burns / Medical Expenses	☐ Travel Delay/Missed Connection	☐ Staff Replacement	
☐ Loss of Baggage/Documents	☐ Trip Cancellation/Curtailment	☐ Others, please specify _____	

SECTION C : DETAILS OF ACCIDENT / INCIDENT

Date & Time of Accident:	Place of Accident:
Circumstance of Loss (please briefly describe the chronology of the accident):	
Name of Witness and relationship to the Insured	Contact No. and email Address of the Witness:

SECTION D : DETAILS OF MEDICAL TREATMENT

Symptoms:	Date when symptoms first appeared:	Date of consultation:
Name Doctor who treated you:		Name & Address of the Hospital where you were treated:
Final Diagnosis:		Date Admitted : _____ Date Discharged: _____

SECTION E : MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIAN)

Name of Patient:		Date of Birth:
Date of First Consultation:	Is condition due to Injury or Sickness? □ Sickness □ Accident on (date and time) _____	Was the patient referred to you by another doctor? □ No □ Yes, please indicate Name and Address of Referral Doctor.

Of what symptom(s) did the patient complain?	According to the patient, how long has he/she been experiencing these symptoms?
To the best of your knowledge, has the patient ever had the same or similar condition(s)? □ No □ Yes, please describe condition _____ Was the condition caused by any underlying disease? □ No □ Yes, please specify _____	What was your final diagnosis?
Did injury result in fracture of bones? □ No □ Yes, please specify _____ Is the patient suffering, had suffered or been diagnosed to have Osteoporosis? □ No □ Yes, please describe condition _____	Will the current condition(s) or symptom(s) result in permanent disability? □ No □ Yes, please specify _____ Do you think the injuries sustained would have prevented him from working? □ No □ Yes, how many days (approximately)? _____
Is there any other factor that may have caused the occurrence of the accident? □ No □ Yes, please specify _____ Is the current condition or symptom related to burn injury? □ No □ Yes, please indicate degree and percentage of affected body surface: _____	Is there a treatment prescribed to the patient? □ No □ Yes, please specify _____ Is the patient recommended for further medical treatment in the future? □ No □ Yes, please specify _____

Discharge Summary (including investigation procedures, result, diagnosis, treatments, complications and follow-up plan):

Name of Hospital/Clinic:	Date of Admission:	Date of Discharge:
Address of Hospital/Clinic:	Phone No. & Fax No.:	Email Address of Attending Physician:

PLEASE READ BEFORE SIGNING: I hereby certify that I have personally examined and treated the above patient for the above described injury and that the facts as given above present my opinion of his/her condition.

Name of Attending Physician/Specialist: Qualification: _____	Signature & Stamp of Attending Physician/Specialist:	Date Signed:

SECTION F : DETAILS OF LOSS OR DAMAGE OF BAGGAGE AND PERSONAL EFFECTS / TRAVEL DOCUMENT

In the table provided below, please enumerate the item/s lost. Please provide Brand, Model and Size. (kindly indicate complete specifications and currency):
Please use a separate sheet if necessary.

	PARTICULARS	PURCHASE COST	DATE/YEAR PURCHASED	REMARKS
01				
02				
03				
04				
05				
06				
07				
08				
09				
10				

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SECTION G : DETAILS OF TRAVEL DELAY / MISSED CONNECTION FLIGHT / BAGGAGE DELAY

Origin:	Destination:	No. of hours delayed:
Original Schedule of Departure (Date and Time):	Original Schedule of Arrival (Date and Time):	Flight No. (Original):
Actual Schedule of Departure (Date and Time):	Actual Schedule of Arrival (Date and Time):	Flight No. (Actual Flight taken):

Reason for delay:
- ☐ Adverse weather condition;
- ☐ Mechanical fault of the common carrier:
- ☐ Sudden outbreak of strike, industrial action, riot, civil commotion or hijack.
- ☐ Others, please specify: _____

Any additional expense for hotel accommodation and restaurant meals?
- ☐ None
- ☐ Yes, please specify how much _____

SECTION H : DETAILS OF BAGGAGE DELAY

Date & Time the Baggage was received:

Any emergency purchase of essential replacement items of clothing and toiletries?
- ☐ None
- ☐ Yes, please specify how much _____

SECTION I : DETAILS OF TRIP CANCELLATION / TRIP CURTAILMENT / STAFF REPLACEMENT

Reason for Trip Cancellation or Curtailment (please choose below):
- ☐ Adverse weather condition;
- ☐ Unanticipated death, serious injury, serious sickness of the Insured;
- ☐ Unanticipated death, serious injury, serious sickness of Insured's immediate family member, travel companion or co-partner;
- ☐ Unanticipated outbreak of strike, riot or civil commotion or infectious disease at the planned destination;
- ☐ Receipt of witness summons, compulsory quarantine or jury service requirement of the Insured;
- ☐ Serious damage to the Insured's residence in the stationed location from fire or flood
- ☐ Others, please specify:

