BANIF BANK

The power of believing

Banif Bank (Malta) p.l.c.
203, Level 2, Rue D' Argens,
Gżira, GZR 1368, Malta
Co. Reg No. C41030

Travel Insurance Claim Form

General Section

Policy Holder Name _____

Full Name of Claimant _____
(If different from above)

Title _____ Email _____

Address _____

I.D. Card _____ Date of Birth | D D | M M | Y Y Y Y |

Occupation of Insured _____

Tel/Mob No _____ Purpose of Flight _____

Is there any other insurance in force, which also covers this loss/expense? ☐ Yes ☐ No

If yes, state which policy/insurance company: _____

_____

Have you ever before claimed under a travel policy? ☐ Yes ☐ No

If yes give details: _____

Length of holiday:_____ Countries visited: _____ Purpose of journey: _____

Personal Baggage Claim

Date of Loss | D D | M M | Y Y Y Y | Time _____

Place _____

State precise circumstances in which loss or damage occurred and the action taken by you _____

State total value of baggage and cash of Insured person or party at the time of loss or damage _____

Date and time advised to police/authorities/security personnel/airline (attach report) _____

Details of items claimed:

Description of lost or damaged property	Date of purchase DD MM YYYY	Cost price	Amount claimed after deduction for age, use, wear & tear	Net amount claimed

NB: Attach receipts, if available, to this form. (If more space is required please use an extra sheet.)

Personal Money Claim

Circumstances of Loss _____

Date | D D | M M | Y Y Y Y | Time _____

Place _____

Date and time advised to police/authorities/security personnel _____

Amount of money lost or stolen (stating currency) _____

Attach a written report from police/authorities in the event of theft and proof of cash taken abroad.

FRM_CRE_TI_APR2015_01

BANIF BANK

The power of believing

Delayed Departure & Missed Departure

Date and Time of original departure:
(as per iterary)

Date | D D | M M | Y Y Y Y | Time _____

Flight No _____ Destination _____

Reason for delay _____

Did you check-in in accordance with your original itinerary? ☐ Yes ☐ No

Date and Time for rescheduled departure:

Date | D D | M M | Y Y Y Y | Time _____

In case of cancellation - Date and Time of official cancellation of flight:

Date | D D | M M | Y Y Y Y | Time _____

Reason for cancellation of flight _____

Cancellation/Curtailment

Scheduled Date and Time of departure:

Date | D D | M M | Y Y Y Y | Time _____

Date of cancellation/curtailment:

Date | D D | M M | Y Y Y Y

Reason for cancellation/curtailment _____

Amount being claimed in respect of travel tickets (net of taxes) and any other non-refundable expenses:

_____

_____

State amounts claimed and attach receipts. If non-recoverable attach any relevant booking conditions.

Number of persons claiming and relationship to insured _____

Date advised to Travel Agent/Tour Operator:

Date | D D | M M | Y Y Y Y

Name of travel agent or ticket issuing office _____

Name of sick and injured person _____

Name and address of doctor giving initial treatment in respect of this illness or injury:

Name _____

Address _____

_____

Has the person concerned ever suffered from this type of illness? ☐ Yes ☐ No

Relationship to insured _____

Nature of illness/injury _____

NB: Attach Medical Certificate.

BANIF BANK

The power of believing

Personal Liability

Date and Time of loss:

Date | D D | M M | Y Y Y Y |

Time _____

Place of incident _____

State circumstances of incident _____

_____

Details of third parties involved:
(including third party legal representatives if applicable)

Name _____ Address _____

_____

Tel No _____ Fax No _____

Email _____

Details of any damaged third party property _____

_____

Medical Expenses

Nature of Injury or Illness _____

Duration of injury or illness | D D | M M | Y Y Y Y | to | D D | M M | Y Y Y Y |

Amount Claimed:

Name & address of doctor giving initial treatment in respect of this illness or injury:

Name _____ Address _____

_____

Has the person concerned ever suffered from this type of illness or injury before? ☐ Yes ☐ No

If yes gives details _____

_____

If not claimant, give name, address and relationship:

Name _____ Relationship _____

Address _____

_____

Name and address of family doctor:

Name _____ Address _____

_____

Do you have a private health insurance policy? ☐ Yes ☐ No

If yes, give details _____

_____

Authorisation Reference Code _____

Do you require any further treatment in Malta related to your injury/illness? ☐ Yes ☐ No

Did you make use of your European Health Insurance card on your admission to hospital? ☐ Yes ☐ No

BANIF BANK

The power of believing

Hospital Benefit

Reason for admittance _____

Date of injury or illness | D D | M M | Y Y Y Y | to | D D | M M | Y Y Y Y |

Has the person concerned ever suffered from this type of illness or injury before? ☐ Yes ☐ No

If yes, give details of last occurrence _____

_____

Do you have a private health insurance policy? ☐ Yes ☐ No

If yes, give details _____

_____

If applicable prior to your journey have you taken the necessary vaccinations/inoculations as recommended by the Health Department? ☐ Yes ☐ No

If yes, give details _____

_____

Attach letter from hospital confirming dates and times of both admittance and discharge.

Data Protection

To the extent that the information supplied by you, whether orally or in writing, constitutes personal data, including sensitive data within the provisions of the Data Protection Act, you consent to the processing of such data for purposes of administering your proposal for insurance, your Policy, underwriting, handling of claims and also for the purposes of detecting, preventing and suppressing fraud and of keeping statistics. We may be required to collect further information from sub-agents, other insurance companies, insurance intermediaries or insurance associations.

Declaration

I/We declare that the statements made are true to the best of my/our knowledge and belief and fully agree with the above and hereby consent to the above treatment of my personal data.

I further authorise my Doctor or any other person who has attended me, or any hospital in which I have been treated to disclose to the Insurance any knowledge or information relating to this claim

Reference Date of the Information | D D | M M | Y Y Y Y |

Customer's Signature _____

N.B. Please attach a seperate note explaining circumstances of claim if applicable. If the space on this form is insuffucuent, please continue on a seperare sheet.