INSURANCE COMPANY (JAMAICA) LIMITED

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TRAVEL CLAIM

POLICY NUMBER:	

Please use BLOCK LETTERS

NAME OF INSURED PERSON	

(If more than one individual is claiming under the same policy, a claim form must be completed for each)

AGE		*(To be inserted where a claim relates to injury or illness)*

FULL ADDRESS	

BUSINESS OR OCCUPATION	

TELEPHONE NOS.	(w)		(h)		(c)		EMAIL ADDRESS	

Have you any other insurance that might cover this claim?	☐ YES	☐ NO	If yes, give particulars	

SECTIONS A & E BAGGAGE/PERSONAL MONEY *Losses under personal money section must be reported to police within 24 hrs.*

Nature and extent of theft, loss or damage
and the circumstances under which this
occurred, including date and time
(Continue details on page 4 if necessary)

When were police notified?	
Address of Police Station	
What steps have been taken to recover the property and with what result?	

	LIST OF ARTICLES FOR WHICH CLAIM IS MADE	WHERE BOUGHT OR OBTAINED	DATE OF PURCHASE	COST PRICE	AMOUNT CLAIMED AFTER DEDUCTION FOR WEAR AND TEAR
SECTION A					
	(Continue on page 4 if necessary)		TOTAL AMOUNT CLAIMED		

	DESCRIPTION (*i.e. personal money, travellers' cheques, etc.)*	AMOUNT CLAIMED
SECTION E		

Declaration at the foot of page 3 must be signed

SECTION B: PERSONAL ACCIDENT

Date and time of accident	
Where did the accident occur?	
State how the accident occurred and what you were doing at the time	
State as precisely as you can what injuries you sustained, identifying right or left as appropriate	
Name and Address of Doctor attending you	
Name and Address of usual Doctor, if different	

How long have you been confined to the house?		Days
For how long have you been wholly disabled?		Days

Are you still so confined?	○ YES	○ NO	
For how long partially disabled?			Days

What is your present state of disability?	
To what extent have you been able to attend to business or engage in any occupation since the accident?	

This medical certificate must be completed by the Doctor attending the insured person when a claim is made under Section B. The fee, if any, must be paid by the insured.

I certify that _____

the person described overleaf is suffering from _____

and has been totally/partially unable to work from the day _____

of _____ *20* _____ *I expect such disablement to continue for* _____ *weeks* _____ *days from the date shown below.*

I am of the opinion that such disablement is the direct and evident consequence of the accident to which the above particulars refer.

Date _____ *Signature* _____

Address _____

SECTION C: CANCELLATION OR CURTAILMENT

State cause of cancellation or curtailment		
If due to your own illness or injury, please complete Medical Expenses part of Section D below and supply Medical Certificate.		
Have any deposits been recovered?	○ Yes	○ No
If not, what steps have been taken to seek recovery?		

Details of cancellation or curtailment charges claimed	Amount
Total Claimed $	

SECTION D: MEDICAL AND OTHER EXPENSES

MEDICAL EXPENSES	Nature of illness or injury			Duration of illness or injury	
	If illness, state if you have ever suffered from this before	○ Yes	○ No	If so, when (give date)	
	Briefly describe the circumstances of illness or injury				

OTHER EXPENSES	Reasons why other expenses for which a claim is made were incurred	

Details and nature of medical and other expenses claimed	Amount
Total Claimed $	

DECLARATION

I hereby warrant the truth of the foregoing statements in every respect.

Date: _____ Signature: _____

(Continuation of SECTION A if necessary)

(Continuation of SECTION A - List of items for which claim is made, if necessary)

Print Form