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

PACIFIC CROSS

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 12920, Indonesia
t. (+62.21) 2598 9878 f. (+62.21) 2598 9879
www.pacificcross.co.id

Insurance Certificate No.		Claim No. (●ffice 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 / Loss of Travel Document / Personal Money

Date, time and place of incident	
State the occurrence of the incident	
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.

Medical Expenses / Emergency Assistance Services

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.*		

Travel Delay

	Date/Time	From	To	Flight No.
Original Schedule				
Delayed Schedule				

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 airticket, confirmation from Airlines/Travel Agent.*		

Personal Accident

Date, time and 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 documents. 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 this capacity.*

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*

Notes

1. *By furnishing this form the Company makes no admission of liability.*
2. *All original itemized bills, copy of round trip air ticket and copy of the Insurance Certificate must be submitted together with this form in order to avoid delay.*
3. *Claims will not be processed unless authorization and declaration are signed by the claimant.*

Supplementary Sheet for claims detail

For Claims Department use only