Chase Plaza Tower 19th Floor,
Jl. Jend. Sudirman Kav. 21
Jakarta 12920, Indonesia

TRAVEL INSURANCE CLAIMS FORM

Please send all claims and inquiries to: PT. International Services Pacific Cross, Chase Plaza Tower 19th Floor, Jl. Jend. Sudirman Kav. 21, Jakarta 1290, Indonesia
t.(+62.21) 25989878 f.(+62.21) 25989879 www.pacificcross.co.id

Insurance Certificate No.	
Claim No. (Office Use)	
Name of Claimant	
Date of Birth (MM/DD/YY)	
Passport or Government I.D. No.	
Postal Address.	
Phone No.	
Fax. No	
E-mail	

☐ Baggage & Personal Effects ☐ Baggage Delay ☐ Lost of Travel Document ☐ Personal Money

Date	Time	Place of incident
State the occurrence of the incident:		

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Amount Claimed	Name of Payee

Please give particulars of items claimed

Item(s)	Original Cost	Date of Purchase

Any other insurance policy covering the items claimed? E.g. credit card protection plan, householder all risk	Yes ☐	No ☐

If yes, please provide the following information.

Name of Insurance Company	Class of Insurance	Policy No.

Remarks: *please attach the relevant supporting documents to certify the expenses/losses and incident and items of claim e.g. airlines baggage irregularity report, original police reports, original purchase receipts of the items claimed.*

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Medical Expenses / Emergency Assistance Service

Date, time, and place of incident		
Diagnosis of conditions / Cause of injury		
Amount Claimed		
Any other insurance policy covering the expenses involved?	Yes ☐	No ☐
If yes, please provide the following information.		
Name of Insurance Company	Class of Insurance	Policy No.

Remarks: *Please attach the relevant medical report and original medical expenses receipts to certify the expenses.*

Curtailment of Trip / Cancellation Charges

Causes of Claims		
Amount Claimed		
Name of Payee		
Name, address, phone no. and contact person of Travel Agent		
Any other insurance policy covering the expenses involved?	Yes ☐	No ☐
If yes, please provide the following information.		
Name of Insurance Company	Class of Insurance	Policy No.

Remarks: *Please attach the relevant supporting documents to certify the expenses and incident of claim. e.g medical report, death certificate, original receipts of amount claimed etc.*

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Travel Delay

Date/time	From	To	Flight No.

Original Schedule			
Reason of Delay			
Reason of Delay			
Hours Delayed			
Any other insurance policy covering the expenses involved?	Yes ☐	No ☐	
If yes, please provide the following information.			
Name of Insurance Company	Class of Insurance	Policy No.	

***Remarks**: Please attach the relevant supporting documents to certify the hours delayed. e.g copy of boarding pass and/or air ticket, confirmation from Airlines/Travel Agent.*

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Personal Accident

Date	Time	Place of accident

State the occurrence of the accident

Please give particulars of the next of kin(s) of the Insured Person

Name	Age	Address	Relationship	Passport or Government I.D. No.

***Remarks**: Please attach the supporting document. e.g. accident report, police report, death certificate and/or any relevant documents. If the next of kin(s) is/are minors (persons under 18 years of age) please give particulars of the official Administrator(s) and provide copies of the documentation authorizing that person to act in his capacity.*

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Authorization and Declaration

I hereby authorize any hospital, physician, or other person and/or authority who has attended or examined me, to furnish to Pacific Cross Insurance Company Limited or its authorized representative and permit the said insurance company (or its representative) to view any and all information requested with respect to my loss, illness or injury, medical history, consultation, prescription or treatment, and copies of police reports, accident reports, airlines or other carriers irregularity reports, statements, all hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as original.

I declare to the best of my knowledge and belief that the above statements and particulars to be true and correct. I further understand and agree that if I have made or shall make any false statement or concealment, all rights to recovery under the Policy shall be forfeited.

Date	Signature of Claimant

Supplementary Sheet for claims detail

For Claims Department use Only

19/F Floor Main Office & Jakarta Sales Office
P +62 21 2598 9878
F +62 21 2598 9879
W pacificcross.co.id