_____

Did you incur additional hotel accommodation expenses?
- ☐ None
- ☐ Yes, please specify how much _____

Did you incur additional travel expenses?
- ☐ None
- ☐ Yes, please specify how much _____

Is there a substitute person sent to travel in your behalf?
- ☐ None
- ☐ Yes, please specify below who attended in your behalf

_____

SECTION J : DETAILS OF PERSONAL LIABILITY INCIDENT

Name, Address and Contact Details of Third Party Claimant:	Name, Address and Contact Details of Witness(es):
Details and Contact Information of the Third Party Claimant's Insurer:	Details and Contact Information of your Overseas Insurer, if any:

IMPORTANT NOTE:
Any claim, demand, lawsuit or legal proceedings relating to the incident which the Insured Person becomes aware of or received from third party claimant should be forwarded to STARR unanswered immediately. No admission of liability, offer to settle or payment of claim with third party claimant is permitted without written consent of STARR.

SECTION K : OTHER INSURANCE COMPENSATION

Do you have other insurance policies covering this loss or expenses incurred? ☐ No ☐ Yes, please provide below information.

Name of Insurer:	Policy Number:	Policy Period:	Benefit & Sum Insured:

SECTION L : DECLARATION AND AUTHORIZATION

- The undersigned hereby declares that to the best of my/our knowledge and belief, the above statement and particulars are fully and truly made;
- I/We agree that if any fraudulent means or devices are used in connection with obtaining any benefit under the Policy, the Policy shall be void against me/us;
- I/We agree that any of my/our personal information collected or held by Starr International Insurance Philippines Branch ("STARR") or its authorized representatives is provided and will be held, used and disclosed by STARR to individuals/organization associated with STARR or any selected third party for the purpose of processing the claims herein, providing data matching and to communicate with me/us for such purposes. The undersigned understand that STARR may not be able to process the claims herein if I/we fail to provide any information requested in this Claim Form. The undersigned further understand that I/we have the right to obtain access and to request correction of my personal information held by STARR. Such request can be made to STARR's Operations Officer-In-Charge at Unit 5, 23rd Floor, Tower 2 The Enterprise Center, 6766 Ayala Avenue corner Paseo de Roxas, Legaspi Village, Makati City 1226 Philippines;
- I/We hereby irrevocably authorize STARR or its authorize representative to obtain my/our medical records from my/our treating physicians, hospitals, clinics, insurance companies, government agencies or other relevant organizations in relation to the accident or claim. This authorization is valid even I/we am/are deceased. My/our next of kin is also bound by this authorization. The original or copy of this authorization has the same effects.

I hereby agree and authorize Starr International Insurance Philippines Branch to pay the benefit in respect of this claim to:

(Please indicate Payee Name in full as per Bank Account in BLOCK CAPITALS)

Signature of Insured Person/Claimant:	For Group Policy Only Signature of Policyholder's Authorized Representative (please indicate full name and position):
Date Signed: _____	Date Signed: _____

In the event that the claim is covered and payable under the policy, please indicate PREFERRED MODE OF PAYMENT:

- ☐ Check for pick-up
- ☐ Bank Deposit (please provide Bank Details) _____

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DOCUMENTARY REQUIREMENTS

For us to proceed with our evaluation of your claim, please **accomplish** and **submit** this **Claim Form** together with the supporting documents enumerated below:

STANDARD DOCUMENTARY REQUIREMENTS (ALL TYPES OF CLAIMS):

1. Copy of Passport showing ID Page, Visa Page (if applicable) and pages with exit & entry dates (if foreigner); Copy of any Government Valid ID (for local)
2. e-ticket or Airline Ticket (original flight schedule);
3. Proof of Relationship to Insured (if Insured is a Minor)

In Addition to Standard Documentary Requirements, please provide the following depending on type of claim:

SECTION 01 & 13: Accidental Death & Funeral Benefit

1. Incident Report;
2. Medical specialist report certifying death &/or Incident Report issued by the competent authorities with findings on the alleged accident;
3. Original or Certified true copy of death certificate;
4. Proof of beneficiary (PSA Certified) - Birth Certificate/Marriage Certificate/ CENOMAR with two (2) valid IDs of the beneficiary;
5. For minor beneficiary - Copy of grant of guardianship, if applicable.

SECTION 01, 02 & 03: Disablement, Burns Benefit & Medical Expenses

1. Original copy of Medical Certificate – please see Section E of the Claim Form, this must be accomplished by the attending doctor and the original copy must be submitted to us;
2. Original copy of all hospital bill, statement of account, invoices and receipts/proof of payments;
3. All hospital & medical records detailing the diagnosis and treatment received;
4. Medical specialist report on sustained permanent disability, if applicable:
5. Incident Report issued by the competent authorities with findings on the alleged accident;
6. Photograph of insured (in amputation/disability cases for benefit computation).

SECTION 04: Starr Global Emergency Assistance Services
(for Elite and Annual Plan)

Please call our Starr Global Emergency Service Hotline:

Hotline: (+632) 8689-6641
e-mail: assistances@assistcard.com

NOTE: *You must call the hotline first to avail of the emergency assistance; any expenses incurred will not be reimbursed if NOT arranged by our assistance services.*

SECTION 05: Personal Baggage
Damage to Luggage / Loss of Personal Baggage

1. Property Irregularity Report from the Airline or Common Carrier or Police Report executed in the area where the lost occurred secured/obtained within 24 hours from date & time of lost;
2. Certification from Airline or Common Carrier that the luggage can no longer be located/found/recovered
3. Photographs taken of the damaged item(s); showing full picture, brand, damaged parts
4. Original copy of Receipts for the repair expenses of damaged luggage

SECTION 06: Baggage Delay

1. Property Irregularity Report or Written Report from the Airline or Common Carrier;
2. Certification from the Airline or Common Carrier that the Insured has not received any compensation for the delay;
3. IMPORTANT: document showing place, date and time the baggage was received and by whom;
4. Original Receipts for the purchase of essential clothing and toiletries

SECTION 07: Travel Document Loss

1. Original copy of Police Report executed in the area where the lost occurred, it must be lost due to theft, robbery or burglary; owner, items lost and amount of loss must be indicated in the report;
2. Original copy of Official receipts for replacement of passport and other travel documents;
3. Original copy of Official receipts for additional travel and accommodation expenses.

SECTION 08: Travel Delay and Missed Connection Flight

1. Certification from Airline indicating reason of delay/cancellation of flight; must contain flight details and passengers affected;
2. Original copy of Boarding Pass;
3. Original copy of Official Receipts for hotel accommodation and meals

SECTION 9, 10 & 15: Trip Cancellation, Trip Curtailment and Hotel Cancellation Benefit

1. Hotel Booking Confirmation;
2. Original copy of receipts of travelling and hotel accommodation expenses;
3. Certification from airline &/or hotel stating that the ticket / reservation was cancelled/not used/terminated early and the amount refunded/not refunded/charges incurred by the insured;
4. All hospital & medical records with Medical Certificate (if reason is serious injury or sickness of the Insured or immediate family member, travel companion or copartner)
5. Certificate/Proof of Relationship with the person who caused the cancellation/curtailment (immediate family member, travel companion, co-partner);
6. Formal written letter from competent authorities certifying the occurrence of the incident and/or court summons;

SECTION 11: Personal Liability

1. Police Report executed in the area where the incident happened;
2. Proof of identification of third party involved, i.e. copy of passport, driver's license, etc.;
3. Proof of amount of damages incurred or costs of medical expenses incurred by third party, i.e. repair receipt, medical receipts, etc.;
4. Legal document establishing liability against the insured;
5. Proof of legal costs incurred.

SECTION 12: Staff Replacement

1. Copy of Company ID of replacement staff
2. Copy of advice from the company about the replacement
3. Copy of Airline Ticket
4. Original Copy of Official Receipt for airfare expenses

SECTION 14: Accidental Comatose

1. Original copy of Medical Certificate – please see Section E of the Claim Form, this must be accomplished by the attending doctor and the original copy must be submitted to us;
2. Original copy of medical invoices and receipts;
3. Medical specialist report;
4. Incident Report issued by the competent authorities with findings on the alleged accident;

NOTE: *Insurer reserves the right to request for additional documents they may find necessary. Such request for documentation shall not be construed as an admission of liability on our part but rather to aide us in our evaluation.*

FOR ANY ENQUIRIES, PLEASE SEND ALL YOUR CORRESPONDENCE TO:

Starr International Insurance Philippines Branch
Unit 5, 23/F, Tower 2, The Enterprise Center
6766 Ayala Avenue corner Paseo de Roxas,
Legaspi Village, Makati City 1226, Philippines
Phone: (632) 8689-6639; 8689-6603; 8689-6632
e-mail: claimcare.ph@starrcompanies.com

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